6 PROFESSIONAL MALPRACTICE AND MISCONDUCT

THE ENFORCEMENT OF SOCIAL WORK ETHICS

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Thus far I have examined the nature of social work values, the process of ethical decision making, and various ethical dilemmas in social work practice. As I have shown, many of the ethical issues that practitioners encounter raise difficult philosophical questions—for example, whether social workers are always obligated to be truthful and to respect clients' right to self-determination, how limited resources should be allocated, and when social workers should blow the whistle on ethical wrongdoing.

Many of these ethical issues do not raise legal questions or issues that would warrant discipline by a regulatory body, such as a state licensing board, or a professional body, such as the National Association of Social Workers. Whether a particular social worker ought to be entirely truthful in response to a client's question about his or her prognosis, how scarce resources at an emergency shelter should be distributed, and a decision by a caseworker whether to blow the whistle on a lazy colleague may not involve legal questions or questions of misconduct. Instead, these ethical dilemmas are more likely to involve ethical issues in their most innocent form, that is, ethical issues requiring thoughtful deliberation and application of sound ethical principles. These are the issues about which reasonable practitioners may disagree.

Unfortunately, however, many ethical issues in social work are not so innocent. They raise questions about ethical misconduct and wrongdoing of a sort that may constitute violations of the law, professional codes of ethics, and publicly enacted regulations. These are cases that may result in lawsuits, ethics complaints, or criminal charges filed against social workers.

In this chapter I shall discuss various examples of unethical behavior or professional misconduct. Some of these cases involve genuine mistakes practitioners may make that lead to allegations of unethical behavior or professional misconduct. Examples include social workers who simply forget to obtain clients' consent before sharing confidential records with third parties, practice social work after neglecting to renew their licenses, and inadvertently bill insurance companies for services that were not rendered. These are cases in which social workers do not intend to harm or defraud anyone; rather, these are cases in which social workers unintentionally make mistakes that injure someone or some organization. The injury is sufficiently serious that the injured party charges the social worker with some form of unethical behavior or professional misconduct.

In contrast, other cases are related to the ethical dilemmas I discussed in chapters 4 and 5. In these cases, social workers face very difficult ethical decisions and do their best to handle them responsibly. These social workers may be remarkably conscientious in the way they go about making the ethical decision. They may review relevant literature, consult with colleagues who have expertise on the subject, document their decision making, and so on. What may happen in spite of this thoroughness and diligence, however, is that some individual or organization may allege that the social worker mishandled the case and acted unethically. Some party may file a lawsuit or ethics complaint alleging that the social worker violated prevailing ethical standards in the profession and that consequently injury resulted. An example is the case in which a social worker has to decide whether to disclose confidential information about a client who is HIV-positive in order to protect the client's lover, who is not aware of her lover's HIV-positive status, from harm. The social worker has to choose between the client's right to confidentiality and the social worker's obligation to protect a third party from harm. It is not hard to imagine that a social worker in this predicament might be sued no matter what course of action she takes. If she respects her client's right to confidentiality and subsequently the client's lover becomes infected, the social worker might be sued or have an ethics complaint filed against her by the

client's lover alleging that the social worker failed to protect her from serious harm. Conversely, if the social worker discloses the confidential information, without her client's permission, in order to protect the client's lover from harm, the social worker might be sued or have an ethics complaint filed against her by her client alleging that the social worker violated the client's right to confidentiality. Thus in some of these cases, even the most conscientious, thoughtful, and prudent social worker can have charges filed against him or her alleging ethical misconduct or unprofessional behavior.

In addition, some cases involve allegations that a social worker engaged in gross professional misconduct and knowingly harmed a client or some other party. These are not the cases in which social workers inadvertently make harmful mistakes, or make difficult ethical decisions in a responsible manner but in a way that triggers an ethics complaint or lawsuit. Rather, these are cases in which there are allegations that social workers willfully violated individuals' rights. Examples include cases where social workers become sexually involved with clients, extort money from clients, and commit fraud against insurance companies. In addition to ethics complaints and lawsuits, these cases may also result in criminal charges.

• THE ADJUDICATION OF SOCIAL WORKERS

There are three prominent ways in which social workers are held accountable for professional misconduct. These include ethics complaints filed against members of the National Association of Social Workers, ethics complaints filed with state licensing or regulatory boards, and lawsuits filed against social workers who have malpractice and liability coverage. In some instances, social workers are also subjected to review by other professional organizations to which they belong, such as the American Board of Examiners in Clinical Social Work, the National Federation of Societies for Clinical Social Work, and the American Association for Marriage and Family Therapy. In addition, criminal charges may be filed against social workers, although this is relatively rare.

Members of NASW may be named in ethics complaints alleging violation of specific principles in the association's code of ethics. Examples are "The social worker should maintain high standards of personal conduct in the capacity or identity as social worker" (principle I.A).; "The social worker should act in accordance with the highest standards of professional integrity and impartiality" (principle I.D); and "The social worker should not exploit professional relationships for personal gain" (principle I.D.2).

In general, there has been a steady increase in the number of ethics complaints filed against social workers. These complaints cite a wide variety of the code's principles, including those related to confidentiality, sexual misconduct, social workers' relationships with colleagues, and conduct as a social worker (Berliner 1989).

Ethics complaints filed against NASW members are processed initially by chapter Committees on Inquiry (COIs). Based on a peer review model, these committees made up of NASW members initially review each complaint and may accept or reject it for further hearing. If a complaint is accepted, the chapter COI conducts a hearing during which the complainant (the person filing the complaint), the respondent (the person against whom the complaint is filed), and witnesses have an opportunity to testify. After hearing all parties and discussing the testimony, the COI presents a report to elected chapter officers summarizing its findings and presenting its recommendations. Recommendations may include sanctions or various forms of corrective action, such as suspension from the NASW, mandated supervision or consultation, censure in the form of a letter, or instructions to send the complainant a letter of apology. In some cases the sanction may be publicized through local and national NASW newsletters or public newspapers. The parties involved in the complaint may appeal the chapter officials' decision, first to the National Committee on Inquiry and then, if necessary, to the executive committee of the NASW national board of directors.

Many states also have licensing or regulatory boards that process ethics complaints filed against social workers. Ordinarily, these boards appoint a panel of colleagues to review the complaint and if necessary to conduct a hearing (Barker and Branson 1993).

In addition, growing numbers of social workers have been named in lawsuits alleging some form of ethical misconduct or malpractice. This trend is clearly reflected in liability claims filed against social

workers insured through the NASW Insurance Trust, the largest insurer of social workers in the United States (Reamer 1994b).

Claims filed against social workers insured by the NASW Insurance Trust can be divided into two broad groups. The first includes claims that allege that social workers carried out their duties improperly or in a fashion inconsistent with the profession's standards (often called acts of commission or of misfeasance or malfeasance). Examples include improper treatment of a client (for example, using a treatment technique for which one has not received proper training), sexual misconduct, breach of client confidentiality, wrongful removal of a child from a home, assault and battery, improper peer review, and improper termination of services.

The second broad category includes claims that allege that social workers failed to perform a duty that they are ordinarily expected to perform, according to the profession's standards (acts of omission or nonfeasance). Examples include failure to obtain a client's informed consent before releasing confidential information, failure to prevent a client's suicide, failure to be available when needed, failure to protect third parties from harm, failure to supervise a client properly, and failure to refer a client for consultation or treatment by a specialist.

Of course, not all claims filed against social workers are substantiated. Some claims are frivolous, and others lack the evidence necessary to demonstrate malpractice and negligence. However, many claims are substantiated, ultimately costing social workers considerable expense and emotional anguish (although insurance coverage helps to ease the financial burden).

Social workers must know what kinds of professional misconduct or unethical behavior constitute malpractice. Malpractice is a form of negligence that occurs when a social worker, or any other professional, acts in a manner inconsistent with the profession's *standard of care*—the way an ordinary, reasonable, and prudent professional would act under the same or similar circumstances (Reamer 1994c).

Lawsuits and liability claims that allege malpractice are civil suits, in contrast to criminal proceedings. Ordinarily civil suits are based on tort or contract law, with plaintiffs (the individuals bringing the suit) seeking some sort of compensation for injuries they claim to have incurred (Hogan 1979). These injuries may be economic (for example, lost wages or medical expenses), physical (for instance, as a result of an assault by a person the social worker was supposed to have been supervising), or emotional (for example, depression that may result from a social worker's sexual contact with a client).

As in criminal trials, defendants in lawsuits are presumed to be innocent until proved otherwise. In ordinary civil suits, defendants will be found liable for their actions based on the standard of *preponderance of the evidence*, as opposed to the stricter standard of *beyond a reasonable doubt* used in criminal trials. In some civil cases—for example, those involving contract disputes—the court may expect *clear and convincing evidence*, a standard of proof that is greater than preponderance of the evidence but less than for beyond a reasonable doubt (Gifis 1991).

In general, malpractice occurs when there is evidence that 1) at the time of the alleged malpractice, a legal duty existed between the practitioner and the client (for example, a social worker has a duty to keep information shared by a client confidential); 2) the practitioner was derelict in that duty, either through an action that occurred or through an omission (confidential information about a client's alcohol use was divulged to the client's employer without the client's permission); 3) the client suffered some harm or injury (the client alleges that he was fired from his job because the social worker inappropriately divulged confidential information to the client's employer); and 4) the harm or injury was directly and proximately caused by the social worker's dereliction of duty (the client's dismissal was the direct result of the social worker's unauthorized disclosure of confidential information).

There are six broad categories of cases that involve malpractice, ethical misconduct, or unprofessional behavior: confidentiality and privacy; delivery of services; supervision of clients and staff; consultation, referral, and records; deception and fraud; and termination of service.

• CONFIDENTIALITY AND PRIVACY

Earlier I discussed ethical dilemmas related to confidentiality. In those cases social workers had to decide how to handle the disclosure of confidential information to protect third parties, to protect or benefit

clients in response to a court order, and to parents or guardians concerning minor children. My discussion focused on the process of ethical decision making rather than the possibility of misconduct involved in the inappropriate disclosure of confidential information.

Social workers can be charged with misconduct if they violate clients' right to confidentiality. Relevant principles from the NASW code of ethics include "The social worker should respect the privacy of clients and hold in confidence all information obtained in the course of professional service" (principle II.H); "The social worker should share with others confidences revealed by clients, without their consent, only for compelling professional reasons" (principle II.H.1); and "The social worker should inform clients fully about the limits of confidentiality in a given situation, the purposes for which information is obtained, and how it may be used" (principle II.H.2).

A social worker who decides to breach a client's confidentiality in order to protect a third party from harm may have an ethics complaint filed against him or her by the social worker's client. The client might claim that the social worker violated his or her right to privacy and that the client was injured as a result. The client may also file a civil suit for damages. Of course, the social worker might also be charged with misconduct by an injured third party if the practitioner decides to respect the client's right to confidentiality and hence does not warn or take steps to protect the third party. This is what happened to the psychologist and other university staff in the famous *Tarasoff* case discussed earlier. As Lewis (1986) has observed, "*Tarasoff* and its progeny established that persons harmed by individuals undergoing therapy may sue that patient's psychotherapist for negligent failure to protect them from the patients' dangerous propensities. Case law also makes it clear that mental health professionals have a duty to maintain the confidential nature of their relationships to those to whom they are rendering treatment. A breach of either duty may result in civil liability" (p. 606).

The *Tarasoff* case and various other "duty to protect" cases that have been litigated since then have helped to clarify the delicate balance between social workers' obligation to respect clients' right to confidentiality and their simultaneous duty to protect third parties from harm. Although some of the court decisions in these cases are contradictory and inconsistent with one another, in general four conditions

should be met to justify disclosure of confidential information to protect third parties from harm: 1) The social worker should have evidence that the client poses a threat of *violence* to a third party. Although court decisions have not provided precise definitions of *violence*, the term ordinarily implies the use of force—such as with a gun, knife, or other deadly weapon—to inflict injury. 2) The social worker should have evidence that the violent act is *foreseeable*. The social worker should be able to present evidence that suggests significant risk that the violent act will occur. Although courts recognize that social workers and other human service professionals cannot always predict violence accurately, social workers should expect to have to demonstrate that they had good reasons for believing that their client was likely to act violently. 3) The social worker should have evidence that the violent act is *imminent*. The social worker should be able to present evidence that the act was impending or likely to occur relatively soon. *Imminence* may be defined differently by different social workers; some social workers think imminence implies a violent incident within minutes, whereas others think in terms of hours or days. In light of this difference of professional opinion, it is important for social workers to be able to explain their definition and interpretation of imminence should they have to defend their decision regarding the disclosure of confidential information. 4) Many, although not all, court decisions imply that a practitioner must be able to identify the probable victim. A number of courts have ruled that practitioners should have very specific information about the parties involved, including the potential victim's identity, in order to justify disclosure of confidential information against the client's wishes. Schutz (1982) summarizes current thinking on the subject of "duty to protect":

> Generally, it is suggested that the authorities and/or the intended victim should be warned. Warning the authorities makes the most sense when the intended victims are the patient's children, since a warning to the victim is ordinarily useless, and the child protective agency often has broader powers than the police—who might say that they cannot detain the patient (particularly after a failed commitment) because he has not done anything yet. If one decides to warn the victim—who is naturally shocked and terrified by the news that someone intends to kill him—and if nothing occurs, one could be liable for the infliction of emotional dis-

> tress by a negligent diagnosis. One way to reduce this risk might be to include as a part of the warning a statement of professional opinion about the nature and likelihood of the threat; to recommend that the victim contact the police, an attorney, and a mental health professional for assistance to detain (or try to commit) the patient; to inform the victim of his legal rights; and to offer assistance with the stress of such a situation. (P. 64)

Social workers can take several additional steps to protect themselves and to help reduce the chances of civil suits and ethics complaints. These include consulting an attorney who is familiar with statutes and case law related to "duty to protect" cases; seeking the client's consent for the social worker to warn the potential victim; and considering asking the client to warn the victim (unless the social worker believes this contact would only increase the risk); disclosing only the minimum amount necessary to protect the potential victim; encouraging the client to surrender any weapons he or she may have; and if clinically warranted, referring the client to a psychiatrist for an evaluation (Austin, Moline, and Williams 1990; Reamer 1994b).

In the final analysis, social workers must use their professional judgment in their decisions about protecting clients' right to confidentiality and protecting third parties from harm. Explicit criteria that can be applied to all situations simply do not exist. As Lewis (1986) concludes, "It must, however, be recognized that psychotherapy is an imperfect science. A precise formula for determining when the duty to maintain confidentiality should yield to the duty to warn is therefore beyond reach" (pp. 614–15).

It is very important for social workers to inform clients at the beginning of their relationship about the limits of confidentiality. Clients have the right to know what information they share with a social worker might have to be disclosed to others against clients' wishes (for example, evidence of child abuse or neglect, or of a client's threat to harm a third party). Social workers who are involved in group treatment, or who provide counseling services to couples and families, must be particularly aware of confidentiality issues. Social workers disagree about the extent to which members of groups, couples, and families have a right to expect that information they share in therapy will not be disclosed to others. Although social workers can encourage others involved in treatment to respect a particular individual's wish for privacy, there is considerable debate about the limits of confidentiality in these contexts. Some social workers believe, for example, that those involved in couples or family counseling should not have the right to convey secrets to the practitioner that will not be shared with others involved in the treatment (for example, family members, spouse, or partner). Other social workers, however, believe that secrets can be appropriate and in some cases can actually enhance the effectiveness of treatment (for example, when the disclosure of a man's extramarital affair would only undermine the substantial progress being made by him and his wife).

"Duty to protect" cases, when social workers may make deliberate decisions intentionally to violate clients' right to confidentiality, are among the more dramatic ways in which social workers can be charged with unethical behavior or misconduct as a result of the way in which they handled confidential information. Far more common, however, are cases in which confidential information about clients is disclosed unintentionally, thus leading to lawsuits or ethics complaints. Very often these cases involve social workers who are simply absent-minded, careless, or sloppy. Examples include social workers who talk about clients in agency waiting rooms, elevators, hallways, or restaurants while in the presence of others; leave confidential documents on top of their desks or in a photocopy machine for others to see; do not dispose of confidential information properly; and so on. In these cases the social workers involved mean no harm. They simply make mistakes, ones that may be costly.

Social workers can take a number of steps to prevent these mistakes or at least minimize the likelihood that they will occur. Social workers should be sure to train all agency staff members, including all professional staff and nonprofessional staff (for example, secretaries, clerical workers, custodians, cooks) concerning the concept of confidentiality, the need to protect confidentiality, and common ways that confidentiality can be violated. Training should cover the need to protect confidential information contained in written records and documents from inappropriate access by third parties outside of the agency (for example, other human service professionals, insurance companies, clients'

family members and guardians) and by other staff within the agency who have no need to know the confidential information. All agencies should have clear policies governing access to confidential information by third parties and clients themselves.

Staff should also be trained about inappropriate release of confidential information through verbal communication. Social workers and other staff members in social service agencies need to be careful about what they say in hallways and waiting rooms, on elevators, in restaurants and other public facilities, on answering machine messages, and over the telephone to other social service professionals, clients' family members and friends, and representatives of the news media.

In addition, social workers should prepare clear written explanations of their agency's confidentiality guidelines. These should be shared with every client (many agencies ask clients to sign a copy acknowledging that the guidelines were shared with them and that they understand the guidelines).

To understand the limits of privacy and confidentiality social workers must be familiar with the concept of *privileged communication.* The right of privileged communication means that a professional cannot disclose confidential information without the client's consent. Among professionals the attorney-client relationship was the first to be granted the right of privileged communication. Over time other groups of professionals, such as social workers, physicians, psychiatrists, psychologists, and clergy, sought legislation to provide them with this right (Wilson 1978).

Whereas confidentiality refers to the professional norm that information shared by or pertaining to clients should not be shared with third parties, the concept of privilege refers specifically to the disclosure of confidential information in court proceedings (Meyer, Landis, and Hays 1988). Many states now grant social workers' clients the right of privileged communication, which means that social workers cannot disclose privileged information in court without clients' consent. Social workers must understand, however, that privileged communication statutes do not guarantee that social workers will never be required to disclose information without clients' consent. In fact, despite a privileged communication statute, a court of law could formerly order a social worker to reveal this information if the judge believed that it was essential to a case being tried (Reamer 1994b). As discussed briefly in chapter 4, in New York state a social worker whose client was presumably protected by the right of privileged communication was ordered to testify in a paternity case after the court ruled that "disclosure of evidence relevant to a correct determination of paternity was of greater importance than any injury which might inure to the relationship between the social worker and his clients if such admission was disclosed" (*Humphrey v. Norden* 1974).

• DELIVERY OF SERVICES

A substantial portion of claims filed against social workers allege some kind of misconduct related to the delivery of services. These services take various forms—such as individual psychotherapy, family treatment and couples counseling, casework, group counseling, program administration, and research—and are delivered in a wide variety of settings, including public and private human service agencies.

Claims alleging improper delivery of services raise various issues, including problems with informed consent procedures, client assessment and intervention, undue influence, suicide, civil commitment proceedings, protective services, defamation of character, and sexual contact with clients.

The concept of informed consent has always been prominent in social work. Consistent with social workers' long-standing embrace of the principle of client self-determination (Bernstein 1960; Freedberg 1989; Keith-Lucas 1963; McDermott 1975; Perlman 1965; Reamer 1987a), informed consent procedures require social workers to obtain clients' permission before releasing confidential information to third parties; allowing clients to be photographed, videotaped, or audiotaped by the media; permitting clients to participate as subjects in a research project; and so on. Relevant principles from the NASW Code of Ethics include "The social worker should make every effort to foster maximum self-determination on the part of clients" (principle II.G); "The social worker should apprise clients of their risks, rights, opportunities, and obligations associated with social service to them" (prin-

ciple II.F.7); and "The social worker should obtain informed consent of clients before taping, recording, or permitting third party observation of their activities" (principle II.H.5).

States and local jurisdictions have different interpretations and applications of informed consent standards. Nonetheless, there is considerable agreement about what constitutes valid consent by clients in light of prevailing legislation and case law. In general, for consent to be considered valid six standards must be met: 1) coercion and undue influence must not have played a role in the client's decision; 2) clients must be mentally capable of providing consent; 3) clients must consent to specific procedures or actions; 4) the consent forms and procedures must be valid; 5) clients must have the right to refuse or withdraw consent; and 6) clients' decisions must be based on adequate information (Cowles 1976; President's Commission 1982; Reamer 1994b; Rozovsky 1984). Social workers should be familiar with ways to prevent the use of coercion to obtain client consent; ways to assess clients' competence to give consent; information that should appear on consent forms (for example, a statement of purpose, possible risks and benefits, clients' right to withdraw or refuse to given consent, an expiration date); the need to have a conversation with clients about the content of the consent form; the need for interpreters in cases where clients do not read or understand English; exceptions to informed consent (for example, genuine emergencies); and common problems associated with consent forms (such as having clients sign a blank form that the social worker plans to complete sometime later, including jargon in the description of the purpose of the consent).

Allegations of improper client assessment and intervention concern a wide range of activities. Very often these claims of malpractice or misconduct allege that the social worker assessed a client's needs or provided services in a way that departed from the profession's standard of care. That is, the social worker failed to assess properly, failed to provide a needed service, or provided a service in a way that was inconsistent with professional standards and caused some kind of harm. Social workers may neglect to ask important questions during an assessment or may use some treatment technique for which they do not have proper training.

It is important to note that courts do not expect perfection in social workers' assessments and service delivery. Judges recognize the inexact nature of these phenomena. What they do expect, however, is conformity with social work's standard of care with regard to assessment and service delivery. Although a client may have been harmed somehow, the social worker may have acted reasonably and in a way that is widely accepted in the profession. An error in judgment is not by itself negligent (Schutz 1982). As a judge concluded in one prominent court case where family members alleged that hospital staff were negligent in assessing a patient's suicide risk, "Diagnosis is not an exact science. Diagnosis with absolute precision and certainty is not possible" (Austin, Moline, and Williams 1990:167).

Many claims related to assessment and service delivery involve suicide. For example, a client who failed in an attempt to commit suicide and was injured in the process, or family members of someone who committed suicide, may allege that a social worker did not properly assess the suicide risk or properly respond to a client's suicidal ideation and tendencies. As Meyer, Landis, and Hays (1988) observe, "While the law generally does not hold anyone responsible for the acts of another, there are exceptions. One of these is the responsibility of therapists to prevent suicide and other self-destructive behavior by their clients. The duty of therapists to exercise adequate care in diagnosing suicidality is well-established" (p. 38).

Some claims include allegations that practitioners used unconventional or nontraditional intervention techniques that proved harmful. As Austin, Moline, and Williams (1990) conclude,

> If you are using techniques that are not commonly practiced, you will need to have a clear rationale that other professionals in your field will accept and support. It is important to consult colleagues when you are using what are considered to be nontraditional approaches to treatment. This is primarily because it is not difficult to prove deviation from average care. Some examples of what may be considered nontraditional therapeutic techniques might include asking clients to undress, striking a client, or giving "far-out" homework assignments. (Pp. 155–56)

Another problem area involves advice giving. Social workers must be careful to not give clients advice outside their areas of training

and expertise. For example, a social worker who gives a client advice about the proper use of medication that a psychiatrist has prescribed could be charged with practicing medicine without a license.

Some claims allege that social workers used what is known as undue influence. *Undue influence* occurs when social workers use their authority improperly to pressure, persuade, or sway a client to engage in an activity that may not be in the client's best interest or that may pose a conflict of interest. Examples include convincing a dying client to include the social worker in her will and becoming involved with a client in a profitable business.

Social workers must also be aware of liability, negligence, and misconduct claims that can arise in relation to protective services, that is, efforts to protect abused and neglected children, elderly, and other vulnerable populations. Every state has a statute obligating mandated reporters, including social workers, to notify local protective service officials when they suspect abuse or neglect of a child. Some states have similar statutes concerned with the elderly.

Social workers need to be familiar with possible allegations that they failed to report suspected abuse or neglect; knowingly made false accusations of abuse and neglect ("bad faith" reporting); inadequately protected a child who was apparently abused or neglected (for example, by failing to investigate a complaint swiftly and thoroughly, failing to place an abused or neglected child in foster care, or returning an at-risk child to dangerous guardians); violated parental rights (for example, by conducting unnecessarily intrusive investigations); or placed children in dangerous or inadequate foster homes (Besharov 1985).

One of the most common allegations of misconduct against social workers involves sexual abuse of clients (Reamer 1994b). This is a very serious problem that is found in other helping professions as well, such as psychiatry and psychology. Various studies suggest that the vast majority of cases involving sexual contact between professionals and clients involve a male practitioner and a female client (Brodsky 1986; Pope 1988). In a typical study, Gartrell et al. (1986; cited in Meyer, Landis, and Hays 1988:23) report in their nationwide survey of psychiatrists that 6.4 percent of respondents acknowledged sexual contact with their own patients; 90 percent of the offenders were male. In

a comprehensive review of a series of empirical studies focused specifically on sexual contact between therapists and clients, Pope (1988) concluded that the aggregate average of reported sexual contact is 8.3 percent by male therapists and 1.7 percent by female therapists. Pope reported that one study (Gechtman and Bouhoutsos 1985) found that 3.8 percent of male social workers admitted to sexual contact with clients. Based on her research on therapists who sexually abuse clients, Brodsky (1986:157–58) concluded that the typical therapist who is sued is male, middle-aged, involved in unsatisfactory relationships in his own life, and perhaps in the process of divorce proceedings. His clients are primarily female and over time he is sexually involved with more than one. The therapist shares details of his personal life with his client, suggesting to her that he needs her, and the therapist spends time during treatment sessions asking her for help with his problems. The therapist is a lonely man and isolated professionally, although he enjoys a good reputation in the professional community. He convinces his client that he is the most appropriate person for her to be sexually involved with.

Several principles in the NASW code of ethics are relevant, directly or indirectly, to sexual misconduct: "The social worker should maintain high standards of personal conduct in the capacity or identity as social worker" (principle I.A); "The private conduct of the social worker is a personal matter to the same degree as is any other person's, except when such conduct compromises the fulfillment of professional responsibilities" (principle I.A.1); "The social worker should act in accord with the highest standards of professional integrity and impartiality" (principle I.D); "The social worker should not exploit professional relationships for personal gain" (principle I.D.2); "The social worker should not exploit relationships with clients for personal advantage" (principle II.F.2); and "The social worker should under no circumstances engage in sexual activities with clients" (principle II.F.5). Further, the most recent principle added to the code of ethics concerning dual relationships is relevant: "The social worker should not condone or engage in any dual or multiple relationships with clients or former clients in which there is a risk of exploitation or of potential harm to the client. The social worker is responsible for setting clear, appropriate, and culturally sensitive boundaries" (principle II.F.4).

• SUPERVISION: CLIENTS AND STAFF

Social workers routinely supervise clients, especially in day-treatment and residential programs. On occasion social workers will be accused of misconduct related to this supervision. Social workers may be charged with, for example, failing properly to supervise residents of an intensive treatment unit of a psychiatric hospital. A resident may have jumped from a window in a suicide attempt, or one resident may have assaulted another, and the allegation may be that the social worker on duty failed to provide adequate supervision.

In addition, many social workers supervise staff. A clinical director in a community mental health center may supervise caseworkers, the director of a battered women's shelter may supervise counselors, and the district director of a public child welfare agency may supervise protective service workers. Typically, supervisors will provide case supervision and consultation, evaluate workers' performance, and offer training. Because of their oversight responsibilities, supervisors can be named in ethics complaints and lawsuits involving mistakes or unethical conduct engaged in by the people who work under them. These claims usually cite the legal concept of *respondeat superior*, which means "let the master respond," and the doctrine of "vicarious liability." That is, supervisors may be found liable for actions or inactions in which they were involved only vicariously, or indirectly. According to respondeat superior and vicarious liability, supervisors are responsible for the actions or inactions of the people they supervise and over which the supervisors had some degree of control. Of course, the staff member who made the mistake that led to the claim against the supervisor can also be found liable.

There are several specific issues that supervisors should be concerned about, including supervisors' failure to provide information necessary for supervisees to obtain clients' consent; to identify and respond to supervisees' errors in all phases of client contact, such as the inappropriate disclosure of confidential information; to protect third parties; to detect or stop a negligent treatment plan or treatment carried out longer than necessary; to determine that a specialist is needed for treatment of a particular client; to meet regularly with the supervisee; to review and approve the supervisee's records, decisions,

and actions; and to provide adequate coverage in the supervisee's absence (Besharov 1985; Cohen and Mariano 1982; Hogan 1979).

Social workers in private practice face special issues. Independent practitioners do not always have easy access to regular supervision. It is important for independent social workers to contract for supervision with a colleague or participate in peer supervision or peer consultation groups. Otherwise, these solo private practitioners may be vulnerable to allegations that they failed to obtain proper supervision should some question be raised about the quality of their work.

Supervisors should be careful to document the nature of the supervision they have provided. They should have regularly scheduled appointments with supervisees, request detailed information about the cases or other work they are supervising, and if possible occasionally observe their supervisees' work. Supervisors should be careful not to sign off on insurance or other forms for cases they have not supervised.

One way for supervisors to minimize the likelihood of malpractice or negligence allegations is to provide comprehensive training to their subordinates. Such training should include a discussion and review of issues related to relevant practice skills, professional ethics and liability, and relevant federal, state, and local statutes. Possible topics include assessment tools, intervention techniques, evaluation methods, emergency assistance and suicide prevention, supervision of clients in residential programs, confidentiality and privileged communication, informed consent, improper treatment and service delivery, defamation of character, boundary issues in relationships with clients, consultation with and referral to specialists, fraud and deception, and termination of services.

• CONSULTATION, REFERRAL, AND RECORDS

There are many occasions when social workers need to or should obtain consultation from colleagues, including social workers and members of other professions, who have special expertise. Clinical social workers may encounter a case in which consultation is needed about a client's unique problem, such as an eating disorder or psychotic symptoms. If the client's presenting problem is outside the social worker's expertise, the social worker should seek consultation

or make an appropriate referral. As the NASW Code of Ethics states, "The social worker should seek advice and counsel of colleagues and supervisors whenever such consultation is in the best interest of clients" (principle II.F.8).

Social workers can be vulnerable to ethics complaints and malpractice allegations if they fail to seek consultation when it is warranted. In addition, social workers can be vulnerable if they do not refer a client to a specialist for an assessment, evaluation, or treatment. For instance, if a client who is being treated for symptoms of depression complains to her social worker that she has chronic headaches, the social worker would be wise to refer the client to a physician who can rule out any organic problem, such as a brain tumor. As Meyer, Landis, and Hays (1988) conclude, if a practitioner proceeds on the assumption that there is no organic damage, he or she "could be held liable for negligently failing to refer the patient to a practitioner capable of treating his problem" (p. 50). Some social workers routinely encourage all clients to have a physical as part of their treatment (Barker and Branson 1993).

Social workers can also encounter ethics complaints or lawsuits when they fail to consult an *organization* for advice. For example, this could happen to a social worker who suspects that a particular child has been abused but decides not to consult with or report to the local child welfare authorities. This may occur when social workers believe they are better off handling the case themselves, they do not have confidence in the child protection agency staff, and they do not want to undermine their therapeutic relationship with their clients. The result may be that the social worker will be cited or sued for failing to consult with a specialist (in this case, the child welfare agency).

Clinical social workers who believe that their work with particular clients is ineffective or has hit a dead end should seek consultation from colleagues. As Schutz (1982) observes,

> When therapy reaches a prolonged impasse, the therapist ought to consider consulting another therapist and possibly transferring the patient. Apart from the clinical and ethical considerations, his failure to seek another opinion might have legal ramifications in the establishment of proximate cause in the event of a suit. While therapists are not guarantors of cure or improvement, extensive treatment without results could legally be considered to have injured the patient; in specific, the injury would be the loss of money and time, and the preclusion of other treatments that might have been more successful. (P. 47)

In addition to case consultation, social workers also provide consultation to agencies and organizations related to program design, evaluation, and administration. It is important for social workers who provide this sort of consultation to have the expertise they claim to have. Otherwise, they risk being named in an ethics complaint or lawsuit if they provide incompetent assistance that somehow harms their client (which could be an individual, family, community, or agency).

Social workers must pay close attention to the procedures they use when they refer clients to another practitioner. They have a responsibility to refer clients to colleagues with strong reputations and to practitioners with appropriate credentials. Otherwise, the social worker may be cited for *negligent referral*. As Cohen (1979) notes, "If a referral is indicated, the professional has a duty to select an appropriate professional or institution for the patient. Barring any extraordinary circumstances, the professional making the referral will not incur any liability for the acts of the person or institution that he refers the patient to, provided that the person or institution is duly licensed and equipped to meet the patient's needs" (p. 239).

Social workers who consult with or refer clients to colleagues should provide careful documentation of the contact in the case record. It is extremely important for social workers to be able to demonstrate the assistance they received in cases, in the event that a client or some other party raises questions concerning the appropriateness of the practitioners' actions.

The same advice applies to record keeping in general. Careful and diligent recording enhances the quality of services provided to clients. Thorough records identify, describe, and assess clients' situations; define the purpose of service; document service goals, plans, activities, and progress; and evaluate the effectiveness of service (Kagle 1987, 1991; Wilson 1980). Recording also helps to maintain the continuity of care. Carefully recorded notes help social workers recall relevant detail from session to session and can enhance coordination of

service and supervision among staff members within an agency. Recording also helps to ensure quality care if a client's primary social worker becomes unavailable because of illness, vacation, or departure from the agency. As Kagle (1987) asserts, "By keeping accurate, relevant, and timely records, social workers do more than just describe, explain, and support the services they provide. They also discharge their ethical and legal responsibility to be accountable" (p. 463).

• DECEPTION AND FRAUD

The vast majority of social workers are honest in their dealings with staff, other social service agencies, insurance companies, and so on. Unfortunately, however, some social workers engage in some form of deception and fraud in their dealings with these parties. As Schutz (1982) suggests,

> Fraud is the intentional or negligent, implied, or direct perversion of truth for the purpose of inducing another, who relies on such misrepresentation, to part with something valuable belonging to him or to surrender a legal right. If one misrepresents the risks or benefits of therapy for one's own benefit and not the patient's, so as to induce him to undergo treatment and pay the fee, this is fraud. Telling a patient that sexual intercourse is therapy may be seen as a perversion of the truth so as to get the patient to part with something of value. Hence, this would be seen as fraud. (P. 12)

Social workers may engage in deception and fraud for various reasons and with different motives. Some social workers—a small percentage, fortunately—are simply dishonest and attempt to take advantage of others for reasons of greed, malice, self-protection, or self-satisfaction. Social workers who become sexually involved with clients, extort money from clients, and bill clients' insurance companies for services that were never rendered are examples. After investigating the extent to which a national sample of clinical social workers deliberately misdiagnose clients, Kirk and Kutchins (1988) conclude that "such acts are legal and ethical transgressions involving deceit, fraud, or abuse. Charges made for services not provided, money collected for services to fictitious patients, or patients encouraged to remain in treatment longer than necessary are examples of intentional inaccuracy" (p. 226).

Kirk and Kutchins (1988) found that in many instances clinicians use a more serious clinical diagnosis than is warranted by the client's clinical symptoms. Nearly three-fourths of the sample (72 percent) reported being aware of cases in which more-serious-than-warranted diagnoses were used to qualify for reimbursement. About one-fourth of the sample reported that this practice occurs frequently. Most of the sample (86 percent) reported being aware of instances of listing diagnoses for individuals although the focus of treatment was on the family (many insurance companies do not reimburse for family treatment). Kirk and Kutchins (1988) conclude from these data that "deliberate misdiagnosis occurs frequently in the mental health professions" (p. 231). These authors acknowledge the possibility that misdiagnosis may occur to benefit clients—to enable them to receive services that they would not be able to afford otherwise—but they argue that social workers' self-interest is often the reason for misdiagnosis: "In particular, misdiagnosis is used so that the therapist's services will qualify for third-party reimbursement. Here the rationale is also nonclinical, but the argument that the therapist is acting only for the client's benefit is strained. The rationale that it is being done so that the client can obtain needed service is colored by the obvious self-interest of the therapist. Agencies, both public and private, also benefit when they obtain reimbursement as a result of such diagnostic practices" (p. 232).

Social workers who market or advertise their services also need to be careful to avoid deception and fraud. Practitioners must be sure to provide fair and accurate descriptions of their services, expertise, and credentials and to avoid exaggerated claims of effectiveness. As the NASW Code of Ethics states, "The social worker should not misrepresent professional qualifications, education, experience, or affiliations" (principle I.B.2); and "The social worker should make no misrepresentation in advertising as to qualifications, competence, service, or results to be achieved" (principle V.M.4). In addition, standard 9 of the NASW's *Standards for the Practice of Clinical Social Work* (1989) states the need for accuracy clearly:

> Standard 9. Clinical social workers shall represent themselves to the public with accuracy.
>
> Interpretation

The public needs to know how to find help from qualified clinical social workers. Both agencies and independent private practitioners should ensure that their therapeutic services are made known to the public. In this regard, it is important that telephone listings be maintained in both the classified and alphabetical sections of the telephone directory, describing the clinical social work services available.

Although advertising in various media was once thought to be questionable professional practice in the past, recent judicial decisions, Federal Trade Commission rulings, as well as current professional practices have made such advertising acceptable. The advertisement must be factual and should avoid false promises of cures.

Social workers must also avoid deception and fraud when applying for liability insurance, employment, a license, or some other form of certification. Social work administrators must be careful not to provide false accounts of grant or budget expenditures, or personnel evaluations. In addition, practitioners must not alter or falsify case records to create the impression that they provided services or supervision that were never actually provided. If a practitioner finds that accurate details were inadvertently omitted from a record, the information can be added, but the record should clearly indicate that the entry was made subsequently. The social worker should sign and date the addition to indicate that it was an amendment.

In some instances, social workers engage in deceit or fraud for what appear to be more altruistic reasons, that is, to be as helpful as they can be to their clients and employers. For example, clinical social workers may underdiagnose clients to avoid giving them unflattering labels that may stigmatize them or injure their self-esteem. In addition to documenting the extent of *over*diagnosis, as described earlier, Kirk and Kutchins (1988) found that social workers sometimes *under*diagnose, presumably to benefit clients. Some of the practices observed and reported by Kirk's and Kutchins's sample suggest that practitioners often misdiagnose in order to help clients, that is, to avoid labeling them. For example, most respondents (87 percent) indicated that a less serious diagnosis than clinically indicated was used frequently or occasionally to avoid labeling clients. Seventy-eight percent reported that frequently or occasionally only the least serious of several appropriate diagnoses was used on official records.

Social workers also must be careful to avoid deception and fraud when they write letters of reference for staff members or when they submit letters to employers or other parties, such as insurers or government agencies, on clients' behalf. On occasion social workers have exaggerated staff members' skills (or problems), or embellished their descriptions of clients' disabilities, in order to be helpful (or harmful). Practitioners incur considerable risk if they knowingly misrepresent staff members' or clients' qualities. Social workers should issue only statements about colleagues and clients that they know to be true or have good reason to believe are true.

Finally, social workers should avoid deception and fraud when they are involved in research or program evaluations. This can be a problem in agencies when continued funding from an outside source may depend on the extent to which research results demonstrate a program's effectiveness. Falsified results may mislead other professionals who try to replicate the agency's program and services, and place social workers involved in the deception in jeopardy. As the NASW Code of Ethics states, "The social worker should not participate in, condone, or be associated with dishonesty, fraud, deceit, or misrepresentation" (principle I.A.2).

• TERMINATION OF SERVICE

In addition to ethical problems related to confidentiality, the initiation and delivery of services, supervision, consultation and referral, and deception and fraud, social workers also need to be concerned about the ways in which they terminate services. Improper or unethical termination of services might occur when a social worker leaves an agency or a community suddenly without adequately preparing a client for the termination or without referring a client to a new service provider. In other instances a social worker might terminate services abruptly to a client in dire need of assistance because the client is unable to pay for the care. Social workers can also encounter problems when they are not available to clients or do not properly instruct them about how to handle emergencies that may arise.

Many ethical problems related to termination of services involve the concept of abandonment. *Abandonment* is a legal concept that

refers to instances when a professional is not available to a client when needed. Once a social worker begins to provide service to a client, she or he incurs a legal responsibility to continue that service or to properly refer a client to another competent service provider. Of course, social workers are not obligated to serve every individual who requests assistance. A particular social worker might not have room to accept a new referral or may lack the unique expertise that a particular client's case may require.

Nonetheless, once a social worker begins service, it cannot be terminated abruptly. Rather, social workers are obligated to conform to the profession's standard of care regarding termination of service and referral to other providers in the event the client is still in need. As Schutz (1982) notes with respect to termination of psychotherapy services, "Once a patient makes a contact with a therapist and the therapist agrees to see him, he is that therapist's patient. The therapist then assumes the fiduciary duty not to abandon the patient. At the very least, therefore, he must refer the patient to another therapist if he elects to terminate the relationship" (p. 50).

Several principles in the NASW Code of Ethics are relevant to social workers' termination of services: "The social worker should terminate service to clients, and professional relationships with them, when such service and relationships are no longer required or no longer serve the clients' needs or interests" (principle II.F.9); "The social worker should withdraw services precipitously only under unusual circumstances, giving careful consideration to all factors in the situation and taking care to minimize possible adverse effects" (principle II.F.10); and "The social worker who anticipates the termination or interruption of service to clients should notify clients promptly and seek the transfer, referral, or continuation of service in relation to the clients' needs and preferences" (principle II.F.11).

Principle II.F.9 suggests that social workers must not extend services to clients beyond the point where they are clinically or otherwise necessary. Unfortunately, some social workers have failed to terminate services when termination is in the client's best interest. For example, unscrupulous independent private practitioners—clearly a minority of private practitioners—have been known to encourage clients to remain in treatment longer than necessary in order to generate income

that would be lost if clients terminated treatment. In the process, clients' lives may be inconvenienced, they may be misled about the nature of their problems, and third-party payers, primarily insurance companies, may be spending funds that do not need to be spent (which may lead to an increase in premiums for other policyholders). A similar phenomenon occurs when social workers in residential programs seek to extend residents' stay beyond what is clinically warranted in order to enhance revenue for the program.

A more common problem occurs when clients' services are terminated prematurely, before termination is clinically warranted. This may occur for several reasons. Clients themselves may request termination of service, perhaps because of the expense or inconvenience involved. In these cases termination of service may be against the advice of the social worker involved in the client's care. For example, clients in residential and nonresidential substance abuse treatment programs may decide on their own that they do not want to continue receiving services. They may leave residential programs against professional advice or may decide not to return for outpatient services.

In other instances, services may be terminated at the social worker's request or initiative, for instance, when social workers believe that a client is not making sufficient progress to warrant further treatment or is not able to pay for services. In some cases program administrators in a residential program may want to terminate a client whose insurance benefits have run out or in order to make a bed available for a client who will generate a higher reimbursement rate because of his or her particular insurance coverage. In a number of cases, social workers terminate services when they find clients to be uncooperative or too difficult to handle. Social workers may also terminate services prematurely because of poor clinical judgment; that is, social workers may believe that clients have made more progress than they have in fact made.

Premature termination of services can result in ethics complaints and lawsuits alleging that, as a result, clients were harmed or injured, or injured some third party because of their continuing disability. A client who attempts to commit suicide following premature termination from a psychiatric hospital may allege that the premature termination was the direct cause of the attempt. Family members who are

physically injured by a client who was discharged prematurely from a substance abuse treatment program may claim that their injuries are the direct result of poor clinical judgment.

On occasion, services must be terminated earlier than a social worker or client would prefer for reasons that are quite legitimate. This may occur because a client does not make reasonable progress or is uncooperative, or because the social worker moves out of town or discovers that she or he does not have the particular skills or expertise needed to be helpful to the client. When this occurs, social workers must be careful to terminate services to clients properly. As Cohen (1979) observes with regard to the termination of counseling services,

> No doctor in private practice is legally compelled to accept any patient for treatment. The mental health professional may feel that he does not have the expertise to deal with a particular problem; he may not have the number of hours needed to provide adequate services; he may not see himself as able to establish a good enough rapport with the patient; the patient may not be able to pay the doctor's fee, etc. But while there are any number of perfectly acceptable reasons for refusing to treat a patient, there is *no* reason to justify abandonment of a patient once treatment begins. Before accepting a new patient, the mental health professional would be wise to schedule an initial consultation for the purpose of a mutual evaluation of suitability. If a doctor accepts a patient but some time later believes he can no longer be of value (because, for example, he has discovered factors operating that are beyond his competence to deal with), "following through" would mean advising this patient of the state of affairs and referring him to an appropriate mental health professional. (P. 273)

Adequate follow-through should include providing clients as much advance warning as possible, along with the names of several other professionals they might approach for help. Social workers should also follow up with clients who have been terminated to enhance the likelihood that they receive whatever services they may need.

Social workers can also face ethics complaints or lawsuits if they do not provide clients with adequate instructions for times when the social workers are not available as a result of vacations, illness, or emergencies. Social workers should provide clients with clear and detailed information, verbally and in writing, about what they ought to do in these situations, such as whom to call, where to seek help, and so on.

Social workers who expect to be unavailable for a period of time—perhaps because of vacation or medical care—should be especially careful to arrange for competent coverage. The colleagues who are to provide the coverage should be given information about the clients sufficient to enable them to provide adequate care should the need arise. Of course, social workers should obtain clients' consent to the release of this information about their cases.

• THE IMPAIRED SOCIAL WORKER

As I observed earlier, many ethics complaints and lawsuits result from genuine mistakes made by social workers who are otherwise competent. In other instances, ethics complaints and lawsuits follow competent social workers' well-meaning attempts to make the right ethical judgment, for example, with respect to disclosing confidential information about a client to protect a third party. In many cases, however, ethics complaints and lawsuits are filed because of mistakes, judgment errors, or misconduct engaged in by social workers who are, in some way, impaired.*

In recent years the subject of impaired professionals has received increased attention. In 1972, for example, the Council on Mental Health of the American Medical Association issued a statement that said that physicians have an ethical responsibility to recognize and report impairment among colleagues. In 1976 a group of attorneys recovering from alcoholism formed Lawyers Concerned for Lawyers to address chemical dependence in the profession, and in 1980 a group of recovering psychologists began a similar group, Psychologists Helping Psychologists (Kilburg, Nathan, and Thoreson 1986; Knutsen 1977; Laliotis and Grayson 1985; McCrady 1989).

Social work's first national acknowledgment of the problem of impaired practitioners came in 1979, when NASW issued a public policy statement concerning alcoholism and alcohol-related problems (NASW 1987). By 1980 a nationwide support group for chemically

*Portions of this discussion are adapted from Reamer 1992b.

dependent practitioners, Social Workers Helping Social Workers, had formed. In 1982 NASW formed the Occupational Social Work Task Force, which was to develop a strategy to deal with impaired NASW members. In 1984 the NASW Delegate Assembly issued a resolution on impairment, and in 1987 NASW published the *Impaired Social Worker Program Resource Book* to help members of the profession design programs for impaired social workers. The introduction to the resource book states:

> Social workers, like other professionals, have within their ranks those who, because of substance abuse, chemical dependency, mental illness or stress, are unable to function effectively in their jobs. These are the impaired social workers. . . . The problem of impairment is compounded by the fact that the professionals who suffer from the effect of mental illness, stress or substance abuse are like anyone else; they are often the worst judges of their behavior, the last to recognize their problems and the least motivated to seek help. Not only are they able to hide or avoid confronting their behavior, they are often abetted by colleagues who find it difficult to accept that a professional could let his or her problem get out of hand.

Organized efforts to address impaired workers began in the late 1930s and early 1940s after Alcoholics Anonymous emerged and in response to the need that arose during World War II to sustain a sound work force. These early occupational alcoholism programs eventually led, in the early 1970s, to the emergence of employee assistance programs (EAPs), designed to address a broad range of problems experienced by workers.

More recently, strategies for dealing with professionals whose work is affected by problems such as substance abuse, mental illness, and emotional stress have become more prevalent. Professional associations and informal groups of practitioners are meeting to discuss the problem of impaired colleagues and to organize efforts to address the problem (Bissell and Haberman 1984; Prochaska and Norcross 1983).

Both the seriousness of impairment among social workers and the forms it takes vary. Impairment may involve failure to provide competent care or violation of the profession's ethical standards. It may also take such forms as providing flawed or inferior psychotherapy to a client, sexual involvement with a client, or failure to carry out professional duties as a result of substance abuse or mental illness. Lamb et al. (1987) provide a comprehensive definition of impairment among professionals:

> Interference in professional functioning that is reflected in one or more of the following ways: (a) an inability and/or unwillingness to acquire and integrate professional standards into one's repertoire of professional behavior; (b) an inability to acquire professional skills in order to reach an acceptable level of competency; and (c) an inability to control personal stress, psychological dysfunction, and/or excessive emotional reactions that interfere with professional functioning. (P. 598)

Impairment among professionals is the result of various causes. Stress related to employment, illness or death of family members, marital or relationship problems, financial problems, midlife crises, personal physical or mental illness, legal problems, and substance abuse may lead to impairment (Guy, Poelstra, and Stark 1989; Thoreson, Miller, and Krauskopf 1989). Stress induced by professional education and training can also lead to impairment, because of the close clinical supervision and scrutiny students receive, the disruption in students' personal lives caused by the demands of schoolwork and field placements, and the pressures of students' academic programs (Lamb et al. 1987).

According to Wood et al. (1985), psychotherapists encounter special sources of stress that may lead to impairment because their therapeutic role often extends into the nonwork areas of their lives (such as relationships with family members and friends), there is a lack of reciprocity in relationships with clients (therapists are "always giving"), therapeutic progress is often slow and erratic, and therapeutic work with clients may stir up therapists' own personal issues. As Kilburg, Kaslow, and VandenBos (1988) observe,

> [The] stresses of daily life—family responsibilities, death of family members and friends, other severe losses, illnesses, financial difficulties, crimes of all kinds—quite naturally place mental health professionals, like other people, under pressure. However, by virtue of their training and place in society, such professionals face unique stresses. And although they have been trained extensively in how to deal with the emotional and behavioral crises of others, few are trained in how to deal with the stresses they themselves will face. . . . Mental health professionals are expected by everyone, including themselves, to be paragons.

> The fact that they may be unable to fill that role makes them a prime target for disillusionment, distress, and burnout. When this reaction occurs, the individual's ability to function as a professional may become impaired. (P. 723)

Unfortunately, many social workers are reluctant to seek help for personal problems. Also, many social workers are reluctant to confront colleagues about their impairment. Social workers may be hesitant to acknowledge impairment within the profession because they fear how colleagues would react to confrontation and how this might affect future collegial relationships (Bernard and Jara 1986; Guy, Poelstra, and Stark 1989; McCrady 1989; Wood et al. 1985). As VandenBos and Duthie (1986) have said,

> The fact that more than half of us have not confronted distressed colleagues even when we have recognized and acknowledged (at least to ourselves) the existence of their problems is, in part, a reflection of the difficulty in achieving a balance between concerned intervention and intrusiveness. As professionals, we value our own right to practice without interference, as long as we function within the boundaries of our professional expertise, meet professional standards for the provision of services, and behave in an ethical manner. We generally consider such expectations when we consider approaching a distressed colleague. Deciding when and how our concern about the well-being of a colleague (and our ethical obligation) supersedes his or her right to personal privacy and professional autonomy is a ticklish manner. (P. 212)

Some social workers may find it difficult to seek help for their own problems because of their belief that they have infinite power and invulnerability, they should be able to work out their problems themselves, an acceptable therapist is not available, it is more appropriate for them to seek help from family members or friends, confidential information might be disclosed, proper treatment would require too much effort and cost, they have a spouse who is unwilling to participate in treatment, and therapy would not be effective (Deutsch 1985; Thoreson et al. 1983).

It is important for social workers to design ways to prevent impairment and respond to impaired colleagues. They must be knowledgeable about the indicators and causes of impairment, so that they can recognize problems that colleagues may be experiencing. Social workers must also be willing to confront impaired colleagues, offer assistance and consultation, and, if necessary as a last resort, refer the colleague to a supervisor or local regulatory or disciplinary body (such as a committee on inquiry of NASW or a local licensing or registration board).

To the profession's credit, in 1992 the president of NASW created the Code of Ethics Review Task Force (chaired by the author) that proposed adding new principles to the code on the subject of impairment. The approved additions, which became effective in 1994, are as follows:

- The social worker should not allow his or her own personal problems, psychosocial distress, substance abuse, or mental health difficulties to interfere with professional judgment and performance or jeopardize the best interests of those to whom the social worker has a professional responsibility (principle I.A.3).
- The social worker whose personal problems, psychosocial distress, substance abuse, or mental health difficulties interfere with professional judgment and performance should immediately seek consultation and take appropriate remedial action by seeking professional help, making adjustments in work load, terminating practice, or taking any other steps necessary to protect clients and others (principle I.A.4).
- The social worker who has direct knowledge of a social work colleague's impairment due to personal problems, psychosocial distress, substance abuse, or mental health difficulties should consult with that colleague and assist the colleague in taking remedial action (principle III.J.13).

Although some cases of impairment must be dealt with through formal adjudication and disciplinary procedures, many cases can be handled primarily by arranging therapeutic or rehabilitative services for distressed practitioners. For example, state chapters of NASW can enter into agreements with local employee assistance programs, to which impaired members can be referred (NASW 1987).

As social workers increase the attention they pay to the problem of impairment, they must be careful to avoid assigning all responsibility to the practitioners themselves. Although psychotherapy and individually focused rehabilitative efforts are appropriate, social workers must also address the environmental stresses and structural factors that can cause impairment. Distress experienced by social workers is often the result of the unique challenges in the profession for which resources are inadequate. Caring social workers who are overwhelmed by chronic problems of poverty, substance abuse, child abuse and neglect, hunger and homelessness, and mental illness are prime candidates for high degrees of stress and burnout. Insufficient funding, unpredictable political support, and public skepticism of social workers' efforts often lead to low morale and high stress (Jayaratne and Chess 1984; Johnson and Stone 1986; Koeske and Koeske 1989). Thus in addition to responding to the individual problems of impaired colleagues, social workers must confront the environmental and structural problems that can cause the impairment in the first place. This comprehensive effort to confront the problem of impaired practitioners can also help to reduce unethical behavior and professional misconduct in social work.

In this chapter I discussed the ways in which some social workers —clearly a minority of the profession—engage in malpractice or ethical misconduct. I reviewed various mechanisms available for sanctioning and disciplining social workers found in violation of ethical standards and discussed the problem of impaired practitioners.

AFTERWORD: A FUTURE AGENDA

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The subject of social work values and ethics is clearly diverse. It includes topics as different as the core values of the profession and malpractice suits. Analysis of these issues incorporates diverse bodies of knowledge ranging from moral philosophy to legal theories of negligence. To understand contemporary issues of professional values and ethics adequately, today's social workers must grasp an impressive array of concepts, many of which were unknown to earlier generations of practitioners.

In these pages I have examined a complex mix of issues. I have explored the nature of social work values and their relevance to the profession's priorities. I have reviewed various typologies for classifying social work's values, and I have reviewed several intense debates about shifts in the profession's value base and mission.

I have also focused on the phenomena of ethical dilemmas and ethical decision making in social work. I have shown how social workers' values influence their ethical decisions, and I have looked at the complicated ingredients involved in ethical decisions related to both direct and indirect practice. Finally, I have addressed the nagging problem of ethical misconduct and various ways in which social workers can prevent ethics complaints and lawsuits. In light of this wide range of issues, what do social workers need to keep in mind as the profession evolves?

First, social workers need to continue to examine the nature of the profession's values and the ways in which they shape the profession's priorities. This is a never-ending process. We can never assume that social work's values are fixed in stone. Although some of the profes-