The Rehabilitation Professional 18(2), pp. 71–80

The Necessity of Professional Disclosure and Informed Consent for Rehabilitation Counselors

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Within the rehabilitation counseling arena, professional disclosure and informed consent are critical concepts for the rehabilitation counselor to understand. Once understood, they become key components of a rehabilitation counselor's daily practice. Counselors need to provide sufficient prior information about their evaluation and services to respect the individual's right to make an informed choice about participating in the activities. This is one of the most important steps for the counselor to make at the outset of the relationship and thereafter. Yet, inconsistency abounds among rehabilitation counselors when it comes to providing a full and adequate disclosure, thereby ensuring the individual's right to informed consent. This article addresses the history of these issues, the manner by which earlier versions of the *Code of Professional Ethics for Rehabilitation Counselors* addressed them, and the changes regarding disclosure and informed consent within the revised 2010 code. Because the code now requires written disclosure, this article provides guidance to rehabilitation counselors for incorporating proper professional disclosure and informed consent protocols into their daily professional activities.

Keywords: professional disclosure, informed consent

The information age, also known as the computer age or the information era, is characterized by the ability of individuals to transfer information freely and have instant access to knowledge that would have previously been difficult or impossible to find (Lallana & Uy, 2003) . The interactions that people have with one another through Web sites, cell phones, chat rooms, personal digital assistants, iPods, and other gadgets have transformed society from the digital era into a connected age (Fine, 2007). Individuals often "Google" medical terms or look to the Internet for data on physicians, services, benefits, and news. Before the digital era, information was limited by our means to obtain it. Now, it is literally at our fingertips, and more information is produced than can be absorbed.

For physicians, explaining the risks and benefits of treatment options so that individuals can make informed decisions may well be one of their most important roles. There is a fine line between enough information to educate a patient and not so much as to frighten one. Historically, the requirements for medical disclosure have included prognosis, risks, benefits, and probability of success for each treatment option, including no treatment (del Carmen & Joffe, 2005; Encyclopedia of Death and Dying, 2009). Although it is difficult in practice to determine how much information is enough, withholding information on the premise that "the doctor knows best" is not an option.

Rehabilitation counselors must adhere to ethical standards for disclosure and informed consent (Commission on Rehabilitation Counselor Certification [CRCC], 2002, 2010)—the key to which is one's provision of knowledge and information, voluntariness (or a lack of pressure and coercion), as well as competency or capacity to perceive, evaluate, and make decisions based on sound reasoning. This article addresses rehabilitation counselors' disclosure and informed consent by providing history and background, definitions, and discussion of the changes in the 2010 code of eth-

ics, with recommendations for practice and future directions.

Disclosure: History and Background

Ethicists have asserted that true autonomy is not possible unless the decision maker possesses the information necessary to make informed decisions (Beauchamp & Childress, 1994). Shaw and Tarvydas (2001) stated that "regardless of the setting, all counselors must ensure that the consumers with whom they work clearly understand such issues as the type of services to be provided, limits on confidentiality, and consumer rights and responsibilities" (p. 40). In a forensic setting, a counselor must make sure that the individual being evaluated fully understands the legal system's right to access and use the information about the consumer's progress and in a manner that the individual may consider harmful to himself or herself (Blackwell & Patterson, 2003; Slonim-Nevo, 1996). Shaw and Tarvydas (2001) cautioned that rehabilitation counseling practicum and internship students must disclose their student status to clients and the fact that confidential information will be shared with supervisors and other students during the course of the clinical experience (Shaw & Tarvydas, 2001). The authors expressed concern with a noticeable lack of information in the literature about the rehabilitation counselors' use of professional disclosure. Shaw and Tarvydas reported that, historically, professional disclosure and informed consent have been mentioned only in conjunction with specific populations (Banja, 1994; Callender, Silverman, Rice & Green, 1980; Harrison & Hunt, 1999), various practice settings (Tarvydas, 1995), and cultural issues (Smart & Smart, 1997).

Individuals sometimes inform the rehabilitation counselor about intent to harm oneself or another. The duty to inform such individuals of the professional's obligation to notify the authorities and warn the person being threatened is real, as widely debated in the mental health community as well as decided by various state courts. Two of the most famous cases in this regard are the *Tarasoff v. Regents of University of California* (1974, 1976) and *Morgan v. Fairfield Family Community Center* (Mossman, 2004). Rehabilitation counselors need to take the time to familiarize themselves with the details of these cases, the courts' rulings, and the state requirements pertinent to the duties of the counselor when confronted with knowledge of the client's intent to harm oneself or another.

What Is Professional Disclosure in Rehabilitation Counseling?

Professional disclosure is defined as the act of sharing the information needed to understand the nature and characteristics of the counseling process toward the goal of furthering informed autonomous decision making (Shaw & Tarvydas, 2001). Professional disclosure may also be understood as a combination of the concepts of informed consent and counseling best practices.

Shaw, Chan, Lam, and McDougall (2004) reported the results from a survey based on a random sample of 261 certified rehabilitation counselors regarding the content, circumstances, timing, and format of their disclosure. In brief, the survey results suggest that whereas many rehabilitation counselors appreciate the importance of professional disclosure, their actual practices do not always reflect full and adequate disclosure. A small number of informational items are routinely provided to all clients upon intake, most of which involve information pertaining to the nature and purpose of treatment, as well as the release of information. Many types of information considered important—and, in some cases, critical—to ensuring fully informed consent are not generally included in the disclosure process. The study found that many rehabilitation counselors do not fully inform their clients about the limits on confidentiality at the outset of the rehabilitation counseling relationship, including the legal responsibility to report situations of potential harm (to self or others) and child or elder abuse. Furthermore, this study revealed that a number of rehabilitation counselors do not disclose limitations on confidentiality at any point during the entire counseling relationship (Shaw et al., 2004). Failure to disclose such critical information may have far-reaching and deleterious effects on all parties, including destruction of the client's trust in the counselor, disruption of needed services, ethics violation charges, and malpractice litigation (Baerger, 2001; Woody, 2000). As indicated by Shaw et al. regarding disclosure, rehabilitation counselors practicing in a proprietary setting do not appear to be any more aware of their legal liability than their counterparts who practice in the public sector. A risk management concern in all practice settings involves the frequency with which the risks and benefits of undergoing evaluation and treatment, including the alternatives to such, are not readily disclosed to clients or are not disclosed at all. Finally, use of a written professional disclosure statement was not a common practice among the rehabilitation counselors in the study.

Trends in Ethical Issues: Advisory Opinions and Complaints

A total of 82 cases have been adjudicated by the Ethics Committee of the CRCC between fiscal year 2000–2001 and 2008–2009. Of these, 8 certificants have been reprimanded; 4 have been placed on probation; 5 have been suspended; and 18 have had their certificate revoked (CRCC, 2009). Competence and conduct with others, business practices, and professional practices are the topics that most frequently

arise in connection with the cases. More than 100 advisory opinions have been issued during this time frame (CRCC, 2009)—33 of which involve questions regarding disclosure, 14 of which involve informed consent. The CRCC conducted an ethics survey in 2006 that revealed the three sections of the code most frequently cited for areas of concern: the counseling relationship, confidentiality, and professional responsibility. Along these lines, professional disclosure in the counseling relationship received prominent mention by the survey respondents as a significant concern when dealing with past ethical dilemmas, whereas Health Insurance Portability and Accountability Act issues and complexities stemming from the release of information were prominently anticipated as future troubling ethical concerns and dilemmas.

Changes in the 2010 Code of Ethics: Professional Disclosure

The code of ethics first mentioned professional disclosure in 1987 (CRCC, 1987) but did not expand on the subject. By 2001, Standard A.3 (Clients Rights) required disclosure to clients at initiation of the counseling process and throughout, as necessary (CRCC, 2001, A.3.a). The code recommended that such disclosure be done by written and oral means. No language was put into place, however, to require that a written professional disclosure statement be used in conjunction with oral disclosure. The counselor was instructed to provide information regarding credentials and the purposes, procedures, limitations, potential risks, and benefits of the services to be provided, along with other pertinent information.

The most significant change in the revised code of 2010 is that written professional disclosure is now required. Standard A.3 (Client Rights in the Counseling Relationship) begins by addressing the professional disclosure statement: "Rehabilitation counselors have an obligation to review orally, in writing, and in a manner that best accommodates any of their limitation, the rights and responsibilities of both rehabilitation counselors and clients" (CRCC, 2010, A.3.a). Furthermore, the counselor is instructed that disclosure commences at the outset of the counseling relationship and should minimally include the following: qualifications, credentials, and relevant experience of the rehabilitation counselor; purposes, goals, techniques, limitations, and the nature of potential risks and benefits of services; frequency and length of services; confidentiality and limitations regarding confidentiality (including how a supervisor and/or treatment team professional is involved); contingencies for continuation of services upon the incapacitation or death of the rehabilitation counselor; fees and billing arrangements; records preservation and release policies; risks associated with electronic communication; and legal issues affecting services.

Rehabilitation counselors are reminded that disclosure of the foregoing may need to be revisited or expanded throughout the counseling relationship. Section F (Forensic and Indirect Services) provides guidance to the rehabilitation counselor when conducting evaluations in a forensic setting. Standard F.1 (Client or Evaluee Rights) directs the counselor to inform evaluees, in writing, that the relationship being established is for the purpose of an evaluation and that a report of findings may be produced. Written consent for evaluations are obtained from those being evaluated or from the individuals' legal representatives/guardians unless a clinical or cultural reason prevents as much, a court or legal jurisdiction orders the evaluation without the required written consent, or deceased evaluees are the subject of the evaluation (CRCC, 2010, F.1.b). In 2001, counselors were encouraged to incorporate a written form as part of their informed consent process when testing individuals (Blackwell, Autry, & Guglielmo, 2001). Section G of the revised code (Evaluation, Assessment, and Interpretation) instructs the rehabilitation counselor to explain the nature and purpose of the assessment and the specific use of results by potential recipients, before the assessment begins (CRCC, 2010, G.1.a). This instruction directs the counselor to give the explanation in the language and development level appropriate to the individual unless a explicit exception has been agreed on in advance. The counselor is to be sensitive to the individual's personal and cultural context and development level (CRCC, 2010, G.1.a). Table 1 presents a comprehensive listing of the areas within the code that address professional disclosure.

The Ethics Committee of the CRCC has developed templates of disclosure statements specific to the various practice settings within which the rehabilitation counselor practices. Rehabilitation counselors are encouraged to visit the commission's Web site to view and download any of these templates for use in their practices (http://www.crccertification.com); the counselor is also encouraged to adapt the templates according to any unique practice needs. Disclosure statements have been referred to as *informed consent statements* (Blackwell & Patterson, 2003; Cottone & Tarvydas, 2007), which reinforces the symbiotic relationship between disclosure and consent. Once a rehabilitation counselor has provided the client or evaluee with information regarding the services and/or the purpose of an evaluation, the next step is to request consent—ideally, one based on a fully informed choice.

Historical Basis for Informed Choice and Consent

Informed choice in medical and health care decisions is a cornerstone for understanding informed consent in rehabilitation. Beginning in the early 20th century, with the advent of medical advances such as anesthe-

Table 1
2010 Code of Ethics: Professional Disclosure

Section A	The Counseling Relationship
A.3.a	Professional Disclosure Statement
A.3.b	Informed Consent
Section B	Confidentiality, Privileged Communication, and Privacy
B.2.a	Danger and Legal Requirements
B.2.b	Contagious, Life-Threatening Diseases
B.2.c	Court-Ordered Disclosure
B.2.d	Minimal Disclosure
B.3.f	Third-Party Payers
B.6.d	Disclosure or Transfer
B.7.c	Disclosure of Confidential Information
Section F	Forensic and Indirect Services
F.1.d	Indirect Service Provision
Section H	Teaching, Supervision, and Training
H.1.c	Informed Consent and Client Rights
H.4.a	Disclosure and Informed Consent for Supervision
H.6.h	Professional Disclosure
H.7.b	Self-Growth Experiences
Section I	Research and Publication
I.2.a	Informed Consent in Research
I.5.d	Disclosure of Research Information
Section J	Technology and Distance Counseling
J.9.b	Intellectual Property
J.11	Distance Counseling Credential Disclosure
J.14	Distance Group Counseling

sia and surgery, physicians began to disclose basic information without always outlining the potential risks of the recommended intervention (Encyclopedia of Death and Dying, 2009). As outlined in Blackwell and Patterson (2003), with the trend toward patient rights (including the right to know what a physician intends to do and why), the parameters of informed consent and duty to inform in medicine have been defined through case law (e.g., *Mohr v. Williams*, 1905; *Scholendorf v. Society of New York Hospital*, 1914; *Salgo v. Leland Stanford Jr University Board of Trustees*, 1957). With the advent of the Nuremberg code of 1947, ethical regulations based on informed consent were established (Vollmann & Winau, 1996). The first directive of the Nuremburg code specifies as an absolute the voluntary consent of the human subject: The person involved should have legal capacity to give consent; be so situated to exercise free power of choice without the intervention of any element of force, fraud, deceit, duress, or any overreaching or other ulterior form of constraint or coercion; and have sufficient knowledge and comprehension of the elements of the subject matter involved to make an understanding and enlightened decision (National Institutes of Health, 2009). Beginning with the *Canterbury v. Spence* decision (1972) and then expanding to other jurisdictions, informed consent was deemed a legal right, with full legal redress equivalent to battery. In essence, the process by which an individual arrives at a decision about health care is based on access to and full understanding of all necessary information. The result is a free and informed decision regarding whether obtaining health services is desired and, if so, by what method or procedure. Courts have found that unless consent is based on full information, including full understanding of the risks of a procedure, a doctor is not protected for liability. These principles have been applied in medical treatment as well as in such areas as family planning and reproductive health care (e.g., Engender Health, 2009).

Informed consent issues have expanded with changes in the medical field and society. With the utilization of life-sustaining treatments such as dialysis, respirators, cardiac resuscitation, and organ transplantation, patients and family members may have an urgent need to be fully informed of treatment risks and benefits and so exercise the authority to protect their wishes. Legal documents such as advance directives, living wills, and health care proxies serve as mechanisms to articulate and protect patient wishes over the "doctor knows best" maxim and the medical tenet that "if it can be done, it should be done" (Encyclopedia of Death and Dying, 2009). Issues of technology (e.g., transmittal of billing and claims information) have led to increased measures for the confidentiality of health information and to specific informed consent requirements that comply with the 1996 Health Insurance Portability and Accountability Act.

The doctrines of medical informed consent have been applied in counseling (e.g., Arthur & Swanson, 1993; Remley & Herlihy, 2010) and incorporated within multiple ethical codes and practice guidelines for assessment, therapy, counseling, and forensic practice (Pope, 2009), including state counseling boards (American Association of State Counseling Boards, 2010). Informed consent has also received increasing attention within the field of rehabilitation and is a critical practice component.

Facilitating empowerment, choice, and independence is a long-standing and integral component of rehabilitation (Patterson, Patrick, & Parker , 2000) and is directly related to ethical principles (Beauchamp & Childress, 1989; Kitchener, 1984). For more than 50 years, choice has been depicted as a partnership between consumer and counselor wherein a counselor assists an individual with decisions (Levine, 1959; Patterson, 1960). Choice was strengthened with the consumer rights movement of the 1970s, as well as the Rehabilitation Act of 1973 and its amendments in 1992 and 1998. Informed consent invokes virtually all ethical principles. If counselors are beneficent in their duty to do good and to do no harm, they must promote choice. Upholding the principle of justice means that all individuals have choices, regardless of the type of disability (Shaw, 1994; Stebnicki, 1997), whereas the principle of fidelity means that counselors keep their promise to promote choice and that they are honest with consumers about the types of choice available to them (Patterson et al., 2000). Although the inherent ethical principle is that of autonomy—given that it honors an individual's right to make decisions—true autonomy is not possible without the information necessary to make an informed decision (Shaw & Tarvydas, 2001).

What Is Informed Consent?

In terms of ethical obligation, an individual has a right to know what to expect when working with a rehabilitation counselor, with clearly defined expectations at the beginning and throughout the process (Blackwell & Patterson, 2003). To be considered informed consent, an individual must do more than express agreement or comply with a request; the legal elements that establish informed consent also include knowledge or information, competence, and voluntariness (Blackwell & Patterson, 2003; Shaw & Tarvydas, 2001). Information must be provided that is sufficient to make decisions, and there must be comprehension of what is disclosed. At a minimum, the nature and purpose of services must be provided, along with the risks, benefits, and available alternatives, although many codes of ethics now require information about procedures, duration of counseling, and confidentiality limitations (Pope, 2009). An individual must be competent to make decisions that may be assessed formally and informally and may change over time (Stebnicki, 1997). Information must be provided in language that an individual can understand. A counselor must make necessary efforts to provide an understandable explanation and form a professional opinion regarding an individual's ability to understand and consent (Blackwell et al., 2001). Finally, consent must be voluntary in that a consumer must not be subject to undue pressure or coercion when making a decision. Examples of subtle pressures include asking an individual to immediately sign a release, without time to think it over or talk to someone, and providing limited examples or an incomplete array of viable choices for services. Informed consent extends to the release and receipt of information pertinent to the individual who is the evaluee or client.

In summary, a properly executed release will contain information regarding the following: what information is to be released, what information is to be received, the intended reason for the release of information, the intended use of the received information, the period for which use of the release of information is acceptable, and the acceptable means by which the information is to be released or received.

Changes in the 2010 Code of Ethics: Informed Consent

For rehabilitation counselors, the requirements for informed consent have increased with each new code. The 2001 code was more specific than the 1987 code regarding the information that rehabilitation counselors must provide, such as credentials. It also emphasized delineation of potential risks; it provided detailed requirements for confidentiality, especially with regard to when confidentiality should be breached; and it gave a thorough explanation of the limits of confidentiality when information is transmit-

ted through electronic communication. Furthermore, an understanding of fees, financial arrangements, and the purposes and use of assessment was required before a counseling relationship began; written or recorded permission was required for taping; and individuals who were referred for evaluation by a third-party payer had to understand how the process was different from counseling and how the product and results were to be used (Blackwell & Patterson, 2003).

The 2001 code remained limited in scope when referring to informed consent, which was primarily addressed through discussion within the counseling relationship (CRCC, 2001, A.3.d) and within evaluation, assessment, and interpretation (CRCC, 2001, F.1). Informed consent within the counseling relationship was addressed under "freedom of choice," which addressed the client's right to choose whether to enter into a counseling relationship, to determine which rehabilitation counselors would provide counseling, and to have any restrictions fully explained that limited client choice. This item also spoke to obligations that rehabilitation counselors had to clients in protecting their informed consent rights (CRCC, 2001, A.3.d). Informed consent within the evaluation, assessment, and interpretation process was specifically discussed under "explanation to clients," which obligated the rehabilitation counselor to explain the nature and purpose of the assessment and the specific use of the results in a language that the client or legally authorized representative could understand. The rehabilitation counselor was obligated to take reasonable steps to ensure the client's understanding regardless of the source of test scoring and interpretation (CRCC, 2001, F.1.a).

As defined by the 2010 *Code of Professional Ethics for Rehabilitation Counselors*, informed consent is a process of communication between rehabilitation counselors and evaluees/clients that results in the authorization or decision by clients based on an appreciation and understanding of the facts and the implications of an action. Informed consent is treated much more extensively and receives prominent mention throughout the 2010 code. Informed consent is not only addressed as its own standard in Section A.3.b but cited in conjunction with cultural considerations, role changes, clients' lacking capacity to consent, and exceptions (i.e., danger/legal requirements, contagious, life-threatening diseases, and court-ordered disclosure). Informed consent is addressed within direct service and indirect service practice settings as follows: counseling relationship; confidentiality, privileged communication, and privacy; relationships with other professionals; forensic and indirect services; evaluation, assessment, and interpretation; teaching, supervision, and training; research and publication; and technology and distance counseling. Whereas professional disclosure is the starting point for the rehabilitation counselor, informed consent is the ongoing process that directs every decision that the rehabilitation counselor makes within his or her daily practice. Table 2 provides a chart of informed consent citations.

Discussion and Future Directions

The studies and research papers cited in this article clearly indicate a significant inadequacy in the practices of rehabilitation counselors, whether in a private practice setting or public sector arena, when it comes to providing full and appropriate professional disclosure as well as securing informed consent. The withholding of professional disclosure robs the client or evaluee of the opportunity and right to be fully informed and make a competent decision regarding participation in an evaluation or a client–counselor relationship with a rehabilitation professional.

Conversations with peers who do not routinely provide a full disclosure statement reveal many explanations and rationalizations for this inadequate practice. In our opinion, intimidation is the primary reason why rehabilitation counselors do not engage in proper disclosure. Rehabilitation counselors may be questioned or pressed for additional details after providing a full explanation of services. Special circumstances—for instance, clients or evaluees with cognitive deficits, individuals for whom English is not their primary language, individuals from cultures different from that of the rehabilitation counselor, minors, technology issues—may prompt rehabilitation counselors to carefully consider the nuances of disclosure and informed consent discussions. For example, some cancer facilities require the assent of older children before evaluation and/or service delivery, even after parents or guardians have made decision on their behalf (American Cancer Society, 2009); thus, rehabilitation counselors providing transition services or life care plans may find that a minor, though not legally competent, wants to make informed choices about his or her life. We recommend peer consultation among rehabilitation counselors to discuss best practices for carrying out professional disclosure. Other measures include the review and adaptation of the professional disclosure templates found at the CRCC Web site and the use of the advisory opinion process available through the CRCC Ethics Committee when one is unsure how to handle challenging disclosure and consent issues.

Consistent and proper professional disclosure will result in a fully informed client or evaluee and ultimately lay the groundwork for a properly executed informed consent. Disclosure and informed consent are not new to the rehabilitation counseling process, nor was the enhanced language of the 2010 code inserted to create a burden for CRCC certificants. By transferring knowledge to someone who has the capacity to consent and is provided the opportunity for voluntary

Table 2
2010 Code of Ethics: Informed Consent

Section A	The Counseling Relationship
A.3.b	Informed Consent
A.3.c	Developmental and Cultural Sensitivity
A.3.d	Inability to Give Consent
A.5.f	Role Changes in the Professional Relationship
Section B	Confidentiality, Privileged Communication, and Privacy
B.2.c	Court-Ordered Disclosure
B.5.a	Responsibility to Clients
Section E	Relationships With Other Professionals
E.2.c	Informed Consent in Consultation
Section F	Forensic and Indirect Services
F.1.b	Informed Consent
Section G	Evaluation, Assessment, and Interpretation
G.1.a	Explanation to Clients
Section H	Teaching, Supervision, and Training
H.1.c	Informed Consent and Client Rights
H.4.a	Disclosure and Informed Consent for Supervision
Section I	Research and Publication
I.2.a	Informed Consent in Research
I.2.d	Confidentiality of Information
I.2.e	Individuals Not Capable of Giving Informed Consent
Section J	Technology and Distance Counseling
J.3.a	Confidentiality and Informed Consent
J.9.a	Informed Consent
J.9.b	Intellectual Property
J.13.b	Internet Sites
J.13.c	Business Practices

choice, rehabilitation counselors demonstrate the highest standards of practice and enhance not only evaluation experiences but the client–counselor relationship.

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Authors' Notes

Declaration of Conflicting Interests: The authors declared no potential conflicts of interests with respect to the authorship and/or publication of this article.

Financial Disclosure/Funding: The authors received no financial support for the research and/or authorship of this article.

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DOI: 10.1177/0034355210368567