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The Ethical Implications for Insurance Rehabilitation Practitioners

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All Certified Rehabilitation Counselors are required to follow their Code of Professional Ethics set forth by the Commission on Rehabilitation Counselor Certification (CRCC), however, rehabilitation counselors who work in the private sector may struggle with this. Many are required to follow specific guidelines set forth by their employer which may contradict what their code of ethics states. This article examined a number of common ethical implications that counselors may come upon as well as identify items in the new code of ethics that address some of these issues. With a better understanding of common ethical dilemmas as well as understanding their code of ethics, one will be better prepared in handling these issues.

Ethics and ethical practices can be found in most professions throughout the world. Tarvydas, Cottone, and Saunders (2010) wrote that "Excellent ethics codes set forth best ethical practices acknowledged in the profession and require innovations in practice that are necessary to protect both consumers and the profession itself" (p. 44). As such, codes of ethics need to be written in general terms to be able to be used in a variety of situations that a rehabilitation counselor may encounter, but at the same time, these rules must be specific enough to provide enough guidance in a given situation. Rehabilitation counselors need to use their professional judgment and engage in information gathering, analyzing, reasoning, and planning to be able to take the most ethical course of action (Shaw & Lane, 2008).

Rehabilitation counselors who work in the private sector, particularly in insurance rehabilitation, may struggle when it comes to following the professional code of ethics as promulgated by the Commission on Rehabilitation Counselor Certification (CRCC). Many individuals who work in insurance also have their certification as a Certified Disability Management Specialist (CDMS), which also has its' own code of professional conduct, for which the rehabilitation counselor must also abide. One of the most difficult things about being a Certified Rehabilitation Counselor (CRC) working in insurance is that you must follow the code of ethics while working in the confines of a policy (J. Moore, personal communication, April 14, 2010). There may be times, because of an individual's policy, a counselor is not able to follow the code of ethics because it would be in conflict with the counselor's own rules and regulations put forth by their employer. This may lead one to as, " Is there a place for ethics in insurance rehabilitation?" "Is it possible for a rehabilitation counselor to follow their professional code of ethics and follow their employer's rules?" "Has the new code of ethics improved on areas of concern for someone working in insurance rehabilitation?"

Given this context as stated above, one must look at what rehabilitation counselors do, what ethical dilemmas they come across, what sections of the new CRCC code of ethics as well as the CDMS code of professional conduct might apply, and see if there are ways to be able to "stay true" to the codes of ethics as rehabilitation practitioners follow the rules set forth by one's employer.

History of Vocational Rehabilitation

Compared to other helping professions, vocational rehabilitation is a relatively new field, having only been around since the beginning part of the 20th century. It wasn't until the 1950s that there was a vocational re-

habilitation organization, the National Rehabilitation Counseling Association, established and it wasn't until the 1970s did individuals with disabilities start to receive more fair opportunities (NRCA, 2010). In retrospect, the first effort to bring together rehabilitation and vocational training was in 1914 with the War Risk Insurance Act. This provided vocational training and rehabilitation services to injured war veterans. A few years later the Smith-Hughes Act of 1917 was passed and then amended to assist veterans from World War I with vocational education (Weed & Field, 2001). Since this time, subsequent legislation has extended services, populations, and increased rights for those served by the public VR program.

In 1935, the Social Security Act permanently set up a vocational rehabilitation program. In 1943, the Borden-Lafollette Act expanded who was eligible for services to include the mentally ill and the blind. It wasn't until 1954 that the Vocational Rehabilitation Act was passed to provide services to more severe disabilities and provide funds for graduate training and research, and to improve rehabilitation facilities (Weed & Field, 2001; Sales, 2002). Amendments to the Vocational Rehabilitation Act were passed in 1965, 1967, 1968 to provide extended evaluations, authorize construction of new facilities, and to include persons with socially handicapping conditions, migrant workers, and disadvantaged persons (Rubin, 2008; Weed & Field, 2001; Sales, 2002).

The Rehabilitation Act of 1973 put more emphasis on services for the most severely disabled and included: (a) Affirmative Action in Federal Housing, (b) Architectural and Transportation Barriers Compliance, (c) Affirmative Action by Federal Contract Recipients, and (d) Equal Opportunities to persons with disabilities. Amendments were made in 1986 to include supported employment programs (Rubin, 2008; Weed & Field, 2001). The Individuals with Disabilities Act of 1975 mandated that states must provide free and appropriate education to children with disabilities, ages 3-21, in the least restrictive environment. The Americans with Disabilities Act in 1990 was passed which prohibits discrimination against persons with disabilities in employment, transportation, public accommodations, and activities of state and local government (Rubin, 2008). The Ticket-to-Work and Work Incentives Improvement Act was passed in 1999 to provide health insurance, among other things, to individuals receiving public assistance (Weed & Field, 2001).

This brief history shows how far along public policy for persons with disabilities has come since the early 1900s, but just like any piece of legislation, there are "loopholes" in the system for individuals to still discriminate against persons with disabilities. Public Policy could always improve, but in order for that to happen, public attitudes toward persons with disabilities need to change first. Vocational rehabilitation counselors have the task of advocating for their clients when the client may not be able to do so in order to achieve their goals. While this may appear very consistent with the notion of empowerment and choice which drives a person-centered approach in the public sector, this same approach may not be as congruent an approach suitable in the private sector.

History of Vocational Rehabilitation in the Private Sector

In the 1970's there began a shift in employment of rehabilitation counselors from the public sector to the private sector (Matkin & Riggar, 1986). Private rehabilitation firms, corporations, insurance firms, as well as self-employment opportunities created a vast number of new employment settings for the traditional rehabilitation counselor. Areas such as insurance rehabilitation, forensic rehabilitation, employer-based disability management, and case management became expanded roles beyond what was expected from a rehabilitation counselor (King, 2009). The rapid rise in healthcare and worker's compensation costs throughout the 1980's placed more emphasis on rehabilitation of injured workers. "This expansion created a shift in service focus and clearly altered the traditional purpose of rehabilitation counseling and the role of the rehabilitation counselor by mediating the traditional consumer-centered outcomes with and increased emphasis on utilizing rehabilitation counseling services for cost management and containment" (King, 2009, p. 58). The continued development of the private sector industry has been in response to many changes to the public sector. Included in these changes are legislation, funding, budgeting, and government policy (King, 2009).

The primary goal of insurance rehabilitation is to return the injured worker or employee, who has acquired a disability, to work in the most expedient manner possible (King, 2009). In order to achieve this, there is a hierarchy for Return-to-Work (RTW) when providing services to injured workers or employees with disabilities. The following process is used to determine the most reasonable and appropriate goal to assist in the employee's RTW (Lynch & Lynch, 1998):

1. RTW same job, same employer
2. RTW same job with modifications, same employer
3. RTW different job, same employer
4. RTW same job, different employer
5. RTW same job with modifications, different employer
6. RTW different job, different employer
7. Self Employment

This process helps the rehabilitation counselor effectively work with their client to achieve the most beneficial outcome for RTW.

Long-Term Disability (LTD), Workers' Compensation, and disability management are three areas that fall under Insurance rehabilitation. Workers' compensation laws have been around since 1910 and although each state has their own laws and statutes concerning workers' compensation, the main reasoning behind the laws is to protect the workers and employers by creating a liability without fault system. Despite whoever was at fault, injured employees receive medical coverage and wages while out of work (King, 2009). Rehabilitation services are usually offered as a service to minimize medical costs associated with being injured and being out of work. On top of a rehabilitation counselor's traditional set of roles, they also require organizational management skills to effectively administer services offered to their clients through third party sources (Zanskas & Leahy, 2007), consult with healthcare providers, perform vocational assessments, provide case management, provide vocational counseling, conduct labor market surveys, provide job modifications and accommodations, and help with job search and development.

LTD provides the employee with a disability a percentage of their income if they are unable to work. LTD policies have evolved over the years to include rehabilitation benefits and RTW incentives for cost containment has increased the need for rehabilitation counselors in the LTD portion of insurance (King, 2009). The primary goal for the rehabilitation counselor is to have the employee return to their own occupation or to a new occupation at comparable earnings. Rehabilitation counselors who work in LTD may perform many of the same tasks as Workers' Compensation, but may also coordinate services with vendors and other agencies to aid the employee in RTW plans with their employer (King, 2009).

Disability management focuses on the facilitation of an employee's recuperation, rehabilitation process, and RTW while controlling costs of injury and disability for the employer and insurance carriers (King, 2009). The rapid growth of both insurance rehabilitation and disability management prompted for the formation of a specialized certification called Certified Disability Management Specialist (CDMS) to acknowledge specialized services under public and private disability compensation systems (CDMS, 2009). The credentialing process certifies that the CDMS have acceptable levels of knowledge and skills in disability management practices and processes. Along with the Certified Rehabilitation Counselor designation, CDMS is recognized as a desirable certification in most private rehabilitation settings (King, 2009).

Common Ethical Issues that Arise

Ethical guidelines represent shared values in professional principles and regulate member's relationships with colleagues and clients as well as protect clients from poor quality services (Estrada-Hernandez, Smiling, & Felder, 2006). However, no code of ethics is set in stone and there can always be exceptions to what is in place. Certified rehabilitation counselors need to be familiar with their code of ethics and be competent in using their own professional judgment to handle ethical dilemmas when they occur.

The main focus of case management for the insurance company has a focus on cost containment among other things such as managed competition and utilization review (Vaughn, Taylor, & Wright, 1998). Since this deviates from the traditional role of the rehabilitation counselor in the public sector, it can create potential ethical concerns for the rehabilitation counselor because the needs of the client and the needs of the third-party payer may not be congruent (Shaw, Chan, Lam, & McDougall, 2004). Ethical dilemmas may arise when a client needs specialized services and equipment that may not be covered by their policy, or if they fail to meet eligibility for a particular service (Vaughn et al., 1998).

Other dilemmas may occur if a counselor forgets to notify a client of a release to return to work which results in the dismissal of an injured employee, this is known as an omission of information (Weed, 2000). In short, rehabilitation counselors find that they need to balance a client's needs for certain services while abiding to their own employer's need to control costs. Rehabilitation counselors and disability managers may also need to be more knowledgeable and aggressive in the risk management aspects of practicing in the private sector as opposed to the public sector. A CRC working in the insurance industry, must thoroughly disclose information regarding the role and responsibilities to the client and the employer or third-party payer; access to services; confidentiality; and other crucial information (Shaw et al., 2004). Professional disclosure and informed consent are two key items that must be addressed with the client in order to allow the client to be able to make informed choices based on the information disclosed to them (Carlisle & Neulicht, 2010).

A 13-year study was conducted from 1993 to 2006 which looked at ethical complaints and violations in rehabilitation counseling. Of the 113 complaints filed, 71 were further reviewed by the CRCC Ethics Committee. Thirty-six of those cases were found to be in violation of the Code of Ethics (Saunders, Barros-Bailey, Rudman, Dew, & Garcia, 2007). The violations can be clustered into 11 main categories:

1. Dual/inappropriate relationships
2. Confidentiality
3. Fees or billing practices
4. Inappropriate financial gain
5. Informed consent

6. Competence
7. Improper research, teaching, administrative practice, or supervision techniques
8. Failure to advocate for the client
9. Inappropriate public statements of disparaging remarks
10. Failure to uphold professional standards
11. Legal issues such as practicing without a certificate or fraudulent use of credentials, using illegal substances, or failure to report abuse situations

Upon review of the cases, 37 individuals were found to be in violation. The largest number of violators (17 total) was employed in private/proprietary sector (Saunders et al., 2007). This number constitutes 46% of the total number of individuals in violation of the code of ethics. The most frequently violated rule was "rehabilitation counselors will obey the laws and statutes where they practice", followed by "rehabilitation counselors will not be dishonest or deceitful."

Another study was conducted from 1997 through 1998 in which 122 CDMS certificants responded out of 459 randomly selected. Roughly 50% of the participants worked in insurance. A list of 33 ethical dilemmas addressed in this study. All 33 were encountered by the rehabilitation counselors with six of them occurring at least once a year in over 75% of the participants (Vaughn et al., 1998). Listed below are the eight most frequent dilemmas in order starting with the most common:

1. Supporting a client's selection of a particular vocational objective conflicts with channeling a client toward a more realistic vocational objective (Dilemma between Autonomy V. Beneficence).
2. Adhering to referral source case movement guidelines conflicts with providing an optimal package of rehabilitation services to a client (Dilemma between Fidelity V. Beneficence).
3. Informing an insurance carrier what a client can do vocationally knowing it will be used to suspend/cancel benefits the client is receiving (Dilemma between Fidelity V. Beneficence).
4. Providing support for a specific type of training requested by the client conflicts with supporting the type of training recommended in the client's evaluation report (Dilemma between Autonomy V. Beneficence).
5. Supporting a client's own choice of services conflicts with providing services that can increase the client's potential (Dilemma between Autonomy V. Beneficence)
6. Encouraging a client to take responsibility for securing necessary medical services to prevent potentially dangerous health complications conflicts with your acting in accordance with the client's request to obtain necessary medical services for him/her (Dilemma between Autonomy V. Beneficence).
7. The client's desire for training conflicts with being asked by the client's attorney to testify to the worst vocational scenario (Dilemma between Nonmaleficence V. Beneficence).
8. Agreeing to provide services for a client requested by the referring funding source conflicts with responding to a client's needs in the most appropriate manner (Dilemma between Fidelity V. Beneficence) (p. 48–49).

Of the eight items listed above, numbers one, three, and eight stand out as key issues that put a rehabilitation counselor/CDMS in a situation where they need to make the difficult decision of following their code of ethics or abide by the policy of the insurance carrier. Looking at number three first, how is a counselor supposed to do good to their client (Beneficence) and be truthful to the client (Fidelity) if the counselor is supposed to report to their employer that this person can do something vocationally that may terminate their benefits, even though the client may still need some services that could be potentially beneficial to the client?

In dilemma number one, the rehabilitation counselor has the obligation to assist the client in attaining their vocational goal (Autonomy), while, at the same time, successfully rehabilitating the client within the shortest amount of time to meet the employer's needs for closure (Beneficence). Rehabilitation counselors seek to support their client's vocational choice while using information that is available to them, such as information from a vocational evaluation that had been conducted. The ethical dilemma arises when the client's choice of a particular vocation is not recommended by the evaluation report. The counselor is now faced with the problem that if they support the vocational evaluation, it may prevent the client from demonstrating skills in an area in which he/she is motivated. On the other hand, if the counselor supports the client's decision then it may result in a waste of the agency's resources (Vaughn et al., 1998).

Dilemma number eight is similar to dilemma two, in that the counselor needs to choose between providing resources from the third party source or choose what is in the best interest for the client. In the public sector, a counselor would be able to utilize more resources to help clients attain their vocational end-goal, yet this is not the case in insurance rehabilitation. The rehabilitation counselor must look at the individual's policy to see to what extent and what services can be offered. From that knowledge, the counselor must work in the confines of the policy to best help their client. If the counselor deviates from this, it could have serious repercussions from their employer,

even though the counselor may have been trying to abide by their code of ethics.

Issues of confidentiality and conflicts of interests have also been seen as areas of concern. With regard to confidentiality, there have been problems related to the Health Insurance Portability and Accountability Act (HIPAA), complications with the release of information, and increasing societal security concerns. The conflicts of interest issues that seem to be most notable are that involving being able to balance the interests of the client's with that of either the payer or the counselor's employer (Tarvydas & Barros-Bailey, 2010). Respondents to this study also reported that there were specific occasions when they were pressured by their payer, supervisor, or other representative in ways that made it difficult to do what was best for the client.

There have also been instances where there have been supervisors who do not have any formal training or have the necessary skills to provide adequate supervision over rehabilitation counselors (Glosoff & Matrone, 2010). Many supervision positions have a dual role, e.g., clinical and administrative. The clinical aspect should promote supervisee growth and development, maintenance of counseling and psychotherapy skills, making sure the client's welfare is in the best interest, assisting in intervention, whereas the administrative side focuses on how the supervisee is functioning in terms of the policies and procedures put in place by the employer (Glossoff & Matrone, 2010). Many times, it is the administrative side that may prevail. "Meeting your numbers" each month or each quarter is what matters more. If a rehabilitation counselor is forced to meet certain demands, then the welfare of the client may be in jeopardy.

New Codes of Ethics

The main premise of the CRC Code of Professional Ethics for Rehabilitation Counselors and the CDMS Code of Professional Conduct for those who function as disability managers or case managers is relatively the same, which is to provide a set of ethical guidelines for certificants to follow. Both codes also mention that not all ethical dilemmas can be addressed in the codes and that the counselor should follow a specific process when considering a difficult ethical dilemma (CDMS, 2009; CRCC, 2010). Since many CRC counselors obtain their Certified Disability Management Specialist Certificate when working in insurance, they must try to abide by both codes. The CDMS code focuses on case management whereas the CRCC code focuses on counseling, but the main premise of each is relatively similar.

The CRC Code of Professional Ethics for Rehabilitation Counselors has just recently been updated and has taken effect as of January 1, 2010. There have been many changes and additions to this new code. One area that has been expanded on is multicultural competence and diversity considerations when helping clients from different cultural backgrounds. The updated code provides guidance for the practice of acceptable conduct and ethical decision making when a counselor is working with culturally diverse groups (Cartwright & Fleming, 2010). Section A of the code sets forth expectations that the rehabilitation counselor will be aware of the client's cultural perspective with regards the counseling relationship, termination of services, gifts, and referring to culturally appropriate services when needed. The old code did not address any of this. Other areas of the new code that have been expanded on to help rehabilitation counselors are confidentiality, privacy, professional responsibility, forensic and indirect services, evaluation, assessment, teaching, supervision, training, technology, and distance counseling (Cartwright & Fleming, 2010). These updated sections should help rehabilitation counselors handle ethical situations better when working with individuals of all cultural backgrounds.

One of the most improved areas in the 2010 Code is the forensics section, Section F. This area has grown from one standard to now having 17 total specific to forensic rehabilitation (Barros-Bailey, Carlisle, & Blackwell, 2010). It includes areas of confidentiality, conflict of interest, foundation of knowledge, and fee disputes amongst a number of other areas to help rehabilitation counselors make more sound decisions when faced with an ethical dilemma. Another key portion of this section is the identification of who the client is. The 2010 Code states in the preamble that "Rehabilitation counselors do not have clients in the forensic setting. The subjects of the objective and unbiased evaluations are evaluees" (CRCC, 2009). This is important to know because it gives rehabilitation counselors a more concrete understanding of who's who in the field of forensic rehabilitation. This improved section should prove to play a vital part in the future of forensic rehabilitation counselors, both who are in the field currently and for those who plan to enter in the future.

Another change in the new code is Section A.5.: Roles and Relationships with Clients. This section more clearly defines dual-relationships in several categories including: (a) sexual or romantic relationships with current clients, (b) sexual or romantic relationships with former clients, (c) prohibited sexual or romantic relationships with certain former clients, (d) nonprofessional interactions or relationships other than sexual or romantic interactions or relationships, (e) counseling relationships with former romantic partners (prohibited), and (f) role changes in the professional relationship. In this section there is the acknowledgment that some dual-relationships can be potentially beneficial depending on the situation and gives guidance for forming positive relationships outside the rehabilitation counseling role when there is reason to do so, but such involvement is not encouraged (Cottone, 2010). Having more clearly defined

definitions and roles for a rehabilitation counselor to follow makes it easier for an individual to be aware of their interactions and to be better prepared in making right ethical choices.

Section C of the new code of ethics addresses advocacy and accessibility. Rehabilitation counselors have an ethical obligation to address oppression and discrimination of special populations in an affirmative manner and this updated section gives a structural ethical outline for counselors to follow when addressing areas of advocacy and accessibility (Waldmann & Blackwell, 2010). The new code of ethics expands on several standards related to advocacy including attitudinal barriers, advocacy in own agency and with cooperating agencies, knowledge of benefit systems, and confidentiality. It also includes three areas focusing on accessibility (accessibility in counseling practice, barriers to access, and referral accessibility). Having these updated and expanded areas places an emphasis on the need for rehabilitation counselors to implement advocacy and accessibility strategies in their counseling process (Waldmann & Blackwell, 2010).

The new code has expanded and improved several sections on in addition to those mentioned above. These new standards should be able to better guide rehabilitation counselors in identifying and addressing ethical dilemmas in a professional manner. Rehabilitation counselors should be well aware and understand the changes in the new code of ethics so they will be able to make sound decisions and best practices.

Educational Changes

Besides presenting the updated CRC Code of Professional Ethics for Rehabilitation Counselors, there are other curricular aspects faculty may wish to consider regarding the private sector work environment as they prepare graduates enter into the profession. Currently, many rehabilitation programs do not incorporate private-for-profit rehabilitation into the curriculum (Benshoff, Robertson, Davis, & Koch, 2008). This raises a concern for future rehabilitation counselors who want to work in areas such as forensic rehabilitation or insurance rehabilitation. Private sector professionals have noted that new graduates were deficient in being able to perform tasks such as transferable skills analysis, conduct vocational assessments, labor market analysis, and being able to provide adequate forensic testimony (Benshoff et al., 2008).

In order to incorporate private sector rehabilitation counseling into current curriculums, one must look at the differences between traditional rehabilitation counseling and the private sector. Public sector rehabilitation is more person-centered in orientation in that the counselor helps empower the client to make decisions and reach their (the client's) goals. Private sector rehabilitation is different in the sense that it is more policy-centered in that a counselor needs to work within the confines of the client's policy to devise a plan to help the client. Private sector rehabilitation counselors also focus more on vocational issues and solution-focused problem solving as well as interact with a wide range of professionals from different businesses, insurance companies, and law (Benshoff et al., 2008; Zanskas & Leahy, 2007).

Educators, who are CRCs, will also need to assess whether they have sufficient knowledge of private sector rehabilitation in order to be effective in teaching this content area. They further need to recognize they should only teach within the boundaries of their competence. If they are lacking in a specific area then, they should address the issue by gaining additional education in order to help prepare graduate students for entering into the profession (Glosoff & Cottone, 2010). Along with all of the current issues going on facing rehabilitation counselor educators, there are also other areas of practice that may be considered for future inclusion into rehabilitation programs. Future code revisions will most likely address such emerging areas as genetics, future advancement in technology, and new practice settings as the field evolves (Saunders & Leahy, 2010).

Conclusion

There are many ethical dilemmas that may arise as an insurance rehabilitation practitioner. Some of these dilemmas may be more easily resolved with a new code of ethics, but others may not. Certificants need to remember that "a code of ethics is a living document reflective of professional issues and dilemmas confronting practitioners and provides guidance for ethical behaviors" (Barros-Bailey & Saunders, 2010, p. 116) and not all dilemmas can be resolved easily. Rehabilitation counselor educators can help by staying up-to-date on current issues and educating prospective students to help them be more aware of these issues. New graduates, as well as rehabilitation counselors who work in the public-sector, need to be aware of the similarities as well as differences in practice between the private and public sector environments even if new graduates don't choose to enter the private sector but might in the future.

Ethics are needed in all professions to help practitioners follow some standard of practice. Those who are experienced in the public sector and its client-centered counseling approach may initially have a difficult time working in the private-sector because the policies and procedures that are put in place by their employer. If a rehabilitation counselor can adapt and work within the confines of a policy while still remaining true to his/her code of ethics, then that person can succeed in working in the private-sector. So, is there a place for ethics in insurance rehabilitation? It all depends on your point-of-view and how much exposure you have to private-sector rehabilitation.

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