

# AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

W W W . A A C A P . O R G

## CODE OF ETHICS

*(Approved by Council on 9/16/2014)*

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### **Preamble**

To guide the professional conduct of the members of the American Academy of Child and Adolescent Psychiatry (AACAP) and all individuals who practice child and adolescent psychiatry within the United States of America, and to provide the highest quality of services to children, adolescents, and families, AACAP affirms these principles of ethical conduct. The principles apply to the medical specialty of child and adolescent psychiatry and should be used by all practitioners of this specialty in every professional context.

AACAP recognizes that a code of ethics cannot anticipate all circumstances. Rather, it is a dynamic entity and likely subject for revision and modification as future developments emerge. The principles of this Code are guidelines, not laws, intended to orient the professional activities of child and adolescent psychiatrists. They should be used consistently and impartially. It is the responsibility of all individuals learning and practicing child and adolescent psychiatry and every member of AACAP to read the Code in its entirety, understand its principles, acknowledge that the Code's guidelines apply at all times, and reflect on the applications of the principles. When principles conflict or questions arise as to how, in a given situation, principles might apply, members should seek consultation from respected peers and from appropriate professional resources such as the Ethics Committee of AACAP.

As professionals, child and adolescent psychiatrists have several enduring and overriding ethical obligations. These include expectations of recognizing ethical issues when they arise; making decisions and arriving at conclusions based on ethical reasoning and principles; seeking consultation when indicated; undertaking lifelong learning and continuing education in subjects relevant to practice; practicing with competence, integrity, humility, compassion, and self-reflection; and treating others in a dignified and humane manner. Notably, ethical practice applies to all engagements with and communications about patients and their families, whether in person, in writing, or through digital, online, or other electronic media, as well as non-clinical work.

As physicians and as members of the community of medical professions, AACAP members subscribe to the American Medical Association (AMA) *The Principles of Medical Ethics* and the American Osteopathic Association (AOA) *Code of Ethics*. In addition, as psychiatrists trained in both general and child and adolescent psychiatry, AACAP members subscribe to the American Psychiatric Association (APA) *The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry*.

The practice of child and adolescent psychiatry, however, requires additional specific clarifications beyond those contained in the above-cited Principles, Code, and Annotations, because, unlike the majority of other medical specialties, patients of child and adolescent psychiatrists are predominantly dependent minors. Ethical dilemmas frequently arise, therefore, reflecting the degrees of youngsters' developmental immaturities and achievements, conflicts between youngsters' aspirations and those of their legal guardians, the need for information exchange between various caregivers, and expectations of advocacy by child and adolescent psychiatrists for their patients. More specifically:

- A. The services of a child and adolescent psychiatrist are usually sought by a patient's parent(s) or guardian(s) [*hereafter described as guardian(s)*] rather than independently by the child or adolescent patient. In turn, the practitioner also has obligations to the individual patient, their guardian(s), and others in the broader community important in the patient's life.
- B. The child and adolescent psychiatrist is responsible for assessing and providing treatment recommendations for young individuals who, owing to their cognitive, emotional,

psychosocial, language and communication, physical, and/or adaptive challenges, typically lack adult developmental capacities.

- C. Agencies enlist the consultative, educational, research, and/or administrative services of child and adolescent psychiatrists. Agency goals may conflict with the welfare of child or adolescent patients and/or their families creating possible conflicts of interest for the practitioner.
- D. Assent, consent, confidentiality, and, separately, professional responsibility, authority, and behavior, must be viewed within the framework of ongoing child development. The rights and interests of the child or adolescent, and the professional's behaviors toward the child or adolescent, demand considerations of maturational factors.
- E. Child and adolescent psychiatrists may embody multiple roles, including those of evaluator, treatment provider, consultant, and supervisor, involving individuals, families, schools, court systems, and other agencies. The practitioner should be sensitive to potential conflicts that can arise from demands stemming from these different roles and entities, and must approach and manage these conflicts in an ethical and transparent fashion.

**Principle I:  
Respect for Human Dignity**

Human dignity recognizes that all human beings possess an inherently valuable worth intrinsic to their humanity. By respecting human dignity, child and adolescent psychiatrists adhere to ethical imperatives that guide patient care, research and other scholarly activities, administrative activities, and interactions with all individuals.

Child and adolescent psychiatrists must engage in their clinical, educational, research, and/or administrative responsibilities with the utmost respect for human dignity and not participate in acts that intentionally contradict or compromise an individual's psychological or physical integrity. Child and

adolescent psychiatrists must provide sufficient attention to the needs and preferences of their patients or human research participants without engaging in bias, discriminatory conduct, or harassment on the basis of race, ethnicity, sexual orientation, gender identity, family composition, socioeconomic status, citizenship or immigration status, religion, age, beliefs, creed, culture, disease, disability, foster care involvement, juvenile justice involvement, language, political leanings, academic/professional backgrounds, or any other factor. Thus, respect for human dignity is the underlying principle from which all other principles are derived.

**Principle II:  
Developmental Perspective**

The child and adolescent psychiatrist should be aware of, and strive to optimize the cognitive, emotional, psychosocial, language and communication, physical, and adaptive development of all children and adolescents. This principle applies to the children and adolescents' relationships with family and friends, and with entities involved with the child, including schools, social welfare agencies, juvenile justice, other court systems, and varied child-serving organizations. This developmental perspective should always be incorporated into the child and adolescent psychiatrist's considerations and actions.

**Principle III:  
Promoting the Welfare of Children and Adolescents  
(*Beneficence*)**

Child and adolescent psychiatry's primary concerns are the welfare, functioning, and optimal development of children and adolescents. These concerns apply to individual children and adolescents as well as to children and adolescents as a group within society. The individual child and adolescent psychiatrist's judgments and actions should reflect these concerns, prioritizing them over familial or societal pressures. The practitioner's actions should be based on contemporary scientific knowledge tempered by collective and personal experience.

Children and adolescents may have ongoing relationships with parents, guardians, extended families, peers, government agencies, schools, and other interested parties. These relationships may be direct or indirect, personal or professional, mediated via direct person-to-person contact or through electronic media. The child and adolescent psychiatrist should be aware of these significant relationships, their importance to the children or adolescents, and the manner in which the practitioner could influence these relationships in order to benefit the welfare and development of the youths.

Ordinarily, it is the child and adolescent psychiatrist's primary responsibility to act on behalf of the needs of the child or adolescent patient and their families. Some professional responsibilities, however, do not involve the potential treatment needs of a child or adolescent; rather, consultation limited to the provision of evaluation is requested by, and provided to, societal entities, e.g., schools, social agencies, juvenile justice, and other court systems. In these circumstances, the child and adolescent psychiatrist must, from the outset, clearly delineate the professional's limited role, to both the child or adolescent and the family. Further, the child and adolescent psychiatrist should also note that the professional's primary responsibility for rendering scientifically sound medical opinion may run counter to the preferences or needs of the child. Nevertheless, in these circumstances as well, the child and adolescent psychiatrist must take into account and actively consider the needs of the child or adolescent and their families.

**Principle IV:**  
**Minimizing Harmful Effects to Children and Adolescents**  
*(Nonmaleficence)*

The child and adolescent psychiatrist should seek to avoid all actions that may have a detrimental effect on the optimum development of the child or adolescent. Further, the professional should strive to reduce harmful effects of the behaviors of others on children and adolescents at the individual, family, local community, and societal levels.

Children and adolescents need nurturing relationships and the support of adults. These needs can create emotional vulnerabilities for the children or adolescents in their relationships with parents, guardians,

and other adults in their lives. These vulnerabilities could lead to exploitation, as a child or adolescent might accept emotional and/or physical violations of their person without complaint, which is an infringement on a youth's human dignity. The child and adolescent psychiatrist must act with awareness of these vulnerabilities and not exploit the relationship with a child or adolescent for personal gain.

The families of children and adolescents seeking services may also experience psychological vulnerabilities as a result of a child or adolescent's illness or other stressors. These vulnerabilities could lead families to respond affirmatively to the ill-advised suggestions or demands of potential caregivers. Identical to the awareness of the emotional vulnerabilities of children and adolescents that is expected of the professional, the child and adolescent psychiatrist must similarly not exploit the needs of the family members and their vulnerability for personal gain. Since the proper evaluation and treatment of patients is paramount, child and adolescent psychiatrists should carefully consider any dealings with patients and their families outside the patient-physician caretaking relationship, as those might undermine the integrity of professional care. Various communities may have problems of access to care. Rural, ethnic, religious, or culturally separate communities, as well as isolated medical centers, are examples of geographic or identifiably unique entities that may render it necessary for child and adolescent psychiatrists to treat the children and/or adolescents of acquaintances, colleagues, friends, or business associates. In such situations, the child and adolescent psychiatrist must take care that the preexisting relationships do not adversely impact objectively applied evaluation and care.

Romantic and/or sexual involvement of a child and adolescent psychiatrist with a current or former patient is always unethical. Romantic and/or sexual involvement of a child and adolescent psychiatrist with the patient's immediate family members or guardians is similarly unethical. Romantic and/or sexual involvement with family members or guardians after the evaluation and treatment period has terminated, whether through direct engagement, social, or other electronic media is ill-advised and strongly discouraged for an indefinite period of time thereafter, as the physician-patient-family relationships engendered during the provision of care rely on the development of mutual trust. Mutual trust derives from an acknowledgement of boundaries that delineate the roles of caregivers and recipients. These boundaries in turn contribute, for both child and adolescent psychiatrists and families,

to behaviors promoting safety and predictability that conform to common expectations. As the emotional residues of the previously forged physician-patient-family relationships often persist after the termination of care, the continued maintenance of established boundaries helps both the professionals and the families to protect against complicating emotional entanglements and to maintain objective physician-patient-family relationships. Further, because children and adolescents suffer from conditions that might be episodic or chronic, and continuity of care is in the best interest of patients, child and adolescent psychiatrists are strongly urged to avoid entering into any relationships with family members or guardians that would preclude or affect their ability to provide treatment in the future.

**Principle V:**  
**Assent and Consent**  
*(Autonomy)*

Guardians are ultimately responsible for the health and welfare of their children. However, respect for human dignity requires that children and adolescents play a role in determining the services they receive and their participation in treatments to the extent of their capacities to understand options and act rationally. The right to assent or dissent to treatment belongs to the individual child or adolescent of minor age. The right of proxy consent for the minor belongs to the child or adolescent's legal guardian(s); of note, some jurisdictions might require consent by adolescents of a specified age. The child and adolescent psychiatrist shall, whenever reasonably possible, obtain the assent of the minor and the consent of the legal guardian prior to engaging in actions involving the child or adolescent.

Provision of emergency medical care is considered an exceptional circumstance. On such occasions, lack of both assent and consent are considered secondary to the overriding need for urgent provision of beneficial care. The emancipated minor is also considered an exceptional circumstance, as that youngster is legally entitled to provide consent for medical services. Similarly, some jurisdictions support the provision of autonomous consent by children and adolescents in situations that involve mental, sexual, and/or reproductive health care, and substance use disorder treatment.

Situations arise in which the desires of the child or adolescent and their guardian(s) conflict. When the

youngster dissents but the guardian consents to treatment, it may be medically necessary to treat the individual minor without his or her concurrence. In such cases, the child and adolescent psychiatrist should carefully consider the health needs of the child or adolescent and the psychological ramifications of treating that individual against his or her wishes.

To facilitate collaborative relationships with minors and their guardians, and to enhance patient autonomy, the child and adolescent psychiatrist should communicate to them, at all times, information that conveys sufficient understanding of the case situation and a thorough explanation of the professional judgments, opinions and factors that guide the child and adolescent psychiatrist's actions and recommendations for treatment.

**Principle VI:**  
**Confidentiality**  
*(Autonomy/Fidelity)*

The development of trust, between the patient, the patient's guardian(s), and the child and adolescent psychiatrist, is essential to beneficial care. Respect for the patient's privacy is of great importance to the establishment and maintenance of that trust. Thus, the child or adolescent's right to privacy of communication is essential in the practice of child and adolescent psychiatry. Certainty that their verbal expressions to child and adolescent psychiatrists are protected as confidential allows minor patients to reveal their feelings and thoughts to the clinicians providing care, with the assurance that the contents of their discussions will not be communicated to others without their permission.

Children and adolescents should be told about their confidentiality rights and the limits of them, in developmentally appropriate fashion, at the outset of their professional relationship with a child and adolescent psychiatrist. When circumstances exist that make this timing not feasible, this discussion should be held at the next propitious opportunity.

Similarly, the guardians of these children and adolescents will often share personal information about themselves and related others with the child and adolescent psychiatrist. These individuals, and the



contents of their communications, are equally entitled to privacy, provided that the communications do not directly or immediately pose a threat to the children and adolescents receiving professional care, themselves, or others.

Release of information regarding a child or adolescent to a third party, including extended and some non-custodial family members, requires the consent of the youngster's guardian(s). There are exceptions to the prohibition of disclosing protected health information without a release of information that are defined within the HIPAA Privacy Rule (*45 CFR 164.506*). These exceptions include core activities related to treatment, payment and health care operations and were designed to enhance access to health care, facilitate payment and allow for certain administrative, financial, legal, and quality improvement activities to be carried out by a covered entity. Child and adolescent psychiatrists should be aware of federal and state laws that specifically address the use and disclosure of health information.

Patients and families should receive explanations that delineate how their personal information might be transmitted, including digitally, and the protections in place that protect their privacy and confidentiality. The releases of information should occur with the assent of the child or adolescent when developmentally and clinically appropriate, with exceptions as noted below:

- A. When the safety or welfare of a child, adolescent, or pertinent others is in jeopardy, the child and adolescent psychiatrist may have the ethical responsibility to divulge information, in spite of the patient's confidentiality rights. When circumstances permit, the child and adolescent psychiatrist should make a reasonable effort to inform the child or adolescent and other interested parties in advance of such disclosures.
- B. Before an evaluation of a child or adolescent for administrative, legal, educational, or other third-party initiated purposes, the child or adolescent and all other interested parties should immediately be informed of the nature and intent of the evaluation and the related limitations on, and possible forfeiture of, rights to confidentiality.
- C. Emancipated minors, i.e., adolescents legally declared no longer under the control of their guardians, retain full confidentiality rights which cannot be abrogated by adult relatives.

Child and adolescent psychiatrists should carefully examine their motives when seeking information about patients and their families from sources other than the family or directly involved professionals and agencies. Accessing such information, via oral, written, or electronic communications, should only be conducted with the patient's and guardian's knowledge, permission, and mutually clear understandings concerning the use of that information, unless overriding safety concerns exist.

**Principle VII:**  
**Third-Party Influence**  
*(Fidelity)*

The child and adolescent psychiatrist must prioritize the welfare of the patient above competing interests. Attempts at influence by third parties raise possibilities of conflicts of interest. It is the obligation of the child and adolescent psychiatrist to recognize these potential conflicts and, in response to these pressures, child and adolescent psychiatrists must maintain vigilance to keep the interests of children and adolescents paramount.

Third-party influence may derive from many sources including guardians, health insurance providers, school system personnel, pharmaceutical companies, industry-related manufacturers, investment concerns, governmental agencies, and colleagues. The child and adolescent psychiatrist should not allow third parties, or the potential or actual compensation deriving from them, to improperly influence professional judgments and actions. These potential influences should not compromise the honesty, openness, and transparency of clinical, educational, and research activities. When possible conflicts of interest arise, the child and adolescent psychiatrist should fully describe the conflicts to all involved parties, and openly disclose these facts publicly when indicated.

Attempts at third-party influence could include gifts, dinners, educational opportunities, recreational outings, medication samples, financial support, remuneration, and monetary investments. The child and adolescent psychiatrist should be conscious of these attempts at influence and how they might persuade the professional to act in ways that may be inconsistent with the best available scientific and clinical evidence and thus compromise the optimal provision of care. The child and adolescent psychiatrist

should not accept enticements that compromise the principles of this Code. When providing clinical care, the practitioner must recognize and weigh potential conflicts of interest and arrive at resolutions that optimize benefits for the patient. When teaching or engaging in promotional activities, the child and adolescent psychiatrist must provide relevant disclosure of third-party support from hospitals, insurance companies, pharmaceutical or other industries, and/or government grants, whether or not the professional perceives a conflict of interest. Likewise, the professional must abide by AACAP member requirements for disclosure as well as those of institutions, funding agencies and federal oversight bodies.

Situations exist in which third parties have direct influence over, or legal responsibility for, a child or adolescent's development and/or care. Such administrative entities could include health insurance providers, schools, social service agencies, and juvenile justice systems. The child and adolescent psychiatrist should provide the relevant parties with a thorough understanding of the affected child's or adolescent's needs in order to optimize that child's care while simultaneously protecting the youngster's privacy rights, independent of the third parties' clinical or administrative preferences.

### **Principle VIII: Research and Other Scholarly Activities**

Research and other scholarly efforts that examine diverse facets of child and adolescent psychiatry provide the foundations for continuously expanding knowledge that give the specialty an increasingly solid, well-grounded evidence base. The first priority of researchers, while maintaining the scientific integrity of their work, is to maximize potential benefits of research to children or adolescents while simultaneously minimizing risks to research participants. Obtaining the guardian's informed permission and, when appropriate, the child or adolescent's informed assent to participate in the research is of equal priority. All aspects of study design and implementation must prioritize the rights, safety, and wellbeing of the child or adolescent participant.

To assure the accumulation of new knowledge and the protection of research participants, the child and adolescent psychiatrist conducting research must ensure that the investigative processes are conducted in an ethical manner, consistent with accepted scientific and medical principles, and are compliant with

all federal, state, local, and institutional regulations. Pertinent committees responsible for the approval and oversight of research involving human subjects and/or ethics committees must approve all research protocols prior to their implementation.

In order that child and adolescent research subjects and their guardians make informed decisions regarding participation in studies, it is expected that researchers will discuss their potential conflicts of interest with the participants before obtaining assent and consent. As well, it is crucial that the potential risks and benefits of the research be clearly described to the guardian(s) and, in a developmentally appropriate manner, the involved children and adolescents.

The level of potential risk to the child or adolescent is critical with regard to consent for participation in research. The child and adolescent psychiatrist should inform the child or adolescent regarding the nature of the study, its goals, and the potential risks and benefits, commensurate with the developmental capacities of the youngster. It is also expected that researchers, in all studies, will thoroughly and carefully consider the matter of assent, in particular when assent cannot be obtained, is refused, or might not be ethically feasible. The guidelines that follow below are intended to be consistent with current National Institute of Health guidelines regarding minors but, in all studies, researchers must always endeavor to establish the most likely option of benefit for each individual research subject.

Research that does not involve risks to the youngster, in which anonymity is totally protected, may or may not require consent of guardians or assent of subjects. Assent of the child or adolescent should be sought, however, if developmentally feasible. In situations involving minimal risk or a minor increment over minimal risk, the consent of guardians and the assent of the child or adolescent must be obtained. In situations involving more than minimal risk but with prospects of direct benefit to the child or adolescent, the child or adolescent developmentally capable of understanding the procedures, risks, and the broader benefits has the right to refuse participation, independent of the possible consent of guardians.

Regardless of the degree of risk, the refusal of a child or adolescent to assent to participation in research should be considered binding. Children and adolescents should never be forced to participate in medical

research. They or their surrogates should never be provided disproportional, excessive, or coercive incentives to participate, as these maneuvers represent undue attempts at influence and thus compromise autonomous assent and consent.

Study results must be made public in a timely manner upon completion of a research project, regardless of the specific findings and outcomes. Pertinent publications must state the identity, credentials, affiliations, sources of support, and possible conflicts of interests of the authors. The manuscripts should include a significant degree of detail regarding study sponsorship, data collection, analysis, and results. The studies must also provide details of reviews by committees responsible for vetting proposed investigational work, whose approvals mandate hewing to strict ethical guidelines for the conduct of research. The publications must adhere to principles underpinning ethically sound publishing including patient disguise and anonymity, obtaining assent and consent from involved patients and families prior to the use of the material, and sound authorial conclusions based on unbiased data analysis. Scholarly activities other than research, such as case presentations, case reports, and teaching exercises using case-based material, delivered orally, in print and electronically, should similarly adhere to ethically sound teaching and publishing guidelines. Patient disguise and anonymity must be ensured, and obtaining prior assent or consent for the use of the material from the involved patients and families is expected.

When questions arise, during the course of ongoing studies, regarding the participation of children, adolescents, or families in specific research protocols, the child and adolescent psychiatrist investigator(s) should seek consultation with established committees responsible for the approval and oversight of research involving human subjects, as well as knowledgeable colleagues. Similarly, in the course of ongoing studies, when new and directly relevant information emerges concerning increased risk or documented efficacy, it must be shared with the child or adolescent research subjects and their families.

Generalizability of research findings and access to research benefits rely on the inclusion of underrepresented populations in research. Representation in research should strive for diversity among researchers and their teams. Attention to diversity in all elements of research recruitment, protocol

design and implementation, and data analysis and interpretation is essential. It is important that study subjects' sociodemographic backgrounds are represented in the populations studied whenever possible.

**Principle IX:  
Advocacy, Equity, and Justice**

Child and adolescent psychiatrists support the principle that competent mental health care and a full array of services should be available for all children, adolescents, and their families, and support efforts to improve access to care at the individual, local community, national, and international levels. Children and adolescents are one of the most vulnerable groups in all societies. In research and other scholarly settings, the burden of risk on subjects should not fall disproportionately on vulnerable populations, e.g., racial or ethnic minorities, gender or sexually diverse, economically disadvantaged, detained or incarcerated, in foster care, or having physical or neurodevelopmental disabilities. Thus, protections for these populations must be in place and observed. While protections for children and adolescents must be considered, however, so must potential benefits. Thus, research involving children and/or adolescents is justified, as is true with other populations, if the results are likely to yield benefits for youth. Child and adolescent psychiatrists support and advocate for research that could benefit all youth, in unrestricted fashion, while simultaneously assuring that exploitation cannot and will not occur.

While child and adolescent psychiatrists, acting alone, are not likely to resolve culturally entrenched problems of injustice, the practitioner should strive to minimize injustices to which an individual child or adolescent might be exposed. Further, the practitioner is urged and encouraged to advocate for provision of appropriate care and services for all youths.

**Principle X:  
Professional Rewards**

The profession of child and adolescent psychiatry provides its practitioners with the potential for personal and professional rewards, tangible and intangible. Such rewards might include financial and

material support, prestige, enhanced working conditions, and private feelings of satisfaction. Child and adolescent psychiatrists should endeavor to be aware of the role these rewards play in their judgments and actions, and not allow these internally motivated influences to undermine their obligations as professionals.

Professionalism is comprised of, in part, adherence to ethical principles, provision of competent practice, proper understanding of the specialty's knowledge base, skillful application of that knowledge, and practice with integrity, honesty, compassion, and sensitivity. Similarly, professionalism applies to related activities that include engagement and communication with colleagues, trainees, and the public, either in person, in writing, or through electronic media. For these professional activities the practitioner can reasonably expect appropriate compensation. These approaches to professional behavior are ones which all child and adolescent psychiatrists should practice.

Consequently, by contrast, the child and adolescent psychiatrist should not exploit his or her influence with children, adolescents, families, or other relationships for improper personal aggrandizement or the undue benefit of organizations and institutions such as hospitals, universities, and corporations. The dual roles of provider of care and institutional employee may lead at times to offers of gifts or rewards by grateful families. These rewards, in turn, could lead to initiatives advancing scientific or scholarly knowledge and increased access to treatment. Such offers may pose potential conflicts of interest - they require careful reflection on the part of the practitioner. In such cases, the conflicts should be disclosed explicitly and resolved with openness and transparency. The pursuit and enjoyment of these personal and professional rewards must not interfere with, or be detrimental to, the development, functioning, and care of individual children and adolescents, their families, and communities, or compromise the integrity and public trust of the profession of child and adolescent psychiatry.

### **Principle XI: Legal Considerations**

In order to practice medicine in optimal fashion, the child and adolescent psychiatrist must have

awareness of the laws governing medical practice in the states in which the physician performs professional work, as well as local and federal laws that may apply. While bearing in mind that laws may vary subtly or substantively between states, the child and adolescent psychiatrist must consider, in particular, those laws concerning reports of child abuse and neglect, custodial arrangements and guardian responsibilities, warnings to others concerning patients' potential self- or other-directed threatening behaviors, assent and consent, release of information, documentation of care, and medical responsibilities and negligence. The child and adolescent psychiatrist must also pay attention to statutes governing medical licensure, maintenance of specialty certification, and problems potentially arising from the treatment of patients that crosses state or other jurisdictional lines. The practitioner must be aware that legal concerns, which may arise in the context of face-to-face patient care, can also arise during indirect communications with and about patients and others when communication technologies, including digital media, are used. Similarly, whether in face-to-face care or via electronic contact, boundary violations, supervisory negligence, abandonment, third party liability, fraud, defamation, and confidentiality and privacy breaches continue to pose potential hazards to which professionals must pay close attention.

Child and adolescent psychiatrists are strongly advised to proceed with great caution regarding the performance of forensic evaluations on patients with whom therapeutic relationships are contemplated or previously exist, inasmuch as such situations are likely to pose conflicts of interest. As well, child and adolescent psychiatrists must pay close attention to documentation of patient-related material as all such recordings have potential forensic implications.

All of these legal considerations do not minimize or supersede the ethical principles of this code. Rather, knowledge and consideration of pertinent laws is an important component of ethically responsible practice.