Clinical Supervision Ethics

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Part 1

Chapter 1: Central Principles of Clinical Supervision

Source: https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4435.pdf.

The Consensus Panel for this TIP has identified central principles of clinical supervision. Although the Panel recognizes that clinical supervision can initially be a costly undertaking for many financially strapped programs, the Panel believes that ultimately clinical supervision is a cost-saving process. Clinical supervision enhances the quality of client care; improves efficiency of counselors in direct and indirect services; increases workforce satisfaction, professionalization, and retention (see vignette 8 in chapter 2); and ensures that services provided to the public uphold legal mandates and ethical standards of the profession:

The central principles identified by the Consensus Panel are:

1. **Clinical supervision is an essential part of all clinical programs.** **Clinical supervision** is a central organizing activity that integrates the program mission, goals, and treatment philosophy with clinical theory and evidence-based practices (EBPs). The primary reasons for clinical supervision are to ensure (1) quality client care, and (2) clinical staff continue professional development in a systematic and planned manner. In substance abuse treatment, clinical supervision is the primary means of determining the quality of care provided.
2. **Clinical supervision enhances staff retention and morale.** Staff turnover and workforce development are major concerns in the substance

abuse treatment field. Clinical supervision is a primary means of improving workforce retention and job satisfaction (see, for example, Roche, Todd & O'Connor, 2007).

3. Every clinician, regardless of level of skill and experience, needs and has a right to clinical supervision. In addition, supervisors need and have a right to supervision of their supervision. Supervision needs to be tailored to the knowledge base, skills, experience, and assignment of each counselor. All staff need supervision, but the frequency and intensity of the oversight and training will depend on the role, skill level, and competence of the individual. The benefits that come with years of experience are enhanced by quality clinical supervision. In the recent years, Falender (2020) stressed that "Clinical supervision is broadly viewed as a means for establishing and ensuring the competence of the supervisee."
4. **Clinical supervision needs the full support of agency administrators.** Just as treatment programs want clients to be in an atmosphere of growth and openness to new ideas, counselors should be in an environment where learning and professional development and opportunities are valued and provided for all staff.
5. **The supervisory relationship is the crucible in which ethical practice is developed and reinforced.** The supervisor needs to model sound ethical and legal practice in the supervisory relationship. This is where issues of ethical practice arise and can be addressed. This is where ethical practice is translated from a concept to a set of behaviors. Through supervision, clinicians can develop a process of ethical decision-making and use this process as they encounter new situations.
6. **Clinical supervision is a skill in and of itself that has to be developed.** Good counselors tend to be promoted into supervisory positions with the assumption that they have the requisite skills to provide professional clinical supervision. However, clinical supervisors need a different role orientation toward both program and client goals and a knowledge base to

complement a new set of skills. Programs need to increase their capacity to develop good supervisors.

7. **Clinical supervision in substance abuse treatment most often requires balancing administrative and clinical supervision tasks.** Sometimes, these roles are complementary and sometimes they conflict. Often the supervisor feels caught between the two roles. Administrators need to support the integration and differentiation of the roles to promote the efficacy of the clinical supervisor. (See Part 2.)
8. Culture and other contextual variables influence the supervision process; supervisors need to continually strive for cultural competence. Supervisors require cultural competence at several levels. Cultural competence involves the counselor's response to clients, the supervisor's response to counselors, and the program's response to the cultural needs of the diverse community it serves. Since supervisors are in a position to serve as catalysts for change, they need to develop proficiency in addressing the needs of diverse clients and personnel.
9. **Successful implementation of EBPs requires ongoing supervision.** Supervisors have a role in determining which specific EBPs are relevant for an organization's client (Lindbloom, Ten Eyck, & Gallon, 2005). Supervisors ensure that EBPs are successfully integrated into ongoing programmatic activities by training, encouraging, and monitoring counselors. Excellence in clinical supervision should provide greater adherence to the EBP model. Because state funding agencies now often require substance abuse treatment organizations to provide EBPs, supervision becomes even more important.
10. **Supervisors have the responsibility to be gatekeepers for the profession**. Supervisors are responsible for maintaining professional standards, recognizing and addressing impairment, and safeguarding the welfare of clients. More than anyone else in an agency, supervisors can observe counselor behavior and respond promptly to potential problems, including counseling some individuals out of the field because they are ill-

suited to the profession. This "gatekeeping" function is especially important for supervisors who act as field evaluators for practicum students prior to their entering the profession. Finally, supervisors also fulfill a gatekeeper role in performance evaluation and in providing formal recommendations to training institutions and credentialing bodies.

11. **Clinical supervision should involve direct observation methods.** Direct observation should be the standard in the field because it is one of the most effective ways of building skills, monitoring counselor performance, and ensuring quality care. Supervisors require training in methods of direct observation, and administrators need to provide resources for implementing direct observation. Although small substance abuse agencies might not have the resources for one- way mirrors or videotaping equipment, other direct observation methods can be employed.

Guidelines for New Supervisors

Congratulations on your appointment as a supervisor! By now you might be asking yourself a few questions: What have I done? Was this a good career decision? There are many changes ahead. If you have been promoted from within, you'll encounter even more hurdles and issues. First, it is important to face that your life has changed. You might experience the loss of friendship of peers. You might feel that you knew what to do as a counselor, but feel totally lost with your new responsibilities (see vignette 6 in chapter 2). You might feel less effective in your new role.

Supervision can be an emotionally draining experience, as you now have to work with more staff related interpersonal and human resources issues.

Before your promotion to clinical supervisor, you might have felt confidence in your clinical skills. Now you might feel unprepared and wonder if you need a training course for your new role. If you feel this way, you're right. Although you are a good counselor, you do not necessarily possess all the skills needed to be a good supervisor. Your new role requires

a new body of knowledge and different skills, along with the ability to use your clinical skills in a different way. Be confident that you will acquire these skills over time (see the Resources section, p. 34) and that you made the right decision to accept your new position.

Suggestions for new supervisors:

- Quickly learn the organization's policies and procedures and human resources procedures (e.g., hiring and firing, affirmative action requirements, format for conducting meetings, giving feedback, and making evaluations). Seek out this information as soon as possible through the human resource department or other resources within the organization.
- **Ask for a period of 3 months to allow you to learn about your new role**. During this period, do not make any changes in policies and procedures but use this time to find your managerial voice and decision-making style.
- Take time to learn about your supervisees, their career goals, interests, developmental objectives, and perceived strengths.
- Work to establish a contractual relationship with supervisees, with clear goals and methods of supervision.
- Learn methods to help staff reduce stress, address competing priorities, resolve staff conflict, and other interpersonal issues in the workplace.
- Obtain training in supervisory procedures and methods.
- Find a mentor, either internal or external to the organization.
- Shadow a supervisor you respect who can help you learn the ropes of your new job.
- Ask often and as many people as possible, "How am I doing?", and "How can I improve my performance as a clinical supervisor?"
- Ask for a regular, weekly meetings with your administrator for training and instruction.
- Seek supervision of your supervision.

Problems and Resources

As a supervisor, you may encounter a broad array of issues and concerns, ranging from working within a system that does not fully support clinical supervision to working with resistant staff. A comment often heard in supervision training sessions is “My boss should be here to learn what is expected in supervision,” or “This will never work in my agency’s bureaucracy. They only support billable activities.” The work setting is where you apply the principles and practices of supervision and where organizations are driven by demands, such as financial solvency, profit, census, accreditation, and concerns over litigation. Therefore, you will need to be practical when beginning your new role as a supervisor: determine how you can make this work within your unique work environment.

Working with Staff Who are Resistant to Supervision

Some of your supervisees may have been in the field longer than you have and see no need for supervision. Other counselors, having completed their graduate training, do not believe they need further supervision, especially not from a supervisor who might have less formal academic education than they have. Other resistance might come from ageism, sexism, racism, or classism. Particular to the field of substance abuse treatment may be the tension between those who believe that recovery from substance abuse is necessary for this counseling work and those who do not believe this to be true.

In addressing resistance, you must be clear regarding what your supervision program entails and must consistently communicate your goals and expectations to staff. To resolve defensiveness and engage your supervisees, you must also honor the resistance and acknowledge their concerns. Abandon trying to push the supervisee too far, too fast. Resistance is an expression of ambivalence about change and not a personality defect of the counselor. Instead of arguing with or exhorting staff, sympathize with their concerns, saying, “I understand this is difficult. How are we going to resolve these issues?”

When counselors respond defensively or reject directions from you, try to understand the origins of their defensiveness and to address their resistance. Self-disclosure by the supervisor about experiences as a supervisee, when appropriately used, may be helpful in dealing with defensive, anxious, fearful, or resist- ant staff. Work to establish a healthy,

positive supervisory alliance with staff. Because many substance abuse counselors have not been exposed to clinical supervision, you may need to train and orient the staff to the concept and why it is important for your agency.

Things a New Supervisor Should Know

Eight truths a beginning supervisor should commit to memory are listed below:

1. The reason for supervision is to ensure quality client care. As stated throughout this TIP, the primary goal of clinical supervision is to protect the welfare of the client and ensure the integrity of clinical services.
2. **Supervision is all about the relationship**. As in counseling, developing the alliance between the counselor and the supervisor is the key to good supervision.
3. Culture and ethics influence all supervisory interactions. Contextual factors, culture, race, and ethnicity all affect the nature of the supervisory relationship. Some models of supervision (e.g., Holloway, 1995) have been built primarily around the role of context and culture in shaping supervision.
4. Be human and have a sense of humor. As role models, you need to show that everyone makes mistakes and can admit to and learn from these mistakes.
5. Rely first on direct observation of your counselors and give specific feedback. The best way to determine a counselor's skills is to observe him or her and to receive input from the clients about their perception of the counseling relationship.
6. Have and practice a model of counseling and of supervision; have a sense of purpose. Before you can teach a supervisee knowledge and skills, you must first know the philosophical and theoretical foundations on which you, as a supervisor, stand. Counselors need to know what they are going to learn from you, based on your model of counseling and supervision.

7. Make time to care of yourself spiritually, emotionally, mentally, and physically. Again, as role models, counselors are watching your behavior. Do you "walk the talk" of self-care?
8. You have a unique position as an advocate for the agency, the counselor, and the client. As a supervisor, you have a wonderful opportunity to assist in the skill and professional development of your staff, advocating for the best interests of the supervisee, the client, and your organization.

Modes of Clinical Supervision

You may never have thought about your model of supervision. However, it is a fundamental premise of this TIP that you need to work from a defined model of supervision and have a sense of purpose in your oversight role. Four supervisory orientations seem particularly relevant. They include:

- Competency-based models
- Treatment-based models
- Developmental approaches
- Integrated models

Competency-based models (e.g., microtraining, the Discrimination Model [Bernard & Goodyear, 2004), and the Task-Oriented Model [Mead, 1990], focus primarily on the skills and learning needs of the supervisee and on setting goals that are **s**pecific, **m**easurable, **a**ttainable, **r**ealistic, and **t**imely (SMART). They construct and implement strategies to accomplish these goals. They key strategies of competency-based models include applying social leaning principles (e.g., modeling role reversal, role playing, and practice), using demonstrations, and using supervisory functions (teaching, consulting, and counseling).

Treatment-based supervision models train to a particular theoretical approach to counseling, incorporating EBPs into supervision and seeking fidelity and adaptation to the

theoretical model. Motivational interviewing, cognitive-behavioral therapy, and psychodynamic psychotherapy are three examples. These models emphasize the counselor's strengths, seek the supervisee's understanding of the theory and model taught, and incorporate the approaches and techniques of the model. The majority of these models begin with articulating their treatment approach and describing their supervision model, based upon that approach.

Developmental models, such as Stoltenberg and Delworth (1987), understand that each counselor goes through different stages of development and recognize that movement through these stages is not always linear and can be affected by changes in assignment, setting, and population served. (The developmental stages of counselors and supervisors are described in detail below).

Integrated models, including the Blended Model, begin with the style of leadership and articulate a model of treatment, incorporate descriptive dimensions of supervision (see below), and address contextual and developmental dimensions into supervision. They address both skill and competency development and affective issues, based on the unique needs of the supervisee and supervisor. Finally, integrated models seek to incorporate EBPs into counseling and supervision.

In all models of supervision, it is helpful to identify culturally or contextually centered models or approaches and find ways of tailoring the models to specific natural and diversity factors. Issues to consider are:

- Explicitly addressing diversity of supervisees (e.g., race, ethnicity, gender, age, sexual orientation) and the specific factors associated with these types of diversity;
- Explicitly involving supervisees; concerns related to a particular client diversity (e.g. those whose culture, gender, sexual orientation, and other attributes differ from those of the supervisee) and addressing specific factors associated with these types of diversity; and

- Explicitly addressing supervisees' issues related to effectively navigating services in intercultural communities and effectively networking with agencies and institutions.

It is important to identify your model of counseling and your beliefs about change, and to articulate a workable approach to supervision that fits the model of counseling you use. Theories are conceptual frameworks that enable you to make sense of and organize your counseling and supervision and to focus on the most salient aspects of counselor's practice. You may find some of the questions below to be relevant to both supervision and counseling. The answers to these questions influence both how you supervise and how the counselors you supervise work:

- What are your beliefs about how people change in both treatment and clinical supervision?
- What factors are important in treatment and clinical supervision?
- What universal principles apply in supervision and counseling and which are unique to clinical supervision?
- What conceptual frameworks of counseling do you use (for instance, cognitive-behavioral therapy, 12- Step facilitation, psychodynamic, behavioral)?
- What are the key variables that affect outcomes? (Campbell, 2000)

According to Bernard and Goodyear (2004) and Powell and Brodsky (2004), the qualities of a good model of clinical supervision are:

- Rooted in the individual, beginning with the supervisor's self, style, and approach to leadership.
- Precise, clear, and consistent.
- Comprehensive, using current scientific evidence-based practices.
- Operational and practical, providing specific concepts and practices in clear, useful, and measurable terms.
- Outcome-oriented to improve counselor competence; make work manageable; create a sense of mastery and growth for the counselor; and address the needs of the organization, the supervisor, the supervisee, and the client.

Finally, it is imperative to recognize that, whatever model you adopt, it needs to be rooted in the learning and developmental needs of the supervisee, the specific needs of the clients they serve, the goals of the agency in which you work, and in the ethical and legal boundaries of practice. These four variables define the context in which effective supervision can take place.

Developmental Stages of Counselors

Counselors are at different stages of professional development. Thus, regardless of the model of supervision you choose, you must take into account the supervisee's level of training, experience, and proficiency. Different supervisory approaches are appropriate for counselors at different stages of development. An understanding of the supervisee's (and supervisor's) developmental needs is an essential ingredient for any model of supervision.

Various paradigms or classifications of developmental stages of clinicians have been developed (Ivey, 1997; Rigazio-DiGilio, 1997; Skolvolt & Ronnerstand, 1992; Todd and Storn, 1997). This TIP has adopted the Integrated Developmental Model (IDM) of Stoltenberg, McNeill, and Delworth (1998) see figure 2, p.10). This schema uses a three-stage approach. The three stages of development have different characteristics and appropriate supervisory methods. Further application of the IDM to the substance abuse field is needed. (For additional information, see Anderson 2001.)

It is important to keep in mind several general cautions and principles about counselor development, including:

- There is a beginning but not an end point for learning clinical skills; be careful of counselors who think they "know it all."
- Take into account the individual learning styles and personalities of your supervisees and fit the supervisory approach to the developmental stage of each counselor.
- There is a logical sequence to development, although it is not always predictable or rigid; some counselors may have been in the field for years but remain at an

early stage of professional development, whereas others may progress quickly through the stages.

Figure 2. Counselor Developmental Model			
Developmental Level	**Characteristics**	**Supervision Skills Development Needs**	**Techniques**
Level 1	• Focuses on self • Anxious, uncertain • Preoccupied with performing the right way • Overconfident of skills • Overgeneralizes • Overuses a skill • Gap between conceptualization, goals, and interventions • Ethics underdeveloped	• Provide structure and minimize anxiety. • Supportive, address strengths first then weakness • Suggest approaches • Start connecting theory to treatment	• Observation • Skills training • Role playing • Readings • Group supervision • Closely monitor clients
Level 2	• Focuses on self and more on client • Confused, frustrated with complexity of counseling • Overidentifies with client	• Less structure provided; more autonomy encouraged • Supportive • Periodic suggestion of approaches • Confront discrepancies	• Observation • Role playing • Interpret dynamics • Group supervision • Reading

	• Challenges authority • Lacks integration with theoretical base • Overburdened • Ethics better understood	• Introduce more alternative views • Process comments, highlight countertransference • Affective reactions to client and/or supervisor	•
Level 3	• Focuses intently on client • High degree of empathic skill • Objective third person perspective • Integrative thinking and approach • Highly responsible and ethical counselor	• Supervisee directed • Focus on personal-professional integration and career • Supportive • Change agent	• Peer supervision • Group supervision • Reading
• Source: Stoltenberg, Delworth, & McNeil, 1998 •			

- Counselors at an advanced developmental level have different learning needs and require different supervisory approaches from those at Level 1; and
- The developmental level can be applied for different aspects of a counselor's overall competence (e.g., Level 2 mastery for individual counseling and Level 1 for couples counseling).

Developmental Stages of Supervisors

Just as counselors go through stages of development, so do supervisors. The developmental model presented in figure 3 provides a framework to explain why supervisors act as they do, depending on their developmental stage. It would be expected that someone new to supervision would be at a Level 1 as a supervisor. However, supervisors should be at least at the second or third stage of counselor development. If a newly appointed supervisor is still at Level 1 as a counselor, he or she will have little to offer to more seasoned supervisees.

Figure 3. Supervisor Developmental Model

Developmental Level	Characteristics	To Increase Supervision Competence
Level1	• Is anxious regarding the role • Is naïve about assuming the role of supervisor • Is focused on doing the "right" thing • May overly respond as an "expert" • Is uncomfortable providing direct feedback	• Follow structures and formats • Design systems to increase organization of supervision • Assign Level 1 counselors
Level 2	• Shows confusion and conflict • Sees supervision as complex and multidimensional	• Provide active supervision of the supervision • Assign Level 1 counselors

	• Needs support to maintain motivation • Overfocused on counselor's deficits and perceived resistance • May fall back to being a therapist with the counselor	
Level 3	• Is highly motivated • Can provide an honest self-appraisal of strengths and weaknesses as supervisor • Is comfortable and evaluation process • Provides thorough, objective feedback	Comfortable with all levels
Source: Stoltenberg, Delworth, McNeil, 1998		

Guidelines on Supervision

Source: https://www.apa.org/about/policy/guidelines-supervision.pdf

The American Psychological Association (2014) published guidelines on supervision. Although they relate specifically to health service psychologists, they are still applicable to any mental health practitioner and supervisor.

Competency-Based Supervision is a metatheoretical approach that explicitly identified the knowledge, skills, and attitudes that comprise clinical competencies, informs learning

strategies and evaluation procedures, and meets criterion-referenced competence standards consistent with evidence-based practices (regulations), and the local or cultural clinical setting (adapter from Falender and Shafranske, 2007). Competency-based supervision is one approach to supervision; it is metatheoretical and does not preclude other models of supervision.

The Guidelines on Supervision are organized around seven domains:

Domain A: Supervisor Competence

Domain B: Diversity

Domain C: Supervisory Relationship

Domain D: Professionalism

Domain E: Assessment/ Evaluation/ Feedback

Domain F: Problems of Professional Competence

Domain G: Ethical, Legal, and Regulatory Considerations

Within each of these seven domains, guidelines for supervision are articulated with supporting rationale informed by the empirical and theoretical literature. Although this framework is useful to present the Guidelines in Supervision, there is considerable conceptual and practical overlap among these domains. Consideration was given to the utility and implementation of the *Guidelines on Supervision* as well as to minimizing redundancy when making decisions about the best domain for a specific guideline.

Domain A: Supervisor Competence

Supervision is a distinct professional practice with knowledge, skills, and attitudes, that supervisors require specific training to attain (Falender, Burnes, & Ellis; 2013; Falender, Ellis, & Burnes, 2013; Bernard & Goodyear, 2014; Reiser & Milne, 2012). Supervision knowledge includes (Association of State and Provincial Psychology Boards, 2020):

- An understanding of the professional practice being supervised (models, theories, and modalities of supervision);

- Research scientific, and evidence-base of the supervision literature;
- Professional/supervisee development;
- Ethics and legal issues specific to supervision;
- Evaluation and process outcome; and
- Diversity in all its forms.

Skills include:

- Providing supervision in multiple modalities (e.g., group, individual);
- Forming a supervisory alliance;
- Providing formative and summative feedback;
- Promoting the supervisee's self-assessment and growth;
- Self-assessing by the supervisor;
- Assessing the supervisee's learning needs and developmental level;
- Discussing relevant multi-cultural issues;
- Eliciting and integrating evaluative feedback from supervisees;
- Teaching and didactics;
- Setting boundaries;
- Knowing when to seek consultation;
- Flexibility; and
- Engaging in scientific thinking and translating theory and research to practice.

Attitudes and values include:

- Appreciation of responsibility for both clients and supervisees;
- Respect
- Sensitivity to diversity;
- A balancing between being supportive and challenging;
- Empowering;
- A commitment to lifelong learning and professional growth

- Balancing supervisee self-care and well-being with work demands of the training experience;
- Balancing obligations to client, agency, and service with training needs;
- Valuing ethical principles;
- Knowing and utilizing psychological science related to supervision
- A commitment to the use of empirically-based supervision; and
- Commitment to knowing one's own limitations

The supervisor serves as role model for the supervisee, fulfills the highest duty of protecting the public, and is a gatekeeper for the profession ensuring that supervisees meet competence standards in order to advance to the next level or to licensure.

1. Supervisors strive to be competent in the psychological services provided to clients/patients by supervisees under their supervision and when supervising in areas in which they are less familiar they take reasonable steps to ensure the competence of their work and to protect others from harm.

Supervisors possess up-to-date knowledge and skills regarding the areas being supervised (e.g., psychotherapy, research, assessment), psychological theories, diversity dimensions (e.g., age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socio-economic status), and individual differences and intersections of these with diversity dimensions. Supervisors also have knowledge of the clinical specialty areas in which supervision is being provided and of requirements and procedures to be taken when supervising in an area in which expertise has not been established (Barnett et al., 2007; Goodyear & Rodolfa, 2012; APA, 2010, 2.01, 2.03).

Supervisors are knowledgeable of the context of supervision including its immediate system and expectations, and the sociopolitical context. Supervisors

are knowledgeable too about emergent events in the setting or context that impact the client(s)/patient(s) (Falender et al., 2004).

2. Supervisors seek to attain and maintain competence in the practice of supervision through formal education and training.

Competence entails demonstrated evidence-based practice as well as in the various modalities (e.g., family, group and individual), theories, and general knowledge, skills, and attitudes and research support of competency-based supervision. Supervisors obtain requisite training in knowledge, skills, and attitudes of clinical supervision (Newman, 2013; Watkins, 2012). Supervisors are skilled and knowledgeable in competency-based models, in developing and managing the supervisory relationship/alliance (Bernard & Goodyear, 2014; Falender & Shafranske, 2004; Ladany, Mori, & Mehr, 2013), and in enhancing the supervisee's clinical skills (Milne, 2009). **The formal education and training should include instruction in didactic seminars, continuing education, or supervised supervision.** At a minimum, education and training in supervision should include: models and theories of supervision; modalities; relationship formation, maintenance, rupture and repair; diversity and multiculturalism; feedback, evaluation; management of supervisee's emotional reactivity and interpersonal behavior; reflective practice; application of ethical and legal standards; decision making regarding gatekeeping; and considerations of developmental level of the trainee (Bernard & Goodyear, 2014; Falender & Shafranske, 2012; Newman, 2013). The supervision reflects practices informed by competency- and evidence-based practice to enhance accountability (Milne & Reiser, 2012; Reese et al., 2009; Stoltenberg & Pace, 2008; Watkins, 2011; Watkins, 2012; Worthen & Lambert, 2007). Assessment entails use of outcome measures and ratings from multiple supervisors (e.g., Reese et al., 2009, Watkins, 2011; Worthen & Lambert, 2007). Assessment strategies include both formative and summative evaluation and procedures for competence assessment.

3. **Supervisors endeavor to coordinate with other professionals responsible for the supervisee's education and training to ensure communication and coordination of goals and expectations.**

Coordination can assist supervisees in managing these multiple roles and responsibilities as well as supervisory expectations. Coordination is especially important to seek when a supervisee is exhibiting performance problems, when the supervisory relationship is under stress, or when the supervisor seeks another perspective (Thomas, 2010).

4. **Supervisors strive for diversity competence across populations and settings (as defined in APA,2003).**

Diversity competence is an inseparable and essential component of supervision competence that involves relevant knowledge, skills, and values/attitudes (for more information, see Domain B: Diversity).

5. **Supervisors using technology in supervision (including distance supervision), or when supervising care that incorporates technology, strive to be competent regarding its use.**

Supervisors ensure that policies and procedures are in place for ethical practice of telepsychology, social media, and digital communications between any combination of client/patient, supervisee, and supervisor (APA, 2013b; Fitzgerald, Hunter, Hadjistavropoulos, & Koocher, 2010). Considerations should include services appropriate for distance supervision, confidentiality, and security. Supervisors are knowledgeable about relevant laws specific to technology and supervision, and technology and practice.

Supervisors model ethical practice, ethical decision-making, and professionalism, and engage in thoughtful dialogues with supervisees regarding use of social networking and internet searches of clients/patients and supervisees (Clinton, Silverman, & Brendel, 2010; Myers, Endres, Ruddy, & Zelikovsky, 2012).

Domain B: Diversity

Diversity competence is an inseparable and essential component of supervision competence. It refers to developing competencies for working with diversity issues and diverse individuals, including those from one's own background. More commonly, these competencies refer to working with others from backgrounds different than one's own but includes the complexity of understanding and factoring in the multiple identities of each individual: client(s), supervisee, supervisor and differing worldviews. Competent supervision attends to a broad range of diversity dimensions (e.g., age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socio-economic status), and includes sensitivity to diversity of supervisees, clients/patients, and the supervisor (APA, 2003, 2004a, 2007a, 2010 (2.03); 2011a, 2011b).

Ancis & Ladany (2010) emphasized that the key factor for the supervisees to be able to conduct ethical and effective practice towards their clients is to possess the capacity to understand and address how culture and other aspects of identity in supervision (as cited by Yeung, 2019).

Supervisors are encouraged to infuse diversity into all aspects of clinical practice and supervision, including attention to oppression and privilege and the impact of those on the supervisory power differential, relationship, and on client/patient and supervisee interactions and supervision interactions.

1. **Supervisors strive to develop and maintain self-awareness regarding their diversity competence, which includes attitudes, knowledge, and skills.**

   Supervisors understand that they serve as important role models regarding openness to self- exploration, understanding of one's own biases, and willingness to pursue education or consultation when indicated. Supervisors also are important role models regarding their diversity knowledge, skills and, attitudes. Supervisors' ability to self-reflect, revise and update knowledge and advance their skills in diversity serve as important lessons for supervisees. Modeling these

competencies helps to establish a safe environment in which to address diversity dimensions within supervision as well as in the larger professional setting.

2. **Supervisors planfully strive to enhance their diversity competence to establish a respectful supervisory relationship and to facilitate the diversity competence of their supervisees.**

Supervisors consider infusion of diversity competence in supervision as an ethical imperative and respect the human dignity of their supervisees and the clients/patients with whom the supervisee works (APA, 2010; Bernard & Goodyear, 2014; Falender, Shafranske, & Falicov, 2014). Supervisors play a significant role in developing the diversity competencies of their supervisees. Research finds that diversity competence among supervisors can lag behind that of their supervisees (Miville, Rosa, & Constantine, 2005). Fortunately, diversity competence can be directly and constructively addressed by supervisors, who in turn can facilitate the diversity competence of their supervisees. Moreover, all supervision can be viewed as multicultural in the same manner that all therapy is multicultural (Pederson, 1990). Adopting such a framework strengthens the supervisory relationship, enhances supervisor competence, and promotes the diversity competencies of both supervisors and supervisees (Andrews, Kuemmel, Williams, Pilarski, Dunn, & Lund, 2013; Dressel, Consoli, Kim,on, 2007; Snowman, McCown, & Biehler, 2012). Viewing diversity as normative, rather than as an exception, aids supervisors in being sensitive to important similarities and differences between themselves and their supervisees that may affect the supervisory relationship.

3. **Supervisors recognize the value of and pursue ongoing training in diversity competence as part of their professional development and life-long learning.**

In order to ensure diversity competence sufficient to provide culturally sensitive supervision, supervisors seek to continue to develop their own knowledge, skills, and attitudes, particularly in diversity domains that are most commonly relevant to their clinical supervision. At a minimum, supervisors should have attained formal

training in diversity through their own doctoral training program or continuing professional development workshops, programs, and independent study, should be familiar with APA guidelines addressing diversity (APA, 2003, 2004a, 2007a, 2011a, 2011b), and should pursue continuing education to maintain current competence and build knowledge in emerging areas (APA, 2010, 2.03).

4. **Supervisors aim to be knowledgeable about the effects of bias, prejudice, and stereotyping. When possible, supervisors model client/patient advocacy and model promoting change in organizations and communities in the best interest of their clients/patients.**

Supervision occurs within the context of diversity and social and political systems. Of special importance is the impact of bias, prejudice and stereotyping, both positive and negative, on therapeutic and supervisory relationships within these systems. Supervisors promote the supervisee's competence by modeling advocacy for human rights and intervention with institutions and systems (Burnes & Singh, 2010).

5. **Supervisors aspire to be familiar with the scholarly literature concerning diversity competence in supervision and training. Supervisors strive to be familiar with promising practices for navigating conflicts among personal and professional values in the interest of protecting the public.**

Considerable scholarship has been published on supervision and diversity (e.g., Bernard & Goodyear, 2014; Falender, Burns, & Ellis, 2013; Miville et al., 2009). Resources include competency-based training models for integrating diversity dispositions of supervisors and supervisees (Miville et al., 2009), and the duty of supervisors to assist supervisees in navigating inevitable tensions between personal and professional values in providing competent client/patient care (e.g., Behnke, 2012; Bienske & Mintz, 2012; Forrest, 2012; Mintz, Jackson, Neville, Illfelder-Kaye, Winterowd, & Loewy, 2009; Winterowd, Adams, Miville, & Mintz, 2009).

Domain C: Supervisory Relationship

The quality of the supervisory relationship is essential to effective clinical supervision (e.g., Bernard & Goodyear, 2014; Falender & Shafranske, 2004; Holloway, 1995; O'Donovan, Halford, & Walters, 2011). Quality of the supervision relationship is associated with more effective evaluation (Lehrman-Waterman & Ladany, 2001), satisfaction with supervision (Ladany, Ellis, & Friedlander, 1999), and supervisee self-disclosure of personal and professional reactions including reactivity and counter transference (Falender & Shafranske, 2004; Ladany , Lehrman-Waterman, Molinaro, & Wolgast, 1999). The power differential is a central factor in the supervisory relationship and the supervisor bears responsibility for managing, collaborating, and discussing power within the relationship (Porter & Vasquez, 1997).

1. Supervisors value and seek to create and maintain a collaborative relationship that promotes the supervisees' competence.

Supervisors initiate collaborative discussion of the expectations, goals, and tasks of supervision. By initiating this discussion, they establish a working relationship that values the dignity of others, responsible caring, honesty, transparency, engagement, attentiveness, and responsiveness, as well as humility, flexibility, and professionalism (Ellis, Ring, Hanus, & Berger, 2013). In discussing the supervisory relationship, the supervisor should: (1) initiate discussions about differences, including diversity, values, beliefs, biases, and characteristic interpersonal styles that may affect the supervisory relationship and process; (2) discuss inherent power differences and supervisor responsibility to manage such differences wisely; and (3) take responsibility to establish relationship conditions that promote trust, reliability, predictability, competence, perceived expertise, and developmentally-appropriate challenge.

2. Supervisors seek to specify the responsibilities and expectations of both parties in the supervisory relationship. Supervisors identify expected program competencies and performance standards, and assist the supervisee to formulate individual learning goals.

The supervisor is encouraged to explicitly discuss with the supervisee aspects of the supervision process such as: program goals, individual learning goals, roles and responsibilities, description of structure of supervision, supervision activities, performance review and evaluation, and limits of supervision confidentiality. The supervisor also provides clarity about duties including that the primary duty of supervisor is to the client/patient, and secondarily to competence development of the supervisee. (The supervision contract is discussed further in the Legal and Ethical Section.)

3. **Supervisors aspire to review regularly the progress of the supervisee and the effectiveness of the supervisory relationship and address issues that arise.**

As the supervisory relationship and the supervisee's learning needs evolve over time, the supervisor should work collaboratively with the supervisee to revise the supervision goals and tasks. When disruptions occur in the supervisory relationship, supervisors seek to address and resolve the impasses and disruptions openly, honestly, and in the best interests of client/patient welfare and the supervisee's development (Safran, Muran, Stevens, & Rothman, 2008).

Domain D: Professionalism

Professionalism goes hand in hand with a profession's social responsibility (see Hodges et al., 2011; Vasquez & Bingham, 2012). The "professionalism covenant" puts the needs and welfare of the people they serve at the forefront (Grus & Kaslow, 2014). Grus and Kaslow (2014) summarized these as: "behavior and comportment that reflect the values and attitudes of psychology (Fouad et al., 2009; Hatcher et al., 2013). The essential components include: (1) integrity – honesty, personal responsibility and adherence to professional values; (2) deportment; (3) accountability; (4) concern for the welfare of others; and (5) professional identity."

1. Supervisors strive to model professionalism in their own comportment and interactions with others, and teach knowledge, skills, and attitudes associated with professionalism.

Supervisory modeling of professionalism occurs across professional settings. Supervisees' understanding of what is professional or ethical is still developing (Gottlieb, Robinson, & Younggren, 2007). Modeling is a powerful means to teach attitudes and behaviors (e.g., Tarvydas, 1995), including professionalism (Cruess, Cruess, & Steinert, 2009).) Supervisors, in vivo, can exemplify virtue, humanism, and honest communication (Grus & Kaslow, 2014, modified from Hatcher et al., 2013).

One important aspect of supervision is to socialize supervisees into a particular profession (e.g., Ekstein & Wallerstein, 1972); to help them learn to "think like" those in that profession.

In interprofessional settings, supervisors model professionalism in cooperative, collaborative, and respectful interaction with team members.

2. Supervisors are encouraged to provide ongoing formative and summative evaluation of supervisees' progress toward meeting expectations for professionalism appropriate for each level of education and training.

Modeling alone is insufficient to teach professionalism; it should be embedded in a larger training curriculum incorporating developmentally expected behaviors (Grus & Kaslow, 2014). Supervisees need clear criteria to judge the extent to which they are demonstrating developmentally appropriate professionalism (Fouad et al., 2009; Kaslow et al., 2009) as well as feedback about the extent to which they are meeting those criteria. The knowledge, skills, and attitudes associated with professionalism have been addressed within and across disciplines with much congruence. These include, "altruism, accountability, benevolence, caring and compassion, courage, ethical practice, excellence, honesty, honor, humanism, integrity, reflection/self-awareness, respect for others, responsibility and duty, service, social responsibility, team work, trustworthiness, and truthfulness" (Grus and Kaslow, 2014).

Domain E: Assessment/ Evaluation/ Feedback

Assessment, evaluation, and feedback are essential components of ethical supervision (Carroll, 2010; Falender et al., 2004). However, supervisors have been found to provide it relatively infrequently (e.g., Ellis et al., 2014; Friedlander, Siegel, & Brenock, 1989; Hoffman, Hill, Holmes, & Freitas, 2005), which leads to failures in gatekeeping and failures of supervisors in informing supervisees about their competency development (Thomas, 2010), and creates potential for ethical complaints (Falvey & Cohen, 2004; Ladany et al., 1999). To be effective, assessment, evaluation, and feedback need to be directly linked to specific competencies, to observed behaviors, and be timely (APA, 2010, 7.06; Hattie & Timperley, 2007).

1. Ideally, assessment, evaluation, and feedback occur within a collaborative supervisory relationship. Supervisors promote openness and transparency in feedback and assessment, by anchoring such in the competency development of the supervisee.

Establishment and maintenance of the supervisory relationship provide the basis for assessment, evaluation, and feedback. Supervisee disclosure of client data is enhanced by a strong relationship (See Domain C in this document on the Supervisory Relationship.)

2. A major supervisory responsibility is monitoring and providing feedback on supervisee performance. Live observation or review of recorded sessions is the preferred procedure.

Supervisee self-report is the most frequently used source of data on supervisee performance and client/patient progress (e.g., Goodyear & Nelson, 1997; Noelle, 2002; Scott, Pachana, & Sofranoff, 2011). The accuracy of those reports, however, is constrained by human memory and information processing as well as by supervisees' self-protective distortion and biases, (Haggerty & Hilsenroth, 2011; Ladany, Hill, Corbett, & Nutt, 1996; Pope, Sonne, & Green, 2006; Yourman & Farber, 1996) that result in their not disclosing errors, resulting in the loss of potentially important clinical data.

The more direct the access a supervisor has to a supervisee's professional work, the more accurate and helpful their feedback will likely be. Supervisors should use live observation or audio or video review techniques whenever possible, as these are associated with enhanced supervisee and client/patient outcomes (Haggerty & Hilsenroth, 2011; Huhra, Yamokoski-Maynhart, & Prieto, 2008). Supervisors should not limit work samples only to those identified by the supervisee; some work samples should be selected by supervisors. Review of work samples should be planful and focus on specific competency development and defined supervision goals (Breunlin, Karrer, McGuire, & Cimmarusti, 1988; Hatcher, Fouad, Grus, Campbell, McCutcheon, & Leahy, 2013). In addition, the developmental level of the supervisee should be considered when identifying methods to monitor and provide feedback to the trainee. An organization can reduce legal risk through direct observation of the supervisee's work (e.g., using live or video observation of sessions) thus satisfying the monitoring standard of care in supervision.

3. Supervisors aspire to provide feedback that is direct, clear, and timely, behaviorally anchored, responsive to supervisees' reactions, and mindful of the impact on the supervisory relationship.

In delivering feedback, supervisors are sensitive to: (a) the power differential as a function of the supervisory evaluative and gatekeeping roles; (b) culture, diversity dimensions (e.g., gender, race, sexual orientation, socio-economic status) and other sources of privilege and oppression (Ancis & Ladany, 2001; Ryde, 2000; Shen-Miller, Forrest, & Burt, 2012); (c) supervisee developmental level (Stoltenberg & McNeill, 2010); (d) the possibilities of the supervisee experiencing demoralization (Watkins, 1996) or shame (Bilodeau, Savard, & Lecomte, 2012) in response to the feedback; and (e) timing and the amount of feedback that a supervisee can assimilate at any given moment (Westberg & Jason, 1993).

Feedback should occur at frequent intervals, with some positive and corrective feedback in each supervision session so that evaluation is not a surprise (Bennett et al., 2006). In instances when a supervisee exhibits problems in professional competence, supervisors are expected to be courageous and provide this difficult

feedback, doing so in a direct and supportive manner. Indirect delivery of difficult feedback to supervisees is not associated with good training outcomes (Hoffman et al., 2005). The difficulty of delivering difficult feedback is especially challenging in multicultural supervision (Burkard, Knox, Clarke, Phelps, & Inman, in press; Shen-Miller et al., 2012). Collaborative conversations among supervisors regarding diversity, consultation, and examination of biases were described as helpful in contextual understanding of individual supervisee development (Shen-Miller et al., 2012).

4. Supervisors recognize the value of and support supervisee skill in self-assessment of competence and incorporate supervisee self-assessment into the evaluation process.

Incorporating the use of supervisee self-assessment into the evaluation of supervisees can enhance skill development, provide useful reflection on the delivery of services, and inculcate attitudes of self-assessment as a lifelong learning tool (Wise, Sturm, Nutt, Rodolfa, Schaffer, & Webb, 2010). Research has shown that there are limitations to the accuracy of self-assessments (Dunning, Heath, & Suls, 2004; Gruppen, White, Fitzgerald, Grum, & Woolliscroft, 2000) indicating that the provision of significant feedback to supervisees should be used to enhance supervisee assessment of self-efficacy (Eva & Regehr, 2011).

5. Supervisors seek feedback from their supervisees and others about the quality of the supervision they offer, and incorporate that feedback to improve their supervisory competence.

It is important that supervisors obtain regular feedback about their work. Supervisors may not obtain regular feedback once they are licensed and as a result may tend to overestimate their competence (e.g., Walfish, McAlister, O'Donnell, & Lambert, 2012) and tend to grow in confidence about their abilities, even though that is not necessarily matched by corresponding increases in ability (see Dawes, 1994). Although studies on supervisee nondisclosures (e.g., Ladany et al, 1996; Mehr, Ladany & Caskie, 2010; Yourman & Farber, 1996) suggest

difficulty in obtaining candid information from supervisees, it is important that supervisors routinely seek—and utilize—feedback about their own supervision (see e.g., Williams, 1994).

Domain F: Professional Competence Problems

Only a small proportion of supervisees in health service psychology programs demonstrate significant problems in professional competence, but most academic and internship programs report at least one supervisee with competence problems in the previous five years (Forrest et al., 1999). When this occurs it can be helpful to consider the multiple contexts in which problem behavior is embedded (e.g., cultural beliefs, licensure and accreditation, peers, faculty, supervisors) (Forrest et al., 2008). Supervisors must be prepared to protect the well-being of clients/patients and the general public, while simultaneously supporting the professional development of the supervisee. They also must be mindful of the effects on the training program itself, as peers typically are aware of trainees with problems of professional competence and often have concerns that those problems are not being addressed (Rosenberg, Getzelman, Arcinue, & Oren, 2005; Shen-Miller et al., 2011; Veilleux et al., 2012).

Supervisors give precedence to protecting the well-being of clients/patients above the training of the supervisee. When supervisees display problems of professional competence decisions made and actions taken by supervisors in response to supervisees' competence problems should be completed in a timely manner (Kaslow, Rubin, Forrest, & et al., 2007). They also are guided by the training program's intentional and well-prepared plans for addressing such problems (Forrest et al., 2013).

1. Supervisors understand and adhere both to the supervisory contract and to program, institutional, and legal policies and procedures related to performance evaluations. Supervisors strive to address performance problems directly.

Effective management of professional competence problems begins with the supervision contract (elements of that contract are presented in the Ethics section of these Guidelines on Supervision) (Goodyear & Rodolfa, 2012; Thomas, 2007).

The contract provides prior written notice of the competencies required for satisfactory performance in the supervised experience (Gilfoyle, 2008) as well as the process of evaluation, the procedures that will be followed if the supervisee does not meet the criteria, and procedures available to the supervisee to clarify or contest the evaluation. This contract shall occur in the context of the program communicating clearly the Due Process Guidelines to the supervisees as required by the Commission on Accreditations Guidelines and Principles (Domains A and G). In the event a supervisee is exhibiting performance problems, supervisors seek consultation to ensure understanding of program, institutional, and legal policies and procedures related to performance evaluations.

2. Supervisors strive to identify potential performance problems promptly, communicate these to the supervisee, and take steps to address these in a timely manner allowing for opportunities to effect change.

Supervisors evaluate on an ongoing basis the supervisee's functioning with respect to abroad range of foundational and functional competencies, including professional attitudes and behaviors that are relevant to professional practice. Their determinations about areas in which the supervisee does not meet competence expectations must (a) take into consideration distinctions between normative developmental challenges and significant competence problems (Fouad et al., 2009; Hatcher et al., 2013; Kaslow et al., 2004; Rodolfa et al., 2005) and (b) be attuned to the intersections between diversity issues and competence (Constantine & Sue, 2007; Kaslow, Rubin, Forrest, & et al., 2007; Shen-Miller et al., 2009). Supervisors also seek consultation from and work in concert with relevant program and institutional participants when addressing potential performance issues.

Especially when potential performance problems are suspected, supervisors directly observe and monitor supervisees' work, and seek input about the supervisee's performance from multiple sources and from more than one supervisor. Supervisee's professional behaviors and attitudes should be carefully documented in writing with dates and specific behaviors included in the record.

Documentation is essential throughout the training trajectory in establishing clarity regarding the performance expectations and the supervisee's attaining the requisite competencies and is important in remediation or in adversarial actions.

Once supervisors have identified that a supervisee has professional competence problems, they have an ethical responsibility to discuss these with the supervisee and to develop a plan to remediate those problems (APA, 2010; 7.06). Supervisors do so in a manner that is clear, direct, and mindful of the barriers to assuring that such conversations are effective and likely to maintain the supervisory relationship (Hoffman et al., 2005; Jacobs et al., 2011).

Conversations addressing competence problems shall occur with sensitivity to issues of individual and cultural differences (Constantine & Sue, 2007; Shen-Miller et al., 2012).

3. Supervisors are competent in developing and implementing plans to remediate performance problems.

In conjunction with the supervisee and relevant training colleagues, the supervisor develops written documentation of areas in which the supervisee has competence deficits, performance expectations, steps to be taken to address deficits, responsibilities for each party, performance monitoring processes, and the timelines that will be followed (Kaslow, Rubin, Forrest, & et al., 2007). The supervisor will follow the steps outlined in this plan, including the development of timely written evaluations that are anchored in the stipulated performance criteria (Kaslow, Rubin, Forrest, & et al., 2007). Supervisors evaluate their role in the supervisory relationship and adjust their role as needed, providing more direction and oversight and assuring that client/patient welfare is not threatened and appropriate care is provided. These responsibilities need to be balanced with both training and gatekeeping responsibilities.

4. Supervisors are mindful of their role as gatekeeper and take appropriate and ethical action in response to supervisee performance problems.

In most situations, supervisees are ethically and legally entitled to a fair opportunity to remediate the competence problems and continue in their program of study (McAdams & Foster, 2007). Supervisors strive to closely monitor and document the progress of supervisees who are taking steps to address problems of competence. Should the supervisee not meet the stipulated performance levels after completing the agreed-upon remediation steps, attending to supervisee due process, supervisors must consider dismissal from the training program. Supervisors must have a clear understanding of competence problems that reflect unethical and/or illegal behavior that is sufficiently serious to warrant immediate dismissal from the training program (Bodner et al., 2012). Such considerations occur in the context of the training program's organization's explicit plans for addressing such problems.

Domain G: Ethics, Legal, and Regulatory Considerations

Valuing and modelling ethical behavior and adherence to relevant legal and regulatory parameters in supervision is essential to upholding the highest duty of the supervisor, protecting the public. Improper or inadequate supervision is the seventh most reported reason for disciplinary actions by licensing boards (ASPPB, 2013c). Supervisees may perceive their supervisors to engage in unethical behavior (Ladany, et al., 1999), sometimes due to misunderstanding the structure of the supervisory relationship and/or a supervisor's failure to secure informed consent. Generally, though, there is some evidence that supervisors and supervisees agree on what comprises ethical behavior (Worthington, Tan, & Poulin, 2002).

1. Supervisors model ethical practice and decision making and conduct themselves in accord with the APA ethical guidelines, guidelines of any other applicable professional organizations, and relevant federal, state, provincial, and other jurisdictional laws and regulations.

Supervisors support the acculturation of the supervisee into the ethics of the profession, their professionalism, and the integration of ethics into their professional behavior (Handelsman, Gottlieb, & Knapp, 2005; Knapp, Handelsman, Gottlieb, & VandeCreek, 2013). Supervisors ensure that supervisees

develop the knowledge, skills, and attitudes necessary for ethical and legal adherence. The supervisor is a role model for ethical and legal responsibility.

Supervisors discuss values that bear on professional practice, applications of ethical guidelines to specific cases, and the use of ethical decision-making models (Koocher & Keith-Spiegel, 2008; Pope & Vasquez, 2011).

The supervisor is responsible for understanding the jurisdictional laws and regulations and their application to the clinical setting for the supervisee (e.g., duty to warn and protect; Werth, Welfel, & Benjamin, 2009).

Supervisors are knowledgeable of legal standards and their applicability to both clinical practice and to supervision.

2. Supervisors uphold their primary ethical and legal obligation to protect the welfare of the client/patient.

The highest duty of the supervisor is protection of the client/patient (Bernard & Goodyear, 2014). Supervisors balance protection of the client/patient with the secondary responsibility of increasing supervisee competence and professional development. Supervisors ensure that supervisees understand the multiple aspects of this responsibility with respect to their clinical performance (Falender & Shafranske, 2012). Supervisors understand that they are ultimately responsible for the supervisee’s clinical work (Bernard & Goodyear, 2014).

3. Supervisors serve as gatekeepers to the profession. Gatekeeping entails assessing supervisees’ suitability to enter and remain in the field.

Supervisors help supervisees advance to successive stages of training upon attainment of expected competencies (Bodner, 2012; Fouad et al., 2009). Alternatively, if competencies are not being attained, in collaboration with the supervisee’s academic program, supervisors devise action plans with supervisees, with the understanding that if the stated competencies are not achieved, supervisees who are determined to lack sufficient foundational or functional competencies for entry to the profession may be terminated to protect potential

recipients of the supervisee’s practice (Forrest et al., 2013). Descriptions of such processes are in the training program’s or organization’s explicit plans for addressing competency problems or the unsuitability of the supervisee for the profession.

4. Supervisors provide clear information about the expectations for and parameters of supervision to supervisees preferably in the form of a written supervisory contract.

A supervision contract serves as the foundation for establishing the supervisory relationship by specifying the roles, tasks, responsibilities of supervisee and supervisor and performance expectations of the supervisee (Bernard & Goodyear, 2014; Osborn & Davis, 2009; Thomas, 2007, 2010). Supervisors convey the value of the points in the supervision contract through conversations with supervisees and may modify the understanding over time as warranted as the goals for supervision change. The contract includes a delineation of the following elements:

a. Content, method, and context of supervision—logistics, roles, and processes

b. Highest duties of the supervisor: protection of the client(s) and gatekeeping for the profession

c. Roles and expectations of the supervisee and the supervisor, and supervisee goals and tasks

d. Criteria for successful completion and processes of evaluation with sample evaluation instruments and competency documents (APA, 2010, 2.06)

e. Processes and procedures when the supervisee does not meet performance criteria or reference to such if they exist in other documents

f. Expectations for supervisee preparation for supervision sessions (e.g., video review, case notes, agenda preparation) and informing supervisor of clinical work and risk situations

g. Limits of confidentiality of supervisee disclosures, behavior necessary to meet ethical and legal requirements for client/patient protection, and methods of communicating with training programs regarding supervisee performance

h. Expectations for supervisee disclosures including personal factors and emotional reactivity (previously described, and worldviews (APA, 2010, 7.04)

i. Legal and ethical parameters and compliance, such as informed consent, multiple relationships, limits of confidentiality, duty to protect and warn, and emergent situation procedures

j. Processes for ethical problem-solving in the case of ethical dilemmas (e.g., boundaries, multiple relationships)

5. Supervisors maintain accurate and timely documentation of supervisee performance related to expectations for competency and professional development.

Keeping supervision records is an important means of documenting the conduct of supervision and supervisee progress (e.g., APA, 2007b; Falvey & Cohen, 2004; Luepker, 2012; Thomas, 2010).

Cultural and Contextual Factors

Culture is one of the major contextual factors that influence supervisory interactions. Other contextual variables include race, ethnicity, age, gender, discipline, academic background, religious, and spiritual practices, and sexual orientation, disability, and recovery versus non-recovery status. The relevant variables in the supervisory

relationship occur in the context of the supervisor, supervisee, client and the setting in which the supervision occurs. More care should be taken to:

- Identify the competencies necessary for substance abuse counselors to work with diverse individuals and navigate intercultural communities.
- Identify methods for supervisors to assist counselors in developing these competencies.
- Provide evaluation criteria for supervisors to determine whether their supervisees have met minimal competency standards for effective and relevant practice.

Models of supervision have been strongly influenced by contextual variables and their influence on the supervisory relationship and process, such as Holloway's Systems Model (1995) and Constantine's Multicultural Model (2003).

The competencies listed in TAP 21-A reflect the importance of culture in supervision (CSAT, 2007). The Counselor Development domain encourages self-examination of attitudes toward culture and other contextual variables. The Supervisory Alliance domain promotes attention to these variables in the supervisory relationship. (See also the planned TIP, *Improving Cultural Competence in Substance Abuse Counseling,* [CSAT, in development *b*].)

Cultural competence "refers to the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic ongoing, developmental process that requires a commitment and is achieved over time" (U.S. Department of Health and Human Services, 2003, p.12). Culture shapes belief systems, particularly concerning issues related to mental health and substance abuse, as well as the manifestation of symptoms, relational styles, and coping patterns.

There are three levels of cultural considerations for the supervisory process: the issue of the culture of the client being served and the culture of the counselor in supervision. Holloway (1995) emphasizes the cultural issues if the agency, the geographic environment of the organization, and many other contextual factors. Specifically, there are three important areas in which cultural and contextual factors play a key role in

supervision: in building the supervisory relationship or working alliance, in addressing the specific needs of the client, and in building supervisee competence and ability. It is your responsibility to address your supervisees' beliefs, attitudes, and biases about cultural and contextual variables to advance their professional development and promote quality client care.

Becoming culturally competent and able to integrate other contextual variables into supervision is a complex, long-term process. Cross (1989) has identified several stages on a continuum of becoming culturally competent (see figure 4).

Although you may never have had specialized training in multicultural counseling, some of your supervisees may have (see Constantine, 2003). Regardless, it is your responsibility to help supervisees build on the cultural competence skills they possess as well as to focus on their cultural competence deficits. It is important to initiate discussion of issues of culture, race, gender, sexual orientation, and the like in supervision to model the kinds of discussion you would like counselors to have with their clients. If these issues are not addressed in supervision, counselors may come to believe that it is inappropriate to discuss them with clients have no ideas how such dialog might proceed. These discussions prevent misunderstandings with Another benefit from these discussions is that counselors will eventually achieve some level of comfort in talking about culture, race, ethnicity, and diversity issues.

If you haven't done it as a counselor, early in your tenure as a supervisor you will want to examine your culturally influenced values, attitudes, experiences, and practices and to consider what effects they have on your dealings with supervisees and clients. Counselors should undergo a similar review as preparation for when they have clients of a culture different from their own. Some questions to keep in mind are:

- What did you think when you saw the supervisee's last name?

• Figure 4.Continuum of Cultural Competence
• Cultural Destructiveness

-Superiority of dominant culture and inferiority of other cultures; active discrimination

- Cultural Incapacity

  -Separate but equal treatment; passive discrimination

- Cultural Blindness

  -Sees all cultures and people as alike and equal; discrimination by ignoring culture.

- Cultural Openness (Sensitivity)

  -Basic understanding and appreciation of importance of sociocultural factors in work with minority populations.

- Cultural Competence

  -Capacity to work with more complex issues and cultural nuances.

- Cultural Proficiency

  -Highest capacity for work with minority populations; as a commitment to excellence and proactive effort.

Source: Cross,1989

- What did you think when the supervisee said his or her culture is X, when yours is Y?
- How did you feel about this difference?
- What did you do in response to this difference?

Constantine (2003) suggests that supervisors can use the following questions with supervisees:

- What demographic variables do you use to identify yourself?
- What worldviews (e.g., values, assumptions, and biases) do you bring to supervision based on your cultural identities?
- What struggles and challenges have you faced working with clients who were from different cultures than your own?

Beyond self-examination, supervisors will want continuing education classes, workshops, and conferences that address cultural competence and other contextual factors. Community resources, such as community leaders, elders, and healers can contribute to your understanding of the culture your organization serves. Finally, supervisors (and counselors) should participate in multicultural activities, such as community events, discussion groups, religious festivals and other ceremonies.

The supervisory relationship includes an inherent power differential, and it is important to pay attention to this disparity, particularly when the supervisee and the supervisor are from different cultural groups. A potential for the misuse of that power exists at all times but especially when working with supervisees and clients within multicultural contexts. When the supervisee is from a minority population and the supervisor is from a majority population, the differential can be exaggerated. You will want to prevent institutional discrimination from affecting the quality of supervision. The same is true when the supervisee is gay and the supervisor is heterosexual, or the counselor is non-degreed and the supervisor has an advanced degree, or a female supervisee with a male supervisor, and so on. In the reverse situations, where the supervisor is from the minority

group and the supervisee from the majority group, the difference should be discussed well.

Ethical and Legal Issues

You are the organization's gatekeeper for ethical and legal issues. First, you are responsible for upholding the highest standards of ethical, legal, and moral practices and for serving as a model of practice to staff. Further, you should be aware of and respond to ethical concerns. Part of your job is to help integrate solutions to everyday legal and ethical issues into clinical practice.

Some of the underlying assumptions of incorporating ethical issues into clinical supervision include:

- Ethical decision-making is a continuous, active process.
- Ethical standards are not a cookbook. They tell you what you do, not always how.
- Each situation is unique. Therefore, it is imperative that all personnel learn how to "think ethically" and how to make sound legal and ethical decisions.
- The most complex ethical issues arise in the context of two ethical behaviors that conflict; for instance, when a counselor wants to respect the privacy and confidentiality of a client, but it is in the client's best interest for the counselor to contact someone else about his or her care.
- Therapy is conducted by fallible beings, people make mistake—hopefully, minor ones.
- Sometimes, the answer to ethical and legal questions are elusive. Ask a dozen people, and you'll likely get twelve different points of view.

Helpful resources on legal and ethical issues for supervisors include Beauchamp and Childress (2001); Falvey (2002b), Gutheil and Brodsky (2008); Pope, Sonne, and Greene (2006); and Reamer (2006).

Legal and ethical issues that are critical to clinical supervisors include (1) vicarious liability (or respondeat superior), (2) dual relationships and boundary concerns, (4) informed consent, (5) confidentiality, and supervision ethics.

Direct Versus Vicarious Liability

An important distinction needs to be made between direct and vicarious liability. **Direct liability of the supervisor might include dereliction of supervisory responsibility, such as "not making a reasonable effort to supervise"** (defined below).

In vicarious liability, a supervisor can be held liable for damages incurred as a result of negligence in the supervision process. Examples of negligence include providing inappropriate advice to counselor about a client, and the assignment of clinical tasks to inadequately trained counselors. The key legal question is: "Did the supervisor make a reasonable to effort to supervise?" A generally accepted time standard for a "reasonable effort to supervise" in the behavioral health field is 1 hour of supervision for every 20- 40 hours of clinical services. Of course, other variables (such as the quality and content of clinical supervision sessions) also play a role in reasonable effort to supervise.

Supervisory vulnerability increases when the counselor has been assigned too many clients, when there is no direct observation of a counselor's clinical work, when staff are inexperienced or poorly trained for assigned tasks, and when a supervisor is not involved or not available to aid the clinical staff. In legal texts, vicarious liability is referred to as "respondeat superior."

Dual Relationships and Boundary Issues

Dual relationships can occur at two levels: between supervisors and supervisees and between counselors and clients. You have a mandate to help your supervisees recognize and manage boundary issues. **A dual relationship occurs in supervision when a supervisor has a primary professional role with a supervisee and, at an earlier time, simultaneously or later, engages in another relationship with the supervisee that transcends the professional relationship**. Examples of dual relationships in supervision include providing therapy for a current or former supervisee, developing an emotional relationship with a supervisee or former supervisee, and becoming an

Alcoholics Anonymous sponsor for a former supervisee. Obviously, there are varying degrees of harm or potential harm that might occur as a result of dual relationships, and some negative effects of dual relationships might not be apparent until later.

Australian Institute of Professional Counsellors (2019) emphasized that “regardless of therapy modality used, the counsellor-client relationship is one of the most important factors in achieving successful outcomes for the client. The same is true of the working alliance between the counsellor-supervisee and the supervisor.” Moreover, Wilson and Lizzion (2009) asserted that the series of evidence has shown that the quality of the relationship between supervisee or supervisor has a long-term effect which can both make or break the supervisee’s growth (as cited by Australian Institute of Professional Counsellors, 2019)

Therefore, firm, as always-or-never rules aren’t applicable. You have the responsibility of weighing with the counselor the anticipated and unanticipated effects of dual relationships, helping the supervisee’s self-reflective awareness when boundaries become blurred, when he or she is getting close to a dual relationship, or when he or she is crossing the line in the clinical relationship.

Exploring dual relationship issues with counselors in clinical supervision can raise its own professional dilemmas. For instance, clinical supervision involves unequal status, power, and expertise between a supervisor and supervisee. Being the evaluator of a counselor’s performance and gatekeeper for training programs or credentialing bodies also might involve a dual relationship. Further, supervision can have therapy-like qualities as you explore counter-transferential issues with supervisees, and there is an expectation of professional growth and exploration. What makes a dual relationship unethical in supervision is the abusive use of power by either party, the likelihood that the relationship will impair or injure the supervisor’s or supervisee’s judgment, and the risk of exploitation.

The **most common basis for legal action against counselors (20 percent of claims) and the most frequently heard complaint by certification boards against counselors (35%) is some form of boundary violation or sexual impropriety** (Falvey, 2002b).

Code of ethics for most professions clearly advise that dual relationships between counselors and clients should be avoided. Dual relationships between counselors and supervisors are also a concern and are addressed in the substance abuse counselor codes and those of other professions as well. Problematic dual relationship between supervisees and supervisors might include intimate relationships (sexual and non-sexual) and therapeutic relationships. Wherein the supervisor becomes the counselor's therapist. Sexual involvement between the supervisor and the supervisee can include sexual attraction, harassment, consensual (but hidden) sexual relationships, or intimate romantic relationships. Other common boundary issues include asking the supervisee to do favors, providing preferential treatment, socializing outside the work setting, and using emotional abuse to enforce power.

It is imperative that all parties understand what constitutes a dual relationship between supervisor and supervisee and avoid these dual relationships. Sexual relationships between supervisors and supervisees and counselors and clients occur far more frequently that one might realize (Falvey, 200b). In many States, they constitute a legal transgression as well as an ethical violation.

The decision tree presented in figure 5 (p.16) indicates how a supervisor might manage a situation where he or she is concerned about a possible ethical or legal violation by a counselor.

Informed Consent

Informed consent is key to protecting the counselor and/or supervisor from legal concerns, requiring the recipient of any service or intervention to be sufficiently aware of what is to happen, and of the potential risks, and alternative approaches, so that the person can make an informed and intelligent decision about participating in that service. The supervisor must inform the supervisee about the process of supervision, the feedback and evaluation criteria, and other expectations of supervisions. The supervision contract should clearly spell out these issues. Supervisors must ensure that the supervisee has informed the client about the parameters of counseling and supervision (such as the use of live observation, video, or audiotaping).

Confidentiality

In supervision, regardless of whether there is a written or verbal contract between the supervisor and supervisee, there is an implied contract and duty of care because of the supervisor's vicarious liability. Informed consent and concerns for confidentiality should occur at three levels: client consent to treatment, client consent to supervision of the case, and supervisee consent to supervision (Bernard & Goodyear, 2004). In addition, there is an implied consent and commitment to confidentiality by supervisors to assume their supervisory responsibilities and institutional consent to comply with legal and ethical parameters of supervision.

With informed consent and confidentiality comes a duty not to disclose certain relational communication. Limits of confidentiality of supervision session content should be stated in all organizational contracts with training institutions and credentialing bodies. Criteria for waiving client and supervisee privilege should be stated in institutional policies and discipline-specific codes of ethics and clarified by advice of legal counsel and the courts. Because standards of confidentiality are determined by State legal and legislative systems, it is prudent for supervisors to consult with an attorney to determine the State codes of confidentiality and clinical privileging.

In the substance abuse treatment field, confidentiality for clients is clearly defined by Federal law: 42 CFR, Part 2 and the Health Insurance Portability and Accountability Act (HIPAA). Supervisors need to train counselors in confidentiality regulations and to adequately document their supervision, including discussions and directives, especially relating to duty-to-warn information early in the counseling process and inform clients of the limits of confidentiality as part of the agency's informed consent procedures.

Under duty-to-warn requirements (e.g., child abuse, suicidal, or homicidal ideation), supervisors need to be aware of and take action as soon as possible in situations in which confidentiality may need to be waived. Organizations should have a policy stating how clinical crises will be handled (Falvey, 2002b). What mechanisms are in place for responding to crises? In what timeframe will a supervisor be notified of a crisis situation? Supervisors must document all discussions with counselors concerning duty-to-warn and

crises, at the onset of supervision, supervisors should ask counselors if there are any duty-to-warn issues of which the supervisor should be informed.

New technology brings new confidentiality concerns. Websites now dispense information about substance abuse treatment and provide counseling services. With the growth in online counseling and supervision, the following concerns emerge: (a) how to maintain confidentiality of information (b) how to ensure the competence and qualifications of counselors providing online services, and (c) how to establish reporting requirements and duty to warn when services are conducted across State and international boundaries. New standards will need to be written to address these issues.

Supervisor Ethics

In general, supervisors adhere to the same standards and ethics as substance abuse counselors with regard to dual relationship and other boundary violations. Supervisors will:

- Uphold the highest professional standards of the field.
- Seek professional help (outside the work setting) when personal issues interfere with their clinical and/or supervisory functioning.
- Conduct themselves in a manner that models and sets an example for agency mission, vision, philosophy, wellness, recovery, and consumer satisfaction.
- Reinforce zero tolerance for interactions that are not professional, courteous, and compassionate.
- Treat supervisees, colleagues, peers, and clients with dignity, respect, and honesty.
- Adhere to the standards and regulations of confidentiality as dictated by the field. This applies to the supervisory as well as the counseling relationship.

Monitoring Performance

The goal of supervision is to ensure quality care for the client, which entails monitoring the clinical performance of staff. Your first step is to educate supervisees in what to expect from clinical supervision. Once the functions of supervision are clear, you should regularly evaluate the counselor's progress in meeting organizational and clinical goals as set forth

in an Individual Development Plan (IDP). As clients have an individual treatment plan, counselors also need a plan to promote skill development.

Behavioral Contracting in Supervision

Among the first tasks in supervision is to establish a contract for supervision that outlines realistic accountability for both yourself and your supervisee. The contract should be in writing and should include the purpose, foal, and objectives of supervision; the context in which supervision is provided; ethical and institutional policies that guide supervision and clinical practices; the criteria and methods of evaluation and outcome measures; the duties and responsibilities of the supervisor and supervisee; procedural considerations (including the format for taping and opportunities for live observations); and the supervisee's scope of practice and competence. The contract for supervision should state the rewards for fulfillment of the contract (such as clinical privileges or increased compensation), the length of supervision sessions, and sanctions for noncompliance by either the supervisee or supervisor. The agreement should be compatible with the developmental needs of the supervisee and address the obstacles to progress (lack of time, performance anxiety, resource limitations). Once behavioral contract has been established, the next step is to develop an IDP.

Individual Development Plan

The IDP is a detailed plan for supervision that includes the goals that you and the counselor wish to address over a certain time period (perhaps 3 months). Each of you should sign and keep a copy of the IDP for your records. The goals are normally stated in terms of skills the counselor wishes to build or professional resources the counselor wishes to develop. These skills and resources are generally oriented to the counselor's job in the program or activities that would help the counselor develop professionally. The IDP should specify the timelines for change, the observation methods that will be employed, expectations for the supervisee and the supervisor, the evaluation procedures that will be employed and the activities that will be expected to improve knowledge and skills.

As a supervisor, you should have your own IDP, based on the supervisory competencies listed in TAP 21-A (CSAT, 2007) that addresses your training goals. This IDP can be

developed in cooperation with your supervisor, or in external supervision, peer input, academic advisement, or mentorship.

Evaluation of Counselors

Supervision inherently involves evaluation, building on a collaborative relationship between you and the counselor. Evaluation may not be easy for some supervisors may. Although everyone wants to know how they are doing, counselors are not always comfortable asking for feedback. And as most supervisors, prefer to be liked, you may have difficulty giving clear, concise, and accurate evaluations to staff.

The two types of evaluation are formative and summative. A formative evaluation is an ongoing status report of the counselor's skill development, exploring the questions "Are we addressing the skills or competencies you want to focus on?" and "How do we assess your current knowledge and skills and areas for growth and development?"

Summative evaluation is a more formal rating of the counselor's overall job performance, fitness for the job, and job rating. It answers the question, "How does the counselor measure up?" Typically, summative evaluations are done annually and focus on the counselor's overall strengths, limitations, and areas for future improvement.

It should be acknowledged that supervision is inherently an unequal relationship. In most cases. The supervisor has positional power over the counselor. Therefore, it is important to establish clarity of purpose and a positive context for evaluation. Procedures should be spelled out in advance, and the evaluation process should be mutual, flexible, and continuous. The evaluation process inevitably brings up supervisee anxiety and defensiveness that need to be addressed openly. It is also important to note that each individual counselor will react differently to feedback; some will be more open to the process than others.

There has been considerable research on supervisory evaluation, with these findings:

- The supervisee's confidence and efficacy are corelated with the quality and quantity of feedback the supervisor gives to the supervisee (Bernard & Goodyear, 2004).

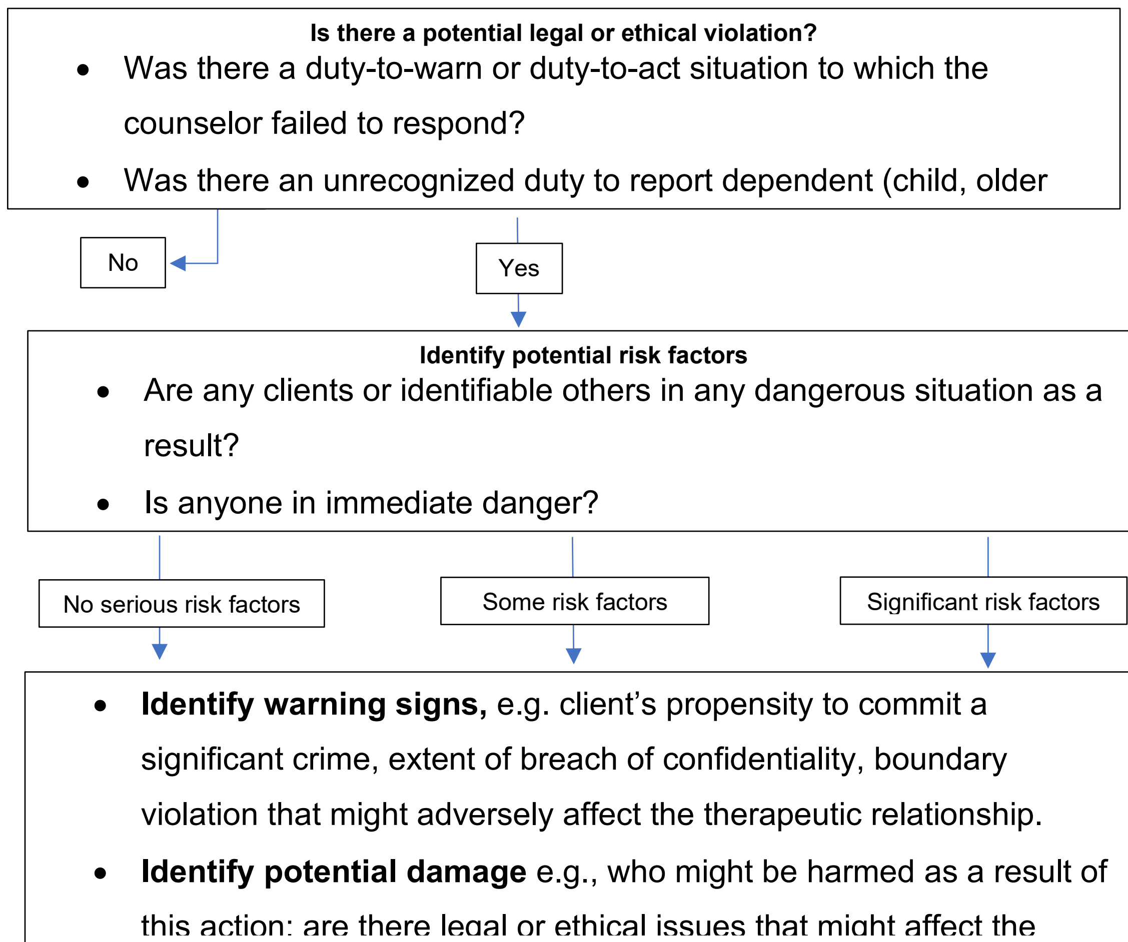
- Ratings of skills are highly variable between supervisors, and often the supervisor's and supervisee's ratings differ on conflict (Eby, 2007).
- Good feedback is provided frequently, clearly, and consistently and is SMART (specific, measurable, attainable, realistic, and timely) (Powell & Brodsky, 2004)

Direct observation of the counselor's work is the desired form of input for the supervisor. Although direct observation has historically been the exception in substance abuse counseling, ethical and legal considerations and evidence support that direct observation as preferable. The least desirable feedback is unannounced observation by supervisors followed by vague, perfunctory, indirect, or hurtful delivery (Powell & Brodsky, 2004).

Clients are often the best assessors of the skills of the counselor. Supervisors should routinely seek input from the clients as to the outcome of treatment. The method of seeking input should be discussed in the initial supervisory sessions and be part of the supervision contract. In a residential substance abuse treatment program, you might regularly meet with clients after sessions to discuss how they are doing, how effective the counseling is, and the quality of the therapeutic alliance with the counselor. (For examples of client satisfaction or input forms, search for Client-Directed Outcome-Informed Treatment and Training Materials at http://www.goodtherapy.org/ clientdirectedoutcomeinformedtherapy.html).

Before formative evaluations begin, methods of evaluating performance should be discussed, clarified in the initial sessions, and included in the initial contract so that there will be no surprises. Formative evaluations should focus on changeable behavior and, whenever possible, be separate from the overall annual performance appraisal process. To determine the counselor's skill development, you should use written competency tools, direct observation, counselor self-assessments, client evaluations, work samples (files and charts), and peer assessments. Examples of work samples and peer assessments can be found in Bernard and Goodyear (2004), Powell and Brodsky (2004), and Campbell (2000). It is important to acknowledge that counselor evaluation is essentially a subjective process involving supervisors' opinions of the counselors' competence.

Figure 5: Deciding How To Address Potential Legal or Ethical Violations



Addressing Burnout and Compassion Fatigue

Did you ever hear a counselor say, “I came into counseling for the right reasons. At first I loved seeing clients. But the longer I stay in the field, the harder it is to care. The joy seems to have gone out of my job. Should I get out of counseling as many of my colleagues are doing?” Most substance abuse counselors come into the field with a strong sense of calling and the desire to be of service to others, with a strong pull to use their gifts and make themselves instruments of service and healing. The substance abuse treatment field risks losing many skilled and compassionate healers when the life goes out of their work. Some counselors simply withdraw, care less, or get out of the field entirely. Most just complain or suffer in silence. Given the caring and dedication that brings counselors into the field, it is important for you to help them address their questions and doubts. (See Lambie, 2006, and Shoptaw, Stein, & Rawson, 2000.)

You can help counselors with selfcare; help them look within; become resilient again; and rediscover what gives them joy, meaning, and hope in their work. Counselors need time for reflection, to listen again deeply and authentically. You can help them redevelop their innate capacity for compassion, to be an openhearted presence for others.

You can help counselors develop a life that does not revolve around work. This has to be supported by the organization’s culture and policies that allow for appropriate use of time off and selfcare without punishment. Aid them by encouraging them to take earned leave and to take “mental health” days when they are feeling tired and burned out. Remind staff to spend time with family and friends, exercise, relax, read, or pursue other lifegiving interests.

It is important for the clinical supervisor to normalize the counselor’s reactions to stress and compassion fatigue in the workplace as a natural part of being an empathic and compassionate person and not an individual failing or pathology. (See Burke, Carruth, & Prichard, 2006.)

Rest is good; selfcare is important. Everyone needs times of relaxation and recreation. Often, a month after a refreshing vacation you lose whatever gain you made. Instead, longer term gain comes from finding what brings you peace and joy. It is not enough for

you to help counselors understand “how” to counsel, you can also help them with the “why.” Why are they in this field? What gives them meaning and purpose at work? When all is said and done, when counselors have seen their last client, how do they want to be remembered? What do they want said about them as counselors? Usually, counselors’ responses to this question are fairly simple: “I want to be thought of as a caring, compassionate person, a skilled helper.” These are important spiritual questions that you can discuss with your supervisees.

Other suggestions include:

- Help staff identify what is happening within the organization that might be contributing to their stress and learn how to address the situation in a way that is productive to the client, the counselor, and the organization.
- Get training in identifying the sign of primary stress reactions, secondary trauma, compassion fatigue, vicarious traumatization, and burnout. Help staff match-up self-care tools to specifically address each of these experiences.
- Support staff in advocating for organizational change when appropriate and feasible as part of your role as liaison between administration and clinical staff.
- Assist staff in adopting lifestyle changes to increase their emotional resilience by reconnecting to their world (family, friends, sponsors, mentors), spending time alone for self-reflection, and forming habits that re-energize them.
- Help them eliminate the “what ifs” and negative self-talk. Help them let go of their idealism that they can save the world.
- If possible in the current work environment, set parameters on their work by helping them adhere to schedule time-off, keep lunch time personal, set reasonable deadlines for work completion, and keep work away from personal time.
- Teach and support generally positive work habits. Some counselors lack basic organizational, teamwork, phone, and time management skills (ending sessions on time and scheduling to allow for documentation). The development of these skills helps to reduce the daily wear that erodes well-being and contributes to burnout.

- Ask them "When was the last time you had fun?" "When was the last time you felt fully alive?" Suggest they write a list of things about their job about which they are grateful. List five people they care about and love. List five accomplishments in their professional life. Ask "Where do you want to be in your professional life in 5 years?"

You have a fiduciary responsibility given you by clients to ensure counselors are healthy and whole. It is your responsibility to aid counselors in addressing their fatigue and burnout.

Gatekeeping Functions

In monitoring counselor performance, an important and often difficult supervisory task is managing problem staff or those individuals who should not be counselors. This is the **gatekeeping function**. Part of the dilemma is that most likely you were first trained as a counselor, and your values lie within that domain. You were taught to acknowledge and work with individual limitations, always respecting the individual's goals and needs. However, you also carry a responsibility to maintain the quality of the profession and to protect the welfare of clients. Thus, you are charged with the task of assessing the counselor for fitness for duty and have an obligation to uphold the standards of the profession.

Experience, credentials, and academic performance are not the same as clinical competence. In addition to technical counseling skills, many important therapeutic qualities affect the outcome of counseling, including insight, respect, genuineness, concreteness, and empathy. Research consistently demonstrates that personal characteristics of counselors are highly predictive of client outcome (Herman, 1993, Hubble, Duncan & Miller, 1999). The essential questions are: Who should or should not be a counselor? What behaviors or attitudes are unacceptable? How would a clinical supervisor address these issues in supervision?

Unacceptable behavior might include actions hurtful to the client, boundary violations with clients or program standards, illegal behavior, significant psychiatric impairment, consistent lack of self-awareness, inability to adhere to professional codes of ethics, or

consistent demonstration of attitudes that are not conducive to work with clients in substance abuse treatment. You will want to have a model and policies and procedures in place when disciplinary action is undertaken with an impaired counselor. For example, progressive disciplinary policies clearly state the procedures to follow when impairment is identified. Consultation with the organization's attorney and familiarity with State case law are important. It is advisable for the agency to be familiar with and have contact with your State impaired counselor organization, if it exists.

How impaired must a counselor be before disciplinary action is needed? Clear job descriptions and statements of scope of practice and competence are important when facing an impaired counselor. How tired or distressed can a counselor be before a supervisor takes the counselor offline for these or similar reasons? You need administrative support with such interventions and to identify approaches to managing worn-out counselors. The Consensus Panel recommends that your organization have an employee assistance program (EAP) in place so you can refer staff outside the agency. It is also important for you to learn the distinction between a supervisory referral and a self-referral. Self-referral may include a recommendation by the supervisor, whereas a supervisory referral usually occurs with a job performance problem.

You will need to provide verbal and written evaluations of the counselor's performance and actions to ensure that the staff member is aware of the behaviors that need to be addressed. Treat all supervisees the same, following agency procedures and timelines. Follow the organization's progressive disciplinary steps and document carefully what is said, how the person responds, and what actions are recommended. You can discuss organizational issues or barriers to action with the supervisee (such as personnel policies that might be exacerbating the employee's issues). Finally, it may be necessary for you to take the action that is in the best interest of the clients and the profession, which might involve counseling your supervisee out of the field.

Remember that the number one goal of a clinical supervisor is to protect the welfare of the client, which, at times, can mean enforcing the gatekeeping function of supervision.

Methods of Observation

It is important to observe counselors frequently over an extended period of time. Supervisors in the substance abuse treatment field have traditionally relied on indirect methods of supervision (process recordings, case notes, verbal reports by the supervisees, and verbatims). However, the Consensus Panel recommends that supervisors use direct observation of counselors through recording devices (such as video and audio taping) and live observation of counseling sessions, including one-way mirrors. Indirect methods have significant drawbacks, including:

- A counselor will recall a session as he or she experienced it. If a counselor experiences a session positively or negatively, the report to the supervisor will reflect that. The report is also affected by the counselor's level of skill and experience.
- The counselor's report is affected by his or her biases and distortions (both conscious and unconscious). The report does not provide a thorough sense of what really happened in the session because it relies too heavily on the counselor's recall.
- Indirect methods include a time delay in reporting.
- The supervisee may withhold clinical information due to evaluation anxiety or naiveté.

Your understanding of the session will be improved by direct observation of the counselor. Direct observation is much easier today, as a variety of technological tools are available, including audio and videotaping, remote audio devices, interactive videos, live feeds, and even supervision through web-based cameras.

Guidelines that apply to all methods of direct observation in supervision include:

- Simply by observing a counseling session, the dynamics will change. You may change how both the client and counselor act. You get a snapshot of the sessions. Counselors will say, "it was not a representative session." Typically, if you observe the counselor frequently, you will get a fairly accurate picture of the counselor's competencies.

- You and your supervisee must agree on procedures for observation to determine why, when, and how direct methods of observation will be used.
- The counselor should provide a context for the session.
- The client should give written consent for observation and/or taping at intake, before beginning counseling. Clients must know all the conditions of their treatment before they consent to counseling. Additionally, clients need to be notified of an upcoming observation by a supervisor before the observation occurs.
- Observations should be selected for review (including a variety of sessions and clients, challenges, and successes) because they provide teaching moments. You should ask the supervisee to select what cases he or she wishes you to observe and explain why those cases were chosen. Direct observation should not be a weapon for criticism but a constructive tool for learning: an opportunity for the counselor to do things right and well, so that positive feedback follows.
- When observing a session, you gain a wealth of information about the counselor. Use this information wisely, and provide gradual feedback, not a litany of judgments and directives. Ask the salient question, “What is the most important issue here for us to address in supervision?”
- A supervisee might claim client resistance to direct observation, saying, “It will make the client nervous. The client does not want to be taped.” However, “client resistance” is more likely to be reported when the counselor is anxious about being taped. It is important for you to gently and respectfully address the supervisee’s resistance while maintaining the position that direct observation is an integral component of his or her supervision.
- Given the nature of the issues in drug and alcohol counseling, you and your supervisee need to be sensitive to increased client anxiety about direct observation because of the client’s fears about job or legal repercussions, legal actions, criminal behaviors, violence and abuse situations, and the like.
- Ideally, the supervisee should know at the outset of employment that observation and/or taping will be required as part of informed consent to supervision.

In instances where there is overwhelming anxiety regarding observation, you should pace the observation to reduce the anxiety, giving the counselor adequate time for preparation. Often enough, counselors will feel more comfortable with observation equipment (such as a video camera or recording device) rather than direct observation with the supervisor in the room.

The choice of observation methods in a particular situation will depend on the need for an accurate sense of counseling, the availability of equipment, the context in which the supervision is provided, and the counselor's and your skill levels. A key factor in the choice of methods might be the resistance of the counselor to being observed. For some supervisors, direct observation also puts the supervisor's skills on the line too, as they might be required to demonstrate or model their clinical competencies

Recorded Observation

Audiotaped supervision has traditionally been a primary medium for supervisors and remains a vital resource for therapy models such as motivational interviewing. On the other hand, videotape supervision (VTS) is the primary method of direct observation in both the marriage and family therapy and social work fields (Munson, 1993; Nichols, Nichols, & Hardy, 1990). Video cameras are increasingly commonplace in professional settings. VTS is easy, accessible, and inexpensive. However, it is also a complex, powerful and dynamic tool, and one that can be challenging, threatening, anxiety-provoking, and humbling. Several issues related to VTS are unique to the substance abuse field:

- Many substance abuse counselors "grew up" in the field without taping and may be resistant to the medium;
- Many agencies operate on limited budgets and administrators may see the expensive equipment as prohibitive and unnecessary; and
- Many substance abuse supervisors have not been trained in the use of videotape equipment or in VTS.

Yet, VTS offers nearly unlimited potential for creative use in staff development. To that end, you need training in how to use VTS effectively. The following are guidelines for VTS:

- Clients must sign releases before taping. Most programs have a release form that the client signs on admission (see Tool 19 in Part 2, chapter 2). The supervisee informs the client that videotaping will occur and reminds the client about the signed release form. The release should specify that the taping will be done exclusively for training purposes and will be reviewed only by the counselor, the supervisor, and other supervisees in group supervision. Permission will most likely be granted if the request is made in a sensitive and appropriate manner. It is critical to note that even if permission is initially given by the client, this permission can be withdrawn. You cannot force compliance.
- The use and rationale for taping needs to be clearly explained to clients. This will forestall a client's questioning as to why a particular session is being taped.
- Risk-management considerations in today's litigious climate necessitate that tapes be erased after the supervision session. Tapes can be admissible as evidence in court as part of the clinical record. Since all tapes should be erased after supervision, this must be stated in agency policies. If there are exceptions, those need to be described.
- Too often, supervisors watch long, uninterrupted segments of tape with little direction or purpose. To avoid this, you may want to ask your supervisee to cue the tape to the segment he or she wishes to address in supervision, focusing on the goals established in the IDP. Having said this, listening only to segments selected by the counselor can create some of the same disadvantages as self-report: the counselor chooses selectively, even if not consciously. The supervisor may occasionally choose to watch entire sessions.
- You need to evaluate session flow, pacing, and how counselors begin and end sessions.

Some clients may not be comfortable being videotaped but may be more comfortable with audio taping. Videotaping is not permitted in most prison settings and EAP services.

Videotaping may not be advisable when treating patients with some diagnoses, such as paranoia or some schizophrenic illnesses. In such cases, either live observation or less intrusive measures, such as audio taping, may be preferred.

Live Observation

With live observation you actually sit in on a counseling session with the supervisee and observe the session first hand. The client will need to provide informed consent before being observed. Although one-way mirrors are not readily available at most agencies, they are an alternative to actually sitting in on the session. A videotape may also be used either from behind the one-way mirror (with someone else operating the videotaping equipment) or physically located in the counseling room, with the supervisor sitting in the session. This combination of mirror, videotaping, and live observation may be the best of all worlds, allowing for unobtrusive observation of a session, immediate feedback to the supervisee, modeling by the supervisor (if appropriate), and a record of the session for subsequent review in supervision. Live supervision may involve some intervention by the supervisor during the session.

Live observation is effective for the following reasons:

- It allows you to get a true picture of the counselor in action.
- It gives you an opportunity to model techniques during an actual session, thus serving as a role model for both the counselor and the client.
- Should a session become countertherapeutic, you can intervene for the wellbeing of the client.
- Counselors often say they feel supported when a supervisor joins the session, and clients periodically say, “This is great! I got two for the price of one.”
- It allows for specific and focused feedback.
- It is more efficient for understanding the counseling process.
- It helps connect the IDP to supervision.

To maximize the effectiveness of live observation, supervisors must stay primarily in an observer role so as to not usurp the leadership or undercut the credibility and authority of the counselor.

Live observation has some disadvantages:

- It is time consuming.
- It can be intrusive and alter the dynamics of the counseling session.
- It can be anxiety-provoking for all involved.

Some mandated clients may be particularly sensitive to live observation. This becomes essentially a clinical issue to be addressed by the counselor with the client. Where is this anxiety coming from, how does it relate to other anxieties and concerns, and how can it best be addressed in counseling?

Supervisors differ on where they should sit in a live observation session. Some suggest that the supervisor sit so as to not interrupt or be involved in the session. Others suggest that the supervisor sit in a position that allows for inclusion in the counseling process.

Here are some guidelines for conducting live observation:

- The counselor should always begin with informed consent to remind the client about confidentiality. Periodically, the counselor should begin the session with a statement of confidentiality, reiterating the limits of confidentiality and the duty to warn, to ensure that the client is reminded of what is reportable by the supervisor and/or counselor.
- While sitting outside the group (or an individual session between counselor and client) may undermine the group process, it is a method selected by some. Position yourself in a way that doesn't interrupt the counseling process. Sitting outside the group undermines the human connection between you, the counselor, and the client(s) and makes it more awkward for you to make a comment, if you have not been part of the process until then. For individual or family sessions, it is also recommended that the supervisor sit beside the counselor to fully observe what is occurring in the counseling session.
- The client should be informed about the process of supervision and the supervisor's role and goals, essentially that the supervisor is there to observe the counselor's skills and not necessarily the client.

- As preparation, the supervisor and supervisee should briefly discuss the background of the session, the salient issues the supervisee wishes to focus on, and the plans for the session. The role of the supervisor should be clearly stated and agreed on before the session.
- You and the counselor may create criteria for observation, so that specific feedback is provided for specific areas of the session.
- Your comments during the session should be limited to lessen the risk of disrupting the flow or taking control of the session. Intervene only to protect the welfare of the client (should something adverse occur in the session) or if a moment critical to client welfare arises. In deciding to intervene or not, consider these questions: What are the consequences if I don't intervene? What is the probability that the supervisee will make the intervention on his or her own or that my comments will be successful? Will I create an undue dependence on the part of clients or supervisee?
- Provide feedback to the counselor as soon as possible after the session. Ideally, the supervisor and supervisee(s) should meet privately immediately afterward, outlining the key points for discussion and the agenda for the next supervision session, based on the observation. Specific feedback is essential; "You did a fine job" is not sufficient. Instead, the supervisor might respond by saying, "I particularly liked your comment about . . ." or "What I observed about your behavior was . . ." or "Keep doing more of . . . ."

Practical Issues in Clinical Supervision

Barnett (2020) emphasized that "Clinical supervision is an essential aspect of every health service provider's professional development and training. Serving as a supervisor of a graduate student or trainee can be a very rewarding professional activity. But, what should you be aware of and what are the factors you should consider if offered the opportunity to provide clinical supervision? A number of clinical, ethics, legal, and practical issues are addressed to assist health service providers to enter into this role in a competent and effective manner. Specific issues addressed include understanding supervisor roles and responsibilities, what specific competencies are needed to be an

effective supervisor and how to develop them, the qualities and practices of effective and ineffective supervisors; the difference between supervision and mentoring, how to effectively infuse ethics, legal, and diversity issues into supervision; and how to effectively end the supervision relationship. Specific guidance is provided and key resources for those interested in learning more about being a supervisor are provided."

Distinguishing between Supervision and Therapy

In facilitating professional development, one of the critical issues is understanding and differentiating between counseling the counselor and providing supervision. In ensuring quality client care and facilitating professional counselor development, the process of clinical supervision sometimes encroaches on personal issues. The dividing line between therapy and supervision is how the supervisee's personal issues and problems affect their work. The goal of clinical supervision must always be to assist counselors in becoming better clinicians, not seeking to resolve their personal issues. Some of the major differences between supervision and counseling are summarized in figure 6.

Figure 6: Differences Between Supervision and Counseling

	Clinical Supervision	**Administrative Supervision**	**Counseling**
Purpose	• Improved client care • Improved job performance	Ensure compliance with agency and regulatory body's policies and procedures.	• Personal growth • Behavior changes • Better self-understanding
Outcome	• Enhanced proficiency in knowledge, skills, and attitudes essential to	Consistent use of approved formats, policies, and procedures.	• Open-ended, based on client needs

	effective job performance		
Timeframe	• Short-term and ongoing	Short-term and ongoing	Based on client needs
Agenda	• Based on agency mission and counselor needs	Based on agency needs	Based on client needs
Basic process	• Teaching/learning specific skills, evaluating job performance, negotiating learning objectives	Clarifying agency expectations, policies and procedures, ensuring compliance	Behavioral, cognitive, and affective process, including listening, exploring, teaching,
Source: Adapted from Dixon, 2004			

The boundary between counseling and clinical supervision may not always be clearly marked, for it is necessary, at times, to explore supervisees' limitations as they deliver services to their clients. Address counselors' personal issues only in so far as they create barriers or affect their performance. When personal issues emerge, the key question you should ask the supervisee is how does this affect the delivery of quality client care? What is the impact of this issue on the client? What resources are you using to resolve this issue outside of the counseling dyad? When personal issues emerge that might interfere with quality care, your role may be to transfer the case to a different counselor. Most important, you should make a strong case that the supervisee should seek outside counseling or therapy.

Problems related to countertransference (projecting unresolved personal issues onto a client or supervisee) often make for difficult therapeutic relationships. The following are signs of countertransference to look for:

- A feeling of loathing, anxiety, or dread at the prospect of seeing a specific client or supervisee.
- Unexplained anger or rage at a particular client.
- Distaste for a particular client.
- Mistakes in scheduling clients, missed appointments.
- Forgetting client's name, history.
- Drowsiness during a session or sessions ending abruptly.
- Billing mistakes.
- Excessive socializing.

When counter-transferential issues between counselor and client arise, some of the important questions you, as a supervisor, might explore with the counselor include:

- How is this client affecting you? What feelings does this client bring out in you? What is your behavior toward the client in response to these feelings? What is it about the substance abuse behavior of this client that brings out a response in you?
- What is happening now in your life, but more particularly between you and the client that might be contributing to these feelings, and how does this affect your counseling?
- In what ways can you address these issues in your counseling?
- What strategies and coping skills can assist you in your work with this client?

Transference and countertransference also occur in the relationship between supervisee and supervisor. Examples of supervisee transference include:

- The supervisee's idealization of the supervisor.

- Distorted reactions to the supervisor based on the supervisee’s reaction to the power dynamics of the relationship.
- The supervisee’s need for acceptance by or approval from an authority figure.
- The supervisee’s reaction to the supervisor’s establishing professional and social boundaries with the supervisee.

Supervisor countertransference with supervisees is another issue that needs to be considered. Categories of supervisor countertransference include:

- The need for approval and acceptance as a knowledgeable and competent supervisor.
- Unresolved personal conflicts of the supervisor activated by the supervisory relationship.
- Reactions to individual supervisees, such as dislike or even disdain, whether the negative response is “legitimate” or not. In a similar vein, aggrandizing and idealizing some supervisees (again, whether or not warranted) in comparison to other supervisees.
- Sexual or romantic attraction to certain supervisees.
- Cultural countertransference, such as catering to or withdrawing from individuals of a specific cultural background in a way that hinders the professional development of the counselor.

To understand these countertransference reactions means recognizing clues (such as dislike of a supervisee or romantic attraction), doing careful selfexamination, personal counseling, and receiving supervision of your supervision. In some cases, it may be necessary for you to request a transfer of supervisees with whom you are experiencing countertransference, if that countertransference hinders the counselor’s professional development.

Finally, counselors will be more open to addressing difficulties such as countertransference and compassion fatigue with you if you communicate understanding and awareness that these experiences are a normal part of being a counselor. Counselors should be rewarded in performance evaluations for raising these issues in

supervision and demonstrating a willingness to work on them as part of their professional development.

Balancing Clinical and Administrative Functions

In the typical substance abuse treatment agency, the clinical supervisor may also be the administrative supervisor, responsible for overseeing managerial functions of the organization. Many organizations cannot afford to hire two individuals for these tasks. Hence, it is essential that you are aware of what role you are playing and how to exercise the authority given you by the administration. Texts on supervision sometimes overlook the supervisor's administrative tasks, but supervisors structure staff work; evaluate personnel for pay and promotions; define the scope of clinical competence; perform tasks involving planning, organizing, coordinating, and delegating work; select, hire, and fire personnel; and manage the organization. Clinical supervisors are often responsible for overseeing the quality assurance and improvement aspects of the agency and may also carry a caseload. For most of you, juggling administrative and clinical functions is a significant balancing act. Tips for juggling these functions include:

- Try to be clear about the "hat you are wearing." Are you speaking from an administrative or clinical perspective?
- Be aware of your own biases and values that may be affecting your administrative opinions.
- Delegate the administrative functions that you need not necessarily perform, such as human resources, financial, or legal functions.
- Get input from others to be sure of your objectivity and your perspective.

There may be some inherent problems with performing both functions, such as dual relationships. Counselors may be cautious about acknowledging difficulties they face in counseling because these may affect their performance evaluation or salary raises.

On the other hand, having separate clinical and administrative supervisors can lead to inconsistent messages about priorities, and the clinical supervisor is not in the chain of command for disciplinary purposes.

Finding the Time To Do Clinical Supervision

Having read this far, you may be wondering, “Where do I find the time to conduct clinical supervision as described here? How can I do direct observation of counselors within my limited time schedule?” Or, “I work in an underfunded program with substance abuse clients. I have way too many tasks to also observe staff in counseling.”

One suggestion is to begin an implementation process that involves adding components of a supervision model one at a time. For example, scheduling supervisory meetings with each counselor is a beginning step. It is important to meet with each counselor on a regular, scheduled basis to develop learning plans and review professional development. Observations of counselors in their work might be added next. Another component might involve group supervision. In group supervision, time can be maximized by teaching and training counselors who have common skill development needs.

As you develop a positive relationship with supervisees based on cooperation and collaboration, the anxiety associated with observation will decrease. Counselors frequently enjoy the feedback and support so much that they request observation of their work. Observation can be brief. Rather than sitting in on a full hour of group, spend 20 minutes in the observation and an additional 20 providing feedback to the counselor.

Your choice of modality (individual, group, peer, etc.) is influenced by several factors: supervisees’ learning goals, their experience and developmental levels, their learning styles, your goals for supervisees, your theoretical orientation, and your own learning goals for the supervisory process. To select a modality of supervision (within your time constraints and those of your supervisee), first pinpoint the immediate function of supervision, as different modalities fit different functions. For example, a supervisor might wish to conduct group supervision when the team is intact and functioning well, and individual supervision when specific skill development or countertransferential issues need additional attention. Given the variety of treatment environments in substance abuse treatment (e.g., therapeutic communities, intensive outpatient services, transitional living settings, correctional facilities) and varying time constraints on supervisors, several alternatives to structure supervision are available.

Peer supervision is not hierarchical and does not include a formal evaluation procedure, but offers a means of accountability for counselors that they might not have in other forms of supervision. Peer supervision may be particularly significant among well-trained, highly educated, and competent counselors. Peer supervision is a growing medium, given the clinical supervisors' duties. Although peer supervision has received limited attention in literature, the Consensus Panel believes it is a particularly effective method, especially for small group practices and agencies with limited funding for supervision. Peer supervision groups can evolve from supervisor-led groups or individual sessions to peer groups or can begin as peer supervision. For peer supervision groups offered within an agency, there may be some history to overcome among the group members, such as political entanglements, competitiveness, or personality concerns. (Bernard and Goodyear [2004] has an extensive review of the process and the advantages and disadvantages of peer supervision.)

Triadic supervision is a tutorial and mentoring relationship among three counselors. This model of supervision involves three counselors who, on a rotating basis, assume the roles of the supervisee, the commentator, and the supervision session facilitator. Spice and Spice (1976) describe peer supervision with three supervisees getting together. In current counseling literature, triadic supervision involves two counselors with one supervisor. There is very little empirical or conceptual literature on this arrangement.

Individual supervision, where a supervisor works with the supervisee in a one-to-one relationship, is considered the cornerstone of professional skill development. Individual supervision is the most labor-intensive and time-consuming method for supervision. Credentialing requirements in a particular discipline or graduate studies may mandate individual supervision with a supervisor from the same discipline.

Intensive supervision with selected counselors is helpful in working with a difficult client (such as one with a history of violence), a client using substances unfamiliar to the counselor, or a highly resistant client. Because of a variety of factors (credentialing requirements, skill deficits of some counselors, the need for close clinical supervision), you may opt to focus, for concentrated periods of time, on the needs of one or two counselors as others participate in peer supervision. Although this is not necessarily a

longterm solution to the time constraints of a supervisor, intensive supervision provides an opportunity to address specific staffing needs while still providing a “reasonable effort to supervise” all personnel.

Group clinical supervision is a frequently used and efficient format for supervision, team building, and staff growth. One supervisor assists counselor development in a group of supervisee peers. The recommended group size is four to six persons to allow for frequent case presentations by each group member. With this number of counselors, each person can present a case every other month—an ideal situation, especially when combined with individual and/or peer supervision. The benefits of group supervision are that it is cost-effective, members can test their perceptions through peer validation, learning is enhanced by the diversity of the group, it creates a working alliance and improves teamwork, and it provides a microcosm of group process for participants. Group supervision gives counselors a sense of commonality with others in the same situation. Because the formats and goals differ, it is helpful to think through why you are using a particular format. (Examples of group formats with different goals can be found in Borders and Brown, 2005, and Bernard & Goodyear, 2004.)

Given the realities of the substance abuse treatment field (limited funding, priorities competing for time, counselors and supervisors without advanced academic training, and clients with pressing needs in a brief-treatment environment), the plan described below may be a useful structure for supervision. It is based on a scenario where a supervisor oversees one to five counselors. This plan is based on several principles:

- All counselors, regardless of years of experience or academic training, will receive at least 1 hour of supervision for every 20 to 40 hours of clinical practice
- Direct observation is the backbone of a solid clinical supervision model.
- Group supervision is a viable means of engaging all staff in dialog, sharing ideas, and promoting team cohesion.

With the formula diagramed below, each counselor receives a minimum of 1 hour of group clinical supervision per week. Each week you will have 1 hour of observation, 1 hour of individual supervision with one of your supervisees, and 1 hour of group supervision with

five supervisees. Each week, one counselor will be observed in an actual counseling session, followed by an individual supervision session with you. If the session is videotaped, the supervisee can be asked to cue the tape to the segment of the session he or she wishes to discuss with you. Afterwards, the observed counselor presents this session in group clinical supervision.

When it is a counselor's week to be observed or taped and meet for individual supervision, he or she will receive 3 hours of supervision: 1 hour of direct observation, 1 hour of individual/one-on-one supervision, and 1 hour of group supervision when he or she presents a case to the group. Over the course of months, with vacation, holiday, and sick time, it should average out to approximately 1 hour of supervision per counselor per week. Figure 7 shows this schedule.

When you are working with a counselor who needs special attention or who is functioning under specific requirements for training or credentialing, 1 additional hour per week can be allocated for this counselor, increasing the total hours for clinical supervision to 4, still a manageable amount of time.

Figure 7. Sample Clinical Supervision Schedule

Counselor	Week 1	Week 2	Week 3	Week 4	Week 5
A	1-hour direct observation 1-hour individual supervision 1-hour group supervision of A's case (3 hours)	1-hour group	1-hour group	1-hour group	1-hour group
B	1 hour group	3-hour group	1-hour group	1-hour group	1-hour group
C	1 hour group	1-hour group	3-hour group	1-hour group	1-hour group
D	1 hour group	1-hour group	1-hour group	3-hour group	1-hour group

E	1 hour group	1-hour group	1-hour group	1-hour group	3-hour group

Documenting Clinical Supervision

Correct documentation and recordkeeping are essential aspects of supervision. Mechanisms must be in place to demonstrate the accountability of your role. (See Tools 10–12 in Part 2, chapter 2.) These systems should document:

- Informal and formal evaluation procedures.
- Frequency of supervision, issues discussed, and the content and outcome of sessions.
- Due process rights of supervisees (such as the right to confidentiality and privacy, to informed consent).
- Risk management issues (how to handle crises, duty-to-warn situations, breaches of confidentiality).

One comprehensive documentation system is Falvey's (2002a) Focused Risk Management Supervision System (FoRMSS), which provides templates to record emergency contact information, supervisee profiles, a logging sheet for supervision, an initial case review, supervision records, and a client termination form.

Supervisory documents and notes are open to management, administration, and human resources (HR) personnel for performance appraisal and merit pay increases and are admissible in court proceedings. Supervision notes, especially those related to work with clients, are kept separately and are intended for the supervisor's use in helping the counselor improve clinical skills and monitor client care. It is imperative to maintain accurate and complete notes on the supervision. However, as discussed above, documentation procedures for formative versus summative evaluation of staff may vary. Typically, HR accesses summative evaluations, and supervisory notes are maintained as formative evaluations.

An example of a formative note by a supervisor might be "The counselor responsibly discussed counter-transferential issues occurring with a particular client and was willing

to take supervisory direction," or "We worked out an action plan, and I will follow this closely." This wording avoids concerns by the supervisor and supervisee as to the confidentiality of supervisory notes. From a legal perspective, the supervisor needs to be specific about what was agreed on and a timeframe for following up.

Structuring the Initial Supervision Sessions

As discussed earlier, your first tasks in clinical supervision are to establish a behavioral contract, get to know your supervisees, and outline the requirements of supervision. Before the initial session, you should send a supportive letter to the supervisee expressing the agency's desire to provide him or her with a quality clinical supervision experience. You might request that the counselor give some thought to what he or she would like to accomplish in supervision, what skills to work on, and which core functions used in the addiction counselor certification process he or she feels most comfortable performing.

In the first few sessions, helpful practices include:

Briefly describe your role as both administrative and clinical supervisor (if appropriate) and discuss these distinctions with the counselor.

- Briefly describe your model of counseling and learn about the counselor's frameworks and models for her or his counseling practice. For beginning counselors this may mean helping them define their model.
- Describe your model of supervision.
- State that disclosure of one's supervisory training, experience, and model is an ethical duty of clinical supervisors.
- Discuss methods of supervision, the techniques to be used, and the resources available to the supervisee (e.g., agency inservice seminar, community workshops, professional association memberships, and professional development funds or training opportunities).
- Explore the counselor's goals for supervision and his or her particular interests (and perhaps some fears) in clinical supervision.

- Explain the differences between supervision and therapy, establishing clear boundaries in this relationship.
- Work to establish a climate of cooperation, collaboration, trust, and safety.
- Create an opportunity for rating the counselor's knowledge and skills based on the competencies in TAP 21 (CSAT, 2007).
- Explain the methods by which formative and summative evaluations will occur.
- Discuss the legal and ethical expectations and responsibilities of supervision.
- Take time to decrease the anxiety associated with being supervised and build a positive working relationship.

It is important to determine the knowledge and skills, learning style, and conceptual skills of your supervisees, along with their suitability for the work setting, motivation, self-awareness, and ability to function autonomously. A basic IDP for each supervisee should emerge from the initial supervision sessions. You and your supervisee need to assess the learning environment of supervision by determining:

- Is there sufficient challenge to keep the supervisee motivated?
- Are the theoretical differences between you and the supervisee manageable?
- Are there limitations in the supervisee's knowledge and skills, personal development, self-efficacy, self-esteem, and investment in the job that would limit the gains from supervision
- Does the supervisee possess the affective qualities (empathy, respect, genuineness, concreteness, warmth) needed for the counseling profession?
- Are the goals, means of supervision, evaluation criteria, and feedback process clearly understood by the supervisee?
- Does the supervisory environment encourage and allow risk taking?

Methods and Techniques of Clinical Supervision

A number of methods and techniques are available for clinical supervision, regardless of the modality used. Methods include (as discussed previously) case consultation, written activities such as verbatims and process recordings, audio and videotaping, and live observation. Techniques include modeling, skill demonstrations, and role playing. (See

descriptions of these and other methods and techniques in Bernard & Goodyear, 2004; Borders & Brown, 2005; Campbell, 2000; and Powell & Brodsky, 2004.) Figure 8 outlines some of the methods and techniques of supervision, as well as the advantages and disadvantages of each method.

The context in which supervision is provided affects how it is carried out. A critical issue is how to manage your supervisory workload and make a reasonable effort to supervise. The contextual issues that shape the techniques and methods of supervision include:

- The allocation of time for supervision. If the 20:1 rule of client hours to supervision time is followed, you will want to allocate sufficient time for supervision each week so that it is a high priority, regularly scheduled activity.
- The unique conditions, limitations, and requirements of the agency. Some organizations may lack the physical facilities or hardware to use videotaping or to observe sessions. Some organizations may be limited by confidentiality requirements such as working within a criminal justice system where taping may be prohibited.

Figure 8. Methods and Techniques in Clinical Supervision

	Description	Advantages	Disadvantages
Verbal reports	Verbal reports of clinical situations Group discussion of clinical situations	• Informal • Time efficient • Often spontaneous in response to clinical situation • Can hear counselor's report, what he or she includes, thus learn of the counselor's	• Sessions seen through eyes of beholder • Nonverbal cues missed • Can drift into case management, hence it is important to focus on the clinical nature of

		awareness and perspective, what he or she wishes to report, contrasted with supervisory observations	the chart reviews, reports, etc., linking to the treatment plans and EBPs
Verbatim reports	Process recordings Verbatim written record of a session or part of session Declining method in the behavioral health field	• Helps track coordination and use of treatment plan with ongoing session • Enhances conceptualization and writing skills • Provides written documentation of sessions	• Nonverbal cues missed • Self-report bias • Can be very tedious to write and to read
Written/File Review	Review of the progress notes, charts, documentation	• An important task of a supervisor to ensure compliance with accreditation standards for documentation • Provides a method of quality control	• Time consuming • Notes often miss the overall quality and essence of the session • Can drift into case management rather than

		• Ensures consistency of records and files	clinical skills development
Case Consultation/Case Management	Discussion of cases Brief case reviews	• Helps organize information, conceptualize problems, and decide on clinical interventions • Examines issues (e.g., cross-cultural issues), integrates theory and technique, and promotes greater self-awareness • An essential component of treatment planning	• The validity of self-report is dependent on counselor developmental level and the supervisor's insightfulness • Does not reflect broad range of clinical skills of the counselor
Direct Observation	The supervisor watches the session and may provide periodic but limited comments and/or suggestions to the clinician.	• Allows teaching of basic skills while protecting quality of care • Counselor can see and experience positive change in session	• May create anxiety • Requires supervisor caution in intervening so as to not take over the session or to create

		direction in the moment • Allows supervisor to intervene when needed to protect the welfare of the client, if the session is not effective or is destructive to the client	undue dependence for the counselor or client • Can be seen as intrusive to the clinical process • Time consuming
Audiotaping	Audiotaping and review of a counseling session	• Technically easy and inexpensive • Can explore general rapport, pace, and interventions • Examines important relationship issues • Unobtrusive medium • Can be listened to in clinical or team meetings	• Counselor may feel anxious • Misses nonverbal cues • Poor sound quality often occurs due to limits of technology

Video taping	Videotaping and review of a counseling session	• A rich medium to review verbal and nonverbal information • Provides documentation of clinical skills • Can be viewed by the treatment team during group clinical supervision session • Uses time efficiently • Can be used in conjunction with direct observation • Can be used to suggest different interventions • Allows for review of content, affective and cognitive aspects, process relationship issues in the present	• Can be seen as intrusive to the clinical process • Counselor may feel anxious and self-conscious, although this subsides with experience • Technically more complicated • Requires training before using • Can become part of the clinical record and can be subpoenaed (should be destroyed after review)

Webcam	Internet supervision, synchronistic and asynchronistic Teleconferencing	• Can be accessed from any computer • Especially useful for remote and satellite facilities and locations • Uses time efficiently • Modest installation and operation costs • Can be stored or downloaded on a variety of media, watched in any office, then erased	• Concerns about anonymity and confidentiality • Can be viewed as invasive to the clinical process • May increase client or counselor anxiety or self-consciousness • Technically more complicated • Requires assurance that downloads will be erased and unavailable to unauthorized staff
Cofacilitation and Modeling	Supervisor and counselor jointly run a counseling session Supervisor demonstrates a specific technique while the counselor observes This may be followed by roleplay with the counselor practicing the skill with time to process learning and application	• Allows the supervisor to model techniques while observing the counselor • Can be useful to the client (“two	• Supervisor must demonstrate proficiency in the skill and help the counselor incrementally

		counselors for the price of one”) • Supervisor must demonstrate proficiency in the skill and help the counselor incrementally integrate the learning • Counselor sees how the supervisor might respond • Supervisor incrementally shapes the counselor’s skill acquisition and monitors skill mastery • Allows supervisor to aid counselor with difficult clients	integrate the learning • The client may perceive counselor as less skilled than the supervisor • Time consuming
Role playing	Role play a clinical situation	• Enlivens the learning process • Provides the supervisor with direct	• Counselor can be anxious • Supervisor must be mindful of not overwhelming

		observation of skills • Helps counselor gain a different perspective • Creates a safe environment for the counselor to try new skills	the counselor with information
Source: Adapted from Mattel, 2007			

- The number of supervisees reporting to a supervisor. It is difficult to provide the scope of supervision discussed in this TIP if a supervisor has more than ten supervisees. In such a case, another supervisor could be named or peer supervision could be used for advanced staff.
- Clinical and management responsibilities of a supervisor. Supervisors have varied responsibilities, including administrative tasks, limiting the amount of time available for clinical supervision.

Administrative Supervision

As noted above, clinical and administrative supervision overlap in the real world. Most clinical supervisors also have administrative responsibilities, including team building, time management, addressing agency policies and procedures, recordkeeping, human resources management (hiring, firing, disciplining), performance appraisal, meeting management, oversight of accreditation, maintenance of legal and ethical standards, compliance with State and Federal regulations, communications, overseeing staff cultural competence issues, quality control and improvement, budgetary and financial issues, problem solving, and documentation. Keeping up with these duties is not an easy task!

This TIP addresses two of the most frequently voiced concerns of supervisors: documentation and time management. Supervisors say, “We are drowning in paperwork.

I don't have the time to adequately document my supervision as well," and "How do I manage my time so I can provide quality clinical supervision?"

Documentation for Administrative Purposes

One of the most important administrative tasks of a supervisor is that of documentation and recordkeeping, especially of clinical supervision sessions. Unquestionably, documentation is a crucial risk-management tool. Supervisory documentation can help promote the growth and professional development of the counselor (Munson, 1993). However, adequate documentation is not a high priority in some organizations. For example, when disciplinary action is needed with an employee, your organization's attorney or human resources department will ask for the paper trail, or documentation of prior performance issues. If appropriate documentation to justify disciplinary action is missing from the employee's record, it may prove more difficult to conduct the appropriate disciplinary action (See Falvey, 2002; Powell & Brodsky, 2004.)

Documentation is no longer an option for supervisors. It is a critical link between work performance and service delivery. You have a legal and ethical requirement to evaluate and document counselor performance A complete record is a useful and necessary part of supervision. Records of supervision sessions should include:

- The supervisor–supervisee contract, signed by both parties.
- A brief summary of the supervisee's experience, training, and learning needs.
- The current IDP.
- A summary of all performance evaluations.
- Notations of all supervision sessions, including cases discussed and significant decisions made.
- Notation of cancelled or missed supervision sessions.
- Progressive discipline steps taken.
- Significant problems encountered in supervision and how they were resolved.
- Supervisor's clinical recommendations provided to supervisees.
- Relevant case notes and impressions.

The following should not be included in a supervision record:

- Disparaging remarks about staff or clients.
- Extraneous or sensitive supervisee information.
- Alterations in the record after the fact or premature destruction of supervision records.
- Illegible information and nonstandard abbreviations.

Several authors have proposed a standardized format for documentation of supervision, including Falvey (2002b), Glenn and Serovich (1994), and Williams (1994).

Time Management

By some estimates, people waste about two hours every day doing tasks that are not of high priority. In your busy job, you may find yourself at the end of the week with unfinished tasks or matters that have not been tended to. Your choices? Stop performing some tasks (often training or supervision) or take work home and work longer days. In the long run, neither of these choices is healthy or effective for your organization. Yet, being successful does not make you manage your time well. Managing your time well makes you successful. Ask yourself these questions about your priorities:

- Why am I doing this? What is the goal of this activity?
- How can I best accomplish this task in the least amount of time?
- What will happen if I choose not to do this?

Resources:

The following are resources for supervision:

- Code of Ethics from the Association of Addictions Professionals (NAADAC; http://naadac.org).
- International Certification & Reciprocity Consortium's Code of Ethics (http://internationalcredentialing.org/).
- Codes of ethics from professional groups such as the American Association for Marriage and Family Therapy (http://www.aamft.org), the American Counseling Association (http://www.counseling.org), the Association for Counselor Education

and Supervision (http://www.acesonline.net), the American Psychological Association (http://www.apa.org), the National Association of Social Workers (http://www.socialworkers.org), and the National Board for Certified Counselors (NBCC; http://www.nbcc.org).

- ACES Standards for Counseling Supervisors; ACES Ethical Guidelines for Counseling Supervisors (http://www.acesonline.net/members/supervision/); and NBCC Standards for the Ethical Practice of Clinical Supervision.

TAP 21A provides detailed appendices of suggested reading and other resources (CSAT, 2007). Additionally, Part 3 of this document provides a literature review and bibliographies (available online only at http://store.samhsa.gov). The following are examples of online classroom training programs in clinical supervision in the substance abuse field:

- http://www.attcnetwork.org/regcenters/ index_midatlantic.asp, Clinical Supervision for Substance Abuse Treatment Practitioners Series.
- http://www.attcnetwork.org/regcenters/ index_midatlantic.asp, Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency.
- http://www.attcnetwork.org/regcenters/ index_northeast.asp, Clinical Supervision to Support the Implementation, Fidelity and Sustaining EvidenceBased Practices.
- http://www.attcnetwork.org/regcenters/ index_northwestfrontier.asp, Clinical Supervision, Part 2: What Happens in Good Supervision.

Other training programs are given in professional graduate schools, such as New York University School of Social Work; Smith College School for Social Work; University of Nevada, Reno, Human and Community Sciences; and Portland State University Graduate School of Education.

For information about tools to measure counselor competencies and supervisor self-assessment tools, along with samples, see the following:

- David J. Powell and Archie Brodsky, Clinical Supervision in Alcohol and Drug Abuse Counseling, 2004.

- L. DiAnne Borders and Lori L. Brown, The New Handbook of Counseling Supervision, 2005
- Jane M. Campbell, Becoming an Effective Supervisor, 2000.
- Janet Elizabeth Falvey, Managing Clinical Supervision: Ethical Practice and Legal Risk Management, 2002.
- Carol A. Falender and Edward P. Shafranske, Clinical Supervision: A Competency Based Approach, 2004.
- Cal D. Stoltenberg, Brian McNeill, and Ursula Delworth, IDM Supervision: An Integrated Developmental Model for Supervising Counselors and Therapists, 1998.

Chapter 2

Introduction

Your clinical supervision system needs to match the unique issues and contextual factors of your agency, and your agency needs to have a clear vision of what it wishes to accomplish with its clinical supervision system and actively determine and understand the processes by which it will get there. The tools presented in this chapter are designed to make the tasks associated with implementing a clinical supervision system easier. You will want to take advantage of the experience of well-established supervision programs and adapt the tools that have worked for them to suit the specific needs of your program.

The resources presented in this chapter are organized to be parallel to Part 2, chapter 1. These tools should be considered as prototypes and, in some cases, might even be used as is, provided they fit the context of your organization. These tools can be used by both clinical supervisors and administrators as part of a comprehensive clinical supervision system.

The Change Book: A Blueprint for Technology Transfer (Addiction Technology Transfer Center [ATTC] National Office, 2004) provides the basis for the organizational change process presented here. You may wish to consult with colleagues who have implemented a clinical supervision system for their organizations, especially if the agency is similar to yours. Managing organizational change is very similar to working with a client in a clinical setting. Your understanding of the recovery process and of the counselor's personal qualities and skills that facilitate recovery are invaluable resources as you apply the tools presented in this chapter.

Assessing Organizational Readiness

You will need to determine the state of readiness of your organization and its personnel to implement a clinical supervision system. This assessment should include agency contextual variables, competence of supervisory staff, clinical competence of counseling staff and organizational integrity, motivation of personnel, the nature of your relationships with staff, environmental variables (such as current or recent organizational changes, financial issues, accreditation, and legislative mandates), and the best methods and

techniques to be used (see Tool 1). Tool 2 will help in assessing organizational readiness to change and identifying and prioritizing barriers to change. Just as a clinician might assess a client's stage of readiness to change, these principles can be applied to implementing a clinical supervision system or other types of organizational change. Tool 3 will help you reach agreement with staff on the goals of supervision.

Tool 1. Initial Organizational Assessment Organizational Context					
Conditions	Not at all 1	A little 2	Possibly 3	Very Likely 4	Definitely 5
Staff have a common set of goals. A goal of the organization is that clinical supervision is valued and should be provided.					
Administrators model a norm of collegiality. Although a supervisee's performance evaluation implies a hierarchy, the organization demonstrates an openness ensuring that each person will be respected and treated as a valuable member of the team.					
The organization promotes professional development. Continuous education and professional growth are promoted for supervisors as well as counselors.					
Progress toward goals is monitored actively and does not wait for outcome evaluation. Ongoing monitoring is valued. Obstacles are identified and handled as an organizational challenge, instead of allowing a situation to deteriorate and be judged as demonstrating a lack of competence of particular staff members					
Support for clinical supervision is appropriately generous. Allotment of time and resources is critical.					
Priority Focus____ Secondary Focus____ *Source: Based on Bernard & Goodyear, 1998; Adapted from Porter & Gallon, 2006.*					

Tool 2: Organizational Stage of Readiness to Change Implementing a Clinical Supervision Implementing a Clinical Supervision Program in Your Agency Stage of Change	
Precontemplation	Unaware of Issue
Contemplation	Considering the issue
Preparation	Designing a plan of action
Action	Implementing the action plan
Maintenance	Maintaining the change

	Stage of Readiness	Incentives to Change	Obstacles to Change	Resources for Change
Board of Directors				
Administration				
Supervisors				
Direct Care Staff				
Support Staff				

Primary Group- Focus of Change

____

____

Expected Outcome and Timeframe

____

____

Secondary Group-Focus of Change

____

____

Expected Outcome and Timeframe

____

____

This part of Tool 2 is designed for use by administrators and supervisors to identify the current barriers in the organization to implementing a comprehensive supervision system. Administrators and supervisors should fill this out separately, and then discuss answers in an executive team meeting.

Tool 2: Organizational Stage of Readiness to Change **Implementing a Clinical Supervision Program in Your Agency** Current Barriers to Change			
Organizational	**Administrative**	**Clinical**	**Other**

List the most important barriers to address within the next 3 months.

___

___

___

What would you like to have happen?

___

___

___

Who do you need to help participate in the change?

___

___

___

Source: Adapted from Porter & Gallon, 2006.

Tool 3. Goals for Supervision

Organizational Context

How does the organization support counselors and supervisors in achieving the organization's mission statement? What steps are needed to gain consensus between administration and direct service personnel to achieve the mission statement? What are the specific steps we can take as administrators to achieve this goal of consensus regarding the philosophy of the organization and its relationship to clinical work?

GOAL:

Cultural Competence

What cultural and contextual factors are unique to this agency? What factors need to be addressed in clinical supervision?

GOAL:

Clinical Competence

What specific knowledge, skills, and attitudes do we expect from our counselors? How do we acknowledge and address the individual counselor's baseline competence and learning style?

GOAL:

Motivation

How can we ensure that the clinical supervisor will help motivate counselors to participate in clinical supervision and perform clinical tasks?

GOAL:

Supervisory Relationship

How can we ensure that the clinical supervisor will help motivate counselors to participate in clinical supervision and perform clinical tasks?

GOAL:

Ethical and Professional Values
How much do we expect that clinical supervisors will proactively teach ethics and professional values?

GOAL:

Source: Adapted from Mattel, 2007

Legal and Ethical Issues of Supervision

Legal and ethical considerations should be paramount as you implement a supervision system. The goal is to know how to operate within the boundaries of legal and ethical codes and regulations for the protection of all parties, including the agency, administration, staff, and clients. Legal and ethical issues of supervision include direct and vicarious liability, confidentiality, informed consent and due process, supervisor and supervisee scope of competence and practice, and dual relationships (see discussion of these issues in Part 2, chapter 1).

The Association for Counselor Education and Supervision (ACES) has standards for counseling supervisors that can serve as guidelines for the substance abuse field (available online at http://www.acesonline.net/members/supervision/). ACES also has ethical guidelines for supervisors that address issues such as protecting client welfare and rights, supervisory roles, and program administration roles. The National Board for Certified Counselors, Inc., has a Code of Ethics pertaining to the practice of professional counseling and clinical supervision. This code, like the ACES code, is reproduced in TAP 21A (Competencies for Substance Abuse Treatment Clinical Supervisors [CSAT, 2007]). Other professions also have similar guidelines, such as the Association of State and Provincial Psychology Boards (reprinted in Falvey, 2002b), the National Association of Social Workers (NASW, Guidelines for Clinical Social Work Supervision, 1994), and the American Association for Marriage and Family Therapy (AAMFT Supervisor Designation: Standards and Responsibilities Handbook, 1999).

Informed consent is important for several reasons: (1) clients are entitled to know and agree to what processes support quality treatment, who will be reviewing information about them, and how this information will be used; (2) counselors are entitled to know how their work will be evaluated, the process of the supervision, and how this information will be used to support both quality care and their professional development; and (3) the administration is entitled to know that supervisory processes are articulated to support quality care and address legal and ethical standards.

Tool 4 is one of a number of sample informed consent for supervision forms that are available.

Tool 4. Informed Consent Template

The consent should include:

The purpose of supervision: the structure and mutual understanding of supervision

- Goals of supervision
- How goals will be evaluated and the specific timeframes
- Specific expectations of the supervisor and the supervisee
- Integration of theoretical models

Professional disclosure: information about the supervisor that includes credentials and qualifications and approach to supervision

- Educational background
- Training experiences
- Theoretical orientation
- Clinical competence with various issues, models, techniques, populations
- Sense of mission or purpose in the field
- Educational plans and professional goals

Supervision process: methods and format of supervision

- Individual, group, peer, dyadic
- Method of direct observation
- Permission to record sessions on audio- or videotape

Due Process: includes written procedures to be followed when a grievance or complaint has been made against the administration, the supervisor, or the counselor. It ensures that all sides are heard and that the complaint and response to the complaint receive due consideration. In this case, informed consent means that all parties are aware of the process for lodging a complaint.

Ethical and legal issues: policies, regulations, and laws regarding supervisory and therapeutic relationships

- Number of supervisees for which the supervisor will be responsible
- Emergency and backup procedures (e.g., supervisor accessibility)
- Ethical codes of conduct
- Process for discussing ethical dilemmas

- Confidentiality regarding information discussed in supervision
- Confidentiality issues when more than one supervisee is involved
- Dual roles and relationships

Process for addressing supervisee issues (e.g., burnout, countertransference)

Statement of agreement

Signed acknowledgement by all parties that they understand and agree to comply with the contract

Source: Adapted from Falvey, 2007.

Selection and Competencies of Supervisors

When hiring or appointing a person as a clinical supervisor, you will need to understand the scope of practice and competence of a supervisor. Consult TAP 21A (CSAT, 2007) and the International Certification and Reciprocity Consortium [IC&RC] Role Delineation Study for Clinical Supervisors (2000).

Administrators can use checklists such as Tool 5 to determine the competencies of a potential clinical supervisor.

Tool 5: Checklist for Supervisor Competencies

Competencies	Poor	Below Average	Average	Above Average	Excellent
Knowledge					
Has knowledge of theory and intervention strategies					
Has knowledge of screening, assessment, and diagnostic standards					
Understands cultural and ethnic issues					
Has knowledge of resources in the community					
Has knowledge of current ethical guidelines and legal issues					

Practice					
Demonstrates mastery of intervention techniques					
Is timely and thorough in documentation					
Is able to develop rapport					
Is able to conceptualize problems					
Can respond to multicultural issues					
Is able to formulate treatment goals					
Personal					
Demonstrates ethical behavior					
Is interpersonally competent					
Is able to identify own strengths and weaknesses					
Is able to accept and learn from feedback					
Is an asset to the profession					
Source: Adapted from Campbell, 2000. Permission pending					

Other sources to consult on the same topic include:

- Bernard and Goodyear, 2004: Evaluation Questionnaires and Scales (pp. 316–339).
- Falvey, 2004b: Ethical Mandates for Professional Competence, Standards for Clinical Supervisor Competence (pp. 25, 28).
- Powell and Brodsky, 2004: ACES Supervision Interest Network, Competencies of Supervisors (pp. 327–332).
- Campbell, 2000 (pp. 257–285).

Supervision Guidelines

Supervision guidelines describe the organization’s commitment to clinical supervision, working terms, principles of supervision at that organization, and required documentation of clinical sessions and clinical supervision. The guidelines should clearly state the frequency of supervision, ongoing feedback procedures, and commitment to ongoing professional development. Tool 7 is an example of such a document.

Tool 7. Clinical Supervision Policy and Procedure

Underlying Principles

Clinical supervision is a powerful tool for managing and ensuring continuous improvement in service delivery. Clinical supervision is comprised of balancing four distinct functions: administrative, evaluative, supportive, and clinical. Fundamental structures include a positive working relationship, client-centered approach, commitment to professional development, and accountability. The following principles ensure high-quality clinical supervision:

- A safe, trusting working relationship that promotes a learning alliance.
- A counselor-centered program with a culturally and contextually responsive focus.
- Active promotion of professional growth and development.
- Shared clinical responsibility ensuring that the client's treatment goals are addressed.
- A rigorous process that ensures ethical and legal responsibility.
- Congruence with the values and philosophy of the agency.

Terms

A healthy **working relationship** is built on shared vision and goals, clear expectations, and the belief in the good intentions of staff members. It demonstrates reciprocal communication where all parties provide comprehensive, timely information that is respectful. Each person is responsible for providing relevant information critical to his or her job function and the mission of the agency. The working relationship recognizes the importance of the chain of command throughout all agency levels. The agency expects that this chain of command supports structure, appropriate boundaries, and decision-making at all levels. The chain of command is followed to ensure effective and efficient communication.

Trust is central to the working relationship. This is manifested in several ways: (1) people are accountable to their work and job responsibilities, (2) confidentiality is maintained, (3) decisions are respected, and (4) misunderstandings are pursued to clarify miscommunication, seek to understand the other person, air emotions, and reach resolution.

The **learning alliance** is based on the belief that the supervisee has specific learning needs and styles that must be attended to in supervision. The relationship between supervisor and supervisee is best formulated and maintained when this frame of reference is predominant. Supervisees participate in a mutual assessment based on a combination of direct and indirect observations.

Guidelines for Clinical Supervision

The principles of clinical supervision are made explicit by a clear contract of expectations, ongoing review and feedback, and a commitment to professional development.

Clear contract of expectations

It is critical that both the supervisor and supervisee share their expectations about the process, method, and content of clinical supervision. This can advance the development and maintenance of a trusting, safe relationship. The following information should be discussed early in the working relationship:

- Models of supervision and treatment.
- Supervision methods and content.
- Ethical, legal, and regulatory guidelines.
- Access to supervision in emergencies.
- Alternative sources of supervision when the primary supervisor is unavailable.

The supervisee will be provided with a job description that outlines essential duties and performance indicators. Additionally, each supervisee will receive an assessment of core counseling skills based on the TAP 21 competencies and other appropriate standards.

Documentation

Supervisory sessions are recorded as notes that indicate the focus of the session, the issues discussed, solutions suggested, and agreed upon actions. Supervisors will maintain a folder for each of their supervisees. The folder will contain the IDP, clinical supervision summaries, and personnel actions (e.g., memos, commendations, other issues). Supervisees are allowed full access to the folders.

Clinical supervision frequency

Each supervisee will receive 4 hours of supervision monthly. A combination of individual and group supervision may be used. Supervisors are to ensure that a minimum of 50 percent of this time is devoted to clinical, as opposed to administrative, supervision.

Ongoing review and feedback

The supervisee will be given an annual performance evaluation that reviews both job expectations and the clinical skills learning plan. Written records of the supervisee will be reviewed on a regular basis. Supervisees will be given specific written feedback regarding their strengths and areas for improvement. The supervision system operates through direct observation of clinical work. This ensures that direct, focused feedback will be provided, increases the degree of trust and safety, and provides an accurate evaluation of skills development progress. Observations will be prearranged and take the form of sitting in on a session, cofacilitating, or videotaping. The supervisee will present a case at a minimum of once per month.

Commitment to ongoing professional development

The supervisee's learning plan should document goals, objectives, and methods to promote professional development. The plan should be completed within the first 6 months of employment and updated annually. Ongoing

supervision should focus on achieving the identified goals. The agency supports supervisees' participation in training to achieve their professional development goals.

Source: Adapted from unpublished Basics, Inc. materials

The Supervision Contract

A supervision contract protects the rights of the agency, the supervisor, and supervisee. A written contract between supervisor and supervisee, stating the purpose, goals, and objectives of supervision is important. Tool 8 is a template for supervision contracts. In addition to the contract, for the purposes of informed consent, it is useful to have a supervision consent form signed by both the supervisor and supervisee, indicating the supervisee's awareness and agreement to be supervised (see Tool 4).

The Initial Supervision Sessions

An initial supervision sessions checklist documents the topics to be covered in initial sessions by the supervisor and supervisee. The goal is that as part of establishing the supervisory relationship, the supervisor and supervisee should discuss the basic issues in substance abuse counseling and in supervision. For new supervisors and for administrators to monitor the implementation of supervision, a checklist, such as Tool 9, can ensure that the important issues are discussed. The example below can aid in setting a preliminary structure for supervision, clarifying goals and expectations, and incorporating feedback so as to promote a sense of openness, trust, and safety. It is understood that not all of these topics can be covered in the first few sessions, but these topics are important considerations in initiating clinical supervision.

Documentation and Recordkeeping

Documentation is unquestionably a crucial risk-management tool for clinical supervisors and is no longer optional in supervision. Legal precedents suggest that organizations are both ethically and legally responsible for quality control of their work, and the supervision evaluation, documentation, and recordkeeping systems are a useful and necessary part of that professional accountability. However, in contrast with the myriad clinical forms and documentation required, there is a paucity of tools for documentation in supervision. Most organizations rely on the personal style and records of individual supervisors, and do not

have an organization-wide standardized system of record keeping for supervision. Documenting supervision should not be burdensome, but it should be systematic and careful. Key components of what should be documented and how it should be documented are provided in the following paragraphs.

A record of supervision sessions needs to be maintained that documents: when supervision was conducted, what was discussed, what recommendations were provided by the supervisor, and what actions resulted. A supervisor should maintain a separate file on each counselor supervised, including:

- Caseloads.
- Notes on particular cases.
- Supervisory recommendations and impressions.
- The supervision contract.
- A brief summary of the supervisee's experience, training, learning needs, and learning styles.
- The individual development plan.
- A summary of all performance evaluations.
- Notations of supervision sessions, particularly concerning duty-to-warn situations, cases discussed, and significant decisions made.
- Notations of canceled or missed supervision sessions.
- Significant issues encountered in supervision and how they were resolved.

By far, the most comprehensive documentation system for clinical supervisors is Falvey's FoRMSS system (2002a), which includes emergency contact information, supervisee profiles, a log sheet for supervision, an initial case overview, a supervision record, and a termination summary that records the circumstances of client termination, client status at termination, and any follow-up or referrals needed. The FoRMSS system alerts supervisors to potential clinical, ethical, or legal risks associated with cases.

Records of supervision must be retained for the period required by the State and pertinent accreditation bodies. The American Psychological Association's guidelines (2007) recommend retaining clinical and supervisory records for at least 7 years after the last

services were delivered. Organization policy may differ from this. Administrators should check with local and State statutes regarding recordkeeping requirements. It is prudent for an organization and supervisor to retain supervision records for at least as long as required by the State and accreditation bodies.

Tool 9. Initial Supervision Sessions Checklist
Education, Training, and Clinical Experience _____ Educational background _____ Training experience _____ Setting(s), number of years _____ Theoretical orientation _____ Clinical competence with various issues, models, techniques, populations, presenting problems, treatment modalities _____ Sense of mission and purpose in the field _____ Educational plans and professional goals of the supervisee _____ Training and awareness of cultural and contextual issues in counseling _____ Training and awareness of community networking in counseling **Philosophy of Supervision** _____ Philosophy of therapy and change _____ Purpose of supervision **Previous Supervision Experiences** _____ Previous supervision experiences (e.g., format, setting) _____ Strengths and weaknesses as counselor and as supervisee _____ Supervisee's competence with stages of counseling process _____ Supervisee's level of development in terms of case planning, notes, collateral support, and networking _____ Supervisory competence with various issues, models, techniques, populations, therapy groups, and modalities _____ Methods for managing supervisor-supervisee differences **Supervision Goals** _____ Goals (personal and professional) _____ Process of goal evaluation and timeframe _____ Requirements for which supervisee is seeking supervision (e.g., licensure, professional certification) _____ Requirements to be met by supervision (e.g., total hours, individual or group supervision) **Supervision Style and Techniques** _____ Specific expectations the supervisee or supervisor has of the parties involved (e.g., roles, hierarchy) _____ Type of supervision that would facilitate clinical growth of the supervisee

_____ Preferred supervision style (didactic, experiential, collegial)
_____ Parallels between therapy and supervision models
_____ Supervision focus (e.g., counselor's development, cases)
_____ Manner of case review (e.g., crisis management, in-depth focus)
_____ Method (e.g., audio- or videotaping, direct observation)

Theoretical Orientation
_____ Models and specific theories in which supervisee and supervisor have been trained, practice, and or conduct supervision
_____ Extent to which these models have been used clinically
_____ Populations, presenting problems, and/or family forms with which the models have been most effective
_____ Interest in learning new approaches

Legal and Ethical Considerations
_____ Ultimate responsibility for clients discussed in supervision in different contexts (e.g., licensed vs. unlicensed counselor, private practice vs. public agency)
_____ Number of cases for which the supervisor will be responsible
_____ Emergency and backup procedures
_____ Awareness of professional ethical codes
_____ Confidentiality regarding the information discussed in supervision
_____ Confidentiality issues when more than one supervisee is involved
_____ Specific issues in situations where dual relationships exist (e.g., former client)
_____ Process for addressing supervisee issues (e.g., burnout, countertransference)

Other
What do we need to know about each other that we have not already discussed?

Source: Adapted from Falvey, 2002b. Permission pending

Tools 10–12 are sample documentation forms. (See also Campbell, 2000.)

Tools 10. Supervision Note Sample Professional Development Plan Current Focus		
Goal/TAP Competencies	Objective	Date of Expected Completion

Supervision Content			
Issue	**Discussion**	**Recommendation/Action**	**Follow-up**

Progress on Professional Development Plan Objectives

____

____

____

Other____

Supervisor________________________________Counselor_____________________________ Date____________

Source: Porter and Gallon, 2006.

Tool 11. Current Risk-Management Review

Case: ______________________________ Date: _____________________________

ISSUES

☐ Informed Consent	☐ Supervisee Expertise
☐ Parental Consent	☐ Supervisor Expertise
☐ Confidentiality	☐ Institutional Conflict
☐ Recordkeeping	☐ Dual Relationship
☐ Records Security	☐ Sexual Misconduct
☐ Child Abuse/Neglect	☐ Releases needed
☐ Risk of Significant Harm	☐ Voluntary/Involuntary Hospitalization
☐ Duty to Warn	☐ Utilization Review Discharge/Termination
☐ Medical Exam Needed	

Discussion:

____

____

____

Recommendation:

____

____

____

Action:

____

____

____

Signature:____________________________Date:__________________________________

Title: ____

Source: Based on Falvey, 2002b

Tool 12. Supervisory Interview Observations		
Statements/Behaviors	Statement Behaviors	Comments
Step 1 SET AGENDA Decrease Anxiety Involve Counselor		
Step 2 GIVE FEEDBACK Empower Individualize		
Step 3 TEACH and NEGOTIATE Share agenda		

Clarity knowledge, skills, attitude Identify learning steps Agree upon methods of learning		
Step 4 SECURE COMMITMENT Clarify expectations Clarify responsibilities Create mutual accountability		

LOOK FOR	OBSERVATIONS, BEHAVIORS, NOTES
SUMMARY OBSERVATIONS	
Interview structure followed?	
Time managed effectively?	
Established nurturing and supportive environment?	
Stayed on course?	
Resistance? Power struggle?	
Agreement secured?	
Follow-up plan created?	
NOTES:	
Source: Based on Porter & Gallon, 2006	

Evaluation of Counselors and Supervisors

Evaluation of counselors and supervisors is both formative (ongoing and evolving over time) and summative (periodic and formal). Nowhere else in supervision does the power differential between the supervisor and supervisee become more evident than in the evaluation process. Feedback and evaluation are necessary and important in an organization's riskmanagement procedures. Agencies need a formal procedure and criteria for staff evaluation. When supervisors conduct supervisee evaluations,

counselors need to understand there is a level of subjectivity in the process. There is no psychometrically valid tool to assess counselor competence. An element of the supervisor's judgment is always involved.

Most evaluation guidelines and tools identify general areas of competence to assess—knowledge, skills, and attitudes—but specific criteria for making an evaluation are left to the individual supervisor and the organization. It is important that the evaluation of staff be closely linked to job descriptions, the supervision contract, and the specific needs of the agency. Levels of competence and fitness for duty should be established by the individual organization, with consideration given to the credentialing and accreditation requirements of the agency. Supervisee triads also offer another option to assist in the evaluation process. A grievance and appeals process should be defined. Finally, supervisors need to be reminded that they are the gatekeepers for the agency, providing feedback, remediation as needed, and dismissal of personnel if indicated.

Tools 13 and 14 aid the supervisee in evaluating the supervisor and the supervisor in assessing the counselor.

Tool 13: Counselor Evaluation of the Supervisor	
This evaluation form gives the supervisor valuable feedback while it gives the counselor a sense of responsibility and involvement in the design and development of supervision. Use a 7point rating scale where: 1 = strongly disagree 4 = neither agree nor disagree 7 = strongly agree	
	Rating
1.Provides useful feedback regarding counselor behavior	
2. Promotes and easy, relaxed feeling in supervision	
3. Makes supervision a constructive learning process	
4. Provides specific help in areas needing work.	
5. Addresses issues relevant to current clinical conditions	
6. Focuses on alternative counseling strategies to be used with clients.	

7. Focuses on counseling behavior.	
8. Encourages the use of alternative counseling skills.	
9. Structures supervision appropriately.	
10. Emphasizes the development of strengths and capabilities	
11. Brainstorms solutions, responses, and techniques that would be helpful in future counseling situations	
12. Involves the counselor in the supervision process	
13. Helps the supervisee feel accepted and respected as a person	
14. Appropriately deals with affect and behavior	
15. Motivates the counselor to assess counseling behavior	
16. Conveys a sense of competence	
17. Helps to use tests constructively in counseling	
18. Appropriately addresses interpersonal dynamics between self and counselor	
19. Can accept feedback from counselor	
20. Helps reduce defensiveness in supervision	
21. Encourages expression of opinions, questions, and concerns about counseling	
22. Prepares the counselor adequately for the next counseling session	
23. Helps clarify counseling objectives	
24. Provides an opportunity to discuss adequately the major difficulties the counselor is facing with clients	
25. Encourages client conceptualization in new ways	
26. Motivates and encourages the counselor	
27. Challenges the counselor to perceive accurately the thoughts, feelings, and goals of the client	
28. Gives the counselor the chance to discuss personal issues as they relate to counseling	
29. Is flexible enough to encourage spontaneity and creativity	

30. Focuses on the implications and consequences of specific counseling behaviors	
31. Provides suggestions for developing counseling skills	
32. Encourages the use of new and different techniques	
33. Helps define and achieve specific, concrete goals	
34. Gives useful feedback	
35. Helps organize relevant case data in planning goals and strategies with clients	
36. Helps develop skills in critiquing and gaining insight from counseling tapes	
37. Allows and encourages self-evaluation	
38. Explains the criteria for evaluation clearly and in behavioral terms	
39. Applies criteria fairly in evaluating counseling performance	
40. Addresses cultural issues of supervisee in a helpful manner.	
41. Discusses cultural and contextual issues of the client, family, and wider systems that open up new resources and avenues for support.	
Source: Adapted from Powell and Brodsky, 2004	

Tool 14. Counselor Competency Assessment Based on TAP 21, Addiction Counseling Competencies: The Knowledge, Skills, and Attitude of Professional Practice (CSAT, 2006)				
Competency Area	**Needs Improvement**	**Able to Perform Skill**	**Proficient**	**Consistent Mastery**
Understand Substance Use Disorders • Models and theories • Recognize complex context of substance abuse				
Treatment Knowledge • Philosophies				

• Practices • Outcomes				
Application to Practice • DSMIVTR • Repertoire of helping strategies • Familiar with medical and pharmacological resources				
Diversity and Cultural Competence • Understand diversity • Use client resources • Select appropriate strategies				
Clinical Evaluation • Screening • Assessment				
Assess Co-Occurring Disorders • Symptomatology • Course of treatment				
Treatment Planning • Based on assessment • Individualized				

• Ensure mutuality • Reassessment • Team participation				
Referral and Followup • Evaluate referrals • Ongoing contact • Evaluate outcome				
Case Management				
Group Counseling • Group theory • Describe, select, and use appropriate strategies • Understand and work with process and content • Facilitate group growth				
Family, Couples Counseling • Theory and models • Understand characteristics and dynamics • Describe, select, and use				

appropriate strategies				
Individual Counseling • Theory of individual counseling • Describe, select, and use appropriate strategies • Understand functions and techniques of individual counseling				
Client, Family, and Community Education • Culturally relevant • Provide current information • Teach life skills				
Documentation • Knowledge of regulations • Prepare accurate, concise notes • Write comprehensive, clear psychosocial narrative				

• Record client progress in relation to treatment goals • Discharge summaries				
Professional and Ethical Responsibilities • Adhere to code of ethics • Apply to practice • Participate in supervision • Participate in performance evaluations • Ongoing professional education				
Source: Porter & Gallon, 2006.				

Other useful resources are:

- Bernard and Goodyear, 2004: Supervision Instruments (pp. 317–326).
- Campbell, 2000: Generic Rating Sheet and Evaluation Form, Supervisee's Basic Skills and Techniques (p. 263); Sample Generic Supervisee Evaluation Form (p. 275).
- Powell and Brodsky, 2004: Evaluation of the Counselor, adapted from Stoltenberg and Delworth, 1987 (p. 351).
- Powell and Brodsky, 2004: Counselor Assessment Forms (p. 373–379).

- Northwest Frontier Addiction Technology Transfer Center Performance Rubric available online at http://www.attcnetwork.org/documents/Final.CS.Rubrics.Assessment.pdf.

Individual Development Plan

After the supervisor and counselor have agreed on goals, they should formulate an individual development plan (IDP) or professional development plan. It should address the expectations for supervision, the counselor's experience and readiness for the position, procedures to be used to observe and assess the counselor's competencies, and the counselor's professional development goals. Some IDP formats follow the 12 Core Functions taking into account the stage of development of the counselor. Other formats might use the competencies in TAP 21. Tool 15 outlines the generic knowledge, skills, and attitudes to be addressed as part of one's professional development plan. Whatever format is adopted, the IDP should provide the counselor with a road map for learning goals.

Tool 15. Professional Development Plan

Staff______________________________Position___________________Date:_______

Practice Dimension:____

Competency number and page from TAP 21:________________________________

Present level of competence from TAP 21 Rating Form:

1 Understands	2 Developing	3 Competent	4 Skilled	5 Master

1= Understands	Comprehends the tasks and functions of counseling
2= Developing	Applies knowledge and skills consistently.
3= Competent	Consistent performance in routine situations.
4= Skilled	Effective counselor in most situations
5= Master	Skillful in complex counseling situations

Describe the counselor's strengths and challenges for this rating: ____

____

____

Expected level of competency to be achieved with this learning plan:

1 Understands	2 Developing	3 Competent	4 Skilled	5 Master

Describe the goal for this learning plan in observable term: ____

List the Knowledge, Skills, and Attitudes relevant to achieving the target competency.

Knowledge:

____

____

Skills____

____

Attitudes____

____

State the performance goal in specific behavioral terms:

____

____

What activities will the counselor complete in order to achieve the stated goal? _____________________________

How will progress evaluated? How will proficiency be demonstrated?_____________________________________

Supervisor signature____Date_________________________

Counselor signature____Date__________________________

UPDATE

Date of “re-observation”_________________________________

Demonstration of knowledge and skills successful? _______________Yes ____________No

If “No”, demonstration needs the following correction and follow-up demonstration rescheduled:

Supervisor Signature:___________________________________ Date:_______________________

Counselor Signature ____ Date:______________________ Source: Adapted from Porter & Gallon, 2006.

Outline for Case Presentations

Counselors often need to be taught how to present cases in supervision. The counselor needs to think about the goals he or she would like to achieve for the client and his or her particular concerns about the case. It is possible to use the case presentation format for

a variety of purposes: to explore the client's clinical needs, to aid in case conceptualization, to process relational issues in counseling (transference and countertransference), to identify and plan how to use specific clinical strategies, and to promote self-awareness for the counselor. In the beginning, the supervisor should structure the case presentation procedures to ensure consistency and conformity to agency guidelines. Tool 16 can be adapted to the particular theoretical model of the agency and the specific needs of the supervisee and organization.

Tool 16. Sample Case Consultation Format
Name of presenter:____ Date:____ Identifying data about the client (age, marital status, number of marriages, number and ages of children, occupation, employment status) Presenting problem:____ Short summary of the session :____ Important history or environmental factors (especially cultural or diversity issues):____ ____ Tentative assessment or problem conceptualization (diagnosis):____ Plan of action and goals for treatment (treatment plan):____ Intervention strategies: ____ ____ Concerns or problems surrounding this case (e.g., ethical concerns, relationship issues): ____ ____ *Source: Adapted from Campbell, 2000.*

Audio- and Videotaping

To ensure competence, the agency should provide instruction on audioand videotaping to all staff. Instruction should include the overall purpose of taping, how to inform the client about the taping procedure, how to use the recording equipment, the placement of taping

devices, how to ensure client confidentiality and obtain signed releases, how to begin the actual session while recording, and how to process the tapes after recording. Tool 17 provides helpful hints for successful audio- and/or videotaping.

Tool 17. Instructions for Audio and Videotaping
1. **Use quality equipment**. Check the sound quality, volume, and clarity. It is best to use equipment with separate clip-on microphones unless you are in a sound studio with a boom microphone. Clip-on microphones are inexpensive and easy to obtain. 2. **Buy good quality tapes**. It is not necessary to buy top-of-the-line tapes, but avoid the cheapest. Better tapes give better sound and picture and can be reused. 3. **Placement of equipment matters**. Use a tripod for the video camera. Check the angle of camera, seating, volume, and the stability of the picture. 4. **Check the background sound and volume**. Choose a quiet, private place to do this, both to protect confidentiality and to improve recording quality. Do not use an open space, an office with windows facing the street, or a place subject to interruption. Loud air conditioning fans, ringing phones and pagers, street noise, and office conversations all disrupt the quality of taping. 5. **Know how to use the equipment**. Conduct a dry run. Be sure to check the placement of chairs, video camera angles, and picture quality before you begin. If the supervisee is especially anxious or unfamiliar with the equipment, have him or her make a practice tape. Be sure those in the picture are the persons agreed on by the supervisor and supervisee. 6. **Protect the confidentiality of the supervisee and the client**. Choose a private, controlled space for taping. Keep the tapes in a locked cabinet and don't include identifying data on the outside of the tape. When finished with supervision, erase the tape completely before reusing; do not just tape over the previous session. 7. **Process with the supervisee any anxiety or concern generated by taping**. Three areas of potential anxiety are the technical aspects (equipment and room availability), concern for the client (confidentiality), and the effect of taping on the session (critical evaluation of performance by the supervisor). 8. **Explain taping**, its goals, and its purpose to the client at least one session before proceeding. Review with the client any concerns about confidentiality. Remember that the more comfortable and enthusiastic the supervisor and the supervisee are with the value of taping, the more comfortable the client will be. Sometimes just reassuring the client that the tape can be turned off at any point if the client is uncomfortable increases a sense of control and reduces anxiety. Usually after the first few minutes of taping, both the client and counselor forget its presence, and this option is rarely used. If the client appears resistant, a decision should be made as to the appropriateness of using this particular method of supervision in this situation.

9. **Get a written release** from the client. Be sure the release includes a description of the purpose of the tape, limits of confidentiality, identities of those viewing the tape, and assurance of erasure of the tape afterward. If the tape is to be used in group supervision or a staffing seminar, the client should be informed of that fact. 10. Before beginning the actual session, **check the equipment** by making a short practice tape covering background material on the client. Then, rewind the tape and play it to check sound, volume, camera angle, and picture. When satisfied, begin the actual session. Source: Adapted from Campbell, 2000.

Further, it is essential that an organization provide documentation to protect the confidentiality of information and to preserve patients' rights. This is especially important if direct observation of clinical sessions is to occur using audio or videotaping. Tool 18 explains the benefits and procedures of taping and can be read by the counselor to the client. The consent form, Tool 19, should be signed and dated prior to taping.

Tool 18. Confidentiality and Audio-or Videotaping
Video recording of clinical processes will be conducted with the client's written, informed consent for each taping. Clients understand that no taping will occur without their consent. A process already in place will ensure the security and destruction of DVDs or erasure of VHS tapes. The purpose of videotaping is to improve counselors' clinical skills through supervision and teaching. • Counselor benefits of videotaping include: • Improving therapeutic skills. • Improving treatment team cohesion. • Improving assessment, treatment planning, and delivery of services. • Improving clinical supervision. Procedure: The client's counselor will explain and fully disclose the reason, policy, and procedure for videotaping the client. Both will sign a specific videotaping release form. The counselor should also explain that refusal to be taped will not affect the client's treatment at the agency. 1. The client must be 18 years old to sign the consent. Those under 18 must have a parent's signature in addition to their own.

2. Respecting the client's concerns is always the priority. Should any client or family member show or verbalize concerns about taping, those concerns need to be addressed.

3. All taping devices will be fully visible to clients and staff while in use.

4. A video camera will be set up on a tripod, consistent with safety standards and in full view of each client. Clients will be notified when the camcorder is on or off.

5. The tape will be labeled when the session is completed, and no copies will be made.

6. Clinical review for supervision or training: The treatment team will review the tape and assess clinical skills for the purpose of improving clinical techniques.

7. The tape will be turned over to the Medical Records Department (if available) for sign out.

8. Tapes and DVDs will be stored in a locked drawer in the Medical Records Department. Within 2 weeks of taping, tapes will be erased and DVDs destroyed in the presence of two clinical staff members who attest to this destruction on a form to be kept for 3 years.

9. Tapes and DVDs may not be taken off premises.

Tool 19. Audio or Video Recording Consent
I,________________________________, consent to be recorded or filmed for supervision purposes. I also agree to allow the clinical staff to review the film as a resource to facilitate staff development for the enhancement of clinical procedures. I understand that any film in which I am a participant will be erased within 2 weeks of the date of filming. I understand that no copies will be made of such film. Patient Signature_________________________________ Date_________________ Witness Signature _______________________________ Date__________________

PART 2: CLINICAL SUPERVISION IMPLEMENTATION GUIDE

Source: https://www.nmbhpa.org/clinical-supervision-implementation-guide/clinical-supervision-and-clinical-practice-guidelines/

A. Overview:

Clinical supervision instructs, models, and encourages self-reflection of the supervisee's acquisition of clinical and administrative skills through observation, evaluation, feedback, and mutual problem-solving. However, it should be understood that there might be opportunities in which the clinical supervisor chooses to give professional direction based on experience, expertise, and/or for ethical or safety concerns. Clinical supervision is delivered within the supervisor's professional practice license and ethical standards. Clinical supervision is provided to all treatment/clinical staff who are either employed or under contract by a provider organization such as group practices or behavioral health specialty organization or an individual provider.

- Clinical supervisors need to meet the standards for clinical supervision as defined by their professional practice board.
- Clinical supervisor responsibilities: provide support, consultation, and oversight of clients' treatment to include: assessment of needs; diagnoses/differential diagnoses (MH, SA, and COD); clinical reasoning and case formulation which addresses documentation; treatment planning and implementation; refining treatment goals and outcomes; selecting interventions and supports; coordination of care; tracking and adjusting interventions. All of the above should be:
    - Continuously reviewed and adjusted according to an individual's status, success and challenges.
    - Teaching the importance of retaining continuity throughout all documentation.
    - Ensuring plans, interventions, goals, and supports are appropriate to diagnosis.

- Clinical Supervision assures that discharge planning starts at the initiation of treatment and is continually developed throughout treatment. The discharge plan assures ongoing support for the individual's continued recovery and success.

- Clinical Supervision assures that an appropriate safety and crisis management plans are in place at the onset of service delivery.

- Clinical Supervision addresses ethics and ethical dilemmas as aligned with the appropriate professional practice board.

Clinical Supervisors will document date, duration, and the content of supervision session for their supervisee(s), which may include a professional development plan. All documents pertaining to clinical supervision will be readily available to the supervisee.

B. Staff Qualifications:

A clinical supervisor has been approved by their respective professional licensing board as having met board requirements for providing clinical supervision. Please see http://www.rld.state.nm.us/boards/default.aspx for current requirements.

C. Guidelines for Clinical Practice and Clinical Supervision

1. INTRODUCTION:

The term **practice** refers to the collective set of actions used to plan and deliver interventions and supports. Practice takes place in collaboration with the person(s) served and the social and service-related networks and supports available to help meet the person's individualized and/or family needs and is guided by self-determination and individual choice. The purpose of practice is to help a person or family to achieve an adequate level of:

- **Well-being** (e.g., safety, stability, permanency for dependent children, physical and emotional health),

- **Daily functioning** (e.g., basic tasks involved in daily living, as appropriate to a person's life stage and ability),

- **Basic supports for daily living** (e.g., housing, food, income, health care, child care), and
- **Fulfillment of key life roles** (e.g., a child being a successful student or an adult being a successful parent or employee).

2. BASIC EXPECTATIONS OF HIGH-QUALITY PRACTICE:

There are five basic functions of quality practice that must be performed for each person served to achieve the greatest benefits and outcomes. These functions listed below are foundational to quality practice and underlie all successful intervention strategies. Because these functions are essential to achieving positive results with clients served, the Behavioral Health Services-Division expects that each person served will, at a minimum, be served in a manner that consistently provides and demonstrates these core practice functions. Providing services to all clients in accordance with these practices is a top priority, and the Behavioral Health Services Division will support organizations to consistently measure their occurrence with clients served using Integrated Quality Service Reviews (iQSR), Clinical Supervision and Quality Improvement strategies based on their organization's comprehensive and ongoing self-assessments. Agencies are encouraged to d e v e l o p strong internal clinical practice development activities including integration of the iQSR or other data-driven fidelity models.

3. BASIC FUNCTIONS OF HIGH-QUALITY PRACTICE:

This practice framework sets forth the actions/functions used by frontline practitioners to partner with a person receiving services to bring about positive life changes that assist the person by maintaining successes and managing challenges as they occur. Typical activities in practice include engaging the client and other key stakeholders in a connected, unifying effort through teamwork and fully understanding the person, their needs and environment. It also includes collaboratively defining results to be achieved, selecting and using intervention strategies and supports, resourcing and delivering planned interventions and supports, and tracking and adjusting intervention strategies until desired outcomes are achieved.

The basic functions of quality practice are:

- **Engaging Service Partners**
- **Assessing and Understanding the Situation**
- Planning Positive Life-Change Interventions
- Implementing Services
- Getting and Using Results

4. THE PRACTICE WHEEL: A PRACTICE MODEL DEFINES THE PRINCIPLES AND ORGANIZING FUNCTIONS USED BY PRACTITIONERS

The practice framework also encompasses the core values and expectations for providing services. The framework functions to organize casework and service delivery, to guide the training and supervision of staff, and clarifies quality measures and accountability. Basic practice functions are illustrated in the "practice wheel" diagram below. The practice wheel can be utilized to guide supervision by providing a framework and expectations for working with persons receiving services. For example, supervision and training could progress along the practice wheel with each function as a topic of focus to strengthen and operationalize expectations.

5. CLINICAL SUPERVISION AS A FOUNDATION FOR STRONG CLINICAL PRACTICE:

Clinical Supervision is the foundation for assuring consistent, high quality practice. It provides a mechanism for clinical practice improvement at both an individual staff level as well as at the organizational level.

6. INDIVIDUAL PRACTITIONER LEVEL SUPERVISION:

The Clinical Supervision for individual frontline practitioners should consistently:

- Provide support, consultation, and oversight of clients' treatment to include assessment of needs; diagnoses/differential diagnoses (MH, SA, and COD); clinical reasoning and case formulation, to include documentation; treatment planning and implementation; refining treatment goals and outcomes; selecting interventions and supports; coordination of care; tracking and adjusting interventions.
    - All of which should be continuously reviewed and adjusted according to an individual's status, success and challenges. Teach the importance of retaining continuity throughout all documentation.
    - Ensure plans, interventions, goals, and supports are appropriate to diagnosis; and, aligned with the supervisee's theoretical orientations
    - Use parallel process where the supervisee's development is being addressed alongside the emerging clinical issues.
- Address the supervisee's steps to insure an individual's active involvement at all levels and that the individual voice and choice are clearly represented and documented.
- Assure that discharge planning starts at the initiation of treatment and is continually developed throughout treatment. The discharge plan assures ongoing support for the individual's continued recovery and success.
- Assure that an appropriate safety and crisis management plans are in place at the onset of service delivery.
- Address ethics and ethical dilemmas as aligned with the appropriate professional practice board.

7. GROUP LEVEL SUPERVISION:

In addition to reinforcing multi-disciplinary teaming, group supervision can serve as a good teaching/training venue in which provider trends are highlighted (e.g., engagement, population profiles, and the presenting severity/types of disorders, theoretical orientation and case conceptualization.) **The Clinical Supervisor's experiences in group supervision can also inform and strengthen the work of the entire team through the use of a recognized Clinical Practice Improvement model.**

8. ORGANIZATIONAL LEVEL BENEFITS OF CLINICAL SUPERVISION:

- **Assures high quality treatment for individuals**.
- Creates clearly defined treatment goals which are measurable and time limited
- Assures the treatment plan is a living, working document with the individual.
- Ensures proper documentation of care and can help with program integrity issues
- Ensures staff are trained and properly implementing Evidenced-based Practices.
- Ensures fidelity to evidenced based practice models (e.g. Multisystem Therapy, Integrated Dual Diagnosis Treatment, Substance Abuse Matrix model)
- Improves staff development and employee retention
- Provides a risk management tool (e.g. Reduction of critical incidence)

9. ORGANIZATIONAL EXPECTATIONS:

Agencies are expected to have policies and procedures that assure that:

- Clinical Supervision is conducted in a manner that ensures adequate attention to each supervisee and quality oversight for the cases;
- Clinical Supervision occurs frequently and follows a structured process that includes individual & group, clinical oversight, and regular access to supervisors;

- Both individual and group clinical supervision occurs multiple times during any month with documentation to evidence that clinical supervision has occurred accordingly.
- All individual practitioner's, group practices' and facilities' Quality Improvement Program should have a Clinical Practice Improvement program that:
  - Utilizes the findings from its Clinical Supervision to the improve the provider performance;
  - Addresses care planning consistent with: wraparound planning approaches; system of care principles; and, a recovery philosophy.
  - Includes process improvement approaches, relevant data collection, fidelity measures and data for outcome monitoring.
  - Has a review protocol should examine strengths and improvements in the following areas:
    - **Engagement**
    - **Teamwork**
    - Assessment & understanding
    - Outcomes & goals
    - Intervention planning
    - Resources
    - Adequacy of interventions
    - Tracking and adjustment

10. GUIDING VALUES AND PRINCIPLES OF PRACTICE

The Behavioral Health Services Division, Human Services Department and the New Mexico Behavioral Health Collaborative hold the following values and principles for

practice in the provision of services to all individuals, youth and families served within the public behavioral health system:

- Individual/family-driven, individualized and needs-based
- Developmentally appropriate
- Inclusive of family or natural supports
- Offers an array of services & supports
- High quality
- Community-based.
- Culturally and linguistically aware and accepting
- Use of early identification and intervention
- Integrative approach
- Trauma responsive
- Strength-based
- Outcome based
- Least restrictive
- Recognize perseverance and resiliency/ trauma informed

11. STATE MONITORING OF CLINICAL PRACTICE AND CLINICAL SUPERVISION

Medicaid funded and state funded agencies who wish to use non-independently licensed providers will need to submit the Supervisory Certification Attestation Form. Contact (bilfornil.bhsd@state.nm.us). A **staff roster** must accompany the attestation with each independent and non-independent provider listed. For the supervisors, please include a letter from the licensing Board designating them as supervisors (LCSW or LISW) or their most recent CEUs in supervision that accompanied their last license renewal (LPCC.)

Once approved, the provider will need to submit their Supervisory Certification notice to the MCO's and Medicaid so that they can render services.

Each time the provider brings on a new non-independently licensed provider, or changes supervisors, they will need to submit an updated roster (with all the columns filled out). For Supervisors, please include a letter from the licensing Board designating them as supervisors (LCSW or LISW) or their most recent CEU's in supervision that accompanied their license renewal (LPCC).

12. CLINICAL SUPERVISION DOCUMENTATION:

The organization's documentation will include:

- Policies that describe the provider's clinical supervision of all treatment staff including their Human Resources requirements for the clinical supervisor (credentials, job description, skill sets, training requirements and schedules).
- Procedures will include:
    - A template that documents when and how clinical supervision is provided to individuals and multidisciplinary teams in individual and group settings;
    - Annual training plan for all staff that provide treatment services.
    - Backup contingency plans for periods of clinical supervisor staff turnover.

13. CLINICAL PRACTICE IMPROVEMENT:

The organization's Quality Improvement Program must have a Clinical Practice Improvement component that:

- Addresses care planning consistent with holistic and comprehensive care planning, system of care principles and, a recovery and resiliency philosophy;
- Examines the provider's strength and weaknesses in the clinical care functions of: engagement, teamwork, assessment & understanding, outcomes & goals,

intervention planning, resources, adequacy of intervention, and tracking & adjustment;

- Includes process improvement approaches, relevant data collection, fidelity measures and data for outcome monitoring;
- Evaluates the outcomes of its clinical interventions and develops improved strategies.

14. TECHNICAL ASSISTANCE FROM THE STATE:

- State staff will monitor agencies for compliance with this clinical supervision requirement should the need arise.
- Dedicate resources and personnel (i.e., state employees or contracted clinicians) to provide technical assistance in identifying acceptable and appropriate policies and procedure through the Supervisory Certification process.
- Explore use of telehealth video conferencing as a tool in clinical supervision.
- Provide Clinical Reasoning and Case Formulation training and consultation to Clinical Supervisors.
- Provide training and supports for supervising specific to those working in integrated settings and teams.

PART 3

Introduction

Therapy records involve a number of demands and constraints. Some of the demands are considering ethical standards, legal requirements, situational contexts and more. As a supervisor, one of your jobs is to aid your supervisees to keep proper records. You may also have some input into agency policies.

Some of the record keeping is required by state and/or federal laws. These will be addressed as you continue through this program. You'll need to combine your training and education, as well as a multitude of skills to recognize pertinent issues and to resolve problems that you run into.

Ten Sixteen Recovery Network (n.d.) gives a good overall picture when it tells its clients that the clinical file serves as a:

1. Basis for planning the client's care and treatment
2. Means of communicating among clinical staff who contribute to your care
3. Legal document describing the care the client received
4. Means by which the client or a third-party payer can verify that she actually received the services billed for.
5. Tool for education (i.e., interns)
6. Source of information for the public health officials charged with improving the health of the regions they serve
7. Tool to assess the appropriateness and quality of care given
8. Basis for accrediting organizations, licensing, and third-party audits to evaluate the treatment.

Because of the nature of the clinical file, also called the therapy records, it's very important to be sure they're used only for proper purposes and in proper situations. It's part of your job as supervisor to aid in this protection of the records.

The American Psychological Association publishes guidelines for keeping records. Thirteen guidelines are given (American Psychological Association, 2007). Although they relate specifically to psychologists, they're applicable to any mental health practitioner and supervisor. The records are not necessarily the sole responsibility of these folks, but a collective responsibility of them and their agency. However, to bring home the importance for you, as a supervisor, to be aware of these guidelines, the original APA wording of "psychologist" has been changed to "supervisor" and some adaptations have been made to fit your role:

Responsibility for Records: Supervisors generally have responsibility for overseeing the maintenance and retention of their supervisees' records.

Content of Records: A supervisor strives to be sure the supervisees maintain accurate, current, and pertinent records of professional services as appropriate to the circumstances and as may be required by the supervisor’s jurisdiction. Records include information such as the nature, delivery, progress, and results of psychological services, and related fees.

1. **Confidentiality of Records**: The supervisor takes reasonable steps to establish and maintain the confidentiality of information arising from service delivery.
2. **Disclosure of Record Keeping Procedures**: When appropriate, supervisors either inform clients or guide their supervisees to inform them of the nature and extent of record keeping procedures (including a statement on the limitations of confidentiality of the records).
3. **Maintenance of Records**: The supervisor strives to be sure the records are properly organized and maintained to ensure their accuracy and to facilitate their use by the supervisor, the supervisee and others with legitimate access to them.
4. **Security**: The supervisor takes appropriate steps to protect records from unauthorized access, damage, and destruction.

5. **Retention of Records**: The supervisor strives to be aware of applicable laws and regulations and to retain records for the period required by legal, regulatory, institutional, and ethical requirements and to keep the supervisees apprised of them.
6. **Preserving the Context of Records**: The supervisor strives to aid the supervisees to be attentive to the situational context in which records are created and how that context may influence the content of those records.
7. **Electronic Records**: Electronic records, like paper records, should be created and maintained in a way that is designed to protect their security, integrity, confidentiality, and appropriate access, as well as their compliance with applicable legal and ethical requirements.
8. **Record Keeping in Organizational Settings**: Supervisors working in organizational settings (e.g., hospitals, schools, community agencies, prisons) strive to follow and help supervisees to follow the record keeping policies and procedures of the organization as well as the Ethics Code of their discipline.
9. **Multiple Client Records**: The supervisor trains the supervisees to carefully consider documentation procedures when conducting couple, family, or group therapy in order to respect the privacy and confidentiality of all parties.
10. **Financial Records**: The supervisor strives to ensure accuracy of financial records. Even if this is not the normal domain of the supervisor, he will want to keep tabs on it.
11. **Disposition of Records**: The supervisor plans for transfer of records to ensure continuity of treatment and appropriate access to records when the supervisee and/or the supervisor is no longer in direct control, and in planning for record disposal, the supervisor endeavors to employ methods that preserve confidentiality and prevent recovery.

There are a number of ways the information and requirements regarding records could be presented. It was decided to use these 13 guidelines as the framework for the more detailed discussions of significant points.

Chapter 2: Therapy Records

Responsibility for Records

Both the supervisor and the supervisee are responsible both ethically and professionally to build and keep up the clinical records. To sound redundant, the records record and, in some way copy or reflect the supervisee's professional work. Often the records are the only way for you, the supervisee, and necessary others to know what the supervisee did and why. Consequently, the supervisee will want to keep high-quality records to reflect high-quality work. If any of it is called into question in the future, accurate records will make explanations and accountability easier.

Some keys to good records are legibility and accuracy, made as soon as possible after therapy or another contact is completed. Logical organization that is replicated in every record is also essential. If there is ever a conflict between agency policies and procedure of the applicable code of ethics, you'll need to address the conflict in the manner delineated in the code of ethics. You must clarify the nature of the conflict, state your commitment both to the agency and the code of ethics, and--as much as possible--resolve the conflict in a way that follows the code of ethics (American Psychological Association, 2007).

Content of Records

Some states have a list of requirements for what is included in the mental health record of any child or young adult that is in foster care. California has no such requirement.

As a matter of course, the client's record is often quite full before much therapy has taken place. Under the guidelines of your agency, you'll need to make some decisions about the record content. You should consider the:

- Nature of the service(s) given to the client
- Source of recorded information

- Intended use of the records
- Professional obligations of each profession contributing to or otherwise using the file

Some agencies have a mandated record format, a list of specific information to be collected and recorded, and a given time frame within which to create the records. Your supervisees will try to include only information pertinent to the purposes of the service given. They--and you--will need to be cognizant of the possible impact on the client of language used in the record (e.g., representing symptoms as a disease, using derogatory terms).

Ethical and legal requirements must be met and risks considered. Information given in broad or vague terms may not be enough for continuity of care or building a satisfactory defense against malpractice, criminal, or state licensing board complaints. On the other hand, some clients may want you to keep a minimal record to give them maximum privacy and protection.

As you struggle with some of these issues, there are several specifics that may offer some guidance (American Psychological Association, 2007):

> The Client's Request. For whatever reasons, a client may ask that only limited records of treatment be kept. Sometimes the client may even make that the deal breaker as to whether or not she will accept treatment. You and the supervisee may decide that treatment cannot be given under this circumstance and that serving such a client is not in the best interest of either the client or the supervisee.
>
> Emergency or Disaster Relief Settings. An emergency or disaster relief situation may not allow or require substantial records. A disaster relief agency may only want short identifying information, the date and quick summary of services rendered, and the name of the provider. Or opportunity to keep detailed records may be lacking, especially in an immediate or short-term crisis. In some settings, such as disaster relief following a hurricane, there is not likely to be intervention

beyond what may occur on-site; the brevity and small number of services provided may not allow detailed records to be constructed even after the crisis.

Alteration of Destruction of Records. Many regulations, statutes and rules of evidence forbid alteration or removal of information once a record has been made. In a litigation, adding or removing information from a record that has been subpoenaed could create liability for your supervisee and yourself. It's best that anything added later be documented as: "When reviewing the file on (date), I realized I had forgotten to mention…."

Legal/Regulatory: Some regulations and statutes order that certain information must, or must NOT be included in the record. For example, a statute may forbid you referring the results of an HIV test or giving information about chemical dependency treatment. You and your supervisee will need to follow all such mandates.

Agency/Setting: The agency for which you work may have policies and procedures about the level of detail permitted in the record. This will be discussed further in the section on *Record Keeping in Organizational Settings*.

Third-Party Contracts: You'll need to think about whether the amount of detail in a record meets the agreements in contracts with the agency and third-party payers. A number of third-party payers' contracts call for specific information to be included in a record. Not meeting the terms of the contract could precipitate non-payment, required reimbursement of funds that were already received, or legal actions.

Three kinds of information may be included in the record of psychological services (American Psychological Association, 2007):

1. Basic information
    - Identifying data (e.g., name, client id number)
    - Contact information (e.g., phone number, address, next of kin)

- Fees and billing information
- Where appropriate, guardianship or conservatorship status
- Documentation of informed consent or assent for treatment
- Documentation of waivers of confidentiality and authorization or consent for release of information
- Documentation of any mandated disclosure of confidential information (e.g., report of child abuse, release secondary to a court order)
- Presenting complaint, diagnosis, or basis for request for services
- Plan for services, updated as appropriate (e.g., treatment plan, supervision plan, intervention schedule, community interventions, consultation contracts)
- Health and developmental history

2. For each contact of substance with a client
   - Date of service and duration of session
   - Types of services (e.g., consultation, assessment, treatment, training)
   - Nature of professional intervention or contact (e.g., treatment modalities, referral, letters, e-mail, phone contacts)
   - Formal or informal assessment of client status

3. Other information, dependent upon the circumstances
   - Client responses or reactions to professional interventions
   - Current risk factors in relation to dangerousness to self or others
   - Other treatment modalities employed, such as medication or biofeedback treatment
   - Emergency interventions (e.g., especially scheduled sessions, hospitalizations)
   - Plans for future interventions
   - Information describing the qualitative aspects of the professional-client interaction
   - Prognosis

- Assessment or summary data (e.g., psychological testing, structured interviews, behavioral ratings, client behavior logs)
- Consultations with or referrals to other professionals
- Case-related telephone, mail, and e-mail contacts
- Relevant cultural and sociopolitical factors

Medical and Psychiatric History

When discussing the presenting complaint, diagnosis, or basis for request for services the therapist will attempt to get a routine, but sound medical and psychiatric assessment. The client may or may not be willing and/or able to give this history. If not, then the therapist must try to get information from family and caregivers. It's possible that much will have already been given to the agency before the client ever appears, such as previous psychiatric assessments and treatments, and the extent the client conformed to past treatment. Review this information as soon as possible.

The therapist may not request information without the consent of the client. However, if that information is given without a request from the therapist, patient confidentiality is not violated (Routine Psychiatric Assessment, 2009).

The interview should first investigate--through the use of open-ended questions--why the client has come. Then exploration for broad view of the client's personal history is pursued. The therapist will review significant past and present life events and the client's responses to them. Using both overt and covert means, a mental status exam (MSE) will be given to determine the cognitive functions of:

- Orientation to person, time and place
- Spatial orientation
- Short- and long-term memory
- Concentration
- Abstract reasoning
- Judgment

- Following commands
- Simple math
- Word finding
- Naming objects
- Writing

Also, to be noted in this initial assessment are:

- Appearance
- Attitude
- Behavior
- Mood and affect
- Speech
- Thought content
- Thought process
- Perceptions
- Cognition
- Insight

Related to the psychiatric history are social history, family health history, responses to normal variations of life, developmental history, daily conduct, and the potential of the client harming himself or someone other person. *The Merck Manual* sums up the most basic things to explore in each of these areas:

Areas to Cover in the Initial Psychiatric Assessment	
Area	**Some Elements**
Psychiatric history	Known diagnoses Previous treatments, including drugs and hospitalizations
Medical history	Known disorders

	Current drugs and treatments
Social history	Education level Marital history, including quality and stability of marriage Employment history, including stability and effectiveness at work Legal history, including arrests and incarcerations Living arrangements (e.g., alone, with family, in group home or shelter, on street) Pattern of social life (e.g., quality and frequency of interaction with friends and family)
Family health history	Known diagnoses, including mental disorders
Response to the usual vicissitudes of life	Divorce, job loss, death of friends and family, illness, other failures, setbacks, and losses
Developmental history	Family composition and atmosphere during childhood Behavior during schooling Handling of different family and social roles Sexual adaptation and experiences
Daily conduct	Use or abuse of alcohol, drugs, and tobacco Behavior while driving
Potential for harm to self or others	Suicidal thoughts and plans Intent to harm others

(Routine Psychiatric Assessment, 2009)

The most important psychological diagnostic tools are the history and the mental status examination (MSE). These tools have been standardized, but they're still primarily subjective measure. They begin the instant the client comes into the office. The therapist pays close attention to the client's presentation--personal appearance, interactions with the office staff and others in the area, and the patient is accompanied by someone (to help determine if the client has social support). Important information about the client can be obtained through these observations that might not be disclosed through an interview or a one-on-one conversation (Brannon and Bienenfeld, 2011).

From this information the therapist will determine a working diagnosis, another permanent part of the record. Depending on agency guidelines, this will probably be based on the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*. (The

fifth edition is/was due in May, 2013.) As a rule, the initial diagnosis remains attached to the client, although other diagnoses may be added if necessary. It's therefore important to be thorough in determining the diagnosis, for it will not only be used as a therapeutic guideline, but also as a determination for payment.

Chapter 3: Client Forms

Required Client Forms

There are a few forms that are required in most mental health records. In some cases, the client only needs to be notified verbally or in writing only. Often these notifications are part of the intake paperwork. This is good, because it will not be easily overlooked. However, often the client will not carefully read what he's signing, so it's recommended that each of the following consents and acknowledgments be given both in writing and verbally. A copy of the signed, written form should be included in the record; in this way there will never be a doubt as to whether the client received the information or not.

Consents and Acknowledgements

In these instances, the client is either giving consent for something, such as treatment, or is acknowledging that she has received information, such as privacy rules.

Informed Consent

Informed consent, which must be in the client file, requires anyone who receives any service or intervention to be adequately aware of what will be happening, what the potential risks are, as well as alternative approaches so that the person can make an informed and intelligent decision to accept and participate in that service. This form is essential for protecting the supervisee and/or supervisor from legal concerns. As supervisor, you must inform the supervisee about what the process of supervision includes, including evaluation criteria and feedback, as well as other supervision expectations. You must be certain that the supervisee has informed the client regarding

counseling and supervision parameters, such as live observation, and audio- or videotaping.

The consent should include:

- The purpose of supervision: The structure and mutual understanding of supervision
    - Goals of supervision
    - How goals will be evaluated and the specific timeframes
    - Specific expectations of the supervisor and the supervisee
    - Integration of theoretical models

- Professional disclosure: Information about the supervisor that includes credentials, qualifications and approach to supervision
    - Educational background
    - Training experiences
    - Theoretical orientation
    - Clinical competence with various issues, models, techniques, populations
    - Sense of mission or purpose in the field
    - Educational plans and professional goals

- Supervision process: Methods and format of supervision
    - Individual, group, peer, dyadic
    - Method of direct observation
    - Permission to record sessions on audio- or videotape

- **Due Process**: Includes written procedures to be followed when a grievance or complaint has been made against the administration, the supervisor, or the counselor. It ensures that all sides are heard and that the complaint and response to the complaint receive due consideration. In this case, informed consent means that all parties are aware of the process for lodging a complaint.

- Ethical and legal issues: Policies, regulations, and laws regarding supervisory and therapeutic relationships
  - Number of supervisees for which the supervisor will be responsible
  - Emergency and back-up procedures (e.g., supervisor accessibility)
  - Ethical codes of conduct
  - Process for discussing ethical dilemmas
  - Confidentiality regarding information discussed in supervision
  - Confidentiality issues when more than one supervisee is involved
  - Dual roles and relationships
  - Process for addressing supervisee issues (e.g., burnout, counter-transference)

- Statement of agreement
- Signed acknowledgement by all parties that they understand and agree to comply with the contract

Source: (Center for Substance Abuse Treatment, 2009b--Adapted from Falvey, 2002)

Although it often is treated as such, informed consent is not a single event. Rather, it's a process that changes over time. During the course of treatment, it's necessary for the therapist to periodically review the risks and benefits of the current approach to therapy, and those of alternative treatment methods, especially when the client's health seems to have changed considerably. These subsequent consent to treatment discussions should be documented just as the first one was (Weiner and Wettstein, 1993).

Consent to Be Treated by a Trainee

Consent to be treated by a trainee is generally included as part of the Informed Consent. Supervisees should tell the client her:

Professional discipline (i.e., social work, counseling, psychology, nursing)
Specialty (i.e., counseling, clinical, school)

Treatment philosophy or orientation

If the client wants to know about the therapist's background working with a particular problem, the therapist should be straightforward in his answer. However, there is no need to answer questions that are more personal. It's very important not to mislead the client in any area, whether it's the proposed treatment or the qualifications of the therapist.

When the therapist is a trainee, you--as the supervisor--have the legal responsibility for the treatment provided. As a part of the informed consent procedure(s), the client should be apprised that the therapist is in supervised training, and your name should be given as the supervisor.

Notice of Privacy Practices

The **Notice of Privacy Practices** is about how the client's mental health information is used and disclosed. The client should get a written notice either with the intake paperwork or on the first visit with the therapist. The notice must tell the client how to exercise her rights under the Health Insurance Portability and Accountability Act (HIPAA). It must also explain how the client can file a complaint with the mental health care provider and, in California, with the Health and Human Services Office of Civil Rights (Privacy Rights Clearing House, 2011).

Except in an emergency situation, the client should sign a copy of the "Notice of Privacy Practices" acknowledging its receipt. That signed copy should be a part of the client's record (University of California, 2003).

Financial Arrangements

There are a couple of potential ways for a client to pay for mental health services:

1. Personal Health Insurance: Insurance policies vary widely in the amount and type of mental health care they will cover. The client will need to know about their particular policy. There are a number of questions they should ask their insurance company. Before they make an appointment, they should ask:

- Will the policy pay for mental health services in the city and state the agency is located in?
- Which mental health services are covered by my policy?
- Can I see the provider of my choice or must I choose from a "preferred list of providers"?
  What happens if I want to see someone not on that list?
- Is there an annual limit on the number of counseling sessions covered?
- Does my plan exclude certain diagnoses or pre-existing conditions?

If the answers to those questions are satisfactory, then the client should ask the company representative:

- Will the company pay for the services I need? If so, will they pay the entire cost?
  - If not, what costs are not covered?
  - Is there a co-pay?
  - Is there a deductible?
  - What is the amount of my plan's "usual, customary, and reasonable (UCR)" coverage?
  - Does fee of the therapist at the agency I want to go to ($___) meet the UCR coverage?
- Do I need a pre-certification, prior authorization, or referral from my primary care provider?

2. Sliding Scale Fee. Community mental health services (and sometimes other services) often offer a sliding scale option. Clients who must pay from their own funds because they have no insurance or because their insurance does not cover the treatment, they need may be able to work out a sliding fee scale from your agency. The agency will then charge the client according to what he can afford based on the financial condition and household income.

No matter which form of payment is agreed upon, the exact agreement must be in writing and signed. A signed copy of this agreement is part of the client's record.

HIPAA and Limits of Confidentiality

It has already been mentioned that a HIPPA "Notice of Privacy Practices" must be signed by the client, indicating their receipt of that notice. The notice likely will give a list of patients' rights under that law. As with any law, changes may be made over time, but in 2011 these rights included:

- The right to receive the Required Notice of Privacy Practices--Discussed earlier.
- The right to request restriction on the uses and disclosures of protected health information (PHI)--The agency must give the client an opportunity to ask for restrictions of uses and disclosures of the PHI for treatment, payment, and operations, and to family, friends, and other involved in their care. However, the agency is not required to agree to the request, but will abide by it if they do agree, except in an emergency. If the restricted PHI is given to a provider for treatment in an emergency, that provider will be requested to not use further or discover the information.
- The right to request confidential communications--The client may ask the mental health agency to give them the communications from their protected health information with no explanation of the reason for the request. The agency will accommodate any reasonable request, although they may ask for payment of costs of mailing if they apply.
- The right to access and copy the designated record set--Unless HIPAA rules allow an exception (such as therapy notes, at the therapist's discretion), the agency must give clients an opportunity to access, inspect, and obtain a copy of the client's designated record set (DRS).

- The right to request amendments of the individual's DRS--The client has the right to request the agency to amend the medical record or other information in the DRS. The request must be in writing and include the reason to support the request. (The

written request will be kept for at least six years.) Within 60 days, the agency must either accept the request and make the amendment, or deny the request in writing.

- The right to request an accounting of disclosures--Although there are stated exceptions, the agency must give the client an accounting of the disclosures it has made of the client's PHI in the six year prior to the request (HIPAA Patient's Rights: University of California Policy, 2010).

In certain times and locations, there has been or is a stigma against receiving treatment for mental health. The confidentiality laws are in place to protect individuals from discrimination coming from this stigma. HIPAA protects not only disclosures made during treatment, but also the fact that the individual is in mental health treatment. This can also be a protection for family members and the therapist from potential danger should a violent individual who has intimidated the client learn that the individual is receiving support and from whom she's receiving it.

Confidentiality is generally counted on as a foundation of the therapist-client relationship. As a rule, therapy is most successful when the client trusts the therapist. The confidentiality laws help to preserve this trust. The therapist must never confirm or deny that an individual is or has been a client, unless there is a legal exception to the confidentiality. In addition, every detail of written and verbal communication in the course of assessment, treatment, testing, or any other communications are also protected as private information.

But there are some legal exceptions to confidentiality: threat of harm to self or others, involuntary commitment, a court order, certain lawsuits, suspicion of abuse of a minor or dependent adult, and detention of a mentally disordered person for evaluation.

- Threat of Harm to Self or Others: This includes risk of suicide and plans to physically harm someone else. When the threat of either of these is significant, which is often a judgment call, the client should be hospitalized for further evaluation and stabilization. The therapist will give the hospital all information

needed for the hospitalization. The therapist should urge the client to go voluntarily, but involuntary commitment may be necessary. The therapist should explain the nature of the hospitalization process, the client's rights, how the therapist plans to support the process, and the client's ability to return to the current therapist after the hospitalization. This may help the client to cooperate.

- Involuntary Commitment: If the client does not cooperate, the therapist must notify the police to initiate evaluation by the resource the county designated to do these. Each state has a specific process to be followed for involuntary commitment. The therapist may give pertinent information about the client to appropriate authorities without client authorization in such situations.

- Dangerous Clients and Tarasoff: When a client or a member of his family reveals that the client poses a threat of grave bodily injury to an identifiable victim, the therapist must immediately notify both the potential victim and the police. "Tarasoff" refers to a California case when only the police were informed and the client killed a woman. The therapist was sued successfully for failing to warn such a victim. The therapist is not liable for making these disclosures.

- Criminal Activity: Criminal activity in itself is not required to be reported. Psychotherapy's worth to society would be significantly reduced if therapists were required to report all criminal activity, because this would prevent many from seeking treatment. The therapist must consider elements such as Tarasoff conditions and definitions of abuse.

- Detention of a Mentally Disordered Person for Evaluation: People who have become disabled to the point of not being able to adequately care for themselves are considered to be gravely disabled. In California these clients may be involuntarily hospitalized for 72 hours (more in some cases) for assessment. If it's determined that the individual continues to be gravely disabled, he may be held for an addition 14 days. Some circumstances, such as a threat of suicide, can cause

another 14-day extension. At the end of that period, if the individual is determined to pose an imminent threat of harm, another 90-day extension may be given. Other states have similar rules.

- Subpoena: A lawsuit may end in a subpoena for client information. Because a subpoena is not a court order, some folks believe it doesn't have the same force. The reason is that subpoenas are usually sent out during the discovery phase of trial preparation. Attorneys are looking everywhere they can for information, not yet knowing what information will be helpful to them.

On the other hand, there are those who believe a subpoena has the same force as a court order (Your MFT Ethics, n.d.a). Your agency should have a guideline as to how you and the therapist should respond to a subpoena for client information. The agency will have conferred with their lawyers regarding their response. There are too many legal variables for you and your supervisees to attempt to respond on your own knowledge. Potential responses to protect client privacy include attempts to:

- Quash the subpoena, probably on a technicality
- State that you can neither deny nor confirm that any specific individual is a client and cannot release information from any client record without a court order or client consent.
- Modify the subpoena
- Negotiate with the issuer of the subpoena

The one thing you should never do is ignore it.

Court-Order Disclosures: If the court orders a therapist to disclose client information when the client will not authorize a release, the therapist may cooperate with the court. Therapists are not expected to bear penalties for contempt of court; it's also assumed that the court has decided that society's needs in such a case override the values of confidentiality to either the client or society.

Reasonable Suspicion of Abuse of Neglect: People in certain professions are legally mandated to report suspected or alleged abuse or neglect of children, elders, or dependent adults. Therapists are in that group. In this case, children are defined as people under age 18; elders are defined as people age 65 or older. The definition of dependent adults is people between 18 and 64 whose mental or physical limitations restrict their ability to care for themselves.

- Reporting: Mandated reported does not require that there is conclusive proof of neglect or abuse; rather, when functioning in her professional capacity, there is "reasonable suspicion" of abuse. The report is to be made to either the police or to the Department of Social Services. It must also be given in writing--by mail, fax, or electronically--within 36 hours for children or within two working days for adults.

Contacting authorities such as a child welfare agency does not necessarily constitute reporting; the therapist may contact them to help determine if the situation fits the mandatory reporting law. The California Welfare and Institutions Code only requires therapists to disclose information they happen upon in the course of profession activity, and only when there is a present danger. It may be considered present danger if an adult client reports past sexual abuse by a person currently in a household with children--the children may be at risk of abuse.

The therapist is not required to report a claim of neglect or abuse if the person reporting it has a mental illness or dementia, there is no corroborating information or evidence, and the therapist reasonably believes that the abuse didn't occur.

- CANRA: In California, the law that pertains to abuse and neglect of children is largely in **The California Child Abuse and Neglect Reporting ACT (CANRS).** The purpose of the Act is "to protect children from abuse and neglect." Included in its intention is protection of the child's welfare during investigation: "In any investigation of suspected child abuse or neglect, all persons participating in the investigation of the case shall consider the needs of the child victim and shall do whatever is necessary to prevent psychological harm to the child victim."

(Source: Your MFT Ethics, n.d.a)

Releases of Information

The HIPAA laws protect the client's privacy. However, the client can overrule many of those laws by signing a release of information, a copy of which should remain in the client's record.

The laws allow for free use of client information for TPO, or "treatment, payment, or operations." The TPO uses of personal health information (PHI), as far as you and your supervisees are primarily concerned, might be summarized as free use within the agency that is providing the treatment, which includes:

- Use by the therapist that originated treatment notes for further treatment.
- Use or disclosure by the therapists for training programs under supervision to practice and improve their abilities in individual, family, joint, or group counseling.
- Use or disclosure by the therapist as defense in legal or other proceedings brought by the clients.

Without a signed release of information, the therapist cannot even acknowledge whether or not an individual is or has been in therapy, let alone any particulars about treatment. The release of information is generally quite specific as to the time during which information may be released to which person or organization. HIPAA rules for release of information beyond the TPO state that the document must:

- Be written in plain language
- Be written in 8-point typeface or larger
- Be separate from all other documents
- Specifically describe health information to be used or disclosed
- State the name or function of the person or organization authorized to make such a disclosure

- State the date after which the provider can no longer disclose information
- State the name or function of the person or organization authorized to receive the information
- State specific uses and limitations of the use of the information by the persons authorized to receive it
- Advise patient of his right to receive a copy of the authorization
- Inform client of her right to revoke authorization under California law.
- Include a statement that the information used or disclosed may be subject to re-disclosure.

Because, without a release of information, you can only advise a referring organization that you cannot release requested information, it's important that you or your agency be sure that the staff of referring organization are aware that this can happen. Employee assistance professionals can aid in such situations in several ways. They can help employers establish company policies and train staff regarding issues such as confidentiality in compulsory referrals. Employee assistance professionals who are also clinicians may also counsel with employers on interpersonal and mental health issues to improve management staff's ability to improve morale, interact with employees, and decrease legal liability.

Chapter 4: Client's Status

Client's Current Status

There are several aspects of what a client's current status can refer to. Those useful to the client's record might be summed up as the status of clinical outcome and quality status (Linkins, Brya, and Johnson, 2011). All of them should be reviewed periodically and a copy of that review placed in the client's file.

Clinical Outcome Status

Clinical outcome began with a mental status examination in the first clinical session or two, which resulted in a treatment plan, both of which become part of the client's record. The client's current clinical outcome status should be reviewed in terms of the client's status within the treatment plan and the current mental status.

Current Status within the Treatment Plan

The treatment plan should be reviewed often, with a focus on the current status of the client in relation not only to the therapy plan, but to any other services and supports that the client is receiving (Prior Authorization Utilization Review, 2007). Report the progress that has been made towards any of the treatment plan goals. Mention whatever has motivated the progress or impeded it. Although all of these are likely in the therapy session notes, it's helpful to group them together in this review. If necessary, revise the treatment plan to fit the current status.

Current Mental Status

The Mental Status Examination is for the purpose of determining how the client is functioning mentally, emotionally and behaviorally at the moment of the exam. As has been mentioned, much of this is accomplished through the keen observation of the therapist. There is actually a wide variation between agencies in terms of data that is actually measured and the strategies and instruments used to collect the data.

Some of the most commonly used mental status assessment measures, besides criteria in the DSM-IV, are the Duke Health Profile, the Global Assessment Scale (GAS) and the similar Global Assessment of Functioning Scale (GAF). Some agencies also use assessments of depression.

Duke Health Profile (DUKE): The DUKE has been popular among health and mental health researchers since it came out in 1998. Its popularity continues to this day, probably because it's a simple to take and score self-report instrument that has a record quite good validity.

There are only 17 items for the client to answer as "Yes, describes me exactly," "Somewhat describes me," or "No, doesn't describe me at all." Of the questions, seven are general attitude questions, two refer to how the client believes he can do two physical tasks, and the rest refer to how the client functioned during the past week.

The assessment covers six health measures (physical health, mental health, social health, general health, and perceived health), a "stand-alone" self-esteem score, and four dysfunction measures (depression, anxiety/depression, pain, and disability). The assessment and scoring forms are freely available online (Duke University Medical Center, 2005).

Global Assessment of Functioning Scale (GAF): The GAF is a revision of the Global Assessment Scale (GAS), a procedure for measuring the overall functioning capability of the client during a specified period of time. Both scales are a single-item rating scale to be filled out by the clinician. There is also a children's form of the GAF.

The GAF is used by the DSM in its "multiaxial" assessment system. The system has five axes for assessment (I: Symptoms that need treatment; II: Personality and developmental disorders; III: Medical or neurological conditions that may influence a psychiatric problem; IV: Recent psychosocial stressors; V: Client's level of function). The GAF is the Axis V component (Mezzich, J. E., 2002).

The GAF reflects the therapist's judgment of the client's ability to function in daily life. It looks at psychological, social, occupational functioning.

The scale ranges from 1 (theoretically very ill and unable to function at all in daily life) to 100 (theoretically very healthy and totally able to function in every area of daily life). The client's 5-axes diagnosis might read as:

Axis I: Adjustment Disorder with Depressed Mood, Alcohol Abuse, Cannabis Abuse
Axis II: No Axis II diagnosis
Axis III: Hyperthyroidism

Axis IV: Divorce on (date)

Axis V: GAF = 56 (on admission), GAF = 65 (on discharge)

Quality Status

Quality refers more to the treatment than to the client. Every agency is pressed for quality improvement in their services by government agencies, payment sources, and clients themselves. New assessment tools frequently appear. The Center for Quality Assessment and Improvement in Mental Health (CQAIMH) has an online "finder" of mental health treatment quality assessment measures (CQAIMH, n.d.). If you find one that fits the kind of treatment, you're offering a client, you can include a periodic update as to the continuing improvement of the treatment quality you're giving.

Treatment Plans and Goals

A mental health treatment plan is a written document that outlines the expectations for therapy. Depending on requirements of payment providers and the agency, the therapist's preferences and the severity of the presenting problem, the plan may be quite formalized or may simply be composed of loose handwritten notes. If an electronic record system is used by the agency, this may dictate the treatment plan format.

Nowadays, formalized treatment plans are required more frequently than in the past. However, no matter how lose or how formalized the treatment plan is, it's always subject to change during the progression of therapy.

The plan is based on needs identified during the initial assessment and diagnostic process. The process used to choose the level of care needed should be documented. Depending on the problem(s), treatment plans may include family information (Council of Juvenile Correctional Administrators, 2007).

A formal treatment plan generally consists of four or five parts--objectives and goals sometimes being combined:

1. Presenting Problem--A brief description of the most significant problem(s) to be addressed. Problems that are not urgent may be set aside for later treatment.
2. Goals of Therapy--An annotated list of both the overall and the interim goal(s) of therapy. Long-ranged goals may not need to be measurable (Utah Division of Substance Abuse and Mental Health, 2009).
3. Objectives--A list of measurable objectives showing what the client will do to reach a goal. Action verbs are used with identifiable outcomes such as frequency and quantity.
4. **Time Estimate**--A brief estimate of the length of time and/or number of sessions needed to reach each objective
5. Methods and Interventions--A short, annotated list of techniques that will be used by the therapist and/or the client to achieve the objectives

Often achieved via informally discussion the situation, the client should always be included in developing the treatment plan and this should be recorded in the record. Some therapists give the client a written copy of the treatment plan; others believe this can cause an unnatural feeling to the therapeutic relationship. However, a copy of the plan should always be given to a client who requests it (Fritscher, 2011).

In addition to the treatment plan itself, often kept in the record is a full descriptive summary that combines biopsychosocial information and a summary of key clinical issues; it functions as a connection between the treatment plan and the assessment. The narrative summary pinpoints diagnostic signs for any existing mental health problems, and includes both the reasons for the assessed level of care and any substitution for that level of care (Utah Division of Substance Abuse and Mental Health, 2009).

Progress

In many ways, psychotherapy is to a certain degree an unstructured process. This causes many clients who are experiencing guided self-discovery and behavioral change to ask themselves if therapy is helping. Repeated taking of a self-report questionnaire to track progress gives both client and therapists a chance to see what is improving from the client's perspective--the most important perspective.

Self-report data given via a formal assessment has often been used to:

- Add to the accuracy of clinical assessments
- Give a basis for treatment planning
- Provide an objective way to track treatment progress
- Use clinically proven guidelines to warn therapists to get stubborn cases back on track
- Aid in preventing hospitalizations through warning guidance
- Give referral sources some outcome-based information to link patients to therapists with a proven track record of giving outstanding treatment to clients with similar needs

An example of such a self-report assessment is the Patient Health Questionnaire (PHQ-9), an assessment for depression that is available online (PHQ-9, (1999). Like other most successful assessments of this sort, it's short (ten questions) with easy-to-answer questions (check the level that best suits: Not at all, Several days, More than half the days, Nearly every day). The validity of the test over time is also good.

These sorts of assessments, grouped under "behavior health outcome management" (BOHM), can be used every session to track progress. With real-time scoring and report generation (which can be done in a very few moments) both clinicians and clients receive excellent evaluation about the course of treatment and whether or not adjustments to the treatment plan should be made (Lambert, 2005).

Although it has not always been the case, some of the newer, more advanced assessments can reliably document improvement on a single domain more than 50% of the time and, with a multi-dimensional analysis, more than 90% of the time (Kraus, Seligman, and Jordan, 2005). With payers and purchasers alike looking for documentation of client improvement, you may want to research and evaluate applicable assessments.

According to the Core Battery Conference (CBC), a core assessment battery should address three distinct areas:

- Quality of life, or general distress
- Symptom clusters (e.g., anxiety, depression, mania, psychosis, etc.)
- Functional domains (e.g., work and social functioning)

Kraus, Seligman, and Jordan (2005) identified only one battery that met all of the criteria defined by CBC with a short questionnaire, the Treatment Outcome Package (TOP Toolkit). The free package includes assessments for children, adolescents, adults, and substance abuse, as well as a couple of assessments of client satisfaction and a wealth of other information (Behavioral Health Laboratories, 2011).

As clients proceed through therapy, progress and treatment plans are reviewed and assessed, and needed changes in the treatment plan are made to reflect the progress or lack thereof. In addition to the continual assessment of progress, the process includes:

- Comparing progress to criteria for continued service or discharge
- Determination of when the client can be treated at a different level of care or treatment approach based on resolution of problems and/or priorities

Treatment often ends when a frustrated client leaves prematurely. Following the procedures outlined above will hopefully reduce the number of times that happens.

Problems in Not Meeting Treatment Goals

Assessments aside, there will be clients who just can't seem to meet treatment goals. This seems especially true in cases involving substance abuse. The treatment plan should include reports of lack of response to treatment or meeting therapy goals, or if the client is disruptive in treatment. As you would expect, the treatment plan needs to be appropriately revised (Office of Alcoholism and Substance Abuse Services, 2010).

Significant Actions Taken and Outcome

The main point in again mentioning "significant actions taken and outcome" is to emphasize their importance in the psychotherapy notes. Sometimes it's helpful to gather them from the individual session notes and group them into a narrative. This can add perspective that will give good guidance as to where you should go next.

Documentation for All Issues with Legal Consequences

Whenever you document a therapy session or other communication with or about a client, always keep in mind the possibility that this documentation could very well sink or save you in an instance of litigation. Some tips to follow in making this documentation the most helpful it can be may sound mundane and unrelated, but with thought you'll likely see the sense of it.

Competent documentation (Lifson and Simon, 1998) should be unambiguous and cognizant of grammar essentials--a misplaced modifier is not your friend:

> "The client is a 21-year-old admitted on 7-5-11 to ___ with a history of psychotic behavior, evaluated at the ___ Center and seen by a social worker there with a chemically induced psychosis."

If you didn't make progress notes, but instead kept "process" notes to remind you of your own associations and counter-transference reactions, as well as your theories about treatment, these may not be truly be private, but may be "discoverable" in the event of litigation involving your client or between your client and you.

You were reviewing your progress notes and noticed that at one point you saw a problem, evaluated benefits and risks of several treatment options, talked them over with your competent client, and outlined a treatment plan to which the client agreed. But you overlooked documenting some elements of the process. How should you handle it? Make a brand new progress note, date it "today," and write, "As I reviewed my note for (date), I see that I overlooked indicating that. . ." This will give the needed information to any who may need to read the note, it makes no attempt to hide the error, and in the event of later litigation, it will be better than no note at all. This all translates to the principle that corrections should be in real time, labeled contemporaneously, and transparent.

If you're bent on self-destruction as a therapist, one of the easiest ways to do this is to keep no notes or poor, incomplete notes. If you noticed something in therapy, you need to respond to it and then document that response.

Although preventing liability for your sake is important, the leading rationale for good documentation is that it contributes to, facilitates and enables, and is essential to client care. Documenting or charting weekly, biweekly, or monthly does you, your clients, and even your colleagues an immeasurable disservice.

These tips can be summarized in three basic rules that will minimize risk to both you and your clients (Lifson and Simon, 1998):

1. Write smarter, not longer.
2. If you didn't write it down, it didn't happen.
3. Never, ever change a record.

The North Dakota Department of Health (n.d.) gives several lists of what to do when "Charting with a Jury in Mind." Some of these are repetitious, which only emphasizes their importance:

- Basic Charting Rules:
    - What is documented, what is not documented, and how it is documented is vital
    - Sins of Omission: Don’t omit the obvious--e.g., failure to make an entry
    - Shadow of a doubt: Don’t allow inaccuracies
    - Tampering with the evidence: Don’t obliterate an entry
    - Relying on recall – Don’t wait to chart
    - Just the facts, Ma'am
    - Don’t chart conclusions
    - Record only what you see and hear
    - Describe, don't label, events and behavior
    - Don’t get personal
    - Neatness counts
    - Chronology of events: Give each entry its own page
    - Failure to communicate – What you don’t say may hurt the patient
    - Juries can't read minds – Document intermediate steps
    - The appearance of error: Being at fault versus appearing to be at fault--the outcome may be the same.

- In notes regarding the continuity of care, be sure to note:
    - Transfer of Health Information to hospital or specialty

Transfer of Health Information to prisons or jails

- Discharge summary

- Daily do's and don'ts for charting:

DO:

- Check the name on the patient’s chart
- Use ink or typewriter, not pencil
- Read the notes on the client before either providing care or charting
- Use concise phases
- Make entries in order of consecutive shifts and days. Write the complete date and time of each entry.
- Sign each entry with your title
- Indicate client non-compliance
- Be sure you know the meaning of all the terms you use
- Use direct patient quotes when appropriate
- Be accurate, factual, timely, and complete
- Use accepted medical abbreviations
- Don’t backdate, tamper with, or add to notes already written
- Don’t write general statements, make them specific: e.g., client is adapting to divorce; instead tell in what ways the client is adapting
- Don’t chart procedures in advance

DON'T:

- Wait until end of shift to chart; either keep notes during sessions or write them immediately after the session
- Chart for someone else
- Throw away notes with errors on them, mark the error and include the sheet
- Erase, obliterate, or write in margins
- Skip lines between entries
- Leave a space before your signature
- Make derogatory remarks about the client

Client Fails to Follow Clinical Directives

It may be that your client--or that of your supervisee--will not progress, or will progress so slowly as to make no difference unless they follow the clinical directives, which will necessarily be part of the treatment plan. But the therapist is frustrated because a particular client continually fails to follow the clinical directives.

Three questions may be asked in such situations (Relaxed Therapist, 2006):

1. Why should your clients do anything you say?
2. Why should your client do what you’re saying now?
3. Why wouldn’t clients follow your suggestions?

The answer to "Why should your clients do anything you say?" may be found in the relationship between you and your client and within yourself. How you see yourself and your role in the therapeutic relationship will decide to what extent you expect the client to follow your advice. If you see yourself--and perhaps more importantly, if your client sees you--as the "bus driver" to take the him to his destination, you'll be the one frustrated if the client keeps challenging the route you take because he wants you to be only the travel agent.

Why should your client do what you're saying now? Because you've studied your heart out and continue to do so in order to know what direction you clients need to go in, you may have come to believe that there is only one right way to recovery. Or you may have a number of ways the client can go towards recovery, but the client believes there is likely only one way and it doesn't fit any of the ways you're suggesting.

You may be the one with the therapy experience, but your client is the one with the "being me" experience. If you client says a certain way won't work for him, you'll save time, energy, and frustration if you don't try to convince him why it will work for him.

Instead, find out why she thinks it won't work for her, why she or her situation are different from everyone else. There may be no different but, then again, there may be. You won't know without asking; you need to ask the client what she thinks WILL work for her. She's

more likely to follow her own advice, and perhaps you can lend a helpful hand in the process--which is the way therapy works in the first place.

The third question, why wouldn't your client follow your suggestion, has a number of potential answers:

- They don't believe it will work.
- They don't believe they can do it.
- They don't understand it.
- They don't want it.
- They fear it will make matters worse.
- They got a negative reaction when they first tried it.
- They couldn't do it at the first attempt.
- They couldn't do it consistently.
- They couldn't do it at all.

Any of those feelings is likely a deal breaker. All of this is reinforcement for the need for the client to be a major part of making the treatment plan.

However, there are times when the client should do what you say, and there will have to be grave consequences if they don't. Examples of these times include:

- If the client in therapy for alcohol treatment may have some mandatory guidelines that, if not followed, could cause harm to the client or another person. Or the therapist may be mandated to report such failures to legal authorities.

- The same is true for a client with a sex addiction problem, or any other problem with legal consequences.

If clients of these sorts do not follow clinical directives, follow the legal protocol that you must, and document the client's failure to follow clinical directives and what you did as a result.

Telephone Conversations with Client and Others

It may be difficult to get into the habit of writing therapy notes about telephone conversations with a client or with others, such as social workers, about them. However, it's just as important--sometimes more important--to document these calls as it is to document a therapy session. If you have a call with a social worker and that person keeps a record and you don't, there could easily be a time when your memory does not match their notes and it could lead to problems. It's especially important to document phone calls that are related to issues with legal consequences.

An example of a dilemma that could arise from not documenting a telephone call:

> A former client is suing you. This individual attempted to commit suicide and was hospitalized after the failed attempt. She's now claiming that you didn't sufficiently intervene when she showed symptoms of suicidal ideation. After you received the lawsuit, you looked through the clinical record and discover that you had neglected to document a call you made to a psychiatrist just before the client's suicide attempt. You consulted with the psychiatrist about the woman's suicidal ideation. It would be unethical to insert a short note about the phone call at the end of the clinical note you had written just before the woman's suicide attempt. You can only hope the psychiatrist made a note that will prove it was this woman you called about; this isn't likely, because--in the name of confidentiality--you didn't mention the client's name.

E-Mails, Phone Messages, and Texts

A new aspect of record keeping has arisen because of modern digital technologies. These present new clinical, ethical, and legal issues in the field of mental health. We are warned frequently of the lack of security/privacy for e-mails, text messages, and mobile phone use. How using these means of communication with or about the clients affects confidentiality is still not clear. Thus, the by-word when using these digital methods is "caution."

Should the actual voice-mail messages, texts, and e-mails be included in the client's clinical record? A basic and simplistic answer is that at the very least, notes on the content of these messages if they have clinical or other significance should be in the record. Messages that it may be important to archive include those during a crisis or other high-pressure situations, or if therapists are flooded with messages from clients in ways that may be or become stalking, harassment, or threatening.

Phone messages from clients are not a new phenomenon. Ever since the advent of the answering machine the potential for clients leaving a message for their therapist has been a reality. There are several ways to handle these messages, in addition to the aforementioned written notes about the content of the message.

- The message may be recorded and transferred to a CD that will be part of the client's file.

- If you have a digital answering system, it can give you the message as an MP3 or similar file. The file can be transferred as an e-mail attachment on some mail systems, which can then be stored on the agency's computers. If the file can't be transferred by your e-mail system, you can copy it to the same CD already mentioned.

- There are systems available, some free (such as Google Voice), that will save the voice-mails as recordings and e-mail them to you, along with a transcript (however inaccurate) of the message. You can then save it in a Web-based e-mail program or download it to the agency's computer system. The rub here is the issue of privacy. If you use a means such as this, you'll need to have your clients sign an Informed Consent form that explains risks involve in using this kind of communication because of the storage method.

E-mail is becoming a common and acceptable way to for therapists and clients to communicate. It can be a time saver for needed rescheduling of appointments, eliminating

the game of phone tag, busy phone lines, being put on hold, and numerous other annoying problems of phone calls.

However, all is not gold when it comes to e-mail communication with clients (Zur, 2010a). What about the suicidal client that sends an e-mail you don't see for 18 hours? Or the client who, by the nature and length of their e-mail, extends the time of their session by half an hour? Or who wants a "short" answer right away to a therapy question? Or--the list could be quite long.

Also, e-mails are fundamentally vulnerable because they can be accessed by unauthorized people fairly easily, compromising the confidentiality and privacy of the communications. Encrypting your e-mails requires the complexity of public and private encryption keys and teaching clients to use them. Or you can use an Informed Consent form that delineates privacy risks so clients can choose whether or not to use e-mails. This consent form would be included with others that clients are required to sign (Zur, 2010b).

The consent form may also include charges that may be incurred when the e-mails and their responses essentially extend therapy session, and any other guidelines you have for the use of e-mail with clients. All of this information must also be stated verbally in a therapy session--probably more than once. Zur (2010a) offers some excellent guidelines for using e-mail with your clients:

- Clarify to yourself your thoughts and feelings regarding e-mail communication with clients. What are your preferences, your limits, etc.?
- If you're considering using e-mails as an adjunct to therapy, make sure you become HIPAA compliant.
- Discuss the issue of e-mail communications with clients, when relevant, in the first session. Learn from them about their expectations and clarify your expectations and boundaries. Continue the dialogue as clinically and ethically necessary throughout the course of therapy.

- Make sure that your office policies include a section on the use of e-mails.
- If you're conducting tele-health, follow state laws, relevant codes of ethics, and have a separate informed consent, which is required in some states, such as California.
- Make sure your computer has a password, virus protection, firewall, and backup system.
- Make sure that each e-mail includes an electronic signature that covers issues such as confidentiality and security.

E-mails should be printed out and included in the client's file.

Texting is one of the newer methods of communication between clients and therapists. Some agencies may not allow therapists to give out their cell phone numbers, preferring that clients that call after hours be transferred to an answering service that will transfer the call to the therapist on-call. And many therapists may not want to offer 24/7/365 availability to their clients. Regardless, it's almost inevitable that there will be a time in the near future when, because of the health market becoming more and more consumer-driven, many administrative and simple communications between clients and therapists will be done via cell phones and texting.

In fact, on-call therapists for an agency might have a company cell phone for use during their on-call time. This may be a problem for those older therapists who can't or won't learn to text.

As with other electronic communications, issues of security, confidentiality, and privacy are an inherent part of texting. A signed Informed Consent form, like the ones mentioned above, or a list of Office Policies that the client receives on intake should be used.

At the very least text messages should be summarized, and the summary placed in the client's file. However, you can also have an actual record of the text itself to place in the file (possibly with a "translation" into "real English" for the sake of others who must read

the file and who are not savvy to all of the texting abbreviations). Here are several ways to keep that record (Zur, 2010b):

1. A service such as *Google Voice* can record and save phone text messages. Therapists would set it up and give that number to clients; they will then have a record of all texts.
2. The service *Missing Sync* connects therapists' phones to their computers and backs up (archives) the text messages.
3. You can use an online for-fee service, such as *Treasure My Text*, that stores the text messages online by allowing for simple uploads of messages via text.
4. Some cell phones, such as iPhones, allow therapists to take screen-shots of their text messages and then send them to their e-mail address as an attachment.

All of these methods involve online services and will therefore have potential--sometimes inherent--problems of security, confidentiality, and privacy. Some programs may have security measure in force, but you'll want to check them out before you use them, and always employ Informed Consent forms.

HIPAA confidentiality rules are always to be considered. If you communicate with your clients through e-mail and if you store clinical records digitally, you must be sure that your computer has impeccable password, firewall, virus protection, logs, and backup systems, encryption if necessary, and other computer safety measures (Zur, 2010b).

You also need to be aware that HIPAA has some special rules for "a health care provider that conducts certain transactions in electronic form (called here a 'covered health care provider')" (HIPAA, 2005):

"In electronic form means: using electronic media, electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or transmission media used to exchange information already in electronic storage media.

Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission."

If you're a covered entity, you must comply with HIPAA's Privacy Rule (HIPAA, 2003) and Security Rule (HIPAA, n.d.), which are different from the HIPAA rules that are discussed elsewhere in this course.

Consultations

Documentation about consultations with a social worker or another professional within your organization is just as important as documenting any other transaction or communication with or about the client. The only reason this topic has been given a section of its own is to emphasize that it's just as important as any other kind of documentation.

Gifts from Clients and Reasons Accepted

No blanket statement can be made that accepting a gift is either always acceptable or never acceptable. Accepting a gift from a client may be unethical at times, but there are times when it's the most ethical and/or helpful thing the therapist could do. Whether or not it's ethical may depend on several factors:

- The nature of the gift
- The cost of the gift
- The therapeutic relationship between the therapist and the client
- The transference or other issues that led to giving the gift

The therapist must address the issue in each individual case. The answers to a couple of questions can help find the answer:

1. Will the acceptance or refusal of the gift adversely affect the well-being and health of the client?
2. What is the meaning behind the gift?

The setting and the nature of the therapeutic relationship influence the decision as well. It may be permissible to accept certain gifts from a client that comes in once a year for a session, but accepting the same gift from a client that is currently having weekly therapy sessions may not be permissible. The primary criterion by which to judge if the action is ethical is the client's best interest (Lyckhom, 1998).

All Information Related to Suicidal, Homicidal or Abuse Concerns

Even though it may be another time burden to suitably document a suicide risk assessment, it's something your supervisee sometimes must do, and you must see the he does it. It's best done immediately after a clinical evaluation of the client (Ministry of Children and Family Development, n.d.).

Although it's tempting to use a form with "Yes/No" check boxes (e.g., Is the client suicidal?) or a subjective rating scale from 1-5, it's better to do a thorough risk assessment and a step-by-step narrative of the clinical judgment and planning that followed.

Clear documentation that records the risk assessment, estimation of risk, approach to safety planning, treatment goals, and clinical consultation is important for a number of reasons:

1. To make relevant information for other professionals should they need it
2. To serve as a quality assurance checklist

3. To indicate that good clinical care often rests on good clinical documentation
4. To protect against malpractice
5. If documentation is poor, the risk of litigation is high even if the clinical care was good

Documentation of suicide risk in an outpatient setting should include:

- Initial interview
- Emergence or re-emergence of suicide ideation, plans, or attempts
- Significant changes in the client's condition

Essential principles to think of when assessing risk of suicide in a young person (Ministry of Children and Family Development, n.d.) include:

- To find out if suicide is a concern, we need to ask clients directly.
- It's not possible to predict individual suicides but we can estimate risk levels based on a thorough assessment.
- Approaches to assessing risk need to be developmentally appropriate and matched to the age and cognitive understanding of the client.
- The perspectives of parents, caregivers and other sources of collateral information should be actively sought out.
- Risk assessment requires an active consideration of the risk/protective factors ratio.
- In general, the greater the number of risk factors and the fewer the protective factors, the higher the potential risk.
- Risk status should be re-evaluated on a periodic basis.
- Treatment plans should correspond to the level of assessed risk.
- Document all clinical decisions and treatment plans.

Perhaps the most important helpful thing an agency can give its therapists to aid in dealing with suicidal, homicidal, or other serious dangers presented by a client is a clear, written

policy of management of these clients. This should include policy regarding supervision when a patient presents such dangers (Cole, 2001).

Chapter 5: Evidence of Continuity of Care

Evidence of Continuity of Care

There are basically two kinds of situations for which documentation of continuity of care is required:

- Evidence of continuity of care from other providers
- Continuity of care upon transition to other providers

If consultations take place, a copy of the consultation should be present in the record as evidence of continuity of care maintained between the two providers (VA Premier Health Plan, 2007).

The non-profit National Committee for Quality Assurance is working with a number of federal and state agencies, as well as private businesses to improve healthcare quality. One of the areas in which they're striving to build this quality is in the area of continuity and coordination of care. The organization has a seal that is widely known as a symbol of quality. Medical organizations that wish to include the seal into their marketing and advertising must pass a rigorous review and report on their performance annually.

One of the requirements in this review is that there is continuity and coordination between medical and mental health care (National Committee for Quality Assurance, 2011). The two questions they must positively answer (and prove) are:

- Does the organization monitor the coordination of general medical care and behavioral health care?
- Does the organization collaborate with its behavioral health specialists in collecting and analyzing data and implementing actions to improve the coordination of behavioral health with general medical care?

Ways some of the medical providers (Excellus BlueCross BlueShield Connection, 2009) live up to these continuity and coordination of care issues are by:

- Evaluating and assisting as to when exchanges of information between providers are necessary
- Determining the content of the exchange
- Ensuring that after the intake assessment, follow-up is timely (no later than the third visit), and appropriate
- Ensuring that the patient's written consent has been obtained

Records are kept as evidence of continuity of care between the primary care physician and the behavioral health provider. Essential collaboration includes sharing or acquiring a summary of recent behavioral health clinical outpatient or inpatient care in the previous 12 months and/or relevant treatment information via written or telephone communication that is included or documented in the treatment record. Records also include written communications and/or documentation of telephone conversations that include an assessment, working DSM-IV diagnosis and a clinical plan of care.

A standard electronic document, the Continuity of Care Document (CCD) is being developed jointly by ASTM International, the Massachusetts Medical Society (MMS), the Health Information Management and Systems Society (HIMSS), and the American Academy of Family Physicians (AAFP). Its purpose is to promote and improve continuity of patient care, to reduce medical errors, and to make certain of at least a minimum standard of the transportability of health information when a patient or client is transferred or referred to, or is otherwise seen by another provider (Continuity of Care Record, 2003).

Confidentiality of Records

Questions sometimes come up in regards to access to records because of differences between state and federal laws. The Health Insurance Portability and Accountability Act

of 1966 (HIPAA) laws are the primary federal laws in these differences. In California there are three main sources of law that may be involved:

- Confidentiality of Medical Information Act (CMIA) Civil Code (Sections 56, et seq.)
- Information Practices Act of 1977 (IPA) Civil Code (Sections 1798, et seq.)
- Patient Access to Health Records Act (PAHRA) at Health and Safety Code (Sections 123100 – 123149.5)

Patient Access to Records

An individual has a right to the confidentiality of her own mental health records. In most cases, this right of confidentiality stipulates that only the individual, her guardian, and her treatment providers may know the content of the record. However, whether or not an individual has the right to access her own records depends on what laws are applicable (M-POWER, n.d.).

HIPAA allows for psychotherapy notes to be withheld, although they encourage providers to give the information to the individual if they believe that is appropriate. HIPAA denies access to records when there is danger to either the individual directly involved or to another person (HIPAA, 2011c), whereas California law only looks at significant risk of "substantial detrimental or adverse consequences "to the individual (California Health and Safety Code, 2010).

If this access to mental health records is denied, the client must be informed of the denial. Also, written records of both the request and the reasons for denial must be put in the client's file (California Health and Safety Code, 2010). If the individual affected directly by that disputes the decision, California's IPA law requires a state agency to re-examine its determination that that particular information is exempt from access (California Department of Health Care Services, 2007).

When there are differences between state and federal laws, the state laws preempt the federal laws. This statement is based on the Federal Register (Standards for Privacy….) statement, "…A state law may also not be preempted because it comes within section

1178(a)(2)(B), section 1178(b), or section 1178(c); in this situation, a contrary federal law would give way."

Inspection by Parents of Child's Mental Health Records

Discretion to Refuse Access to Parents: In most cases, parents and guardians are allowed access to the health and mental health records of the child or youth. However, in California at least, in the instance of minors aged 12 and older, if the health care provider determines that such access would have a damaging effect on his professional relationship with the minor client or on the minor's psychological well-being or physical safety. Under Section 123115(a)(2), this decision of the availability of the minor's records for inspection shall not attach any liability to the provider, unless the decision is established to be in bad faith (California Health and Safety Code, 2010).

Discretion to Not Inform Parents without a Minor's Consent: The California Family Code (2010) requires the health care provider to involve a parent or guardian in a minor's treatment unless the provider determines that this involvement would not be appropriate. This decision and any attempts to contact parents must be documented in the minor's record. There will be some necessary sharing of certain confidential information if parents are involved in treatment. Nonetheless, participation in treatment does not mean parents necessarily have a right to access the confidential records. To whatever extent possible, providers should try to regard the minor's right to confidentiality while still involving parents in treatment (California Family Code, 2010).

Discretion to Inform Providers without Authorization: Records kept in connection with treatment or prevention of drug abuse that is regulated, conducted, or assisted--whether directly or indirectly--by the California Department of Alcohol and Drug Programs cannot be shared with providers who are not working for the same treatment or prevention program except in an emergency (California Health and Safety Code, 2010). Health care providers working for programs that are not state assisted may share information for treatment or referral services with other providers. However, without written client

authorization, they may not share psychotherapy notes (California Civil Code Section 56-56.07, 2010 and National Center for Youth Law, 2010).

Disclosure of Record Keeping Procedures

Disclosure of record keeping procedures is potentially a part of informed consent (American Psychological Association, 2007). As you recall, an Informed Consent document is a statement of what will be happening in therapy, its risks, benefits, and alternatives, and signed by the client before beginning therapy and giving consent for therapy. A notice of HIPAA privacy laws that has been signed as having been explained to the client is also a part of the informed consent process. Also discussed were informed consent forms for using e-mail, texting and other electronic communications between client and therapist.

Sometimes, the client might want to know how the records will be maintained, and this may include disclosure of record keeping procedures. This may be particularly important if the procedures will probably affect confidentiality or if the client articulates expectations about record keeping that are different from required procedures.

It's possible that the way in which records are maintained could potentially affect the client in ways that she might not anticipate. It's encouraged that you and your supervisees inform clients about such situations. For example, more and more often certain client records may become part of an electronic file that can be accessed by a wide range of institutional staff. In some educational settings, federal, state, and institutional regulations require record keeping procedures that could enlarge the range of people who have access to the records of a school psychologist.

When mental health client records are released with appropriate permission to do so, from that point it's possible that they might be distributed further without the therapist's or client's knowledge or consent. The client should be alerted of this possibility before the consent for release of information is signed. An example of this, records released in a context of litigation may be placed in the public domain and be accessible to anyone.

Maintenance of Records

To be clinically useful and legally safe, clinical records must be kept up-to-date and be well organized.

Records are only useful if efficient retrieval is possible. Records that are organized logically and updated systematically, and that are thorough and accurate accomplish this. The therapist and supervisor can more easily monitor ongoing care and interventions. If the client's care needs to be transferred elsewhere, for whatever reason, this sort of records allow for continuity and coordination of care.

Organizational Methods

There are a variety of methods for organizing the records to aid in storage and retrieval. Logical and consistent methods will generally be most useful. For example, a logical file labeling system will assist in recovering records (American Psychological Association, 2007).

Dividing the files into several sections may be helpful:

- Psychotherapy notes
- Client information that is intended to be shared with others
- Material generated by the client, client's family members, prior treatment providers, or other third parties
    - Behavioral ratings or logs
    - Diaries
    - Journals

    - Letters
    - Pictures
    - Videos
    - Greeting cards

Because psychological test data may require especially careful consideration before being released, and therefore may best be clustered within the file to make that perusal easier. A specific, often overlooked, area of concern is the re-release of data from previous therapist's records as a part of the record that should be released. Should the therapist decided not to release that information, having that in a separate part of the file will make it easier to carry out that decision.

When asked for legitimate release of information for which a release form has been signed, the therapist must still consider several items:

- HIPAA regulations regarding psychotherapy notes
- Breadth of records requested
- Client's wishes
- Situational demands

For example, the therapist has received a court order of "any and all records" that were used when the therapist formed certain opinions. It would likely be necessary to re-release some third-party information that is in the record. However, the therapist can give advance notification to the client, allowing enough time for an objection to be raised before responding to such requests for records.

Psychotherapy Notes

For privacy reasons, HIPAA has given its own definition of psychotherapy notes. A discussion of progress notes follows the outline of the applicable HIPAA definition and rules.

HIPAA Definition of Psychotherapy Notes

Some items that have traditionally been included as parts of the psychotherapy notes have been defined by HIPAA as something separate. HIPAA's definition of psychotherapy notes is:

> "**Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record.** Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date" (HIPAA, 2003).

Note that items that this definition pretty much limits psychotherapy notes to anything relating to the contents of therapy session conversations and does NOT include:

- Medication prescription and monitoring
- Counseling start and stop times
- Modalities and frequencies of treatment furnished
- Results of clinical tests
- Summaries of:
  - Diagnosis
  - Functional status
  - Treatment plan
  - Symptoms
  - Prognosis
  - Progress

HIPAA states that psychotherapy notes are to be kept separate from the rest of the record. Only the provider who took the notes (or others within the provider's agency) can access them, unless there is a HIPAA complaint authorization from the client (American Psychological Association, 2007).

Providers are exempt from forwarding or otherwise sharing psychotherapy notes with other entities without client authorization, except for legally defined exceptions. Physically integrating information included in the above list into the psychotherapy notes does not automatically mutate it into protected information.

If a provider has integrated information excluded from the definition of psychotherapy notes with a psychotherapy note (e.g., results of clinical tests, symptoms), the provider is responsible for extracting information that is required to reinforce the reasonableness and necessity of a Medicare claim, or other legal request for information (Provider Inquiry Assistance, 2005).

The Department of Health and Human Services (HHS) Office for Civil Rights (OCR) is responsible for enforcing the privacy protections and access rights for consumers. The HIPAA privacy rule does not require or allow any new government access to medical information, with one exception: the rule does give OCR the authority to investigate complaints and to otherwise ensure that covered entities comply with the rule. In order to ensure covered entities, protect patients' privacy as required, the rule provides that health plans, hospitals, and other covered entities cooperate with the Department's efforts to investigate complaints or otherwise ensure compliance (U.S. Department of Health and Human Services, 2001).

Progress Notes

Psychotherapy notes are sometimes called progress notes. Some of the information that HIPAA excludes in its definition of psychotherapy notes are summaries. However, the

specifics that formed the basis for the summaries are included in the psychotherapy, or progress notes. The progress notes:

- Include date and duration of the session
  - Document cancellations and no shows
  - Document gaps in service (incarcerations, hospitalizations, vacations, etc.)
- Include type of intervention
- Refer back to objectives stated in the treatment plan
- Record what was said or done in the session
- In a form that will be most helpful to the therapist, record:
  - Hypotheses
  - Personal reactions
  - Doubts, expectations
  - Possible interpretations
  - Supervisory recommendations
- Financial arrangements for payment and associated information

Face-to-Face Therapy

Anyone acquainted with the field of therapy is familiar with face-to face therapy. The client and therapist meet and have a session. This most often takes place in the therapist's office, but can also occur in hospitals, jails, or similar settings. But because of the experience of the years for this kind of therapy, record keeping and process notes easily fall into the descriptions above.

Electronic Therapy

Before the advent of the Internet, face-to-face therapy was the only type of therapy, except for crisis telephone services. In recent years, therapists have taken advantage of the Internet and the telephone to offer almost the whole gamut of therapeutic services.

This kind of therapy not only has a number of names (e.g., TeleMental Health, Telehealth, E-Therapy, E-Counseling), it's also provided by a variety of means:

- Avatars
- Chats
- E-Mail
- Skype
- Telephone
- Texts
- Video-conferencing

A variety of client populations have eagerly sought these sorts of therapy, including those who:

- ➢ Don't want to be seen going into a therapist's office
- ➢ In rural areas that are some distance from a therapist's office
- ➢ Are incarcerated
- ➢ Are homebound
- ➢ Work better with frequent, intermittent conversation, rather than a block of time each week
- ➢ Are more comfortable with the anonymity of text formats than face-to-face formats

In the recent years, because of the global pandemic, therapy sessions are now being held over the web. Slowly the entire world adapted and transitioned to such means to cater to the growing needs of the people. But despite the convenience that the telehealth has provided for the most part, this solution does not go without any repercussions or issues.

However, clinical, ethical, and legal facets of electronic therapy are in many respects still under construction. There is an ongoing discussion, for example, as to whether most of these formats conform to HIPAA privacy and confidentiality laws. Whole courses are available to train the "electronic therapist" in the ethical and legal considerations (including conducting therapy across state lines, HIPAA, reimbursement, etc.), as well as

the delivery of electronic therapy with its practice, logistic, and technologic aspects (Zur, Ofur, 2011d).

Nonetheless, if your supervisees provide any kind of electronic therapy, records must be kept. The rules and regulations and other discussions above all apply.

Security

In light of confidentiality and privacy for every individual, there must be suitable protection against unauthorized access to or loss of the records. As a safeguard against electronic and physical breaches of confidential information, there needs to be limited access to the records. New challenges to preservation of security have appeared because of advances in technology. However, there must be a plan in place to protect the records (American Psychological Association, 2007).

Two basics to consider are:

1. The medium on which the records are stored

   Paper records must be kept in safe location where they may be protected not only from unauthorized access, but also from damage or destruction (water, mold, fire, insects). Condensed records, or a full copy of them, may be kept in separate locations to better protect them from disasters--natural or unnatural.

   Electronic records may need protection from different kinds of damage--mechanical insult or electric fields; power outages or surges; attacks from viruses, worms, and other destructive programs. A plan for archiving files may include off-site storage of data or file and system backups.

2. Access to the records

Access to paper records may be controlled by storing files in locked cabinets or other such containers that are housed in locked offices or storage rooms.

Access to electronic records may be controlled via security procedures such as firewalls, passwords, authentication, and data encryption.

Retention of Records

There are numerous potential circumstances that might require a release of client records after termination of client contact (e.g., legal proceedings, requests from treatment providers or the clients themselves). They may also be needed at some time for the social worker or therapist to show the nature, quality, and rationale for services provided. It's also a possibility that the records might be requested to give light in resolving a legal dispute and administering justice when the nature of the treatment provided or the psychological condition of the client at the time of services would be needed (American Psychological Association, 2007).

This gives rise to the question of just how long you *should* keep the records. Perhaps the most practical answer is, "As long as necessary for the future care of the client, and as long as the record may be used in the defense of the therapist" (Cole, 2001). The APA states that, unless there is an overriding requirement, it would be good to keep records for seven years after the last service delivery date for adults or until three years after a minor reaches the age of majority, whichever is later. However, they also state that you may want to keep them longer. These suggestions are the law in California; each state has its own laws.

In deciding whether to keep the records for a longer period of time, you would want to weigh the potential benefits associated with keeping the records versus risks associated with potential privacy loss or having information that is outdated/obsolete. Possibilities

that you may want to consider when making the decision to continue to keep or to eradicate files include:

- ✓ Earlier records of symptoms of a mental disorder might be helpful for the client in later diagnosis and treatment.
- ✓ Or, the client might be better served if later diagnosis and treatment was not influenced by something more than seven years in the past.
- ✓ The client might have engaged in behavior as a minor that, if disclosed later (when, for example, he decided to run for Congress) could prove demeaning or embarrassing.
- ✓ Keeping the record over an extra-long time might be expensive and/or logistically challenging.

One other item to consider: The client has the right to amend his medical records as long as you have the record (Pritts, 2005).

Preserving the Context of Records

There are times for which the information in a client's record is specific to a given time frame or a particular situational context during which the services were delivered. Over time, as the context changes, the meaning and relevance of the information may also change. The information in the record should be recorded in such as way as to preserve the context.

For example, if you or your supervisee assess or treat an individual who is under extreme external stress or who is in crisis, those stresses may affect the client's functioning in that

setting, but the client's behavior in that situation may not be at all representative of the client's normal functional characteristics.

Or--a child who is being severely physically abused may show low scores in a cognitive assessment that may not be close to accurately predicting future functioning of the child. Or if you need to write a case summary of a client who had been violent, but only in the midst of one psychotic episode, you would want to carefully record the context in which the behavior took place. Always try to create and maintain a client's records in such as way as to show related information about the context in which the record is created (American Psychological Association, 2007).

Electronic Records

Issues pertinent to electronic records have already been discussed. But, because of the extreme importance and uniqueness of electronic records, it will be tied together here with some addition information.

Aspects of electronic record keeping that need to be kept in mind are:

- Limitations to their confidentiality
- Methods of keeping the records secure
- Measures needed to maintain the integrity of the records
- Unique challenges of disposing of the records

In many cases, those in the social work and mental health fields will be subject to the HIPAA Privacy Rules and Security Standards. This requires a detailed analysis of the risks associated with your electronic records. It would likely be helpful to conduct that risk analysis even if you're not technically subject to the HIPAA rule.

These HIPPA requirements are also a means to help you to closely examine certain office practices:

- Assuring that you handle personal health information in a manner that will protect clients' privacy
- Defining acceptable deidentification if needed for research or other purpose
- Clearly defining required elements in a release of information authorization

Whether the Security Regulations apply or not, the swift changes in the technologies for service delivery, media storage, and billing necessitate frequent consideration of how to use these methods and media in terms of record keeping standards (American Psychological Association, 2007). The ease of creating, transmitting, and sharing electronic records can expose you to risks of unintentional disclosure of confidential information.

Some precautionary actions include:

- Use case identification numbers, not clients' Social Security numbers to identify records
- Use passwords and/or encryption to protect confidential materials
- Become aware of special issues raised when using electronic methods and media; get training or consult with a specialist when necessary

Record Keeping in Organizational Settings

Organizational settings, often present unique record keeping challenges. Record keeping requirements for organizations may be substantially different from requirements in other settings. You may run into conflicts between the organizations' practices and establish professional guidelines, legal and regulatory requirements, or ethical standards. In addition, ownership of and responsibility for a record is not always clearly defined. A

number of service providers may access and contribute to the record, potentially affecting the degree to which you may execute control of the record and its confidentiality.

This may be summarized as potential:

1. Conflicts between organizational and other requirements
2. Ownership of the records
3. Access to the records

You, your colleagues, and your agency's management may need to consult with one another to define record keeping procedures that serve the needs of different disciplines, while at the same time meeting acceptable record keeping guidelines and requirements. In this consultation, you'll need to review local, state, and federal regulations and laws that pertain to the organization. If there is a conflict between an ethics code and the organization's policies, you'll need to clarify the nature of the conflict, make your (and others involved) ethical commitments known, and resolve the conflict in a way that is compatible with those ethical commitments.

The nature of your legal relationship with the organization may dictate record keeping practices. The physical record of your services may be owned by the organization and you may not take it with you. However, if the relationship is one of consultation, you may be the one who owns and is responsible for the record. It will be helpful to clarify these issues when you begin your relationship with an organization, minimizing the possibility of misunderstandings.

If a team of people from different disciplines is involved in service delivery, there may need to be wider access to records than usual. Because others (e.g., nurses, physicians, paraprofessionals, etc.) may have access to and may make entries into the client's record, you may have much less direct control over it. This is another call for you to help in developing and refining organizational record keeping policies.

Note that because multidisciplinary records may not have the highest level of confidentiality, you and your supervisees will want to record only information that matches organizational requirements and that is necessary to correctly picture the service provided. Other information may then be kept in a separate and confidential file (American Psychological Association, 2007).

Multiple Client Records

Record keeping issues may be more complex when you provide services to multiple clients, such as in a group therapy session. If the records include information about more than one specific client, legitimate disclosure of information regarding that client may put another client's confidentiality in jeopardy.

It's the responsibility of you and your supervisees to keep records in a fashion that assists authorized disclosures but at the same time protects privacy of other clients. When you provide services to several people who have a relationship (e.g., spouses or parents and children), you must define at the beginning:

1. Which individuals are clients
2. Your relationship with each person, including your role and the likely uses of the services you give or the information obtained.

If it looks like you may be asked to play potentially conflicting roles (e.g., family therapist and then witness for one part in divorce proceedings), you must take judicious steps to appropriately clarify, modify, or withdraw from a specific role or roles.

In a group therapy setting, you must describe at the beginning each party's role and responsibility, and the limits of confidentiality. If you're asked to provide services to someone who is already receiving similar services elsewhere, you must consider carefully any treatment issues and potential welfare of the client(s). Discuss these issues with the client (or the client's guardian or other legal representative) to diminish risks of conflict

and confusion. Also, when appropriate, consult with the other service providers, always being cautious and sensitive to therapeutic issues (American Psychological Association, 2010).

Other precautionary steps you can take include:

- In the informed consent form, include whether information is kept jointly or separately and who can authorize its release.

- In couples, family or group therapy, clarify the identified clients, then create and maintain completely separate records for all identified clients.

- If the family itself is the identified client, you may need to keep a single record, dependent upon practical concerns, ethical guidelines, and third-party reporting requirements.

To successfully "pull all of this off," you'll need to be familiar with regulatory and legal requirements concerning the release of a record that contains information about more than one client (American Psychological Association, 2007).

Financial Records

Financial records are considered by HIPAA to be part of the protected psychotherapy notes; at least they're not on the list of unprotected information. As a rule, a fee agreement or policy will be part of the record, and is the foundation for documenting reimbursement for services. Precise financial records aid payers to evaluate the nature of the payment obligation, and also aid in knowing which services have been billed and paid. Records that are up-to-date can forewarn both the provider and the client of accruing balances that, if not addressed, could adversely affect the professional relationship.

Financial records include (American Psychological Association, 2007), as appropriate:

- Type and duration of the service given
- Client's name
- Fees paid for the service
- Agreements concerning fees
    - Fee agreements or policies identify the amount to be charged for service and the terms of any payment agreement. It will identify how missed appointments will be handles, acknowledge third-part payer preauthorization requirements, copayment agreements, payment schedule, interest that an unpaid balance will accumulate, suspension of confidentiality when collection procedures must be used, and methods that may be used to solve financial disputes.
- Barter agreements
    - An accurate recording of bartering agreements and transactions ensures that the record clearly shows how the provider was compensated. Reporting the source, nature, and date of each barter transaction gives clear indication when needed about the exchange of goods for services. Because the provider could potentially have more power in negotiating a bartering agreement, painstaking documentation protects both parties. The documentation may include the provider's basis for initially concluding that the arrangement is neither clinically contraindicated nor exploitive.
- Balance adjustment issues
    - The rationale for, description of, and date of any balance adjustment made with either the client or a third-party payer should be part of the record. This can decrease the potential for misunderstandings or perceived obligations that might affect the relationship.
- Copayment issues
- Date, amount, and source of payment received
- Concerns about collection
    - Often also useful is documentation of collection efforts, including notification of the intention of using a collection service.

Disposition of Records

Certain events require collection, storage, transfer, or disposal of client records. These events are:

1. Unexpected events (disability, death, or involuntary termination of practice)
2. Planned events (retirement, closing a practice, voluntarily leaving employment)

Disposition of client records must be handled in such a way that confidentiality is maintained and client welfare safeguarded (American Psychological Association, 2007). This refers to all private information--written or unwritten--such as communications during the time of providing service, computer files, e-mail or fax communications, written records, and video-tapes. This means that the therapist needs to have suitable plans in place from the beginning of her job. Also to be planned for, in case of unexpected changes, are contingencies for continuation of services (Barnett and Zur, 2011).

In the circumstance of unexpected events, the plans might include control and management of closed records by an agency or trained individual. In the circumstance of planned events, depending on who the employer is, the provider may wish to retain custody and control of the closed records.

It may be helpful to have a method for notifying clients regarding any changes in the custody of their records, especially recently terminated services or open cases. You'll want to check legal and regulatory requirements to see if you should post a public notice about changes in this custody, such as a notice in the newspaper.

If records are to be disposed of permanently, they must be disposed of in such a way that they cannot be recovered, such as shredding. You must to provide for confidentiality in transportation to the shredding facility, as well as in that facility. This might require

accompanying the records through the disposal process or having a confidentiality agreement with those responsible for the disposal.

Disposal of electronic records have unique challenges, because you may not have the technical expertise to fully erase or otherwise delete records before, as an example, disposing of an external back-up storage device or a computer hard drive or other electronic record repository. Even though efforts may be made to erase or delete records, they may still be accessible for some "geeks" with specialized knowledge. You'll possibly need to work with a technical consultant to find a satisfactory method for destruction of electronic records. These could include physical destruction of the entire medium or demagnetizing the storage device.

Evaluation of the Supervisee

In spite of the awareness that a big part of supervision is the supervisor's evaluation of the supervisee, it's apparently something that is often far from the favorite task of a supervisor. Some of the reasons for this include (Lichtenberg et al., 2007):

- Defining competencies in precise and measurable terms
- Reaching agreement within the profession about the key elements of each competence domain
- Establishing an armamentarium of tools for assessing all components of competence, including the knowledgebase, skills, and attitudes (and their integration)
- Determining appropriate, agreed-upon minimal levels of competence for individuals at different levels of professional development and when "competence problems" exist for individuals assuring the fidelity of competency assessments
- Establishing mechanisms for providing effective evaluative feedback and remediation

But Lichtenberg et al. (2007) believed that "the single biggest obstacle would be convincing those who are skeptical of the value of … implementation of comprehensive competence assessments across the professional lifespan."

However, no matter what problems are related to it, supervisor evaluation of the supervisee is an established fact and must be faced. Interestingly, unless things have dramatically changed in the 21st century, supervisees frequently receive no evaluation until the last day of the required training, and then receive some negative feedback about which they had heard nary a word in the course of training. You can see why the lack of performance evaluation has been the most commone ethical violation reported by supervisees in supervision (Ladany and Lehrman-Waterman, 1999).

For contrast with the above list from Lichtenberg et al. (2007), the primary reasons given in 1993 of why supervisors often *don't give* negative feedback were (Robiner, Fuhrman, and Ristvedt, 1993):

1. Definition and Measurement: Supervisors reported concern about the methodology, reliability, and validity of the scales or measures they use, or they're concerned that anecdotal feedback does not meet criteria for accurate assessment.

2. Legal Liability: Supervisors were concerned with legal and administrative issues--legal liability if the supervisee would dispute the feedback (especially in light of the first concern, fearing the feedback may not be defensible).

3. Interpersonal Issues: Many supervisors feared that the evaluation might cause the supervisor to come under unwelcome scrutiny; they also feared that it might risk jeopardizing the supervisory alliance or interpersonal relationship established with the supervisee.

It's ironic that supervisees report that supervisors who give abundant constructive feedback and evaluation are their best supervisors (Falender, 2010). The Association of State and Provincial Psychology Boards (2003) suggested that summative evaluation be given to supervisees in written form four times during each training year.

Summative evaluations of supervisees would examine the outcome of their clinical work. It would include:

- Outcome evaluations that investigate whether the supervisee caused demonstrable effects on specifically defined target outcomes
- Impact evaluation is broader and assesses the overall or net effects--intended or unintended--of the supervisee as a whole
- Secondary analysis reexamining existing data to address new questions or methods not previously employed (Trochim, 2006)

A related type of evaluation is formative evaluation, which tries to improve or strengthen the person being evaluated. As it relates to supervisees, it examines their delivery of therapy or a social work program, the quality of this delivery, and assessment of the context. A formative evaluation includes:

- Praise or support
- Constructive feedback focused on suggestions or analysis
    - Thinking about what other options might have been helpful
    - Wondering about the rationale for particular interventions
    - Thinking more about process than content, effect rather than content, or generally refocusing the therapy process
    - Specific and directive for beginning level supervisees; more open-ended and thought provoking for more advanced supervisees

Current thinking is moving towards a 2-way feedback, where supervisees also evaluate supervisors. Supervisees might fear that summative feedback could influence their own

evaluations negatively, and thus be cautious in giving summative feedback to supervisors. However, if you, the supervisor, are truly open to feedback and accepting of it, it can be very helpful to both you and the supervisee. If, however, you respond with dismissive behaviors, resistance, or even anger, it will obviously not be a helpful process (Falender, 2010).

Options to aid effective competency-based evaluations:

- Track for outcomes in client progress; examples of a tool for this are Lambert's Outcome Questionnaire (OQ) and its child and adolescent equivalent (Y-OQ) and the other measurements that were discussed earlier in the course can be uses, such as depression scales.

- A self-assessment to assess and extend one's areas of practice, or just to see how current the supervisee's knowledge and skills are. Belar et al. (2001) offer a template that a supervisor can use to devise pertinent self-assessments for his specific use.

- Use a multi-source feedback (also known as "360-degree feedback"). The individual being rated (supervisor should do on himself first, then the supervisee would follow suit) first rates himself, and then is rated by peers, administrators, clerical staff, clients, supervisors (who were first rated by the supervisee), and others in the setting. The coordinating supervisor integrates the results to make a comprehensive feedback.

- The supervisor(s) should be certain that the evaluation documents include every important performance area in the supervisee's setting. If something is overlooked in the evaluation documents, it should necessarily also be overlooked in the final evaluations.

- ➢ Use other evaluation measures such as alliance measures, supervision outcomes, and diversity/multicultural competence assessments.

If the supervisee does not meet performance standards, she can be given an action plan for improvement, or in most drastic situations, a longer period of time of required supervision. Supervisees who don't meet standards after the action plan approach are rare (Falender, 2010).

Red flags for performance problems include:

- Delinquent paperwork
- Chronic lateness
- Client cancellations (by client or supervisee)
- Changes in interaction style or behavior
- Inconsistencies between notes and descriptions of cases in supervision

Not meeting performance standards are reflected in professional functions in one or more of the following (Lamb, Anderson, Rapp, Rathnow, qne Sesan, 1986):

- Inability or unwillingness to acquire and integrate professional standards into one’s repertoire of professional behavior
- Inability to acquire professional skills to reach acceptable level of competence
- Inability to control personal stress, psychological dysfunction, and/or excessive emotional reactions that may affect professional functioning
- Supervisees don't acknowledge, understand, or address the problem even when raised
- The problem is not just a reflection of a skill deficit rectifiable through academic or didactics
- The quality of intern service is consistently negatively impacted
- The problem is not restricted to one area of functioning
- Disproportionate amounts of attention by training personnel is required

- The intern’s behavior does not change as a function of feedback, remediation efforts, and/or time

After you've determined that the supervisee is not meeting performance criteria, and you've given feedback directly to him, work with the supervisee to develop a plan (based on data you can find in regard to successful completion of the behaviors in the past and factors that facilitated those) for change or completion. Construct a time-line with intermediate check-in points that are fairly close together, and document the meeting in which all of this took place (Falender, 2010).

The initial check-in should be within a few days of the meeting; be sure to follow up to see if appropriate progress is being made. Even with appropriate progress, continue monitoring even past indications that the behavior has changed. If the problem behaviors don't decrease, take appropriate steps that might include:

- Consultation with the school (a step that could even have occurred earlier)
- Consultation with Human Resources or Personnel Department
- Consultation with Administrative personnel on site
- Increased supervision or different supervision modalities
- Introducing a co-therapist
- Reducing workload or, if necessary, removing clients from caseload as needed
- Suggesting outside supports such as therapy or whatever is indicated
- Leave of absence

Continue with these steps until the problem is solved or until you determine that the supervisee's position must be terminated (Falender, 2010). All steps must be carefully documented.

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APPENDIX A: CODE OF ETHICS OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS

Source: https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

The NASW Code of Ethics is intended to serve as a guide to the everyday professional conduct of social workers. This Code includes four sections:

- The first Section, "Preamble," summarizes the social work profession's mission and core values.

- The second section, "Purpose of the NASW Code of Ethics," provides an overview of the Code's main functions and a brief guide for dealing with ethical issues or dilemmas in social work practice.
- The third section, "Ethical Principles," presents broad ethical principles, based on social work's core values, that inform social work practice.
- The final section, "Ethical Standards," includes specific ethical standards to guide social workers' conduct and to provide a basis for adjudication.

Preamble

The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. A historic and defining feature of social work is the profession's focus on individual well-being in a social context and the well-being of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living.

Social workers promote social justice and social change with and on behalf of clients. "Clients" is used inclusively to refer to individuals, families, groups, organizations, and communities. Social workers are sensitive to cultural and ethnic diversity and strive to end discrimination, oppression, poverty, and other forms of social injustice. These activities may be in the form of direct practice, community organizing, supervision, consultation, administration, advocacy, social and political action, policy development and implementation, education, and research and evaluation. Social workers seek to enhance the capacity of people to address their own needs. Social workers also seek to promote the responsiveness of organizations, communities, and other social institutions to individuals' needs and social problems.

The mission of the social work profession is rooted in a set of core values. These core values, embraced by social workers throughout the profession's history, are the foundation of social work's unique purpose and perspective:

- service

- social justice
- dignity and worth of the person
- importance of human relationships
- integrity
- competence.

This constellation of core values reflects what is unique to the social work profession. Core values, and the principles that flow from them, must be balanced within the context and complexity of the human experience.

Purpose of the NASW Code of Ethics

Professional ethics are at the core of social work. The profession has an obligation to articulate its basic values, ethical principles, and ethical standards. The *NASW Code of Ethics* sets forth these values, principles, and standards to guide social workers' conduct. The *Code* is relevant to all social workers and social work students, regardless of their professional functions, the settings in which they work, or the populations they serve.

The *NASW Code of Ethics* serves six purposes:

1. The *Code* identifies core values on which social work's mission is based.
2. The *Code* summarizes broad ethical principles that reflect the profession's core values and establishes a set of specific ethical standards that should be used to guide social work practice.
3. The *Code* is designed to help social workers identify relevant considerations when professional obligations conflict or ethical uncertainties arise.
4. The *Code* provides ethical standards to which the general public can hold the social work profession accountable.
5. The *Code* socializes practitioners new to the field to social work's mission, values, ethical principles, and ethical standards.

6. The *Code* articulates standards that the social work profession itself can use to assess whether social workers have engaged in unethical conduct. NASW has formal procedures to adjudicate ethics complaints filed against its members.* In subscribing to this *Code,* social workers are required to cooperate in its implementation, participate in NASW adjudication proceedings, and abide by any NASW disciplinary rulings or sanctions based on it.

*For information on NASW adjudication procedures, see *NASW Procedures for the Adjudication of Grievances*.

The *Code* offers a set of values, principles, and standards to guide decision making and conduct when ethical issues arise. It does not provide a set of rules that prescribe how social workers should act in all situations.Specific applications of the *Code* must take into account the context in which it is being considered and the possibility of conflicts among the *Code*'s values, principles, and standards. Ethical responsibilities flow from all human relationships, from the personal and familial to the social and professional.

Further, the *NASW Code of Ethics* does not specify which values, principles, and standards are most important and ought to outweigh others in instances when they conflict. Reasonable differences of opinion can and do exist among social workers with respect to the ways in which values, ethical principles, and ethical standards should be rank ordered when they conflict. Ethical decision making in a given situation must apply the informed judgment of the individual social worker and should also consider how the issues would be judged in a peer review process where the ethical standards of the profession would be applied.

Ethical decision making is a process. In situations when conflicting obligations arise, social workers may be faced with complex ethical dilemmas that have no simple answers. Social workers should take into consideration all the values, principles, and standards in this *Code* that are relevant to any situation in which ethical judgment is warranted. Social workers' decisions and actions should be consistent with the spirit as well as the letter of this *Code*.

In addition to this *Code,* there are many other sources of information about ethical thinking that may be useful. Social workers should consider ethical theory and principles generally, social work theory and research, laws, regulations, agency policies, and other relevant codes of ethics, recognizing that among codes of ethics social workers should consider the *NASW Code of Ethics* as their primary source. Social workers also should be aware of the impact on ethical decision making of their clients' and their own personal values and cultural and religious beliefs and practices. They should be aware of any conflicts between personal and professional values and deal with them responsibly. For additional guidance social workers should consult the relevant literature on professional ethics and ethical decision making and seek appropriate consultation when faced with ethical dilemmas. This may involve consultation with an agency-based or social work organization's ethics committee, a regulatory body, knowledgeable colleagues, supervisors, or legal counsel.

Instances may arise when social workers' ethical obligations conflict with agency policies or relevant laws or regulations. When such conflicts occur, social workers must make a responsible effort to resolve the conflict in a manner that is consistent with the values, principles, and standards expressed in this *Code*. If a reasonable resolution of the conflict does not appear possible, social workers should seek proper consultation before making a decision.

The *NASW Code of Ethics* is to be used by NASW and by individuals, agencies, organizations, and bodies (such as licensing and regulatory boards, professional liability insurance providers, courts of law, agency boards of directors, government agencies, and other professional groups) that choose to adopt it or use it as a frame of reference. Violation of standards in this *Code* does not automatically imply legal liability or violation of the law. Such determination can only be made in the context of legal and judicial proceedings. Alleged violations of the *Code* would be subject to a peer review process. Such processes are generally separate from legal or administrative procedures and insulated from legal review or proceedings to allow the profession to counsel and discipline its own members.

A code of ethics cannot guarantee ethical behavior. Moreover, a code of ethics cannot resolve all ethical issues or disputes or capture the richness and complexity involved in striving to make responsible choices within a moral community. Rather, a code of ethics sets forth values, ethical principles, and ethical standards to which professionals aspire and by which their actions can be judged. Social workers' ethical behavior should result from their personal commitment to engage in ethical practice. The *NASW Code of Ethics* reflects the commitment of all social workers to uphold the profession's values and to act ethically. Principles and standards must be applied by individuals of good character who discern moral questions and, in good faith, seek to make reliable ethical judgments.

With growth in the use of communication technology in various aspects of social work practice, social workers need to be aware of the unique challenges that may arise in relation to the maintenance of confidentiality, informed consent, professional boundaries, professional competence, record keeping, and other ethical considerations. In general, all ethical standards in this *Code of Ethics* are applicable to interactions, relationships, or communications, whether they occur in person or with the use of technology. For the purposes of this *Code*, “technology-assisted social work services” include any social work services that involve the use of computers, mobile or landline telephones, tablets, video technology, or other electronic or digital technologies; this includes the use of various electronic or digital platforms, such as the Internet, online social media, chat rooms, text messaging, e-mail, and emerging digital applications. Technology-assisted social work services encompass all aspects of social work practice, including psychotherapy; individual, family, or group counseling; community organization; administration; advocacy; mediation; education; supervision; research; evaluation; and other social work services. Social workers should keep apprised of emerging technological developments that may be used in social work practice and how various ethical standards apply to them.

Ethical Principles

The following broad ethical principles are based on social work's core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence. These principles set forth ideals to which all social workers should aspire.

Value: ***Service***

Ethical Principle: *Social workers' primary goal is to help people in need and to address social problems.*

Social workers elevate service to others above self-interest. Social workers draw on their knowledge, values, and skills to help people in need and to address social problems. Social workers are encouraged to volunteer some portion of their professional skills with no expectation of significant financial return (pro bono service).

Value: ***Social Justice***

Ethical Principle: *Social workers challenge social injustice.*

Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people. Social workers' social change efforts are focused primarily on issues of poverty, unemployment, discrimination, and other forms of social injustice. These activities seek to promote sensitivity to and knowledge about oppression and cultural and ethnic diversity. Social workers strive to ensure access to needed information, services, and resources; equality of opportunity; and meaningful participation in decision making for all people.

Value: ***Dignity and Worth of the Person***

Ethical Principle: *Social workers respect the inherent dignity and worth of the person.*

Social workers treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity. Social workers promote clients' socially responsible self-determination. Social workers seek to enhance clients' capacity and opportunity to change and to address their own needs. Social workers are cognizant of their dual responsibility to clients and to the broader society. They seek to resolve conflicts between clients' interests and the broader society's interests in a socially responsible manner consistent with the values, ethical principles, and ethical standards of the profession.

Value: ***Importance of Human Relationships***

Ethical Principle: *Social workers recognize the central importance of human relationships.*

Social workers understand that relationships between and among people are an important vehicle for change. Social workers engage people as partners in the helping process. Social workers seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the well-being of individuals, families, social groups, organizations, and communities.

Value: *Integrity*

Ethical Principle: *Social workers behave in a trustworthy manner.*

Social workers are continually aware of the profession's mission, values, ethical principles, and ethical standards and practice in a manner consistent with them. Social workers act honestly and responsibly and promote ethical practices on the part of the organizations with which they are affiliated.

Value: *Competence*

Ethical Principle: *Social workers practice within their areas of competence and develop and enhance their professional expertise.*

Social workers continually strive to increase their professional knowledge and skills and to apply them in practice. Social workers should aspire to contribute to the knowledge base of the profession.

Ethical Standards

The following ethical standards are relevant to the professional activities of all social workers. These standards concern (1) social workers' ethical responsibilities to clients, (2) social workers' ethical responsibilities to colleagues, (3) social workers' ethical responsibilities in practice settings, (4) social workers' ethical responsibilities as professionals, (5) social workers' ethical responsibilities to the social work profession, and (6) social workers' ethical responsibilities to the broader society.

Some of the standards that follow are enforceable guidelines for professional conduct, and some are aspirational. The extent to which each standard is enforceable is a matter of professional judgment to be exercised by those responsible for reviewing alleged violations of ethical standards.

1. Social Workers' Ethical Responsibilities to Clients

1.01 Commitment to Clients

Social workers' primary responsibility is to promote the well-being of clients. In general, clients' interests are primary. However, social workers' responsibility to the larger society or specific legal obligations may on limited occasions supersede the loyalty owed clients, and clients should be so advised. (Examples include when a social worker is required by law to report that a client has abused a child or has threatened to harm self or others.)

1.02 Self-Determination

Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals. Social workers may limit clients' right to self-determination when, in the social workers' professional judgment, clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others.

1.03 Informed Consent

(a) Social workers should provide services to clients only in the context of a professional relationship based, when appropriate, on valid informed consent. Social workers should use clear and understandable language to inform clients of the purpose of the services, risks related to the services, limits to services because of the requirements of a third-party payer, relevant costs, reasonable alternatives, clients' right to refuse or withdraw consent, and the time frame covered by the consent. Social workers should provide clients with an opportunity to ask questions.

(b) In instances when clients are not literate or have difficulty understanding the primary language used in the practice setting, social workers should take steps to ensure clients'

comprehension. This may include providing clients with a detailed verbal explanation or arranging for a qualified interpreter or translator whenever possible.

(c) In instances when clients lack the capacity to provide informed consent, social workers should protect clients' interests by seeking permission from an appropriate third party, informing clients consistent with the clients' level of understanding. In such instances social workers should seek to ensure that the third party acts in a manner consistent with clients' wishes and interests. Social workers should take reasonable steps to enhance such clients' ability to give informed consent.

(d) In instances when clients are receiving services involuntarily, social workers should provide information about the nature and extent of services and about the extent of clients' right to refuse service.

(e) Social workers should discuss with clients the social workers' policies concerning the use of technology in the provision of professional services.

(f) Social workers who use technology to provide social work services should obtain informed consent from the individuals using these services during the initial screening or interview and prior to initiating services. Social workers should assess clients' capacity to provide informed consent and, when using technology to communicate, verify the identity and location of clients.

(g) Social workers who use technology to provide social work services should assess the clients' suitability and capacity for electronic and remote services. Social workers should consider the clients' intellectual, emotional, and physical ability to use technology to receive services and the clients' ability to understand the potential benefits, risks, and limitations of such services. If clients do not wish to use services provided through technology, social workers should help them identify alternate methods of service.

(h) Social workers should obtain clients' informed consent before making audio or video recordings of clients or permitting observation of service provision by a third party.

(i) Social workers should obtain client consent before conducting an electronic search on the client. Exceptions may arise when the search is for purposes of protecting the client

or other people from serious, foreseeable, and imminent harm, or for other compelling professional reasons.

1.04 Competence

(a) Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience.

(b) Social workers should provide services in substantive areas or use intervention techniques or approaches that are new to them only after engaging in appropriate study, training, consultation, and supervision from people who are competent in those interventions or techniques.

(c) When generally recognized standards do not exist with respect to an emerging area of practice, social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm.

(d) Social workers who use technology in the provision of social work services should ensure that they have the necessary knowledge and skills to provide such services in a competent manner. This includes an understanding of the special communication challenges when using technology and the ability to implement strategies to address these challenges.

(e) Social workers who use technology in providing social work services should comply with the laws governing technology and social work practice in the jurisdiction in which they are regulated and located and, as applicable, in the jurisdiction in which the client is located.

1.05 Cultural Awareness and Social Diversity

(a) Social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.

(b) Social workers should have a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups.

(c) Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical ability.

(d) Social workers who provide electronic social work services should be aware of cultural and socioeconomic differences among clients and how they may use electronic technology. Social workers should assess cultural, environmental, economic, mental or physical ability, linguistic, and other issues that may affect the delivery or use of these services.

1.06 Conflicts of Interest

(a) Social workers should be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. Social workers should inform clients when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the clients' interests primary and protects clients' interests to the greatest extent possible. In some cases, protecting clients' interests may require termination of the professional relationship with proper referral of the client.

(b) Social workers should not take unfair advantage of any professional relationship or exploit others to further their personal, religious, political, or business interests.

(c) Social workers should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client. In instances when dual or multiple relationships are unavoidable, social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries. (Dual or multiple relationships occur when social workers relate to clients in more than one relationship, whether professional, social, or business. Dual or multiple relationships can occur simultaneously or consecutively.)

(d) When social workers provide services to two or more people who have a relationship with each other (for example, couples, family members), social workers should clarify with all parties which individuals will be considered clients and the nature of social workers' professional obligations to the various individuals who are receiving services. Social workers who anticipate a conflict of interest among the individuals receiving services or who anticipate having to perform in potentially conflicting roles (for example, when a social worker is asked to testify in a child custody dispute or divorce proceedings involving clients) should clarify their role with the parties involved and take appropriate action to minimize any conflict of interest.

(e) Social workers should avoid communication with clients using technology (such as social networking sites, online chat, e-mail, text messages, telephone, and video) for personal or non-work-related purposes.

(f) Social workers should be aware that posting personal information on professional Web sites or other media might cause boundary confusion, inappropriate dual relationships, or harm to clients.

(g) Social workers should be aware that personal affiliations may increase the likelihood that clients may discover the social worker’s presence on Web sites, social media, and other forms of technology. Social workers should be aware that involvement in electronic communication with groups based on race, ethnicity, language, sexual orientation, gender identity or expression, mental or physical ability, religion, immigration status, and other personal affiliations may affect their ability to work effectively with particular clients.

(h) Social workers should avoid accepting requests from or engaging in personal relationships with clients on social networking sites or other electronic media to prevent boundary confusion, inappropriate dual relationships, or harm to clients.

1.07 Privacy and Confidentiality

(a) Social workers should respect clients' right to privacy. Social workers should not solicit private information from or about clients except for compelling professional reasons. Once private information is shared, standards of confidentiality apply.

(b) Social workers may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client.

(c) Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or others. In all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed.

(d) Social workers should inform clients, to the extent possible, about the disclosure of confidential information and the potential consequences, when feasible before the disclosure is made. This applies whether social workers disclose confidential information on the basis of a legal requirement or client consent.

(e) Social workers should discuss with clients and other interested parties the nature of confidentiality and limitations of clients' right to confidentiality. Social workers should review with clients circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. This discussion should occur as soon as possible in the social worker-client relationship and as needed throughout the course of the relationship.

(f) When social workers provide counseling services to families, couples, or groups, social workers should seek agreement among the parties involved concerning each individual's right to confidentiality and obligation to preserve the confidentiality of information shared by others. This agreement should include consideration of whether confidential information may be exchanged in person or electronically, among clients or with others outside of formal counseling sessions. Social workers should inform participants in family, couples, or group counseling that social workers cannot guarantee that all participants will honor such agreements.

(g) Social workers should inform clients involved in family, couples, marital, or group counseling of the social worker's, employer's, and agency's policy concerning the social

worker's disclosure of confidential information among the parties involved in the counseling.

(h) Social workers should not disclose confidential information to third-party payers unless clients have authorized such disclosure.

(i) Social workers should not discuss confidential information, electronically or in person, in any setting unless privacy can be ensured. Social workers should not discuss confidential information in public or semi-public areas such as hallways, waiting rooms, elevators, and restaurants.

(j) Social workers should protect the confidentiality of clients during legal proceedings to the extent permitted by law. When a court of law or other legally authorized body orders social workers to disclose confidential or privileged information without a client's consent and such disclosure could cause harm to the client, social workers should request that the court withdraw the order or limit the order as narrowly as possible or maintain the records under seal, unavailable for public inspection.

(k) Social workers should protect the confidentiality of clients when responding to requests from members of the media.

(l) Social workers should protect the confidentiality of clients' written and electronic records and other sensitive information. Social workers should take reasonable steps to ensure that clients' records are stored in a secure location and that clients' records are not available to others who are not authorized to have access.

(m) Social workers should take reasonable steps to protect the confidentiality of electronic communications, including information provided to clients or third parties. Social workers should use applicable safeguards (such as encryption, firewalls, and passwords) when using electronic communications such as e-mail, online posts, online chat sessions, mobile communication, and text messages .

(n) Social workers should develop and disclose policies and procedures for notifying clients of any breach of confidential information in a timely manner.

(o) In the event of unauthorized access to client records or information, including any unauthorized access to the social worker's electronic communication or storage systems, social workers should inform clients of such disclosures, consistent with applicable laws and professional standards.

(p) Social workers should develop and inform clients about their policies, consistent with prevailing social work ethical standards, on the use of electronic technology, including Internet-based search engines, to gather information about clients.

(q) Social workers should avoid searching or gathering client information electronically unless there are compelling professional reasons, and when appropriate, with the client's informed consent.

(r) Social workers should avoid posting any identifying or confidential information about clients on professional websites or other forms of social media.

(s) Social workers should transfer or dispose of clients' records in a manner that protects clients' confidentiality and is consistent with applicable laws governing records and social work licensure.

(t) Social workers should take reasonable precautions to protect client confidentiality in the event of the social worker's termination of practice, incapacitation, or death.

(u) Social workers should not disclose identifying information when discussing clients for teaching or training purposes unless the client has consented to disclosure of confidential information.

(v) Social workers should not disclose identifying information when discussing clients with consultants unless the client has consented to disclosure of confidential information or there is a compelling need for such disclosure.

(w) Social workers should protect the confidentiality of deceased clients consistent with the preceding standards.

1.08 Access to Records

(a) Social workers should provide clients with reasonable access to records concerning the clients. Social workers who are concerned that clients' access to their records could cause serious misunderstanding or harm to the client should provide assistance in interpreting the records and consultation with the client regarding the records. Social workers should limit clients' access to their records, or portions of their records, only in exceptional circumstances when there is compelling evidence that such access would cause serious harm to the client. Both clients' requests and the rationale for withholding some or all of the record should be documented in clients' files.

(b) Social workers should develop and inform clients about their policies, consistent with prevailing social work ethical standards, on the use of technology to provide clients with access to their records.

(c) When providing clients with access to their records, social workers should take steps to protect the confidentiality of other individuals identified or discussed in such records.

1.09 Sexual Relationships

(a) Social workers should under no circumstances engage in sexual activities, inappropriate sexual communications through the use of technology or in person, or sexual contact with current clients, whether such contact is consensual or forced.

(b) Social workers should not engage in sexual activities or sexual contact with clients' relatives or other individuals with whom clients maintain a close personal relationship when there is a risk of exploitation or potential harm to the client. Sexual activity or sexual contact with clients' relatives or other individuals with whom clients maintain a personal relationship has the potential to be harmful to the client and may make it difficult for the social worker and client to maintain appropriate professional boundaries. Social workers--not their clients, their clients' relatives, or other individuals with whom the client maintains a personal relationship--assume the full burden for setting clear, appropriate, and culturally sensitive boundaries.

(c) Social workers should not engage in sexual activities or sexual contact with former clients because of the potential for harm to the client. If social workers engage in conduct

contrary to this prohibition or claim that an exception to this prohibition is warranted because of extraordinary circumstances, it is social workers--not their clients--who assume the full burden of demonstrating that the former client has not been exploited, coerced, or manipulated, intentionally or unintentionally.

(d) Social workers should not provide clinical services to individuals with whom they have had a prior sexual relationship. Providing clinical services to a former sexual partner has the potential to be harmful to the individual and is likely to make it difficult for the social worker and individual to maintain appropriate professional boundaries.

1.10 Physical Contact

Social workers should not engage in physical contact with clients when there is a possibility of psychological harm to the client as a result of the contact (such as cradling or caressing clients). Social workers who engage in appropriate physical contact with clients are responsible for setting clear, appropriate, and culturally sensitive boundaries that govern such physical contact.

1.11 Sexual Harassment

Social workers should not sexually harass clients. Sexual harassment includes sexual advances; sexual solicitation; requests for sexual favors; and other verbal, written, electronic, or physical contact of a sexual nature.

1.12 Derogatory Language

Social workers should not use derogatory language in their written, verbal, or electronic communications to or about clients. Social workers should use accurate and respectful language in all communications to and about clients.

1.13 Payment for Services

(a) When setting fees, social workers should ensure that the fees are fair, reasonable, and commensurate with the services performed. Consideration should be given to clients' ability to pay.

(b) Social workers should avoid accepting goods or services from clients as payment for professional services. Bartering arrangements, particularly involving services, create the potential for conflicts of interest, exploitation, and inappropriate boundaries in social workers' relationships with clients. Social workers should explore and may participate in bartering only in very limited circumstances when it can be demonstrated that such arrangements are an accepted practice among professionals in the local community, considered to be essential for the provision of services, negotiated without coercion, and entered into at the client's initiative and with the client's informed consent. Social workers who accept goods or services from clients as payment for professional services assume the full burden of demonstrating that this arrangement will not be detrimental to the client or the professional relationship.

(c) Social workers should not solicit a private fee or other remuneration for providing services to clients who are entitled to such available services through the social workers' employer or agency.

1.14 Clients Who Lack Decision-Making Capacity

When social workers act on behalf of clients who lack the capacity to make informed decisions, social workers should take reasonable steps to safeguard the interests and rights of those clients.

1.15 Interruption of Services

Social workers should make reasonable efforts to ensure continuity of services in the event that services are interrupted by factors such as unavailability, disruptions in electronic communication, relocation, illness, mental or physical ability, or death.

1.16 Referral for Services

(a) Social workers should refer clients to other professionals when the other professionals' specialized knowledge or expertise is needed to serve clients fully or when social workers believe that they are not being effective or making reasonable progress with clients and that other services are required.

(b) Social workers who refer clients to other professionals should take appropriate steps to facilitate an orderly transfer of responsibility. Social workers who refer clients to other professionals should disclose, with clients' consent, all pertinent information to the new service providers.

(c) Social workers are prohibited from giving or receiving payment for a referral when no professional service is provided by the referring social worker.

1.17 Termination of Services

(a) Social workers should terminate services to clients and professional relationships with them when such services and relationships are no longer required or no longer serve the clients' needs or interests.

(b) Social workers should take reasonable steps to avoid abandoning clients who are still in need of services. Social workers should withdraw services precipitously only under unusual circumstances, giving careful consideration to all factors in the situation and taking care to minimize possible adverse effects. Social workers should assist in making appropriate arrangements for continuation of services when necessary.

(c) Social workers in fee-for-service settings may terminate services to clients who are not paying an overdue balance if the financial contractual arrangements have been made clear to the client, if the client does not pose an imminent danger to self or others, and if the clinical and other consequences of the current nonpayment have been addressed and discussed with the client.

(d) Social workers should not terminate services to pursue a social, financial, or sexual relationship with a client.

(e) Social workers who anticipate the termination or interruption of services to clients should notify clients promptly and seek the transfer, referral, or continuation of services in relation to the clients' needs and preferences.

(f) Social workers who are leaving an employment setting should inform clients of appropriate options for the continuation of services and of the benefits and risks of the options.

2. Social Workers' Ethical Responsibilities to Colleagues

2.01 Respect

(a) Social workers should treat colleagues with respect and should represent accurately and fairly the qualifications, views, and obligations of colleagues.

(b) Social workers should avoid unwarranted negative criticism of colleagues in verbal, written, and electronic communications with clients or with other professionals. Unwarranted negative criticism may include demeaning comments that refer to colleagues' level of competence or to individuals' attributes such as race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical ability.

(c) Social workers should cooperate with social work colleagues and with colleagues of other professions when such cooperation serves the well-being of clients.

2.02 Confidentiality

Social workers should respect confidential information shared by colleagues in the course of their professional relationships and transactions. Social workers should ensure that such colleagues understand social workers' obligation to respect confidentiality and any exceptions related to it.

2.03 Interdisciplinary Collaboration

(a) Social workers who are members of an interdisciplinary team should participate in and contribute to decisions that affect the well-being of clients by drawing on the perspectives, values, and experiences of the social work profession. Professional and ethical obligations of the interdisciplinary team as a whole and of its individual members should be clearly established.

(b) Social workers for whom a team decision raises ethical concerns should attempt to resolve the disagreement through appropriate channels. If the disagreement cannot be resolved, social workers should pursue other avenues to address their concerns consistent with client well-being.

2.04 Disputes Involving Colleagues

(a) Social workers should not take advantage of a dispute between a colleague and an employer to obtain a position or otherwise advance the social workers' own interests.

(b) Social workers should not exploit clients in disputes with colleagues or engage clients in any inappropriate discussion of conflicts between social workers and their colleagues.

2.05 Consultation

(a) Social workers should seek the advice and counsel of colleagues whenever such consultation is in the best interests of clients.

(b) Social workers should keep themselves informed about colleagues' areas of expertise and competencies. Social workers should seek consultation only from colleagues who have demonstrated knowledge, expertise, and competence related to the subject of the consultation.

(c) When consulting with colleagues about clients, social workers should disclose the least amount of information necessary to achieve the purposes of the consultation.

2.06 Sexual Relationships

(a) Social workers who function as supervisors or educators should not engage in sexual activities or contact (including verbal, written, electronic, or physical contact) with supervisees, students, trainees, or other colleagues over whom they exercise professional authority.

(b) Social workers should avoid engaging in sexual relationships with colleagues when there is potential for a conflict of interest. Social workers who become involved in, or

anticipate becoming involved in, a sexual relationship with a colleague have a duty to transfer professional responsibilities, when necessary, to avoid a conflict of interest.

2.07 Sexual Harassment

Social workers should not sexually harass supervisees, students, trainees, or colleagues. Sexual harassment includes sexual advances; sexual solicitation; requests for sexual favors; and other verbal, written, electronic, or physical contact of a sexual nature.

2.08 Impairment of Colleagues

(a) Social workers who have direct knowledge of a social work colleague's impairment that is due to personal problems, psychosocial distress, substance abuse, or mental health difficulties and that interferes with practice effectiveness should consult with that colleague when feasible and assist the colleague in taking remedial action.

(b) Social workers who believe that a social work colleague's impairment interferes with practice effectiveness and that the colleague has not taken adequate steps to address the impairment should take action through appropriate channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations.

2.09 Incompetence of Colleagues

(a) Social workers who have direct knowledge of a social work colleague's incompetence should consult with that colleague when feasible and assist the colleague in taking remedial action.

(b) Social workers who believe that a social work colleague is incompetent and has not taken adequate steps to address the incompetence should take action through appropriate channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations.

2.10 Unethical Conduct of Colleagues

(a) Social workers should take adequate measures to discourage, prevent, expose, and correct the unethical conduct of colleagues, including unethical conduct using technology.

(b) Social workers should be knowledgeable about established policies and procedures for handling concerns about colleagues' unethical behavior. Social workers should be familiar with national, state, and local procedures for handling ethics complaints. These include policies and procedures created by NASW, licensing and regulatory bodies, employers, agencies, and other professional organizations.

(c) Social workers who believe that a colleague has acted unethically should seek resolution by discussing their concerns with the colleague when feasible and when such discussion is likely to be productive.

(d) When necessary, social workers who believe that a colleague has acted unethically should take action through appropriate formal channels (such as contacting a state licensing board or regulatory body, the NASW National Ethics Committee, or other professional ethics committees).

(e) Social workers should defend and assist colleagues who are unjustly charged with unethical conduct.

3. Social Workers' Ethical Responsibilities in Practice Settings

3.01 Supervision and Consultation

(a) Social workers who provide supervision or consultation (whether in-person or remotely) should have the necessary knowledge and skill to supervise or consult appropriately and should do so only within their areas of knowledge and competence.

(b) Social workers who provide supervision or consultation are responsible for setting clear, appropriate, and culturally sensitive boundaries.

(c) Social workers should not engage in any dual or multiple relationships with supervisees in which there is a risk of exploitation of or potential harm to the supervisee, including dual relationships that may arise while using social networking sites or other electronic media.

(d) Social workers who provide supervision should evaluate supervisees' performance in a manner that is fair and respectful.

3.02 Education and Training

(a) Social workers who function as educators, field instructors for students, or trainers should provide instruction only within their areas of knowledge and competence and should provide instruction based on the most current information and knowledge available in the profession.

(b) Social workers who function as educators or field instructors for students should evaluate students' performance in a manner that is fair and respectful.

(c) Social workers who function as educators or field instructors for students should take reasonable steps to ensure that clients are routinely informed when services are being provided by students.

(d) Social workers who function as educators or field instructors for students should not engage in any dual or multiple relationships with students in which there is a risk of exploitation or potential harm to the student, including dual relationships that may arise while using social networking sites or other electronic media. Social work educators and field instructors are responsible for setting clear, appropriate, and culturally sensitive boundaries.

3.03 Performance Evaluation

Social workers who have responsibility for evaluating the performance of others should fulfill such responsibility in a fair and considerate manner and on the basis of clearly stated criteria.

3.04 Client Records

(a) Social workers should take reasonable steps to ensure that documentation in electronic and paper records is accurate and reflects the services provided.

(b) Social workers should include sufficient and timely documentation in records to facilitate the delivery of services and to ensure continuity of services provided to clients in the future.

(c) Social workers' documentation should protect clients' privacy to the extent that is possible and appropriate and should include only information that is directly relevant to the delivery of services.

(d) Social workers should store records following the termination of services to ensure reasonable future access. Records should be maintained for the number of years required by relevant laws, agency policies, and contracts.

3.05 Billing

Social workers should establish and maintain billing practices that accurately reflect the nature and extent of services provided and that identify who provided the service in the practice setting.

3.06 Client Transfer

(a) When an individual who is receiving services from another agency or colleague contacts a social worker for services, the social worker should carefully consider the client's needs before agreeing to provide services. To minimize possible confusion and conflict, social workers should discuss with potential clients the nature of the clients' current relationship with other service providers and the implications, including possible benefits or risks, of entering into a relationship with a new service provider.

(b) If a new client has been served by another agency or colleague, social workers should discuss with the client whether consultation with the previous service provider is in the client's best interest.

3.07 Administration

(a) Social work administrators should advocate within and outside their agencies for adequate resources to meet clients' needs.

(b) Social workers should advocate for resource allocation procedures that are open and fair. When not all clients' needs can be met, an allocation procedure should be developed that is nondiscriminatory and based on appropriate and consistently applied principles.

(c) Social workers who are administrators should take reasonable steps to ensure that adequate agency or organizational resources are available to provide appropriate staff supervision.

(d) Social work administrators should take reasonable steps to ensure that the working environment for which they are responsible is consistent with and encourages compliance with the NASW Code of Ethics. Social work administrators should take reasonable steps to eliminate any conditions in their organizations that violate, interfere with, or discourage compliance with the Code.

3.08 Continuing Education and Staff Development

Social work administrators and supervisors should take reasonable steps to provide or arrange for continuing education and staff development for all staff for whom they are responsible. Continuing education and staff development should address current knowledge and emerging developments related to social work practice and ethics.

3.09 Commitments to Employers

(a) Social workers generally should adhere to commitments made to employers and employing organizations.

(b) Social workers should work to improve employing agencies' policies and procedures and the efficiency and effectiveness of their services.

(c) Social workers should take reasonable steps to ensure that employers are aware of social workers' ethical obligations as set forth in the NASW Code of Ethics and of the implications of those obligations for social work practice.

(d) Social workers should not allow an employing organization's policies, procedures, regulations, or administrative orders to interfere with their ethical practice of social work.

Social workers should take reasonable steps to ensure that their employing organizations' practices are consistent with the NASW Code of Ethics.

(e) Social workers should act to prevent and eliminate discrimination in the employing organization's work assignments and in its employment policies and practices.

(f) Social workers should accept employment or arrange student field placements only in organizations that exercise fair personnel practices.

(g) Social workers should be diligent stewards of the resources of their employing organizations, wisely conserving funds where appropriate and never misappropriating funds or using them for unintended purposes.

3.10 Labor-Management Disputes

(a) Social workers may engage in organized action, including the formation of and participation in labor unions, to improve services to clients and working conditions.

(b) The actions of social workers who are involved in labor-management disputes, job actions, or labor strikes should be guided by the profession's values, ethical principles, and ethical standards. Reasonable differences of opinion exist among social workers concerning their primary obligation as professionals during an actual or threatened labor strike or job action. Social workers should carefully examine relevant issues and their possible impact on clients before deciding on a course of action.

4. Social Workers' Ethical Responsibilities as Professionals

4.01 Competence

(a) Social workers should accept responsibility or employment only on the basis of existing competence or the intention to acquire the necessary competence.

(b) Social workers should strive to become and remain proficient in professional practice and the performance of professional functions. Social workers should critically examine and keep current with emerging knowledge relevant to social work. Social workers should

routinely review the professional literature and participate in continuing education relevant to social work practice and social work ethics.

(c) Social workers should base practice on recognized knowledge, including empirically based knowledge, relevant to social work and social work ethics.

4.02 Discrimination

Social workers should not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical ability.

4.03 Private Conduct

Social workers should not permit their private conduct to interfere with their ability to fulfill their professional responsibilities.

4.04 Dishonesty, Fraud, and Deception

Social workers should not participate in, condone, or be associated with dishonesty, fraud, or deception.

4.05 Impairment

(a) Social workers should not allow their own personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties to interfere with their professional judgment and performance or to jeopardize the best interests of people for whom they have a professional responsibility.

(b) Social workers whose personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties interfere with their professional judgment and performance should immediately seek consultation and take appropriate remedial action by seeking professional help, making adjustments in workload, terminating practice, or taking any other steps necessary to protect clients and others.

4.06 Misrepresentation

(a) Social workers should make clear distinctions between statements made and actions engaged in as a private individual and as a representative of the social work profession, a professional social work organization, or the social worker's employing agency.

(b) Social workers who speak on behalf of professional social work organizations should accurately represent the official and authorized positions of the organizations.

(c) Social workers should ensure that their representations to clients, agencies, and the public of professional qualifications, credentials, education, competence, affiliations, services provided, or results to be achieved are accurate. Social workers should claim only those relevant professional credentials they actually possess and take steps to correct any inaccuracies or misrepresentations of their credentials by others.

4.07 Solicitations

(a) Social workers should not engage in uninvited solicitation of potential clients who, because of their circumstances, are vulnerable to undue influence, manipulation, or coercion.

(b) Social workers should not engage in solicitation of testimonial endorsements (including solicitation of consent to use a client's prior statement as a testimonial endorsement) from current clients or from other people who, because of their particular circumstances, are vulnerable to undue influence.

4.08 Acknowledging Credit

(a) Social workers should take responsibility and credit, including authorship credit, only for work they have actually performed and to which they have contributed.

(b) Social workers should honestly acknowledge the work of and the contributions made by others.

5. Social Workers' Ethical Responsibilities to the Social Work Profession

5.01 Integrity of the Profession

(a) Social workers should work toward the maintenance and promotion of high standards of practice.

(b) Social workers should uphold and advance the values, ethics, knowledge, and mission of the profession. Social workers should protect, enhance, and improve the integrity of the profession through appropriate study and research, active discussion, and responsible criticism of the profession.

(c) Social workers should contribute time and professional expertise to activities that promote respect for the value, integrity, and competence of the social work profession. These activities may include teaching, research, consultation, service, legislative testimony, presentations in the community, and participation in their professional organizations.

(d) Social workers should contribute to the knowledge base of social work and share with colleagues their knowledge related to practice, research, and ethics. Social workers should seek to contribute to the profession's literature and to share their knowledge at professional meetings and conferences.

(e) Social workers should act to prevent the unauthorized and unqualified practice of social work.

5.02 Evaluation and Research

(a) Social workers should monitor and evaluate policies, the implementation of programs, and practice interventions.

(b) Social workers should promote and facilitate evaluation and research to contribute to the development of knowledge.

(c) Social workers should critically examine and keep current with emerging knowledge relevant to social work and fully use evaluation and research evidence in their professional practice.

(d) Social workers engaged in evaluation or research should carefully consider possible consequences and should follow guidelines developed for the protection of evaluation and research participants. Appropriate institutional review boards should be consulted.

(e) Social workers engaged in evaluation or research should obtain voluntary and written informed consent from participants, when appropriate, without any implied or actual deprivation or penalty for refusal to participate; without undue inducement to participate; and with due regard for participants' well-being, privacy, and dignity. Informed consent should include information about the nature, extent, and duration of the participation requested and disclosure of the risks and benefits of participation in the research.

(f) When using electronic technology to facilitate evaluation or research, social workers should ensure that participants provide informed consent for the use of such technology. Social workers should assess whether participants are able to use the technology and, when appropriate, offer reasonable alternatives to participate in the evaluation or research.

(g) When evaluation or research participants are incapable of giving informed consent, social workers should provide an appropriate explanation to the participants, obtain the participants' assent to the extent they are able, and obtain written consent from an appropriate proxy.

(h) Social workers should never design or conduct evaluation or research that does not use consent procedures, such as certain forms of naturalistic observation and archival research, unless rigorous and responsible review of the research has found it to be justified because of its prospective scientific, educational, or applied value and unless equally effective alternative procedures that do not involve waiver of consent are not feasible.

(i) Social workers should inform participants of their right to withdraw from evaluation and research at any time without penalty.

(j) Social workers should take appropriate steps to ensure that participants in evaluation and research have access to appropriate supportive services.

(k) Social workers engaged in evaluation or research should protect participants from unwarranted physical or mental distress, harm, danger, or deprivation.

(l) Social workers engaged in the evaluation of services should discuss collected information only for professional purposes and only with people professionally concerned with this information.

(m) Social workers engaged in evaluation or research should ensure the anonymity or confidentiality of participants and of the data obtained from them. Social workers should inform participants of any limits of confidentiality, the measures that will be taken to ensure confidentiality, and when any records containing research data will be destroyed.

(n) Social workers who report evaluation and research results should protect participants' confidentiality by omitting identifying information unless proper consent has been obtained authorizing disclosure.

(o) Social workers should report evaluation and research findings accurately. They should not fabricate or falsify results and should take steps to correct any errors later found in published data using standard publication methods.

(p) Social workers engaged in evaluation or research should be alert to and avoid conflicts of interest and dual relationships with participants, should inform participants when a real or potential conflict of interest arises, and should take steps to resolve the issue in a manner that makes participants' interests primary.

(q) Social workers should educate themselves, their students, and their colleagues about responsible research practices.

6. Social Workers' Ethical Responsibilities to the Broader Society

6.01 Social Welfare

Social workers should promote the general welfare of society, from local to global levels, and the development of people, their communities, and their environments. Social workers should advocate for living conditions conducive to the fulfillment of basic human

needs and should promote social, economic, political, and cultural values and institutions that are compatible with the realization of social justice.

6.02 Public Participation

Social workers should facilitate informed participation by the public in shaping social policies and institutions.

6.03 Public Emergencies

Social workers should provide appropriate professional services in public emergencies to the greatest extent possible.

6.04 Social and Political Action

(a) Social workers should engage in social and political action that seeks to ensure that all people have equal access to the resources, employment, services, and opportunities they require to meet their basic human needs and to develop fully. Social workers should be aware of the impact of the political arena on practice and should advocate for changes in policy and legislation to improve social conditions in order to meet basic human needs and promote social justice.

(b) Social workers should act to expand choice and opportunity for all people, with special regard for vulnerable, disadvantaged, oppressed, and exploited people and groups.

(c) Social workers should promote conditions that encourage respect for cultural and social diversity within the United States and globally. Social workers should promote policies and practices that demonstrate respect for difference, support the expansion of cultural knowledge and resources, advocate for programs and institutions that demonstrate cultural competence, and promote policies that safeguard the rights of and confirm equity and social justice for all people.

(d) Social workers should act to prevent and eliminate domination of, exploitation of, and discrimination against any person, group, or class on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical ability.