NAADAC

Legal and Ethical Issues in Supervision

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This specialty online training series on clinical supervision in the addiction profession. Today's topic is ethical and legal issues in supervision, presented by Dr. Thomas Durham, the author of NAADAC's newest manual, clinical supervision and overview of function, processes, and methodology. If you have not done so already, make sure to visit our web page and get your very own copy of the most up-to-date research on clinical supervision in our industry and an incredibly engaging workbook.

My name is Samson Teklemariam and I'm the director of training and professional development for NAADAC, the association for addiction professionals and I'll be the organizer for this session. This online training is produced by NAADAC. Closed captioning is provided by caption access.Please check your most recent confirmation e-mail or our Q and A chat box for the link to used closed captioning. Every NAADAC online training series has its own web page that houses everything you need to know about that particular series. If you missed a part of that series and decide to pursue the certificate of achievement, you can register for the training you missed, take it on demand at your own pace, make a payment, and take the quiz.

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Of course, watch and listen to the entire training, then pass the online quiz, which is posted on our website now, but you will receive the password as you review the -- as you review the webinar today, maintain records of your invoice and receipt of payment for registration and any CE that you've received from the series. These records will be required once you apply for the certificate of achievement for clinical supervision in the addiction profession. Then e-mail ce at naadac.org if you have any difficulty with this process. Also, please note you will have to listen closely to this entire webinar to capture the password for access to the CE quiz. The password will be one full word, all lower case, but will be revealed to you in three separate moments throughout this webinar. If you happen to miss one part of the password, no worries; you will have access to this recording and be able to capture it by viewing the archived recording. Here I will share with you the first part of your three-part password to access the CE quiz. The first part is the word [redacted] (for the hearing impaired please email ce@naadac.org for CE Quiz password assistance).

We are using GoToWebinar for today's live event and here are some important instructions. You've entered into what's called listen-only mode. That means your mic is automatically muted to prevent any disruptive background noise. If you have any trouble hearing the presenter, I recommend switching to a telephone line as some Internet connections are not strong enough to handle webinars. If you have any questions for the presenter, just type them into the Q and A box. We will gather those questions and I will pose those questions to the presenter during the designated time for live Q and A or your questions will be answered in a Q and A (inaudible) on our website.

Also, the presenter is giving two handouts to you. You will see "handouts " directly under the questions box. When you click on "handouts, " you should see two PDF files. Now, if you're having some trouble finding these, no worries, our presenter will read the case scenarios for you during the training and the PDF files will be posted on the same web page you used to register for this training within about 24 hours. With no further delay, let me introduce to you today's presenter. Dr. Thomas Durham has been involved in the field of addiction treatment since 1974 as a counselor, a clinical supervisor, a program director, and an educator. Dr. Durham is semi retired and currently provides (inaudible). Until the end of 2018, Dr. Durham served as NAADAC's director of training. He also worked in government contracting (inaudible) and the department of defense while at (inaudible) international. Dr. Durham also served as the executive director of the (inaudible) institute and project director of the central east addiction technology center from 2004 to 2017 Dr. Durham taught graduate courses in psychology as an ad /SKWR*UPBGT professor at (inaudible) university. NAADAC is delighted to continue this series presented by our author of the clinicalsupervision workbook and this accomplished trainer. So, Tom, if you're ready, I will hand this over to you.

>> Thank you, Samson. Let me move on to the next slide and we will get going.
Okay. So here are the learning objectives of what we're going to be talking about today. I'm not going to read these off, but I'll summarize them. We're going to talk about ethical issues, legal considerations, look at the supervisor's role, and the supervisor's obligations with regards to both ethical and legal issues in supervision. You will see as we go along there's a lot of crossover between legal issues and ethical issues. First of all, some underlying assumptions. As it says here, ethical decision-making is a continuous process. It's important to note that clinical supervisors, as therapists themselves, not only have an obligation to obtain a thorough grasp of ethical decision /-PB had making, they also are in the best possible position to ensure that their supervisees each obtain a complete and (inaudible) understanding that pertain to their role as counselors.

Clinical supervisors can be viewed as a significant means of acquiring legal and ethical competence. But as it says here, there are no cookbook answers. The dilemmas are often elusive. Standards are sometimes not easy to follow. Each situation is unique. And the simple fact is, people make mistakes. I also want to point out, though, that supervisors must have a good knowledge about ethics and law, and in some cases, ethical standards become the basis for legal decisions. For example, courts may determine liability based on profession's ethical standards, but at other times ethical codes and law may be in conflict.

For instance, ethical codes hold confidentiality (inaudible), yet law requires releasing ethical information in cases of child or elder abuse, for instance, or in case there's a duty to warn. We'll talk about that in a while. That symbiotic relationship makes it crucial for supervisors and (inaudible) to understand all behaviors that can lead to ethical transgressions and/or legal liability. Supervisors are gate keepers. In other words, as a clinical supervisor, we're in a position to decide -- to help decide whether or not a supervisee is equipped to continue in the field. And we're also -- but we're also a gatekeeper with regards to ethical and legal issues. We want to make sure that all ethical and legal parameters are followed by the people that we supervise, and in that regard, we're responsible for upholding the highest standards. But as it says on that third bullet, we're also role models for staff. Clinical supervisors who follow the ethical code and stay within the realm of both ethical and legal standards are modeling that behavior to the people they're supervising. And thus we are responsible for maintaining an awareness of and responding to ethical concerns. Here is a statement out of the TIP52, the CSAT TIP on clinical supervision.

Astute clinical supervisors help integrate solutions to everyday legal and ethical issues into clinical practice. So we're going to take a look -- first we're going to take a look at some legal issues in supervision, then we're going to take a look at some ethical issues in Supervision. They often interchange. In fact, you can say everything on this list is not only a legal issue but also an ethical issue, but this is the way they're categorized in the workbook that Samson mentioned. So we'll talk about these four issues first and then we'll talk about ethical issues. So number one, duty to warn. Most of you probably know about the landmark case of Tarasoff. If you don't, bear with me here. If you do, bear with me because I'm going to read a little bit about it.

First of all, this is a landmark case that set a legal precedent regarding duty to warn. This case decided in 1976, it says on the screen, involved a wrongful death suit brought against the university of California by the parents of a murdered student whose name is Tatiana Tarasoff. Two months before Ms. Tarasoff was murdered (inaudible) that he intended to kill her. The therapist consulted with his superiors and they agreed that Mr. (Inaudible) be involuntarily committed. The campus police were notified and ask to pick Mr. (Inaudible) up and carry off commitment procedures. However, the campus police did not commit him as they reported he appeared rational and promised not to harm Ms. Tarasoff, as if the campus police were experts at this, right?

Mr. Podor then discontinued therapy and two months later murdered Ms. Tarasoff.
The suit in the Tarasoff case was brought against the university on two grounds, failure to commit and failure to warn. But the court only upheld the university's liability for failure to warn. As part of the ruling, the court clarified that the duty to warn arises when a client possesses serious danger and when a victim has been clearly identified. Or could be identified, as it says in that second bullet, upon a moment's reflection. The court also ruled that the duty of the therapist might require more than the warning of the intended victim. This may include voluntary commitment, notification of police, or other steps necessary to prevent violence.

The implication of the Tarasoff case for clinical supervisors include the insurance that supervisees remain alert to any potential for violence by a client, and that if suspected, a reasonable valuation of this potential is made. Thus, it is incumbent on the supervisor to keep supervisees aware of their duty to warn, including the conditions under which it is appropriate to implement a warning for the protection of a potential victim and that any warning constitutes direct contact of the intended victim along with a specific explanation of the threat. Note, however, that since the Tarasoff ruling -- this is significant -- court cases in several states have made various interpretations of duty to warn.

For instance, in the state of Florida, in 1991, a statute was passed that specifies it is permissible to warn third parties at risk of being harmed but is not mandatory; thus it's visible that everyone be aware of what their local laws are with regards to duty to warn. It may differ from state to state. Let's move on to liability. There are several factors here. These factors that are listed here came out of a textbook that I have, a great book that's listed in your reference at the end of the slides called the counselor and the law by Marie Wheeler and Bert Bertram. And these are important to keep in mind. I'm going to give you a little bit more information about each. First one, the supervisor's control over the supervisee.

Has the supervisor exercised appropriate control over the supervisee? For example, in one particular case, the court found that the lack of supervision by the supervisor and any lack of formalized process by the agency constituted negligence in exercising proper control over employee conduct. So the important thing is to be able to prove that the supervisor has exercised appropriate control, and this is usually done through documentation and through Scheduling. Number two, the location and time at which the act occurred. To warrant any legal action, the act must have occurred in the course of counseling. For example, if the act occurred outside of the counseling facility, it would not likely be considered to have occurred in the course of counseling and there would be no grounds for supervisory negligence. Number three, the motivation of the supervisee for committing the act. When a supervisee acts out of personal interest and not out of an intention to benefit the client, then the act may not be considered within the scope of the supervisory relationship.

For instance, if the supervisee is attempting to be helpful but the act fell outside of the realm of supervisor expectations and resulted in harm to the client. In other words, the supervisee may be held liable but the supervisor may not be. You know, one important term that I haven't mentioned that I think are important on this slide is what we're talking about here with regards to supervisor liability is what is termed as vicarious liability. So in other words, you the supervisor may be held liable to the actions of the supervisee, but these are the factors that I'm listing here that would determine negligence or would protect the supervisor from liability. The next one is the supervisee's scope of duty to perform the act. The supervisee must be acting within a clearly defined scope of duties authorized by the supervisor.

In one particular case in 1997 in the state of North Dakota, negligence was found in supervision due to the lack of clear, quote/unquote, scope of employment that could directly lead to

employee conduct that causes harm to other employees or third persons. In other words, it's important that the role of the supervisee be well-documented. So there's no question as to whether or not they're performing outside of their duty to perform the act, and thus, if they are, it's well-documented, they could be held liable but not the supervisor. And then, finally, whether it is foreseeable by the supervisor that the supervisee would perform the act. An example is a court case in 1986 where a supervisor was held liable for the sexual misconduct of a supervisee with a client due to the supervisees mishandling of transference by the client. In this case the court held that it was a foreseeable supervisory issue.

In other words, in this particular case, the supervisor should have seen that there was an issue of transference that was happening between the counselor and the client, and this was not dealt with in supervision; it was ignored. Probably a similar example would be where supervision is not being held on a regular basis, and so the behavior or acts by the counselor with the client could be sexual, could be harmful in other ways, but they weren't being monitored by the supervisor. In those cases, the supervisor will also be held liable. Again, with all these, I think the key word here is active supervision and documentation, the two key words for protecting against vicarious liability.

The important thing is, though, that we are aware of what our supervisees are doing for the protection of the client. That's number one. But there are also ways that we can ensure that what the supervisee is doing is not harmful to the client and, hence, we're protecting our own liability as well. One -- oh, yeah, next slide. One thing I want to also mention, and this comes from a textbook that is also listed at the end of your -- the slide show, it's called the essentiallies of clinical supervision by Jane Campbell. Some of you are familiar with it. I think it's used in a lot of graduate programs. But what Campbell does is she lists a number of -- what she calls a number of sound risk management strategies for supervisor's self-protection. And these are the /STRAT /KWRAOES that are listed here on this slide.

You know, some of it is pretty standard and basic, like establishing an open and trusting supervisory relationship. But these are all key issues. Now, number two, maintain professional liability insurance, many of you work in agencies where you are covered by your agency's insurance, but if you're in private practice, you would maintain your own liability insurance. And if you're looking to purchase an insurance policy for liability and you're a member of NAADAC, you can get a great deal through NAADAC, so check that out if you're in the market for liability insurance. Obviously, you know, you want to practice within the boundaries of your competence.

We're going to talk about competence as a separate issue later on. Supervisory competence and we want to monitor our counselors to make sure they're practicing within the boundaries of their own competence. I mentioned this before, document carefully, document frequently, and document thoroughly. And that's really important, keep a confidential record of what you're doing with each supervisee. It may come in handy at some later date. Of course, respect the due process rights of the supervisee. And I'm going to talk about that a little later, so I'm not going to get into that right now. Consult with colleagues, as well as your own supervisor. You

know, I think, you know, advice to any supervisor, if you are in a situation, especially where your supervisee may be faced with an ethical dilemma or you're unsure of whether or not they are or if you have any concerns at all and you're not sure how to handle that, go to your own supervisor. Everyone should have a supervisor.

Supervisors need to have supervisors and someone you can go to to consult with, to make sure that you're doing the right thing, that you're on the right track, and so are the people that you're supervising. And, of course, keep up-to-date with evolving ethical standards and legal development. And I mentioned the NAADAC code of ethics, there's another slide coming up with the link to that. You know, every, I don't know, three or four years, something like that, NAADAC updates their ethical standards, because they are evolving. But it's important to keep up with those evolving standards as well as legal developments. Okay. We're going to talk about confidentiality next.

And I'm splitting this into two categories, what I call supervisee consultation, in other words confidentiality in the relationship with your supervisee, as well as the supervisee's -- or the confidentiality with regards to client information that you need to be sure that your supervisees are following. So, first comes out of the NAADAC code of ethics that I just mentioned. "Clinical supervisors shall not disclose confidential information in teaching or supervision without the expressed written consent of a client, and only when appropriate steps have been taken to protect the client's identity and confidentiality." In other words you're getting information about a client from your supervisee. That's protected in the same way that information is protected in the clinical relationship. And this bottom bullet here, "Although not covered by confidentiality regulations, personal supervisee information must be respected with utmost sensitivity." One thing I want to say about that is that confidentiality is also imposed on all clinicians involved in group supervision.

When client information is shared. Many of you provide group supervision of your supervisees where client information is shared among group members. And it's also important to note that, though federal confidentiality regulations such as 45 CER, part 2 -- I'm sorry, 42 CER part 2, (inaudible) among other clinical staff within the same program, supervisors are advised to remind group members -- in other words, your supervisees in this case -- to limit personal client information, not to repeat outside what is heard in the group, and to use first names only when referring to clients during group supervision. I think this is vital. We're not talking about clients in the group, we're talking about supervisees in the group, and they're talking about client information, and that needs to be respected in the same way. With regards to client information, three things are defined here: Confidentiality, privilege, and privacy. "Confidentiality is the counselor's ethical duty to protect private client communication, " simple as that.

"Privilege is the protection of confidential communications between two parties in the context of a judicial setting." And "privacy is a basic right of a person to be left alone and to control his or her personal information." All these need to be respected in the course of therapy and treatment, and all these need to be respected with regards to supervisory relationships as

well. And it says at the bottom, confidential of substance abuse disorder client information is governed by the federal regulation 42 CFR, Part 2 that I mentioned before. Now, that's a whole another webinar in itself, and we're not going to go into all the different nuances of that regulation. But be aware of it, if you're not already. Be aware of it, check it out, go online, get the information with regards to that federal regulation. Next thing we're going to talk about is standards of care.

And I'll read the first quote here. It's defined as a level of care that is consistent with the degree of learning, skill, and ethics ordinarily possessed and expected by reputable counselors practicing under similar circumstances. With regards to that second bullet, which I'm not going to read, I'm going to just dwell on this a little, that, you know, not only -- well, as it says here, supervisors are held to an assurance that professional activities are consistent with what is expected of similarly trained professionals in similar settings. I know I said I wasn't going to read that and I just read it. But counselors are bound to the (inaudible). Also it's important to note that one is encouraged to become familiar, again, with the NAADAC code of ethics, as it says in that bottom bullet. That was developed as a statement of values to govern
the conduct of addiction professionals and as a guide for making clinical decisions. The code can be accessed at the link that you see on your slide. You know, another thing, too, the standards of care are continuously evolving and may differ among subspecialties in the counseling field, there are a lot of unifying principles. It's also important to be aware of what those unifying principles are. A quote here from Wheeler and Bertram in their text that I mentioned earlier, that are also listed on the first bullet there, is a level of care that is consistent with the degree of learning, skill, and ethics ordinarily possessed and expected by reputable counselors practicing under similar circumstances." Let's move on to ethical obligations. Now, before we get into the ethical categories I want to discuss, I have a couple slides here just to talk about the general information on ethical obligations of clinical supervisors and counselors. You know, one of the duties of the clinical supervisor is to give the counselors a framework for decision making. You know, we want the counselors to get to the point where they can think ethically. I think that comment comes up in a later slide. But by doing that, we're promoting their own ethical thinking. We can do this through training, we can do this through individual supervision, we can do this through group supervision. In individual supervision, I think it's important to pose questions to the supervisee, and I've got a list of them coming up in a later slide, that kind of provokes their thinking with regards to whether or not they have any clients where there may be some ethical concerns. Obviously we're in a role as a supervisor that we want to monitor the ethical conduct of our counselorsment we want to be aware of what's going on, and we do this by questioning them, by knowing what's going on with their clientele. We can do this by observing them, perhaps if we have the opportunity to observe their work, which I encourage all supervisors to do, you know, whether you're sitting in on a group or doing cotherapy with them, those are types of observations that I think can give you a lot of valid Information. And another thing as is mentioned on this fourth bullet is we want to make sure that they are -- know what the expectations are, be absolutely clear on what your expectations are of them with regards to ethical issues. Know that boundaries -- and we're going to talk about boundaries in a little while, but it's important to set boundaries to make sure that the supervisees are aware of what those boundaries are, why it's important not to cross those

boundaries. Promote cultural humility. And finally ensure autonomy. One of the bottom lines of clinical supervision is to ensure that the supervisees can get to a point where they can, quote/unquote, self-supervise. As I always say, it doesn't mean they would go without supervision, but they reached a level of autonomy where they make the right decisions, whether those are clinical decisions, ethical decisions, et cetera, et cetera. Ensure autonomy is a clear (inaudible).

We also want to take a look at -- and some of you may be familiar with the book by White and Popovits called Critical Incidents. It's a great text of a lot of -- it includes a lot of different case studies and a lot of different scenariosment, you know, what would you do in this case? What's the right answer? Which of these -- for which of these is there no answer? Because sometimes it's difficult to find the answer with an ethical dilemma. But also in this text, they talk about ethical decision-making, and these are some of the questions to be posed. You know, whose interests are involved? Who can be harmed? Who are the stake holders?
How are they affected? Are there any conflicts in interests? What universal values apply?
Are there any values conflict? You know, sometimes we find a values conflict within, say, for instance, the NAADAC code of ethics and values held by a particular treatment agency. You know, be aware of when there might be a value conflict. They have nothing to do with legal issues. And, of course, know what laws, standards, policies, historical practices, et cetera, et cetera, should be able to guide the decision.

Be aware of what the standards are, be aware of what your agency policies are, be aware of the law and the code of ethics. Also, we want to take a look at some of the issues that may arise such as, you know, what's more important, client welfare or supervisee welfare? Well, we all know the bottom line of course is client welfare, but oftentimes we can get there by making sure our supervisees are doing the right thing. There's autonomy, again. Autonomy of the supervisee versus expectations of the supervisor. Obviously we want to give autonomy of our supervisees, but sometimes we may need to pull the reins in a little if they're not meeting the expectations. Then there's the double standard of self-care. Really what that means is I , as a clinical supervisor, am promoting the idea of self-care among those that I supervise. I better be a good role model of self-care.

There's a double standard if that's not happening. And then of course there's competency and what comes is ongoing education, awareness of one's limitation and, you know, think about the supervisee as well as the supervisor when we talking about competency. Ongoing education, awareness to one's limitation, and for the supervisor to be able to monitor and observe the supervisee, as I had said previously. Here are some of those questions that I mentioned. Now, I got this from a colleague many years ago who said, I want to know what the answers are to these questions. It doesn't mean I'm going to ask them every time I see my supervisee, but I want to make sure that I know the answers to these questions. Since our last meeting, has anything happened that might put you in a different light with a client? You know, we're talking about issues such as transference, countertransference, you know, is there any tension in the relationship. Number two, do you have any concerns about your client? That's a pretty broad question, but any concerns at all. You know, that's probably a good opening question for many

supervisory sessions.

Number three, are there any clients dangerous or suicidal? Number four, have you failed in any way to maintain client confidentiality? And then finally, is there anything that a client shares with you that gives you a duty to warn? Again, you wouldn't necessarily ask all of these questions every supervisory session, but the important thing is to be able to know what these answers are. And if you don't know what these answers are, then yes, you need to ask those questions. Oftentimes in the course of the supervisory relationship, especially when there's a lot of trust, where there's a lot of collaboration, this information is going to come out anyway, and you would not need to ask the questions because your supervisee is being very open with what's going on with them with regards to their clients. But it's an important thing to keep in mind, you know, as you're exploring issues in supervision, do you know the answers to these questions?

So now we're going to look at five ethical issues that are critical to clinical supervision. I've got one or two slides for each one of these. So let's start with competence, which I had talked about before. You know, is the competence -- and we talked about that first bullet already.Again, think in terms of the supervisor as well as the supervisee. With regards to the supervisor, do competent clinicians always make competent supervisors? The answer is really no. We know that not every competent clinician has what it takes to be a competent supervisor. We also know, though, that many people are promoted to be a supervisor because they're a competent clinician. I would say most people who are competent clinicians make good supervisors, but that's not always the case.

So that's an issue of competence. Is the supervisor competent because they've had the specialized training, such as that third bullet explains there, process and methods of supervision. You know, have they had training in supervision? Have they gained an in-depth of treatment in both substance abuse disorders and CODs? Because without proper training and experience, supervisors would be at risk for harm. So not only with concern with the supervisee obtaining a level of competence and making sure that they are appropriately providing therapy and counseling to the people that they serve due to the fact that they're trained and have reached a level of competence to do that, but we're also talking about the clinical supervisor. Has the clinical supervisor reached that level of competence, that they are not doing harm in their role as a supervisor? So it's important for you as supervisors to maintain your ability and maintain your awareness of what supervisee competence is as you're growing as a clinical supervisor. And to understand your own limits of your level of -- or, I'm sorry, the limits of the supervisee as well as your own limits of competence. And then, again, we mentioned this in our earlier slide, gaining cultural humility is also an issue of competence. And as it says there, both for oneself as a supervisor as well as his or her supervisees. Next one is dual relationships and boundary control.

These are some of the issues that come up in supervision that become boundary issues. We know that the boundary issues are much more clearly defined in the counselor/client

relationship than they are in a supervisor/supervisee relationship. Number one there, it says supervising a family member. That's an ethical issue, and I always relate to way back when, when I was on a certification board and we had to disallow an application because a husband and wife were in private practice together, and they were considering each other their supervisors. Well, you know, they were being supervised by an intimate partner, not an outside professional, and we felt that was an ethical issue and we disallowed that speculation. Developing a business relationship with a supervisee. That's a secondary relationship that may be formed. You know, a good example in our field is you're working for a public defend ant agency as a full-time job and you develop a private practice on the side.

Maybe your partner in private practice is someone you supervise at your agency. That's a boundary issue. You've developed a dual relationship. What's wrong with a dual relationship? It's simple. Your focus has shifted from one relationship to another. And if it's shifted away from the primary supervisory relationship, then there are some ethical concerns there. Another danger in crossing a boundary is allowing supervision to slip into psychotherapy. You know, we're all trained therapists, so we do what we know best in supervision; we use our therapeutic skills, which are valid and helpful in many different ways. But if we allow supervision to slip into psychotherapy, and usually when that happens, it's because the supervisee wants that to happen.

But if a supervisor allows that to happen, then they develop a dual relationship.
And now talking about issues that are relevant to that personal -- personal issues that are relevant to that supervisee, and, again, their focus is elsewhere. It should be on the supervisee and his or her relationship with the clientele, not on their personal stuff. Obviously people bring personal information into supervision, and there are some relevant things that are dealt with that need to be dealt with. You know, if someone has a counter transfertial (inaudible) and they bring that to their supervisor, (inaudible) they talk about that a little bit in supervision, but that doesn't necessarily become therapy. It is important, though, for supervisors to be aware when that's beginning to happen so that they know when to refer or when to recommend that a person either goes to their E AP or goes into therapy with a list of options. If they ask you, who should I see for therapy?

Don't give them one person. Give them at least three options, you know, choose from this list. But what makes it most -- I think what makes it cleanest is when an agency has an employee assistance program, and you can refer them there. Only game in town. Many of you probably work in rural communities where you know everybody, and it's so
common that, you know, dual relationships are formed because they're social relationships that are formed and then someone comes into the agency and everybody knows each other.
This can happen in supervision. Actually, it happens more likely with the next bullet, promotion from the ranks. But we have one of our case studies, scenarios coming up is about that. What happens when someone is promoted from the ranks and they are supervising someone who was a colleague or had a social relationship with? What happens then? Can they keep those two separate? Will it interfere? Will that social relationship interfere with the supervisory relationship? Or is there an appearance of favoritism? Even though it may not be there, but it

may look like that to other people.

So a lot of things to keep in mind with regards to boundary issues around issues of promotion from the rank. And then the issue of -- "two hatter " issues for supervisors in recovery. An example is, you know, you wouldn't necessarily attend a self-help meeting with your supervisee, for instance. Or develop a sponsor relationship, et cetera, et cetera. I think we're pretty well-grounded on that one. But it can happen and I know it has happened. Now, what -- you know, I mention that we do what we do best as a supervisor because we know therapy. And yes, there are some similarities between therapy and supervision because we do what we know, as it says on that second bullet. We call this an isomorphic influence, a fancy term meaning something taking on the same form. Or as it says in that bottom bullet, supervision is the isomorph, a near-replication of therapy.

We also model therapeutic behavior in supervision. So what we model with our supervisees, it's not therapy, but certain behavior is what we've learned as therapy is that we find (inaudible) in developing one-on-one relationships. And so we do model appropriate therapeutic behavior in supervision. In fact, that is known as downward parallel process, when what we do in supervision is taken on by the supervisee and they apply that in their counseling sessions. If you attended my webinar in October, I think it was, on supervisory relationships, I talked a little bit about parallel process, both upward and downward. I'm not going to dwell too much on that, but a downward parallel process can be a positive thing if we as supervisors model therapeutic behavior that the supervisees then take on in their relationship with their clients. So there is that isomorphic influence that presents a danger of allowing supervision to slip into therapy. But a good clinical supervisor is a therapist doing supervision, not a supervisor doing therapy. And I think Samson is going to say something right now.

>> Yes. Thank you, Tom. And just as a reminder, everyone, in order to access the online CE quiz, please view the entire training and listen for the password. The password is revealed in three separate sections during the training. We have already revealed the first part earlier in the Training. Here, I'll share with you the second part of your three-part password. The second part is the word [redacted] (for the hearing impaired please email ce@naadac.org for CE Quiz password assistance).
And, of course, if you have any questions for our presenter, please make sure to send them into the questions box, and our presenter will answer them in the order in which they are received during our live Q and A, or they will go online in one week in a Q and A spreadsheet. And now, back to our presenter.
>> Okay. Thank you, Samson. Okay. We're going to move on to the next area of ethical issues in supervision, and that's informed consent. The document of informed consent originated, believe it or not -- well, you probably do believe this -- it originated as a requirement for (inaudible). The document, though, extends the counseling by requiring counselors to inform clients of the counseling approach or theory used in therapy. So, supervisors, as it says under the Client -- yeah, let's stay with the client first -- seek assurance that supervisees are following the obligation to provide relevant treatment information to clients. And that they inform clients of

the process of sharing information. You know, how is information going to be shared? You know, what they need to know about the fact that the counselor will be sharing information with other staff members, but that that doesn't go outside of, you know, certain staff members or certain group of staff members. And be sure they receive consent by client when the supervisor observes a session.

So if I'm going to observe the session of my supervisee and their client, I need to make sure that the client has consented that, or my supervisee needs to be assured that the client has consented to that observation. So supervisors must seek assurance that supervisees are following the obligation of informing clients of the definition of the basic counseling relationship between the counselor and the client. Since certain clinical information is shared beyond the counseling relationship, who receives the information and the process by which it will be shared must also be clarified to the client. This is to include the fact that confidential information will be discussed with the supervisor and other relevant staff members. This must include the requirement of supervision, who the supervisor is, their contact information and credentials.

Failure to do so could result in both the counselor and supervisor being subject to a claim of neglect or breach of confidentiality. Informed consent regarding information of clients is also addressed in the NAADAC code of ethics, that I referred to before. So this is important to, you know, keep several things in mind with regards to informed consent with regards to the counselor/client relationship as well as the supervisor/supervisee's relationship. And as it says on that bottom bullet, document all of the above. Okay. We're going to talk about due process. Due process involves constitutional protection and assurance that notice and hearing is provided before the removal of an important right and that the criteria used in the removal is fair. That's kind of a legal definition of due process. Due process duties in the human services area must be clearly understood and followed primarily to protect the rights of clients.

Due process also extends to supervisees as well. However, the supervisee may bring suit against the supervisor and can succeed in the lawsuit if they have not been given prior warning or opportunity with notice. In other words, due process was not followed leading up to termination. So this is an important factor in supervision, that if we are supervising someone who has a job performance problem, we need to document what we've done with them, document that we've followed the normal procedure that our HR development has (inaudible), so if termination does come, there will be no question or legal grounds for suing the agency. So that's one type of due process. But make sure, you know, that there's a clear procedure that ensures supervisee's due process, that their rights are being protected, as it says in that final bullet. So we're getting near the end, but I want to talk a little bit about promoting ethical thinking, and then I'm going to read a couple case studies.

First of all, the clinical supervisor has the obligation to help supervisees develop the ability to think forward. The consequences of the professional behavior, and thus help reduce the incidents of unethical conduct by Supervisees. This is not an easy task, as ethical misconduct inevitably occurs. However, enhancing one's ability to make independent clinical decisions that are ethically sensitive can be achieved through modeling by the supervisor. We talked about

modeling before. I think it's important that we develop the type of relationship with the supervisee that we can work with them in getting them to the point where they can begin to think ethically, where they are autonomous in their ethical decision-making. Some of this, as it says there, as I mentioned, is achieved through our own modeling. We talked about that several times during this webinar, but I think that's significant to keep in mind. But it's also important to be vigilant and alert, as it says on that second-to-last bullet, with regards to our observation of what the counselors are doing to help them achieve the ability to think forward and to be thinking ethically. One way to do this, as it says on that bottom bullet, is to have brainstorming sessions with the superviseeor with a group of supervisees, where you can perhaps review, you know, relevant ethical codes, explore whether personal values are in conflict, maybe bring up a case study.

There are a lot of things you can do in a group setting around the area of brainstorming and processing that can help people grasp the ability to think forward and to think ethically. So before I do this slide, I want to say one more thing. I want to mention that -- I think this is coming up in a quote. Never mind. I don't need to mention it yet. I forgot about that, something I added. But what I'm going to do now is I'm going to read two scenarios. After each scenario, you're going to get a polling question. These are the scenarios that Samson has mentioned at the beginning. These are in PDF. You can download these. I'm going to read them now. They're really brief. And then even though what you download has some questions to ponder, and what I would encourage you to do is download, after the webinar is over, if you haven't done so already, download the scenarios and look at the questions to ponder. How would you react to this? If we were in a live workshop, I'd say, okay, let's split into small groups and each small group take a different case and then answer those questions, where it says questions to ponder. You know, put your heads together.

How would you respond to this scenario? You know, we're not able to do that because we're not all in the same room, so instead, I've got a polling question after each. So here is the first case. You supervise Joan, who has been a therapist at your agency for the past three years. Three months ago, she began dating a man by the name of Mark whom she had met through mutual friends. This past weekend Mark mentioned in passing that he was in counseling with his ex-wife at your agency before they decided to divorce. This is -- your supervisee is bringing this to you. Joan is your supervisee. This morning Joan enters your office to discuss this situation in light of the agency's policy that prohibits social and intimate relationships between staff and clients, and former clients. Joan was not involved in a primary counseling relationship with Mark, nor was she employed by the agency when Mark was a client. She was completely unaware of Mark's status, a former client, until this past weekend. So we're going to move to a polling question. That's the scenario. Okay. Polling question's next. Oops, went the wrong way. How did that happen? There we go. Okay. So Samson, take it away.

>> All right, everyone, you will see this polling question launch on your screen. It's based on the scenario presented to you by the presenter. Again, as a reminder, that scenario is also on the handouts tab. Which of the following best fits with what you would do in this situation? A, Joan

must leave her job, B, nothing, C, restrict Joan from client records. And it's great, it looks like a good percentage of you already responded. You will also see this scenario on the web page, the
same web page used to register for this training about 24 hours after the live training has completed. We will go ahead and close the poll. And just as a reminder, if you have any questions for the presenter, you can go ahead and send them into the questions box of your GoToWebinar control panel. I'll close the poll now and share the /ROLTS, and I'll
turn this back over to Tom.

>> Okay. Restrict Joan from client records got 92 percent. And when I present this in a workshop, that's usually what the groups come up with, is, you know -- and,
yeah, some of you said nothing. And, you know, we don't have all the facts here. We don't have Joan in the room with us. So there's not necessarily a right answer here, although I think all of you agree not to choose A, Joan must leave her job, so that was great. Okay. Now we've got another one. Now I'm going to read the case of Sarah, scenario 2. I alluded to this one earlier. Sarah was recently promoted to a position where she now supervises staff members who were once her peers. Some of you, this may have happened to some of you out there. Probably has. One of her former peers, Janet, has been a personal friend for several years.They often socialize outside of work and often have family get-togethers since they have children of similar ages.

Their social relationship is known by other staff members, but they both are adamant about keeping their social life separate from their work environment. So Sarah is now Janet's supervisor, and they have a personal social relationship outside of work, and now they are faced with the dilemma of the fact that Sarah now supervises Joan, where before they were peers. So, polling question No. 2. There we go. Okay. All yours, Samson.

>> Perfect. Thanks, Tom. The second polling question will pop up on your screen in just a moment on this case study. The question is asking, Which of the following best fits with what you think should be done in this situation? A, discontinue their social relationship, B, keep the social relationship separate, or C, assure staff no favoritism. Again, you see the poll pop up on your screen. Almost half of you have already interacted. Thank you for doing that. And as you are completing this poll, as a reminder, in order to access the CE quiz, please make sure to view the entire training and listen for the password. The password is revealed in three separate sections, and here I'll share with you the final part of your Password. The final part is the [redacted] (for the hearing impaired please email ce@naadac.org for CE Quiz password assistance).
Of course, if you have any questions for our presenter, please make sure to send them into the questions box and our presenter will answer them in the order in
which they are received during the live Q and A, or they will be posted on our website about a week after the live webinar.

Before I turn this back over to Tom, just as a reminder, if you missed any part of the online CE quiz password, you will also have free access to view the recording of this training where you

can fast forward or view through for you to capture the password during
the recording. I'm going to go ahead and close the poll. Thank you for your answers and I'll share the results and turn this back over to Tom.

>> Wow. This is interesting. A third -- exactly a third answered each one of them. And, you know, this is one that is difficult to answer. I think that, you know, in some cases, yeah, they probably could be able to keep the relationship separate, but it could also be that appearance of favoritism, so they may have to assure staff that there's no favoritism. It's interesting, though, that a third of you thought they should discontinue their social relationship. And I know a lot of people in the field that would agree with that, that, you know, because of the appearance of favoritism or because of the special relationship they have. It's a tough one to answer and deal with, but it happens a lot. So thank you for your involvement in that. And next, okay, yeah, this is what I was going to read earlier and then I realized I have it on a slide /-PT. This is a quote from another text that's listed at the back of the slide show as part of the references by Remle and Herlihy, and many of you have heard a similar quote before, I'm sure, which says, "laws dictate the minimum standards of behavior that society will tolerate, whereas ethics represent the ideal standards expected by the profession." You know, think about that. Laws dictate the minimum standards of behavior that society will tolerate, whereas ethics represent the ideal standards expected by the profession." And, of course, oftentimes they are in conflict, as I said earlier. So, do we have time for questions, Samson? I know we're getting close to the top of the hour and you have to close things up.

>> We are, yes. I'll go ahead and give you one, maybe two questions. We have about six of them that came in. They're a little long. So I'll read the first question.
The first question is, in the area of competence, as a supervisor, I am often forced to supervise counselors who are using EBPs that I know nothing about. It's evidence-based practices.
If I have ten supervisees, each of them using three to five different evidence-based practice curriculum, do I have to be (inaudible) in each of those to be a competent supervisor or can I assume a role of supervising them on how to properly use any EBP in a general use?

>> Well, that's a really good question, and you have that many supervisees and they're all operating -- all using different evidence-based practices, yeah, that presents quite a dilemma if you're not up to speed on those practices. My first reaction is, learn as much as you can about those practices and perhaps start with your supervisee. You know, tell me about what you've learned. Tell me about why you're using this with your client. You know, maybe get some literature on it. If you have the time, go to a workshop on it. But get as much information as you can because, certainly, they -- you want to be assured that they are competent in that evidence-based practice. If you don't understand it, then how can you assess their competence? That's a good question. The other thing is, is there anyone else at your agency
you can consult with? You know, another supervisor, perhaps, who has experience in that evidence-based practice. Maybe even bring them in on a supervisory session, if time allows. Or use them as a resource for you, so that you can get more up to speed on it so you can best provide supervision to that individual. That's one question. Do you have another or are we out of time? >> I think we're out of time. Everyone else, we'll get to your questions in a Q and A

document that will be posted on our website on the same page you used to register for this training. Tom, did you want to speak to this quote?

>> Yeah. First of all, I'll just that I'll answer that question in writing as well as the others, so they will be posted. And I'll get them back to Samson within a week. And yeah, I just want to end with a quote." True humility is not thinking less of yourself; it's thinking of yourself less." I love that quote. And, before we move on to Samson, I just want to point out that -- well, thank you, first of all. But also point out that here are my references that I used to develop this slide presentation. So, Samson, I'll turn it back to you. Thank you all for attending.

>> And thank you so much, Tom. Congratulations, everyone. You just completed Part 3 of the 6-part special training series on clinical supervision in the addiction profession. You are that much closer to completing eligibility for the certificate of achievement, which can be an excellent resource to add to your career portfolio and résumé that can validate your education, interest, and studies in the area of clinical supervision. Please make sure to register for Part 4, stages of clinical supervision, where the author of our new workbook, Tom, clinical supervision and overview of functions processes and methodology. He will cover and add onto the content that is discussed in chapter 9 on stages of clinical supervision. That will be live on Wednesday, December 11, 2019, from 3:00 to 4:00 p.m. eastern. Registration is only $25 per training, which includes eligibility for the certificate of achievement and, of course, access to the CE quiz. Just as a reminder for those who missed our earlier instructions, here are the instructions to obtain a CE certificate.

You see the website there, No. 2, where the online CE quiz is posted. It's posted and available there now. You would have to use the password that was revealed to you during this training. When you go into the quiz, make sure to enter it all lower case, one word. If you missed part of the password, you'll be able to view the recording of this training as a part of your registration. Of course, if you have not joined NAADAC yet as a member, there are some incredible benefits. If you're interested in learning more, visit www. naadac.org/join. Or visit us anytime at NAADAC at our website. Thank you again Tom for your valuable expertise. I look forward to seeing you all for the next part of this training series. And I encourage you to (inaudible). You can stay connected with us on LinkedIn, Facebook, and Twitter. Have a great day.

(End of meeting.)