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ETHICS, BOUNDARIES AND DUEL RELATIONSHIPS. PROFESSIONAL ISSUES FOR ADDICTION PROFESSIONALS

Welcome to the growing family of coursework participants at CEU Matrix - The Institute for Addiction and Criminal Justice Studies.

This distance learning course was developed for CEU Matrix by Diane Sherman, Ph.D. It is based on information found in NAADAC manuals on counselor codes of ethics dating from 2011 to 2017.

This course contains the NAADAC course materials, along with the post test and evaluation that are required to obtain the certificate of completion for the course. You may submit your answers online to receive the fastest response and access to your online certificate of completion. To take advantage of this option, simply access the Student Center at <http://www.ceumatrix.com/studentcenter>; login as a Returning Customer by entering your email address, password, and click on 'Take Exam'. For your convenience, we have also enclosed an answer sheet that will allow you to submit your answers by mail or by fax.

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ETHICS, BOUNDARIES AND DUAL RELATIONSHIPS. PROFESSIONAL ISSUES FOR ADDICTION PROFESSIONALS

This course is derived from 4 separate articles released by NAADAC over the last few years. Topics covered include:

- The necessity of revising NAADAC Code of Ethics
- Why the code of ethics is important and how it can help professionals facing challenging situations
- How ethical decisions can vary from one person to another
- Ethics don't always come naturally
- Dual relationships between counselor and client
- Curbing inappropriate actions between addiction professionals and patients
- The role of non-clinical staff
- The NAADAC code of ethics approved October, 2016
- How and when it is appropriate to file an ethics complaint

I wanted to get some background on why the NAADAC Code of Ethics were being revised, as well as the importance of the code to the profession. The Chair of the NAADAC Ethics Committee, Anne Hatcher, EdD, CAC III, NCAC II, was just the person to talk to.

Donovan Kuehn: Why was the code of ethics revised?

ANNE HATCHER: The NAADAC Ethics Committee is instructed to review the code of ethics and make revisions as needed every two years. Two years ago the committee recommended standards related to evaluation, assessment and interpretation of client data. The recommendations were made as a result of a request from a member who needed guidelines. A review of other codes of ethics found standards on evaluation, assessment and interpretation of client data while the NAADAC Code of Ethics did not address the issue. To the best of my knowledge, the recommendations submitted were not reviewed by the executive board and so the suggested change was not made. In early 2010, we were asked to review of the code of ethics and to make suggestions for revisions. The committee worked diligently comparing the NAADAC Code of Ethics to the codes of ethics of other professional organizations working with similar populations. In addition, some of the committee members made suggested revisions based on the experience of being asked to respond to ethical dilemmas and grievances. We found that the current code of ethics did not describe ethical standards in a clear manner that would support us in addressing some of the grievances.

Some sections of the recommended code were rewritten to fit with the situations most likely to face us in 2011 as compared with the situations that arose in 2008.

DK: Why is it important for professionals to have a code of ethics?

AH: A code of ethics is a statement of an organization's standards for professional behavior. All of us are likely to make mistakes in judgment unintentionally or when we are in stressful situations. The stated code of ethical standards provides a guideline for evaluation of the situations in which we find ourselves and helps us evaluate the choices that face us. Rarely is an ethical dilemma a clear choice between right and wrong. Usually it is a choice between rights; the code of ethics guides us in making a choice that more clearly fits the values of the profession and our own professional standards for behavior.

DK: How can the code of ethics help professionals who are facing challenging situations?

AH: When faced with a situation that the addiction professional finds uncomfortable or questionable, the code of ethics provides a standards with which the possible actions can be compared. As I said to your first question, the code of ethics provides a guideline for members of the ethics committee when responding to a grievance filed against a member or an agency holding NAADAC provider status. The revised code of ethics provides more detail than the previous one because, ethics committee members found themselves essentially saying "this person's behavior does not meet our concept of professional standards and the code of ethics has no statement relating to the decision we need to make."

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WHEN PERSONAL AND PROFESSIONAL VALUES DANCE

OUR CORE VALUES LEAD US ON OUR PROFESSIONAL JOURNEY

Frances Patterson, PhD, MAC, BCPC

Do you ever consider why one person makes an ethical decision one way and another person arrives at a different decision? Some questions may come into play when an ethical situation arises.

Is this situation an ethical violation?

Do I need to report this situation?

Will I hurt my colleague if I report this?

How is this going to affect me?

Are there clients involved?

Dilemma: Marc, a Licensed Clinical Social Worker who works with eating disorders, was presenting a workshop at a national addictions conference. During the workshop many participants noticed that Marc appeared to be under the influence of either alcohol or other drugs. His behaviors indicated there may be some impairment. Marc completed his workshop and afterwards many counselors who attended it were talking among themselves about Marc. They expressed disbelief that he would “show up high” to present. None of them approached him to express their concern. As a result, gossip ran rampant throughout the conference.

What is the core value or belief that would prevent these counselors from approaching Marc and to perpetuate the gossip? When questioned about this one may hear many different answers.

“It’s not my place to stick my nose in his business.”

Possible belief: I don’t have a right to question another person’s behavior.

“I am not the ethics police.”

Possible belief: I have a responsibility to monitor my own behavior, not his.

“I don’t know if he is really impaired. It could be something else wrong.”

Possible belief: I don’t judge other people. It may embarrass him if I say something.

“I don’t want to ruin his career.”

Possible belief: I have to protect my colleagues.

“I don’t know him. And I don’t know if he is a recovering person. If not, doesn’t he have a right to drink if he wants?”

Possible belief: People have a right to do what they want.

“This is a conference. He’s not seeing clients here.”

Possible belief: Even as professionals, we have a right to our personal lives.

Our core values and beliefs lead us on our professional journey. They determine our philosophies and choices, why we chose a career in addictions counseling, the modality we use, even the population we choose as our focus. Our values not only influence how we interact with clients, but also how we interact with other professionals and how we make ethical decisions. The situations that are absolute e.g. sex with a client, financial dealings with a client, etc. are the easy ones. It is the grey areas that make it difficult and where, often times, there is a conflict between personal values and professional ethics.

In the example above, personal values have kept these counselors from addressing an ethical concern. Although the individuals may not be aware of the belief underlying their hesitancy to confront Marc, there may be a conflict between personal values and ethical obligations. This brings us to our ethical obligations around impaired colleagues. Is Marc impaired? If he is in fact under the influence or impaired while teaching a workshop at a professional conference, there is definitely some level of impairment. His judgment, at the very least, is impaired. Is this any different then being under the influence at work? Would these same counselors confront a colleague who came to work in the same condition as Marc?

An impaired professional is obligated to seek help. The professional has a responsibility to determine if the problem is affecting his/her professional competency. Often, an impaired person cannot make this determination because of that very impairment.

Continuation of **WHEN PERSONAL AND PROFESSIONAL VALUES DANCE**
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Frances Patterson, PhD, MAC, BCPC

Therefore, we as professionals have an ethical obligation to help our impaired colleagues obtain help. If we don't help them, who will? Would we offer them any less help and respect than we would an impaired client?

We are the gatekeepers of our profession. If Marc is not willing to seek help and he continues to be impaired, we have an obligation to report that ethical violation. Lack of reporting is a major issue in our profession. We have ethical and legal obligations to report violations that continue to be unresolved. Failure to report major ethical violations is a violation in and of itself. If Marc is also a licensed or certified alcohol and drug counselor, he may also be in violation of his licensure or certification requirements.

Do not assume that someone else will make the report relieving you of the responsibility. Remember, we are not in this alone. Talk with a supervisor or colleague. Seek support from others and document all aspects of the incident. When possible, speak with the person who is in violation. Make sure you have your facts in order. Then, if needed, make the proper report. You are not the one ruining that person's career. You are protecting clients, the community and our profession. Examine your values, beliefs and ethical obligations. When a conflict arises, make sure your decisions are ethically sound. Be true to yourself, your colleagues and your profession.

Frances Patterson, PhD, LADAC, MAC, BCPC, CCJAS, QSAP, QCS, received her bachelor's and master's degrees at Virginia Commonwealth University in the Alcohol and Drug Education Rehabilitation Program and doctorate in Clinical Psychology at California Southern University. In addition to being a licensed alcohol and drug counselor in Tennessee, she is a NAADAC certified Masters Addictions Counselor and Qualified Substance Abuse Professional. She has worked as a counselor and program administrator in treatment programs in Virginia and Tennessee over the past 23 years, is the owner of Footprints Consulting Services, LLC in Nashville, Tenn., serves as the chair of the NAADAC clinical issues committee and is a member of the Ethics committee. She can be contacted at frances@footprints-cs.com.

Additional Reading William White and Renee Popovits, *Critical Incidents: Ethical Issues in the Prevention and Treatment of Addiction*. Lighthouse Institute, Bloomington, IN 2001
Barton Bernstein, J.D., LMSW, and Thomas Hartsell, Jr., JD. *The Portable Ethicist for Mental Health Professionals*. John Wiley & Sons, New York, 2000

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NATURAL ETHICS

ETHICS DON'T ALWAYS COME NATURALLY

Kevin Quint, LADC (Nevada)

Counselor ethics consist of principles and standards that govern how we conduct ourselves in our clinical work. Some of these principles include non-maleficence (“do no harm”), beneficence (“do good”), client autonomy (freedom of choice, informed consent, etc.), justice (fairness) and fidelity (keeping your word to the client). These are all high plane ideals that are found in most professional codes of ethics. Ethical principles help us stay the course, so to speak, in our interactions with clients.

This all sounds so natural and so uncomplicated. Just do the right thing. That will take care of all ethical concerns. Right? Not really...

You see, a common myth is that alcohol and drug counselors bring an intact and appropriate set of ethics with them to the job. Embedded in this myth is the wrong-headed notion that we all have common sense. Unfortunately, ethics don't always come naturally and they don't always coincide with everyone's version of common sense. That's not because counselors are inherently immoral. It's because ethics are not as simple as they seem. And in certain situations we just don't know what to do.

I'm pretty sure that the vast majority of alcohol and drug counselors don't need to be told not to sleep with a client. But what about that slippery slope that starts with an innocent hug that may lead to emotional and physical arousal and weeks or months later ends up in a sexual relationship between counselor and client? I'm also pretty sure that the vast majority of counselors in our field know that breaking client confidentiality is not only illegal but it is unethical. But what happens when you see a client in the grocery store or at church or in the park? How do you know what to do?

The examples could go on, but the point is that while ethical principles are often natural and intuitive, the practical application of those principles can be elusive and difficult.

Hugs aren't necessarily wrong, but how do you know when to hug and when not to hug? Saying “Hello” to a client or former client in the grocery store isn't necessarily wrong, but how do you decide what to say or if you should say anything at all?

I believe that these issues, and the questions surrounding them, point to the fact that not all aspects of ethics are clear to everyone and we sometimes need help in navigating what can be murky waters. The clarity we need can and should be developed through several avenues but particularly through the supervisory process.

Clinical supervisors need to be practitioners of high ethical conduct. Clinical supervisors need to be able to impart those standards to those under their charge, as well. I would go so far as to maintain that one of the most important roles of a clinical supervisor is to provide support, structure and accountability to their supervisees in the area of professional ethics.

That's my opinion, of course. But if clinicians entering the field are mentored by their supervisors in developing and exercising a strong sense of ethics, I believe that many complaints that come to licensing and certification boards would decrease dramatically. So what's a supervisor to do? Here are a few thoughts:

- Supervisors need to deeply care about ethics. This is really an issue of passion and attitude. It's contagious.
- Supervisors need to demonstrate ethics to those they work with. This isn't about “Do as I say, not as I do.” Supervisors need to lead by example. I once investigated a complaint against an intern related to alleged sexual misconduct with a client. By the end of the investigation, I discovered that the agency leadership had set a poor ethical example for their interns to follow. The intern was still held responsible for wrongful behavior, but I believe that situation could have been prevented through exercise of ethical principles in leadership.

Continuation of **NATURAL ETHICS**
ETHICS DON'T ALWAYS COME NATURALLY
Kevin Quint, LADC (Nevada)

- Supervisors need to teach their supervisees the basic principles of ethics. This can take the form of in-service trainings, case review, and general conversation. This becomes an everyday process, both formal and informal. This training should include development of an ethical decision making model and other guidance on how to work through ethical dilemmas
- Supervisors need to understand the gravity of NOT infusing the highest ethical standards in their supervisees. I once supervised an intern who engaged in inappropriate behavior on social media with a former client who was also a minor. As a result, the counselor was discharged from employment. But the question I was asked by my boss was, "Did you do everything you could BEFORE the incident to ensure that this person knew that this was inappropriate and unethical behavior?" After a great deal of introspection and soul searching, I believe I had performed my duty, but I also realized that I could have been dragged into any lawsuit or complaint against this intern. My license is connected to all those who I supervise. That reality is never far from my mind
- Finally, supervisors need to carefully choose who they supervise. I used to have the attitude of "Come One, Come All." I thought I was obligated to take on whoever asked. One day, a colleague asked me why I agreed to supervise a particularly difficult person. The only answer I could come up with was, "Because he asked." I felt a little foolish and realized that I hadn't even considered this person's capacity for ethical and skillful clinical work.

I should confess that I used to think that ethics all come naturally. But doing the right thing isn't always as apparent as it seems. I encourage all treatment programs, practices, and clinicians to engage in learning, living, and breathing counselor ethics.

I'll agree that some aspects of ethics come naturally but overall ethics need to be learned and they need to be practiced. This will help us stay the course as we encounter various complex and difficult issues and dilemmas in our practice and in our efforts to help the people we serve.

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DUAL RELATIONSHIP

PROBLEM OR PART OF OUR PRACTICE

Anne S. Hatcher, EdD, CAC III, NCAC II, Chair, NAADAC Ethics Committee

“Just don’t have sex with your client; following the ethical code is easy if you remember that rule.” However, the “No Intercourse Rule” applies to far more than having sexual encounters with a client or with another person who holds lower status than that of a professional. “

The addiction professional understands that the goal of treatment services is to nurture and support the development of a relationship of equals of individuals to insure protection and fairness of all parties” (NAADAC Code of Ethic, Principle I, Standard 3, 2011). The primary goal when working with addiction clients is to support responsibility and change in the client’s life and to encourage independence (Swenson, 1997). A dual relationship is interacting with others in such a way that it interferes with one’s objectivity, professional judgment and/or conduct. A legal definition of a dual relationship might be maintaining relationships with clients that are likely to impair professional judgment or increase risk of client exploitation.

With this information in mind, the reader is asked to consider the unique relationships that might develop in addiction counseling. Typically the counselor is a person who has life experience abusing psychoactive substances and who is now in recovery. Clients and counselors might find themselves in the same 12-step meeting or at social events attended by addiction professionals as well as persons in recovery. In some cultural groups, interactions between clients or potential clients and professional counselors are a part of everyday life and not easily avoided. Small towns and rural locations provide even more opportunities for interaction between client and counselor in settings other than the treatment facility. Other options for multiple interactions are found through social networks and other online sites where personal and professional information is posted. How much information can a counselor post online before a boundary is crossed?

Some clients use search engines to find out where a counselor lives and organizations in which she/he is active. With some diligence, clients searching online might even learn about debts the counselor owes. In such situations, whose boundary has been crossed and is an ethics complaint appropriate?

For many years, legal and ethical standards have advised mental health/addiction counselors to avoid interacting with clients in any situation other than the clinical treatment setting. A shift in this thinking began in the 1990s. Increased recognition that some boundary crossings such as self-disclosure and non-sexual touching might be clinically valuable in specific situations altered the rules to state that a dual relationship must be therapeutically helpful to the client or clearly defined to minimize harm to the client. One author cited by Corey, Corey & Callanan (2011) noted that the goal of ethical decision-making is to minimize the potential for exploitation. Zur (2011) described a number of situations in which a dual relationship might be a problem and contrasted those situations with dual relationships that might actually enhance the lives of both client and counselor. On the helpful side, he noted that dual relationships in which the counselor and client have established agreed upon boundaries are more likely to prevent sexual relationships than to encourage them. A problem is very likely to occur if the counselor also works as an expert witness and is called upon to be an expert witness in a client’s court case. Unexpected dual relationships can occur when a counselor is assigned to work with a client and then learns that the new client is the ex-spouse of a current client. In some situations and where boundaries are discussed and agreed upon, a dual relationship might facilitate recovery. Exploring the ramifications of being in a dual relationship and making a clearly thought out decision is recommended for addiction counselors. The following scenarios are included to help the reader think about situations in which he/she might find him/herself.

Continuation of **DUAL RELATIONSHIP**

PROBLEM OR PART OF OUR PRACTICE

Anne S. Hatcher, EdD, CAC III, NCAC II, Chair, NAADAC Ethics Committee

Identify the slippery slope in these situations where one or more actions might be interpreted as a dual relationship:

Case #1 Ed, an addiction professional, counsels recovering persons at a DUI treatment center. On weekends, Ed teaches workshops required for persons seeking state certification in Idaho. The Idaho state certification board is taking applications for a position that requires the employee to evaluate course work completed in other states and that is included in applications for certification in Idaho. Ed has submitted his application.

Case #2 Gregory is a contract counselor who facilitates groups in several treatment agencies. In one of his groups, there is a very attractive woman that he would like to know better. Gregory suggested that she drop out of his group and enroll in a group facilitated by Sandra that meets at the same time. Since the groups end at the same time, they can meet for coffee afterwards.

Case #3 Georgina supervises entry-level addiction counselors at an addiction treatment agency with ten offices scattered across a metropolitan area. One of her supervisees, Larissa, who has ten years of recovery, reported that she used cocaine once last week. Larissa immediately began attending Cocaine Anonymous (CA) groups and entered individual counseling. She asked Georgina to be her sponsor in CA so she does not have to reveal her plans to be a counselor to a stranger.

Case #4 Felix is enrolled in an online course required for state certification as an addiction counselor. Online students taking state certification courses must take each of the three exams at a testing site where a proctor is present. Felix lives in a small town more than 60 miles from the nearest test site so he has asked permission to have his employer proctor the exams.

Case #5 Betsy, MSW, MAC, is an addiction counselor at San Juan Pueblo. She grew up in this community and understands the culture as well as the problems with alcohol and drug use. Tribal members consider each other to be relatives and refer to them as brothers, sisters, cousins, aunts, uncles, grandmother or grandfather. The state certification board/grievance committee has received a report that Betsy is counseling her brother who was arrested for driving under the influence of marijuana.

Case #6 Constance is a community college addiction studies educator who has a small private practice where she counsels persons in recovery. One of her students enrolled in a class taught by Constance after being a client for a year. Constance is required to serve on a community board to meet the service requirements of her teaching position. She has applied to the governor's office to be a member of the state board that reviews applications for addiction counselor certification, monitors agencies that provide state required workshops, evaluates reports of ethical violations and updates educational requirements for persons who are pursuing state certification.

Case #7 Susie Q is a state certified addiction counselor who became a counselor after 17 years of prescription drug abuse, becoming sober and completing a bachelor's degree in addiction studies. Two weeks ago, Susie attended her cousin's wedding and the reception. She had several glasses of wine before starting her drive back home. A police officer stopped her for not coming to a complete stop at a stop sign. The officer completed a roadside sobriety test after smelling alcohol on Susie's breath. A breathalyzer test indicated a BAL of 0.06. Susie was court ordered to complete five alcohol education classes and to work as a receptionist rather than as counselor for eight months. Susie enrolled in alcohol education classes taught in a town 30 miles from her home. Last night Carl, the group facilitator, seemed tired.

Continuation of **DUAL RELATIONSHIP**

PROBLEM OR PART OF OUR PRACTICE

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He reported that he had been working overtime filling in for group facilitators who were on vacation. Susie suggested that she might be able to help him by facilitating a group or two in an office owned by the same agency and located in her home-town.

Case #8 Tracy has completed all course work for a doctorate in counseling. While taking courses, she has also worked with clients through the college counseling center. Her research for the dissertation was on the correlation between sexual trauma and alcohol abuse. The first draft of the dissertation has been written and reviewed by Tracy's advisor. He suggested that the document be read and edited by someone who has specific training in editing and who is not familiar with the topic of the paper. Among Tracy's clients at the counseling center is a student who is a single mother and who is always struggling to make ends meet. The client was an editor for The NY Times Sunday Magazine for 10 years prior to being laid off when the magazine decided to change its format. Tracy wants to offer the extra counseling sessions requested by the client for free in return for the editing assistance.

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Addiction Professional Magazine

SPECIAL SERIES: Treatment centers have capacity to lessen chance of sexual misconduct

by Alison Knopf, Contributing Writer

Leaders in the credentialing of addiction professionals insist that treatment facilities can wield influence in stemming inappropriate sexual behavior by staff—incidents that are under-reported and damaging to organizations' reputation and bottom line.

"If [clinical] supervision was more centered around the ethics of those counselors, we would see a decrease in the number of ethics complaints," says Mary Jo Mather, executive director of the International Certification & Reciprocity Consortium (IC&RC), representing credentialing boards. "I can't tell you the number of times I get a call from a counselor who's asking me about an ethics question, and they never thought to ask their supervisor. There's something wrong with that."

Supervisors need to be aware of issues surrounding inappropriate actions toward patients, and not help treatment program administrators sweep them under the rug, says Patterson. One problem, she says, is that schools no longer are teaching about transference and countertransference, the phenomena in which a patient views the therapist as representing someone important in his/her life (such as a mother or husband) and the therapist in turn projects some feelings onto the patient.

Many addiction counselors come out of school thinking they're supposed to be a robot, says Frances Patterson, a member of the ethics committee for NAADAC, The Association for Addiction Professionals. "They think they're not supposed to feel, they're not supposed to like a client or dislike a client," Patterson says. "Then when they have these feelings, they think there's something wrong with them."

That's a key part of supervision, which must be ongoing, says Patterson, adding, "You never outgrow supervision—that's what keeps us out of trouble." It's also helpful to remember that if you're doing something you don't want to talk to someone about, there probably is something wrong, she says.

Kathryn Benson, chair of the National Certification Commission for Addiction Professionals, which is run by NAADAC, frequently talks on the phone to counselors who are confused. "It's not their fault if they're not getting good guidance from their agencies," Benson says. "They're afraid of retaliation. I'm not going to let them hang alone out there."

On the other hand, it also is hard to blame supervisors, because most of the time they are "doing the best they can with what they are working with," says Benson. "This isn't about pointing fingers—it's about coming up with a solution."

Sometimes the counselor is so afraid of the situation that he/she doesn't tell anyone, including the supervisor. But this fear proves destructive, says Benson. "I tell people they will get trapped in their own fear, because if you find yourself attracted to a client, you'll get trapped into thinking that there's

something wrong with you, and you're defective as a counselor," she says. "You're having a human feeling."

The counselor's job is to convey this to the supervisor, and the supervisor's job is to understand that this is human nature, and that the supervisor will help the counselor manage this.

"This is about real life," says Benson. "You cannot prevent everything." Even with the best policies and the best training, treatment programs still may not be able to prevent sexual misconduct. But where the true liability lies is in how the treatment program responds to a situation once aware of it.

Benson stresses that the absolutely wrong move to make when an incident of sexual misconduct occurs is to transfer the patient immediately to another counselor. "That's the mark of a poorly trained supervisor and clinician, who believes that the first response is to transfer," she says. "That's harmful to the counselor and to the client." Many people come to treatment with abandonment issues, and if the first time they show up they get rejected—which is how they will interpret a transfer to another counselor—they will feel that they must be worthless if even the therapist doesn't want to talk to them, Benson explains.

Patient blaming

Benson says patients don't seduce counselors. Rather, the patient comes into a program and is at the level of coping that he/she has in life at the time. "It's not at all uncommon, particularly for females, to use their bodies," she says. "They use sex as a way of controlling and minimizing further damage to themselves." It's a convoluted sense of survival, but by being in control of sex, these women believe they can reduce their chances of being harmed.

Counselors are trained in how human beings developed coping skills to help them survive, says Benson. "The burden is always on the clinician, on the staff person, to manage themselves," she says. "We're the professionals."

Patterson is outraged when she hears counselors claim to have been seduced by patients. "The patient is acting like a patient, using the coping skills she has," says Patterson. "The only way she knows how to interact is sexually."

Because of the disease patients arrive with, and the past trauma they may have experienced, it may take them months or more to report sexual misconduct, says IC&RC's Mather. "Maybe a year later they're back in treatment someplace else, and they realize this wasn't supposed to happen," she says.

Dual relationships

The concept of sexual misconduct has been broadened to include dual relationships, which are banned by ethics codes. A dual relationship is one that is outside of the clinical care the counselor is providing. On one end of the spectrum is running into a patient or former patient at a 12-Step meeting and interacting with them with a "social feel" to the relationship, including an activity such as going out

with a group for coffee. On the other end of the spectrum is full physical intimacy. The potential harm to the client varies, but it exists in all dual relationships.

Sean Conaboy, a risk management consultant with NSM Insurance Group in Philadelphia, recalls the slippery slope of relationships he witnessed in treatment programs. "When I was managing facilities and doing clinical supervision, I would see the relationships that would start to occur, and blossom into something that was inappropriate," Conaboy says. "We had to do a lot of training, a lot of policies and procedures. This is a danger sign, but these are human beings, and it happens. You have to deal with it."

IC&RC recently changed its code of ethics to ban not only exploitation of clients, but also dual relationships. "Sometimes it isn't physical, but it has crossed over from the professional relationship," says Mather. "Maybe they're texting at night, meeting for coffee, not doing anything sexual. It's still a dual relationship, and not allowed."

Role of non-clinical staff

While administrative staff are less likely to have dual relationship issues, they do get to make the big decisions. They're the people in power, and as Patterson said, "They look at lawsuits and the bottom line."

That's why consultants who work with treatment programs on ethics training frequently request to meet with non-clinical staff as well as clinicians. Treatment centers, says Benson, need to understand that the costs of letting the counselor simply go work at another program, with nothing ever reported, are too high.

When Benson works with a facility that is going through a sexual misconduct situation, she tells administrators that they need to terminate the employee, report the person to the appropriate authority, get the patient placed in another treatment program, and pay for that treatment. "They do not like hearing this," she says.

Importance of investigating

While investigating claims is onerous and expensive, it's something that treatment programs need to do, says Conaboy. "Firing the counselor and hoping they don't get sued won't make the problem go away," he says. Conaboy stressed that no attorney will sue only the counselor—the employing organization will get sued as well.

All cases end up being settled out of court, because treatment programs don't want the publicity of a trial, says Conaboy. "Attorneys [for patients] make their money on the settlements, and on the billable hours," he says.

An organization must be acutely aware of the dangers of wrongful termination, says Conaboy. "We've all worked and dealt with transference," he says. "Patients lie, they fabricate, they're delusional, they're

trying to get back at you. So, don't rush to judgment." There must be due process, in which allegations are thoroughly investigated.

Sexual misconduct presents a "very challenging set of dynamics" for a treatment organization, says Conaboy. "And no matter how well managed you are, these things still happen, because this is human behavior." Some of the most prestigious programs have experienced these situations, he says.

All hospitals have general, professional, and sexual misconduct/abuse and molestation insurance coverage, and behavioral health providers should as well, says Conaboy. "Different carriers handle the premiums differently," he says. In many cases, the sexual misconduct coverage is bundled into general and professional liability coverage.

A preventive culture

"Ethical violations don't happen in a vacuum," says Sandy Wummer, corporate director of performance, standards and research at Pennsylvania-based Caron Treatment Centers. "We try from the beginning to create a culture of ongoing training and supervision around ethical issues."

Caron focuses on preventing ethical violations, says Wummer. A key component involves having a treatment team, not a single individual, treating each patient, she says. "When there are multiple staff members, this eliminates some of the boundary issues, the transference and countertransference," Wummer says.

She adds, "Ethical issues always arise, in any kind of medical treatment. It's how you respond that matters." Caron also educates patients and their families about ethical and appropriate behavior "on our part and on their part," she says.

What if the sexual relationship is between patients? "This is a clinical issue, a treatment team issue," says Wummer. "There are patients whose histories may lend themselves to that behavior—patients come here with a lot of issues."

If a patient reports sexual misconduct, Caron has processes in place to investigate. "It's a patient advocate process," says Wummer. "We take every allegation seriously. In the rare case that we have an allegation of an inappropriate relation between a staff member and a patient, we would explain to the counselor first that there is an allegation." In some cases, the counselor would have to stay home until the investigation is concluded.

"If we find an allegation to be accurate, we would take appropriate steps through the HR process and the licensing boards," says Wummer. "That is not a choice—that is a regulation."

It's important to use an allegation, whether it's true or not, as an opportunity for training, supervision and learning, she says. Doing nothing in response to an allegation sets up an organization for liability in many areas, says Wummer.

"It will cause repeat behavior," she says.

One patient's ordeal

Pamela Banker, who lives in Geneseo, N.Y., was arrested for drunk driving and had been sent to court-ordered treatment in 1999. The counselor who supervised her told her that if she didn't submit to his sexual advances, she would be sent to prison for 14 years.

When Banker did report the abuse (which she said went on for seven years) to her probation officer, the officer told the counselor. He retaliated by forcing her to plead guilty to drunk driving in the treatment court where he served as coordinator, so that she would stay under his jurisdiction.

Ultimately Banker was sent to prison for three years, for relapsing to alcohol use, which was triggered by the sexual abuse. The counselor eventually was allowed to resign, citing health reasons.

Banker's story was not reported until she filed a lawsuit in 2009, citing the abuse. The employer was the state because she had been in a state-run treatment program. The state refused to pay any award, saying that what the counselor did occurred outside of his purview as an employee.

The state Office of Alcoholism and Substance Abuse Services (OASAS) did confirm to *Addiction Professional* that its review of the situation concluded that the counselor had violated applicable ethical standards. OASAS adds that he is no longer credentialed by the state agency.

The patient's lawsuit was dropped, and Banker, who lives on \$750 a month in disability, says she owes her lawyer more than \$6,000. In August, a reporter with the Democrat & Chronicle newspaper met with her, and published her story on Aug. 29. *Addiction Professional* contacted Banker in early September, and she said she wants her story to be told.