Ethical Decision-making
by Administrators, Clinicians and Peer Service Providers

Licensed Professional Counselors Association of Georgia
Counselor Supervision Summit, Macon GA

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Participants will use a four-step model to consider dilemmas that are only partially addressed by professional codes of ethics and agency policies and procedures. Participants also practice interpersonal skills for effective team building and ethical decision-making while documenting resolutions in an Ethical Decision-making worksheet. Explorations of several boundary management and other vital issues inform mission-congruent and values-based resolutions that empower staff and those whom we serve. Upon completion of this session, participants will be able to:

1) List four vulnerabilities that are essential to making ethical decisions.
2) Implement an ethical decision-making worksheet.
3) Incorporate a Catalogue of Organizational Practices and Ethics (COPE) into your agency's new employee orientation and ongoing in-service trainings.

A Moment of Still Silence

Simon & Garfunkel. (1966). *Sounds of silence*.

"If we had a keen vision of all that is ordinary in human life, it would be like hearing the grass grow or the squirrel's heart beat, and we should die of that roar which is the other side of silence."
George Eliot (Mary Ann Evans). (1872). *Middlemarch*.

David Crosby. (1988). *Compass*.

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What Do You Think?

Julie and Mark, sister and brother, are traveling together in France on summer vacation from college. One night while staying alone in a cabin near the beach, they decide that it would be interesting and fun if they tried making love. At the very least, it would be a new experience for each of them. Julie is already taking birth control pills, but Mark uses a condom too, just to be safe. They both enjoy making love but decide to not do it again. They keep that night a special secret, which makes them feel even closer to each other. Do you think it is acceptable for two consenting adults, who happen to be siblings, to make love?

Three Points About Ethical Decision-making

☑ ~69% immediately answer "No" (Haidt, 2012; Haidt, Koller & Dias, 1993)

1. Morality begins with culture-based affect (feelings) = instant and automatic judgement = System 1 (Kahneman, 2011); Elephant (Haidt)

☑ Why or how did you come to that answer?

2. We confabulate, invent reasons (cognition), "on the fly" = System 2; Rider

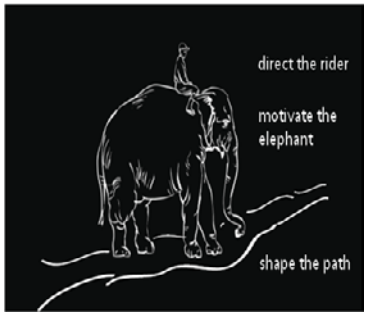
☑ Refuting reasons generally doesn't change minds ("but, but, but… I don't know, it just *feels* wrong/right!)

3. Cognitive arguments do not diminish the cause of the position (affect) if they address only what was made up after the judgement occurred!

Rider (System 2) to Elephant (System 1) doesn't work

Haidt, J. (2012). *The righteous mind: Why good people are divided by politics and religion.*
Kahneman, D. (2011). *Thinking, fast and slow*.

What Works?



→ Check reference materials

➲ **First, appreciate/validate the other's perspective and values!**

→ Develop a Code of Organizational Practices and Ethics (COPE)

Adapted from Haidt, J. (2012). *The righteous mind: Why good people are divided by politics and religion.*

Boundary Management and Intimacy Issues Worksheet

See below in this handout

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A Four Step Ethical Decision-making Model

1. Identify the potentially vulnerable parties
2. Recognize the core values that apply to this situation, and what actions are suggested by the values
3. Consult the laws, standards, and historical practices may guide your behavior
4. Document: a) what you considered doing, b) who you consulted - identified enablers and disablers, & c) what you decided to do

Seven Potential Domains of Accountability/Vulnerability/Risk

1. You
2. Individual/family being served
3. Service provider peers
4. Agency/organization
5. Profession/recovery support services field
6. Recovery communities
7. Larger community/public safety

Ethical Decision-making Worksheet

See the *Worksheet* and *Ethical Incidents* in this handout

Scenario #1

Your organization supports Addiction Recovery Awareness Day at the Capitol, gets its logo on the tee shirt, and purchases shirts for staff and clients to wear who attend the rally. Clients are told that all services are canceled that day. Some clients decide they do not want to participate. Other say they want to go but they don't want to wear the shirts.

COPE: Your Practices & Ethics

- Develop an agency-specific *Catalog of Organizational Practices and Ethics (COPE)* to inform the decisions and behavior of all staff, volunteers and clients/peers/residents
- Add Ethical Decision-Making Worksheets to your COPE as situations arise
- Use your COPE for monthly/quarterly/bi-annual staff development meetings
- Include your COPE in new hire orientations

COPE Checklist

See in this handout

Additional Resources

1. Corey, G., Corey, M. S., & Callahan, P. (2014, 9th ed.). *Issues and ethics in the helping professions.*
2. White, W. L., et al. (2007). *Ethical guidelines for the delivery of peer-based recovery support services.*
3. White, W. L. & Popovits, R. M. (2001, 2nd ed.). *Critical incidents: Ethical issues in the prevention and treatment of addiction.*

Boundary Management and Intimacy Issues Worksheet 150630

Adapted by George S. Braucht; LPC, CPCS & CARES with permission of William L. White. From White, W., the PRO-ACT Ethics Workgroup, with legal discussion by Popovits R. & Donohue, B. (2007). *Ethical guidelines for the delivery of peer-based recovery support services*. Philadelphia: Philadelphia Department of Behavioral Health and Mental Retardation Services.

I am taking this as a/an: ✓all that apply

Administrator ☐ Clinical Supervisor ☐ Clinician ☐ Peer service provider☐

Instructions: ✓ <u>one</u> of the three vulnerability zones for each of the below behaviors.

Helper Behavior with a Client/Peer/Resident = CPR AOD = alcohol or other drugs	Vulnerability Continuum Safe Always OK	Vulnerable Sometimes OK, sometimes not	Danger Never OK
1. Give a gift			
2. Accept a gift from a CPR or CPR's family			
3. Lend or borrow money			
4. Manage a CPR's money			
5. Give a hug			
6. "You are a very special person"			
7. "Relapse is a part of recovery"			
8. Invite to a holiday dinner at your home			
9. Joke about breast or penis size			
10. Have sex with a former CPR			
11. Have a relationship with a CPR's family member			
12. Give a CPR your personal cell phone number			
13. Use profanity or curse words			
14. Use drug culture or street slang			
15. "I'm going (or been) through a rough divorce myself"			
16. "You're very attractive"			
17. Address the CPR by her first name			
18. Attend mutual support group meetings with CPRs			
19. Hire a CPR do some paid work at your sister's house			
20. "Praise God" or "Praise Allah"			
21. Work with a CPR to whom you previously sold AOD			
22. Sponsor a CPR who you are assigned at work			
23. Attend a CPR's wedding			
24. Tell another staff member that her/his CPR admitted using AOD during a mutual support group meeting			
25. Give a CPR a ride in your personal vehicle			

Adapted by George S. Braucht; LPC, CPCS & CARES from White, W. L. & Popovits, R. M. (2001, 2nd Edition). *Critical incidents: Ethical issues in the prevention and treatment of addiction* and Gentile, M. C. (2010). *Giving voice to values: How to speak your mind when you know what's right*.

Name: Date: COPE #

Incident title/theme:

Brief summary of the incident:

Step One: What is the potential risk level to each party?

	Potential Risk of Harm (✓)		
Party	Minimal	Moderate	Significant
You			
Individual/Family Being Served			
Service Provider(s)			
Service Provider Organization/Agency			
Professional Service Field			
Recovery Community			
Community/Public Safety			

Step Two: ✓ each core recovery value that applies to this situation. What action would that value suggest? *Note: Consider replacing the below with your organization's values.*

✓	Core Value	Suggests this Course of Action
	Autonomy/Choice (Self-direction; freedom over destiny)	
	Obedience (Obey legal/ethical directives)	
	Conscientious Refusal (Disobey legal/ethical directives)	
	Beneficence (Do good; help others)	
	Gratitude (Pass good along to others)	
	Competence (Knowledge/skills)	
	Justice (Be fair; distribute by merit)	
	Stewardship (Use resources wisely)	
	Honesty and Candor (Tell the truth)	
	Fidelity (Keep your promises)	
	Loyalty (Don't abandon)	
	Diligence (Work hard)	
	Discretion (Respect confidence and privacy)	
	Self-improvement (Be the best that you can be)	
	Non-maleficence (Do no harm; hurt no one)	
	Restitution (Make amends to injured persons)	
	Self-Interest (Protect yourself)	
	Other Culture-Specific Value:	

Step Three: What laws, organizational policies, professional ethics codes and standards and historical practices influence your behavior in this situation?

Enablers:

Disablers:

Step Four: Document

1. What options you considered:

2. Who you consulted:

   Enablers:

   Disablers:

3. What decision-based scripts you made and what you did to rehearse:

4. The outcome of the decision(s) made and action(s) taken:

Catalogue of Organizational Practices and Ethics (COPE) Checklist 141105

Adapted by George Braucht; LPC, CPCS & CARES with permission from William L. White. From: White, W. L. & Popovits, R. M. (2001, 2nd Edition). *Critical incidents: Ethical issues in the prevention and treatment of addiction*. Lighthouse Institute: Bloomington IL. Available at www.chestnut.org/LI/bookstore/index.html

A. Organizational Culture

1. Are the organization's vision and mission statements, values, performance objectives and measures, and Code of Organizational Practices and Ethics (COPE) written with sufficient clarity to allow their application in daily decision-making and discussions among staff/volunteers/clients? No ❑ Yes ❑

2. Are education, experience and certification/licensure requirements for each agency position set to promote the likelihood that staff/volunteers have prior knowledge and skill in ethical decision-making? No ❑ Yes ❑

3. Is the COPE integrated into the organization's personnel policies or corporate compliance program? No ❑ Yes ❑

4. Are organizational vision, mission, values and ethical standards included raised during employee/volunteer hiring and included in staff/volunteer/client orientations? No ❑ Yes ❑

5. Are ethical issues addressed in the in-service training schedule, not just as a special topic, but integrated as a dimension of all training topics? No ❑ Yes ❑

6. Are opportunities provided for staff/volunteers/clients to explore ethical issues with other professionals within and outside the organization? No ❑ Yes ❑

7. Are formal arrangements maintained that allow organizational leaders to access outside consultation on complex ethical-legal issues? No ❑ Yes ❑

8. Are opportunities provided for staff/volunteers/clients to periodically review and revise the COPE? No ❑ Yes ❑

9. Do organizational leaders frequently model COPE-based decision-making, recite the organization's vision and mission, explain the organization's values, and talk about key ethical issues in all communications with staff/volunteers/clients and during community outreaches? No ❑ Yes ❑

10. Is COPE adherence a component of all staff/volunteer/client performance evaluations? No ❑ Yes ❑

Catalogue of Organizational Practices and Ethics (COPE) Checklist (cont.)

11. Is ethical conduct a core value of the organization as reflected in agency history and mythology; the organization's brand including symbols, slogans, designation of heroes and heroines; and storytelling in organizational literature and during community outreach? No ❑ Yes ❑

12. Are rituals built into organizational life that identify and celebrate instances of COPE-compliant behavior, identify practices that undermine or deviate from COPE, and promote recommitting to the COPE, e.g., staff/volunteer/client meetings, advances (traditionally referred to as retreats), strategic planning meetings, etc.? No ❑ Yes ❑

13. Are processes in place through which staff/volunteers/clients can identify and rectify stressors that can contribute to poor ethical decision-making (role overload/conflicts, incompatible values and procedures, etc.)? No ❑ Yes ❑

14. Is an employee assistance program available that addresses personal impairments that could affect staff/volunteer ethical judgment and conduct? No ❑ Yes ❑

B. Ethical Decision-Making

15. Have staff/volunteers/clients been oriented to the multiple parties whose interests must be reviewed in ethical decision-making? No ❑ Yes ❑

16. Are instances of COPE compliances celebrated and violations immediately and consistently addressed? No ❑ Yes ❑

17. Are the forums clearly defined within which ethical issues can be explored, e.g., individual supervision, team meetings, etc.? No ❑ Yes ❑

C. Ethical Violations

18. Do staff/volunteers/clients clearly understand the mechanism for reporting questionable behavior or COPE violations, and the results of subsequent investigations? No ❑ Yes ❑

19. Are the potential consequences of COPE breaches clearly defined and communicated to staff/volunteers/clients? No ❑ Yes ❑

20. Are the procedures through which COPE violations are addressed clearly defined and communicated to staff/volunteers/clients? No ❑ Yes ❑

In addition to adhering to the Codes of Ethics of the American Mental Health Counselors Association, the American Counseling Association and the Georgia Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists, a Certified Professional Counselor Supervisor (CPCS) shall comply with the following.

1. Supervisee Status Disclosure to Clients: Ensure that supervisees inform clients of their professional status (e.g., intern) and of all conditions of supervision. A CPCS shall ensure that supervisees inform their clients of any status other than being fully licensed or qualified for independent practice. For example, a CPCS shall ensure that supervisees inform clients if they are students, interns, trainees or, if licensed with restrictions, the nature of those restrictions (e.g., associate or license-eligible).

    1.1. Additionally, a CPCS shall ensure that supervisees inform clients of the pertinent requirements of supervision (e.g., the audio recording of all counseling sessions for purposes of supervision).

2. Supervisee Confidentiality Disclosure to Clients: Ensure that supervisees inform clients of clients' rights to confidentiality and privileged communication when applicable, as well as the limits of confidentiality and privileged communication.

    2.1. The general limits of confidentiality are when harm to self or others is threatened, when the abuse (or imminent harm) of children, adolescent, elders or persons with disabilities is suspected, and in cases when the court compels the mental health professional to testify and break confidentiality. These are the current generally accepted limitations to confidentiality and privileged communication, but they may be modified by state law or federal statute.

3. Supervisee Informed Consent to Supervision: Inform supervisees about the process of supervision, including supervision goals, case management procedures, evaluation processes, and the CPCS's preferred supervision model(s). A CPCS shall also inform supervisees of the CPCS's credentials, areas of expertise, and training in supervision.

4. Confidentiality of Supervision Records: Keep and secure supervision records and consider all information gained in supervision as confidential.

5. Supervisor/Supervisee Dual Relationships: Avoid all dual relationships with supervisees that may interfere with the CPCS's professional judgment or exploit the supervisee to include social media and other areas not previously addressed. Sexual, romantic, or intimate relationships between a CPCS and supervisees shall not occur. CPCS shall not engage in sexual harassment or sexual bias towards supervisees.

    5.1. Certified Professional Counselor Supervisors shall not supervise relatives.

6. Client Crisis Plan: Supervisee will identify the client and circumstance of crisis and supervisor will provide written procedures regarding emergency situations. Information shall

include all contact information regarding emergency centers near location. (These procedures may or may not be reflective or aligned with the procedures established in their place of employment).

7. Evaluation of Supervisee: Provide supervisees with adequate and timely feedback as part of an established evaluation plan. These evaluations may include clinician development plans or remediation plans.

8. Assisting Supervisees: Render assistance to any supervisee who is unable to provide competent counseling services to clients.

9. Intervening for Impaired Supervisees: Intervene in any situation where the supervisee is impaired and clients may be at risk. The CPCS may encourage or recommend that a supervisee seek their own services per their discretion and/or consultation.

10. Endorsing Impaired Supervisees: Refrain from endorsing an impaired supervisee when such impairment deems it unlikely that the supervisee can provide adequate counselor services.

11. Trained Supervision Only: Offer supervision only for professional services for which supervisor is trained or has supervised experience. A CPCS shall not assist in diagnosis, assessment, or treatment without prior training or supervision. A CPCS shall correct any misrepresentations of his or her qualifications made by others.

12. Legal and Ethical Standards of Practice: Ensure that supervisees are aware of the current ethical standards related to the supervisees' professional practice, as well as legal standards that regulate the supervisee's professional practice.

13. Multicultural and Diversity Issues: A CPCS will engage and encourage supervisees to examine and explore their own multicultural biases that may impede their counseling and supervisory relationships.

14. Supervisor Responsibility for Supervisee's Clients: Ensure that both supervisees and clients are aware of their rights and of due process procedures. A CPCS shall be ultimately responsible for the welfare of supervisees' clients.

15. Consent Orders: If your license is placed under a consent order with the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists, the CPCS supervisor will immediately notify the CPCS Committee. Upon notification, your CPCS will be revoked and you will immediately be removed from the CPCS listing.

16. Professional Conduct with Colleagues: A CPCS will treat professional colleagues with the same dignity and respect afforded to clients. Professional discourse should be free of personal attacks, foul language, or other inappropriate behaviors.

17. Professional Conduct with Supervisees': A CPCS will treat supervisees with the same dignity and respect afforded to clients and professional colleagues. Professional discourse should be free of personal attacks, foul language, or other inappropriate behaviors. Supervision provided by a CPCS shall be provided in a professional and consistent manner to all supervisees regardless of age, race, national origin, religion, physical disability, sexual orientation, political affiliation, marital or social or economic status.

18. Professional Conduct with LPCA-GA Staff and Volunteers (which includes LPCA-GA Board members): A CPCS will treat LPCA-GA staff and volunteers with the same dignity and respect afforded to clients, colleagues, and supervisees. Professional discourse should be free of personal attacks, foul language, or other inappropriate behaviors.

19. CPCS Who Are CE Providers Conducting Themselves in A Professional manner: A CPCS who provide CEs shall abide by all rules and regulations of the Ga Composite Board, LPCA-GA, and NBCC with regard to the delivery of professional workshops. This includes but is not limited to:

    19.1. providing training for which they have been approved and are trained/qualified to provide,

    19.2. submitting sign-in sheets after workshops to the CPCS Committee upon request,

    19.3. advertising workshops on their websites for the public's view,

    19.4. providing workshops live, in-person at a named location, so designated on the CE certificate, and

    19.5. providing webinars, only if approved for delivery in that format, so designated on the CE certificate.

20. CPCS Utilizing Tele-Supervision: Prior to providing supervisory services through electronic means (including but not limited to phone and Internet), CPCSs ensure they are compliant with all relevant laws for the delivery of such services, including completion of the 9 CEs required by the GA Composite Board.

    20.1. Additionally, a CPCS must: (a) determine that technologically-assisted supervision is appropriate for supervisees, considering professional, intellectual, emotional, and physical needs; (b) inform supervisees of the potential risks and benefits associated with technologically-assisted services; (c) ensure the security of their communication medium; and (d) only commence electronic supervision after appropriate education, training, or supervised experience using the relevant technology.

Failure to comply with the CPCS Code of Ethics may be reported to the Licensing Board and may be grounds for removal from the CPCS certification program. **FILE A COMPLAINT with the LICENSING BOARD** Read More...

Approved by the CPCS Supervisor Review Board (April 2010)
Approved by the LPCA Board of Directors (June 2010)
Revised 02-04-17
Questions should be directed to the CPCS Committee at lpcacpcs@gmail.com.

#1: Reviewing the intake form before greeting Avery, a new client, Val Edate, your supervisee, realizes this is the former spouse of a former client. The therapy with the ex was brief and focused on how to leave the marriage. The prospective client is using a different last name and gives no indication of being aware of the ex's previous treatment with Val. The session began with asking about the reason for the referral from the client's physician – anxiety. During this conversation Avery indicates continuing interactions with the ex because they share responsibilities for three children.

#2: Counselor Greta Listner receives a phone call from Dr. Bailey, a well-known internist in the area who only occasionally makes referrals to Greta. This time the potential patient is Dr. Bailey's 17-year-old child, Neil, who is described as suffering with an eating disorder and perhaps some Borderline Personality Disorder traits – Greta's specialties! Dr. Bailey advises that Neil has been taking fluoxetine (Prozac) and clonazepam (Klonopin) under his care since he discovered the eating disorder 4 months ago. He doesn't want to refer to a psychiatrist and he'll pay for all treatment without involving insurance. Feeling somewhat uncomfortable with the medication management issue, you advise that you'll call him back after looking at your schedule. Greta then calls you for a consult.

#3: Dr. Faith Miller is treating a 35-year-old female, Cassidy Butch, who is feeling depressed and experiencing problems at work. During the first several sessions, Cassidy indicates that Sundance, her partner, is also depressed and in treatment. A major concern is the sense that her partner is more depressed than when treatment started as he's drinking alcohol more frequently and seems more distant than before. The psychologist treating Sundance allegedly advised him to discontinue his medication in favor of St. John's Wort, an herbal remedy. Upon discussing the case in supervision, Dr. Miller suggested that the appropriate course of action is to meet with both Cassidy and Sundance to evaluate not only the marriage but how impaired Sundance is along with Cassidy's ability to accurately assess her husband and their marriage.

#4: Bestin Debiz, a female counselor in a very rural area that has no other female counselors, has been working with Devon weekly for about 2 months and they have developed a good working alliance. Devon has discussed significant events in his past, details about failed relationships, and sexual fantasies. The primary therapeutic issues are depression and loneliness. During the session before this case is brought to supervision, Devon relates being excited about meeting a new friend. As the conversation continues, the counselor is surprised to learn that the new friend is the former partner of the Bestin's husband. Devon reveals that he became aware of that after four dates and recently felt comfortable enough to tell Bestin. Also, he is pleased because the relationship appears to be taking on a more serious tone. Bestin feels overwhelmed and stuck and so is turning to you.

#5: Your supervisee works in an acute care hospital providing trauma services. A physician requests an evaluation of Finley, a 46-year-old who took half a bottle of prescription narcotics combined with about a fifth of vodka. Upon arriving in the intensive care unit, the patient's respiratory status is deteriorating, he is marginally coherent and unable to give any consistent response. Upon checking the medical chart, a note quotes Finley as saying, "This wasn't supposed to have happened." The ICU nurse asks the counselor to offer an opinion regarding the patient's capacity to accept or refuse intubation. Then a family member arrives with a notarized advance directive, signed within the last 12 months, specifically outlining Finley's wishes to not be placed on a ventilator or any artificial life support. Again, the IUC staff asks for the counselor's input. After giving an opinion, the counselor calls you.

#6: Dr. Lilith Fair is a counselor on a small rural college campus who calls you for a consult. Jesse, an undergraduate, has been seen for challenges related to self-esteem and depression. An ongoing theme revolves around her sexual orientation after recently coming out to her parents who were accepting of a gay orientation and lifestyle. Now, Jesse wants to start a LGBTQ student organization to meet periodically on campus to provide one another support, problem-solve and perhaps provide psychoeducation. Jesse asked several faculty members to be the faculty advisor but while supportive, each turned down the offer likely because the campus is small and in a conservative area. Jesse s now asking Dr. Fair to serve in the advisor role.

#7: Dr. Tell works with Kevin, a high school senior with depression, anxiety and relationship challenges. During the last session. Kevin indicated that her boyfriend has lost interest in sex and has become more involved with online pornography - then she suddenly stopped talking. After waiting several moments, Dr. Tell asked what was happening. Kevin said she was hesitant to talk any more about the issue for fear of what Dr. Tell may do. Although Dr. Tell reminded Kevin of the confidentiality laws, she continued to struggle with uncertainty until she blurted out that, during a heated discussion, her boyfriend said that looking at online porn was not as bad as what his uncle did. She continued by detailing how her boyfriend described how his uncle collected and distributed child porn. The boyfriend expressly forbid Kevin to tell anyone. Kevin then asked if she should just give the pertinent information about the uncle to Dr. Tell so that the authorities could be advised without her getting involved. Kevin was feeling very helpless and vulnerable.