A Case for Standards of Counseling Practice

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A mature counseling profession has entered the decade of the 1990s. Several factors including professionalism, accountability, health care consumerism, credentialism, and public demands for quality mental health care indicate a need for more definitive statements on standards of practice in counseling. In response to this need, an 8-point proposal for standards of practice in mental health counseling is offered.

With a confluence of significant forces shaping the next decade of counseling in the United States, the 1990s are full of promise. From my perspective, five discernable forces influencing the counseling profession include (a) a growing demand for quality mental health counseling; (b) increasing public awareness of specific issues in mental health care and general health care consumerism; (c) increasing demands for quality assurance, accountability, and containment of mental health care cost; (d) a progressing state-by-state wave of credentialism and licensure; and (e) increasing national emphasis on counselor professionalism. Positively affecting the profession of counseling, these forces signal that the 1990s must be a decade with clear and definitive standards of practice.

Existing laws, standards of practice, and codes of ethics have shaped the expectations and views that counselors have of professional conduct. The time has undoubtedly come, as VanZandt (1990) stated, for professionalism in counseling to become a matter of personal initiative. Also, Hopkins and Anderson (1990), Corey, Corey, and Callanan (1988), Tennyson and Strom (1986), Van Hoose (1986), and Kitchener (1984) have advanced calls for counselors to rise to a higher standard of ethical reasoning and responsibility. It is evident that the profession must outline agreed-upon standards of practice.

Gibson and Mitchell (1990) observed: "A profession's commitment to appropriate ethical and legal standards is critical to the profession's earning, maintaining, and deserving the public's trust. Without this trust, a profession ceases to be a profession" (p. 451). Beyond this important point of public trust, VanZandt (1990) proposed an expectation that counselors grow in professional ideals and standards and stated, "Professionalism should impel us to go beyond our own ideals and to encourage high standards ... from colleagues, as well" (p. 245).

As can be seen, the forces of public and professional accountability, consumerism, credentialism, professionalism, and a growing public demand for higher quality mental health care are dictating a need for higher standards of practice. In response to this need, an 8-point proposal for standards of practice in counseling is presented.

PROPOSED STANDARDS OF PRACTICE

The following standards of practice represent a challenging but minimally acceptable criterion for quality assurance in the counseling profession. As the profession enters the new decade, eight concerns about case management, clinical treatment, and professional competency stand out as critical issues. These eight include minimal standards for influencing the use or need for (a) professional disclosure statements, (b) treatment plans, (c) clinical progress notes, (d) formative evaluations, (e) documentation of consultation or supervision, (f) professional performance evaluation and peer review, (g) psychotherapy for impaired practitioners, and (h) awareness of and responsiveness to ethical and legal foundations of the profession.

Adopting professional standards in the aforementioned eight areas provides a basis for accountability, reduced ethical and legal vulnerability, and consistency in training and practice in mental health counseling. The following discussion summarizes my position that the counseling profession should clearly articulate standards of practice, including definitive statements about each of these eight concerns.

Professional Disclosure Statements

All counselors involved in mental health counseling should provide consumers with professional disclosure statements. A professional disclosure statement should respond to a client's ethical rights to informed consent. It is a document that sets forth counselors' qualifications, treatment philosophies and methods, and business management practices. Ideas about such a standard of practice have been recently discussed in the literature.

In a study of professional disclosure in the counseling relationship, Hendrick (1988) investigated areas of counselor disclosure that clients might find desirable. Hendrick's finding affirmed that clients do want information about their counselors, including information about counselor training and orientation to therapy. In an earlier study, Epperson and Lewis (1987) also concluded that there is a "need for more explicit pretherapy information to enable clients to make an informed choice about entering a counseling relationship" (p. 266). A client's informed consent is an important precondition for the effective initiation of counseling.

Baruth and Huber (1985) related informed consent to the ethical issue of client rights. Ethical codes adopted by various professional associations require their membership to inform consumers regarding the extent and nature of services offered. Informed consent requirements are reflected in several professional ethical codes or standards of practice: (a) the American School Counselor Association's (ASCA) *Role Statement: The Practice of Guidance and Counseling By School Counselors* (ASCA, 1981); (b) the American Association for Counseling and Development (AACD) *Ethical Standards* Section B.8: Counseling Relationship (AACD, 1988); (c) the American Psychological Association (APA) *Ethical Principles of Psychologists* Principle 4.g: Public Statements and Principle 6: Welfare of the Consumer (APA, 1989); (d) The American Mental Health Counselors Association (AMHCA) *Code of Ethics for Mental Health Counselors* Principle 4: Public Statements and Principle 6.e: Welfare of the Consumer (AMHCA, 1986); (e) the *Code of Ethics* of the National Academy of Certified Clinical Mental Health Counselors (NACCMHC) Principle 6: Welfare of the Consumer (NACCMHC, 1982); and (f) the *Code of Professional Ethics* of the

American Association for Marriage and Family Therapy (AAMFT) Principle 7: Advertising (AAMFT, 1988).

Various codes of ethics affirm clients' rights to informed consent and call for varying degrees of professional disclosure. The 1986 *Code of Ethics for Mental Health Counselors* (cited in Gibson & Mitchell, 1990) provides a definitive statement on a client's right to informed consent:

> Mental health counselors are responsible for making their services readily accessible to clients in a manner that facilitates the client's ability to make an informed choice when selecting a service provider. This responsibility includes a clear description of what the clients may expect in the way of tests, reports, billing, therapeutic regime and schedules and the use of the mental health counselor's Statement of Professional Disclosure. (p. 517)

Paradise (1990) reported that in the state of Louisiana, consumers' right to informed consent is not only an ethical standard but is also a statutory requirement for licensure. Although the profession asserts practical, ethical, and legal needs for professional disclosure statements in counseling, the preferred format and content of a statement is indefinite and vague, giving professionals in the field considerable flexibility in describing their work and responding to clients' needs.

Gill (1986) offered a model of professional disclosure that may be of considerable value in informing potential clients about the theoretical, philosophical, and practical approaches, methods, and strategies that counselors use in treating mental health problems. Gill's model requires clinicians to outline attainable results, populations served, and client rights and responsibilities. A professional disclosure statement also might explain areas of competency and limits of practice. Other topics covered in a professional disclosure statement might include a description of the client-counselor relationship, fees and billing policies, and policies on management of records, confidentiality, and procedures for crisis management.

Besides Gill's work (1986), Paradise (1990), Gross (1977), Swanson (1979), Winborn (1977), and Remley (1989) also have offered practical examples and suggestions for developing professional disclosure statements. A consumer rights brochure developed by the National Board of Certified Counselors and Chi Sigma Iota Honor Society (1988) also may yield valuable information for developing a consumer-oriented disclosure statement.

Consumers of mental health care need to know about their counselors, their treatment approaches, and their management practices. Professional disclosure statements are effective means of achieving this desired goal.

Treatment Plans

Counseling is a process of carrying out and evaluating treatment provided within a psychotherapeutic milieu. Combined with a consistent philosophy, theory, and practical formulation of treatment, assessment, and diagnostic observations are developed into treatment plans designed to achieve developmental, remedial, or rehabilitative goals and objectives. Developmental, remedial, and rehabilitative goals and objectives of the counseling process are more efficiently achieved through the appropriate use of treatment plans. Counselors' use of treatment plans should be a fundamental standard of client care.

A basic treatment plan should include a psychosocial history and objective data that relate to a diagnostic system such as the *Diagnostic and Statistical Manual-Revised (DSM-III-R;* American Psychiatric Association, 1987). Initial appraisal also should consider a client's adaptive functioning, prognosis, and preferred treatment options. An evaluation of the adequacy of the counselor's skill and experience and need for referral and other expert consultations are other important planning considerations. Concurrent therapist involvement and potential for a dual relationship also should be elements of routine assessment data.

Treatment planning and case management are exceptionally complex processes of compiling, collating, and synthesizing information about counseling, the client, and the counselor. In a recent study by the Virginia Board of Professional Counselors, Anderson (1989) reviewed reasons for a 20% incidence of failures during oral licensure examination sessions from 1988–1989. The study involved the examination of 262 candidates for licensure. The board certified 52 failures and noted 136 citations of deficiencies in candidate performance. Content analysis of reasons given for examination failures revealed that 58.2% of the examination failures resulted from deficiencies in the candidate's ability to integrate assessment and diagnostic data with theory, techniques, treatment planning, and case management strategies.

An effective treatment plan should clearly outline a consistent relationship among diagnosis, treatment goals, counselor philosophy, theory, and counseling techniques. Developing and executing a treatment plan, which require a high level of conceptual and planning ability, may be the most difficult and demanding aspects of the therapeutic process. Effective planning for treatment requires a demonstration of those complex skills.

Piazza and Baruth (1990) proposed guidelines for maintaining client records and an outline of the important elements of treatment planning. Seligman's (1986) illuminating examination of diagnosis and treatment planning gives a very useful description of various dimensions of the treatment planning process. A more recent work by Seligman (1990) also contributes a wealth of planning information for treating adult mental disorders. Each of these works may be helpful to counselors concerned about this critically important aspect of counseling practice. Treatment planning cannot continue to be an optional element of clinical practice. Demands for accountability and cost effectiveness compel us to require treatment planning as necessary and essential for the delivery of quality mental health care.

Clinical Progress Notes and Records

One widely held opinion is that mental health counselors are not legally or ethically required to maintain case notes (Remley, 1989); Piazza and Baruth (1990), however, offered a notable caution in stating, "Keeping client records is necessary both for the client's welfare and for the protection of the counselor" (p. 313). A practical reality is that case notes and other records of clinical assessments and evaluations, referrals and consultations, and case summaries serve three important functions in treatment. Notes and records provide (a) a summary of the course and results of treatment, (b) a basis for treatment justification and an ethical and legal defense, and (c) a basis for future treatment of a client by the same or a different practitioner (Kissel, 1983; Mitchell, 1991); Pressman, 1979). These three important functions of clinical notes and records offer compelling reasons why maintaining records and following a record retention policy should be a minimally expected standard of practice in counseling.

Maintaining progress notes serves to reduce ethical and legal risk and provides data for formative and summative evaluations, referral, or future treatment planning. Opinions regarding the content and format of case notes vary. Yet, a broadly accepted position is that case notes should be objective and factual documentation of clinical processes and

outcomes (Kissel, 1983; Pressman, 1979; Snider, 1987). Remley (1989) offered a summary of important legal, ethical, and practical aspects of maintaining case notes. A discussion of case notes in counseling by Hass and Malouf (1989), Kissel (1983), Mitchell (1991), Nan and Pfost (1985), Piazza and Baruth (1990), Seligman (1986), and Snider (1987) also may be helpful to clinicians who want to reassess this aspect of their clinical practice.

Formative Clinical Evaluations

Clients should contribute to setting counseling goals and should participate in evaluating the process and outcomes of treatment. Minimum standards of practice should include an expectation that counselors will conduct formative or ongoing evaluations of treatment, including clients' evaluation inputs.

The AACD *Ethical Standards* Section A.1 (1988) requires the pursuit of continuous professional evaluation. One specific expectation states, "Members must gather data on their effectiveness and be guided by the findings" (AACD, 1988). Continual evaluation of professional effectiveness requires evaluation of counselor practice. Formative evaluations of counselor effectiveness are a means to achieving the desirable standard of professional self-evaluation, which can direct plans for professional growth and development.

Formative evaluations in counseling practice involve periodic evaluations of treatment processes and outcomes in relationship to a defined criterion or objective of a treatment plan. Therapists may find it useful to involve clients in formative appraisals of counseling, especially during middle phases of treatment. Periodic assessment of content concerns such as goals, methods, and strategies, and process questions such as how clients experience empathy, positive regard, genuineness, and immediacy can contribute useful feedback about clients' experiences in treatment and clients' perceptions of progress.

Silberschatz, Curtis, and Nathans (1989) explored the application of a "patient plan" as a means of case formulation and treatment. The patient plan was described as statements of a patient's goals, inhibiting beliefs, typical responses in treatment, and desired insights. Although the concept of a patient-specific treatment plan has not had the benefit of broad applications and critical review, the concept does seem especially suited to process and outcome research and evaluation in counseling.

Formative evaluations provide evaluative feedback regarding the counseling process. The outcomes of such periodic assessments of treatment are valuable elements of a record of treatment and are convincing bases upon which to justify the course of treatment or changes made to improve treatment.

Clinical Outcome Evaluation and Research

Although formative evaluations of counselor effectiveness are periodic and focused on intermediate goals of counseling, outcome evaluations and research center on the overall effectiveness of the counselor in achieving goals and objectives of the treatment plan. Outcome assessments may be difficult because counseling is a private and closed interpersonal process. Sources of useful and objective valuative information about counselors' performance are scarce if information is limited to the counselor's perception of their outcome effectiveness. Mental health counselors should continually seek reliable and diverse sources of information about their performance and the efficacy of treatment. Constructive information about the counseling process comes from four primary sources: (a) personal evaluation, (b) formal peer supervision and consultation, (c) informal and anecdotal client reactions, and (d) formal outcome appraisals.

Mental health counselors may find it difficult and somewhat unappealing to conduct formal outcome studies or other clinical research. Such studies are not a popular aspect of contemporary clinical practice nor have they been a dominant part of the clinical tradition of the applied behavioral sciences (Gladding, 1989; Vacc & Loesch, 1987). Minimal standards of clinical practice, however, should include periodic appraisal of counselor effectiveness. Self, peer, and client valuative reactions and responses are sources of data useful in performance evaluations. Because the therapist's performance is a potent variable affecting the outcome of treatment, it is necessary to establish a minimum standard of practice that requires counselors to evaluate their effectiveness. Consultation, supervision, and peer review are other sources of evaluative information available to the counselor.

Documentation of Consultation, Supervision, and Referral

Mental health consultation, case supervision, and referral are treatment options useful to mental health counselors (Bloom, 1977; Caplan, 1970; Corey, Corey, & Callanan, 1988; Dougherty, 1990; Gladding, 1988; Hershenson & Power, 1987; Kurpius, 1978; Kurpius & Robinson, 1978). Mental health counselors should affirm minimal standards of practice that require the judicious use of consultation, case supervision, and referral between behavioral health professionals. These treatment strategies are valuable sources of objective clinical assessments, especially during the formative stages of treatment planning and latter stages of treatment. Such activities can yield opinions useful as a basis for more reliable clinical judgment and personal and professional accountability. Formal records or case notations about these essential treatment activities provide a helpful second opinion and convincing evidence of the appropriateness of treatment.

Supervision is recognized as an important element of counselor training as well as an integral component of continuing clinical practice. Supervision is defined by the Association for Counselor Education and Supervision (ACES, 1989) as the following:

> [T]eaching and developmental activities such as observation, consultation, modeling, role playing, review of records, and other procedures, all of which are related to the interaction between a counselor and client(s). (p. 7)

ACES (1989) has recently adopted standards for counselor supervisors' knowledge, competencies, and responsibilities. One purpose of these supervision standards is to identify practice standards that ensure that some measure of accountability to the public and training institutions is established. Although these standards focus on standards of supervision as a consulting practice, they also provide a solid ethical basis for qualitatively defining knowledge, competencies, and responsibilities of those engaged in the provision of such professional consultation. Similar ethical standards of supervision are being reviewed by various state boards of professional counseling (Borders, 1990) and national accreditation and certification organizations. Clearly, the need exists for clinical supervision to be viewed as an essential training and ongoing clinical requirement of the profession. Bernard and Goodyear (1992) provided a good review of the literature and pragmatic assessments of clinical supervision in the field of counseling.

Psychotherapy for Impaired Practitioners

Mental health care providers may find their effectiveness impaired because of difficulty in managing personal life experiences and professional demands. Trends in ethical complaints (APA, 1988) suggest, in part, that intimate dual relationships, substance abuse, greed, and an inability to maintain confidentiality are signs of personal and professional impairment that results in ethical complaints and legal charges. The APA *Ethical Principles of Psychologists* Principle 2.f states the following:

> Psychologists recognize that personal problems and conflicts may interfere with professional effectiveness. Accordingly, they refrain from undertaking any activity in which their personal problems are likely to lead to inadequate performance or harm to a client, colleague, student, or research participant. (APA, 1989)

Robinson (1988) related counselor competency to levels of counselor personal functioning and concluded that "our competency is limited by our own self-awareness and psychological health and maturity" (p. 4).

A popular term for the syndrome of personal incapacity affecting professional performance is *burnout*. Watkins (1986) provided an examination of burnout and discussed implications of this disability. In a more recent article, Stadler, Willing, Eberhage, and Ward (1988) insisted that the problem of impaired counselors has not been adequately addressed in the literature. One recommendation of these authors is that counseling professionals should "directly confront their own vulnerability and the personal pain associated with healing work" (Stadler et al., 1988, p. 260). Their conclusion was that "impaired mental health care professionals do present a threat to the maintenance of professional standards and quality care" (p. 259).

Mental health practitioners should heed the cautions of Stadler et al. (1988) and Robinson (1988) and become more sensitive to their vulnerability to personal and professional impairment. Self-appraisal and peer and client evaluation of a counselor's conduct can reveal important clues of an eminent or existing disability. Seeking competent professional assistance is a reasonable expectation for an impaired practitioner who shows symptoms of burnout, occupational maladjustment, or other incapacitating physical, emotional, or mental disability. Robinson's (1988) observations summarize well the issue of ethics and impairment:

> Each of us has an ethical responsibility for objective and thorough self-examination to determine our readiness to be a counselor, to acknowledge when we have become 'impaired,' and to seek help for our own concerns and pains. Perhaps these are our first and foremost ethical responsibilities—to determine our abilities to be of professional assistance to the client. (p. 4)

Responsible peer review, assertive professional regulation and discipline, and mandated treatment for impaired practitioners are standards that must be embraced in the 1990s.

Legal and Ethical Awareness

A thorough understanding of one's code of ethics is the foundation of professionalism. Offering a description of the code of ethics in counseling as "a basis for articulating the responsibilities of a member of a profession," Mabe and Rollin (1986, p. 294) cautioned:

> We fear that many professionals may see a code of ethics as the sole basis for explicating responsibility for its members. The code is clearly a central part, but only a part, of the basis for explication of professional responsibility. A professional code is necessary but not sufficient for the exercise of professional responsibility.

Sensitivity to current legal and ethical principles and issues in counseling and a knowledge of their limitations in defining the appropriateness of treatment are essential to the practice of counseling. Members of the profession should know and understand legal and ethical issues confronting the profession. As has been our tradition, we should continue to maintain and emphasize this minimal criterion of professionalism in counseling.

A recent AACD national teleconference on ethics and the law in counseling provided an informative overview of current legal and ethical challenges facing counseling practitioners. The codes of ethics for AACD and AMHCA, the *Ethical Standards Casebook* (Herlihy & Golden, 1989), and the AACD "National Teleconference: Legal and Ethical Challenges in Counseling" (AACD, 1989) are excellent resources to help achieve and maintain a minimum standard of ethical and legal awareness. Counselors also can find sound advice on legal and ethical issues in recent contributions by Thompson (1989), Corey, Corey, and Callanan (1988), Corey (1991), and Hopkins and Anderson (1990) and an excellent examination of ethical concerns from a perspective of time and stages of treatment in counseling by DePauw (1986).

SUMMARY

The counseling profession will reach a significantly higher level of professional maturity in the 1990s. Collectively, the profession and its members will attain enhanced professionalism through influences and initiatives of individual practitioners who seek higher standards of professional conduct. I call on the profession as a whole to adopt minimum standards of practice in eight essential areas: (a) use of professional disclosure statements; (b) treatment plans; (c) clinical progress notes and records; (d) formative process evaluations; (e) documented consultation, supervision, and referral; (f) summative performance evaluations; (g) treatment for impaired professionals; and (h) greater ethical and legal awareness. Future discussions and reanalysis of these proposed standards can lead to definitive statements of practice standards that will provide for more accountability and effectiveness in counseling practice.

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