

Ethical Dilemmas Facing Clinical Supervisors in Integrated Health Care Settings

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Abstract

The various professions in Integrated Health Care Settings (IHCS) implement confidentiality differently. Lower status clinical social workers in IHCS need to advocate effectively for their profession's perspective. Clinical social work supervisors have special responsibilities. This article explicates this ethical dilemma and explains how a social worker traversed this dilemma.

Keywords: Ethical dilemma, clinical supervision, integrated healthcare, confidentiality, and psychotherapy notes

Introduction

The entire March 2013 issue of *Families, Systems & Health: The Journal of Collaborative Family Healthcare* focused on how, in IHCS, various professions' ethical guidelines can co-exist and conflicts can be dealt with. Regrettably, social workers and clinical supervisors were not included. This article addresses these issues from a supervising clinical social worker's perspective.

The article will first explore the relevant issues for clinical social work supervisors in IHCSs and will also share how the author dealt with these challenges in the IHCS that he worked in.

The Study Issue: Ethical Dilemmas in an Integrated Health Care Setting

Clinical social work supervisors face unique ethical challenges when they work in IHCS. IHCS

maximize integrated, holistic care by integrating behavioral health into a health setting. The various professions in these IHCS teams come at relevant ethical issues from different value stances and different levels of power. These settings are common on college campuses, rural settings, military care, and when treating populations with unmet mental health needs due to a high degree of stigma (Mullin & Stenger, 2013, p. 69).

There are a variety of ways that healthcare administrators integrate behavioral health into their setting. In some, the behavioral health practitioners (BHPs) (including clinical social workers) consult in 15- or 30-minute increments in the same curtained exam rooms that the primary care physicians (PCPs) use. (BHPs are comprised of psychiatrists, psychiatric nurse practitioners, psychologists, clinical social workers, marriage and family therapists, and counselors.) In others, behavioral health is provided behind closed doors in offices slightly removed from the hubbub of the PCP's environment, and short-term therapy is provided within the 50-minute hour context. In some IHCS settings, the BHPs only see clients who are referred by the PCP, in others they see those clients—as well as self-referred clients. (Bryan, Corso, Neal-Walden & Rudd, 2009, p. 149). BHPs in an IHCS are more likely to work on helping clients cope with chronic physical health problems (e.g., pain, asthma, diabetes) than are their colleagues in traditional settings (Cummings, O'Donohue, Hayes, & Follette, 2001, p.24).

The various professions that work together in

an IHCS have different codes of ethics and traditions related to client confidentiality, informed consent, and record keeping (Browne, A et al., 1995, p. 1002; Dobmeyer, 2013, p. 67; Hodgson, Mendenhall, & Lamson, 2013, p. 28; Hudgins, Rose, Fifield, & Arnault, 2013, p. 9; Hudgins, Rose, Fifield, & Arnault, 2014, p. 388). The hierarchy, which decides how the IHCS agency will resolve its ethical conflicts, has administrators at the top, PCPs near the top, ancillary health care providers under the PCP's direction next, and BHPs as members of the team who do not directly work under the PCP's direction, but are considered independent providers in a relatively new and ambiguously collegial position (Boice, 2012, pp. 136–37). BHPs are perceived as acclimating to the IHCS and coming to it with impractical ideas about patient care from prior experiences in 'specialty clinics' (Dobmeyer, 2013, p. 67; Hudgins et al., 2013, p.15; Hudgins et al., 2014, p. 383; Kanzler, Goodie, Hunter, Glotfelter, & Bodart, 2013, p. 48). To cope within this new environment, Boice (2012) recommends, "BHPs should work diligently at building collaborative relationships while being careful to respect and avoid criticizing the (IHCS) culture" (pp. 136–37). Kanzler et al. (2013) cautions "(BHP's) ethics code(s) ... seem most applicable to mental health providers practicing in specialty mental health clinics. As such, the (BHP) may have to extrapolate discipline-specific ethical principles and incorporate the ethics guidance from health care professionals (e.g., AMA) to ensure ethical practice in the (IHCS) environment" (p. 48). In stark contrast, Hudgins et al. (2013) discourages:

the assumption by some in the field that due to the more medically focused interventions of a BHP in an (IHCS), that BHPs differ from that of a traditional or specialized mental health provider ... and their practice is, therefore, not governed by the regulations applied to their licenses. ... The assumption of immunity of the BHP from mental health licensing laws and ethical standards has not yet been tested, and BHPs ... remain

under scrutiny by (their profession's) standards as their interventions are seen to fall within the scope of their regulatory boards. Licensing laws apply to one's profession and not exclusively to the type or location of practice. ... If it waddles, quacks, and swims like a duck, it will be treated like a duck, even if you are calling it an elephant (p. 15).

BHPs often have little formal power, but they can have significant influence on how their IHCS implements client confidentiality, informed consent, and record keeping if they use their active listening and effective teamwork skills (Kotter, 2010) and can demonstrate that their work improves patient outcomes (Runyan, Robinson, & Gould, 2013, p. 4). In this IHCS mélange of various physical health and BHP professionals, tough ethical issues are extant and being worked out. The voices of social workers and clinical supervisors need to be included in this conversation.

Non-supervising BHPs can more easily defer to their IHCS's values of efficiency and holistic medical care. Therefore, *de minimus* progress notes can be used and they can require clients to sign a Notice of Privacy Protection form (NPP) that broadens who, within the IHCS, can read their short, sparse, efficient notes. Non-supervising BHPs may need to keep their own triple locked, handwritten "psychotherapy notes" out of the electronic health record (EHR) in order to track clinical process and sensitive material, or—if their EHR software allows—create psychotherapy notes, in addition to their progress notes, that are only accessible to them. This meets the minimal legal standards that differentiate short, efficient "progress notes" from much more highly protected "psychotherapy notes" (Luepker, 2012, p. 91)—as long as these handwritten notes are considered a part of the client's chart. However, this may pose a dilemma. It would not allow the mental health team to best treat their client in crises when the BHP is absent. In addition, the non-supervising BHP would need to rationalize why they are prioritizing agency efficiency over

their client's self-determination when a client does not want to sign an NPP that allows a broad array of IHCS staff to read their mental health progress notes. These notes may be succinct, but they do document that the client is in therapy, as well as their diagnoses and prognosis. Many clients want to limit who has access to that "succinct" information. Non-supervising BHPs can ethically practice in an IHCS, but it involves decisions that could affect the quality of patient care since the notes in the EHR are designed to not be robust and detailed and since some clients will feel coerced by the requirement that the IHCS's NPP had to be signed. A potential outcome of this is that some staff will have access to their client's mental health progress notes, even though the client doesn't want those staff to even know that they are in therapy. A non-supervising BHP could say that the reduction in stigma about receiving mental health services where clients receive their physical health care and the potential efficiencies that allow more clients to be served can tilt the balance of conflicting ethical concerns toward accommodating the IHCS's ethical priorities. Non-supervising BHPs would be wise to not consider this a settled issue since IHCS administrators may push to broaden the NPP, so even more IHCS staff, outside consultants and others can read their progress notes (coaches, team doctors, physical therapists, dieticians, etc.) In addition, administrators and insurance companies who prioritize the values of efficiency and do not fully understand the importance of confidentiality in psychotherapy (or "behavioral health") may push legislation to change the Health Insurance Portability and Accountability Act (HIPAA) and state licensure laws to save money and serve more clients with limited resources.

Why is it more challenging for the BHP who is a clinical supervisor? Clinical Social Work supervisors are more responsible than their non-supervising BHP peers in the ethical resolution of confidentiality, informed consent that respects client self-determination, and how records are documented. In addition to responsibility for being an exemplar with their own clinical work, they are responsible for their supervisees' work and for teaching them

how to be ethical clinicians (Boulianne, Laurin & Firket, 2013; Cohen, 2004; Congress, 1992; Jacobs, David & Meyer, 1995; Kadushin & Harkness, 2002; Munson, 2001; Storm & Todd, 2002). Clinical supervisors rely on standards of clinical social work supervision, HIPAA, and both NASW's and the Society for Clinical Social Work's Codes of Ethics. Supervising BHPs are concerned about the values of efficiency and holistic care, but give priority to the values of (1) protecting client privacy and confidentiality, (2) expanding students' and interns' scopes of practice while maintaining clinical quality through close supervision and (3) respecting client self-determination. Supervisors, therefore, seek to minimize the IHCS staff who can read their supervisees' clients' mental health notes and to ensure that clients can "opt out" of a holistic, integrated health care agency's HIPAA NPP without losing access to services.

Clarity about the three different kinds of mental health notes promotes the understanding of what documentation options exist for mental health practitioners in the United States. HIPAA (HIPAA, 2010), prompted by the court rulings *Jaffee v. Redmond* (1996) and *Berg v. Berg* (2005), designates two types of mental health documentation that are a part of a client's chart, and traditional psychotherapy supervision practice uses a third that is not a part of the client's chart. The three types of documentation are: (1) progress notes, (2) psychotherapy notes, and (3) process recordings. Some non-clinicians confuse what a psychotherapy note is versus a process recording because the definition of a psychotherapy note, within HIPAA, includes analyzing the content of the therapeutic process. Hudgins et al. (2013) clarifies how the first two "notes" are legally defined in HIPAA:

No distinction is made for information generated by a BHP (compared to a health care practitioner) according to HIPAA, except in the case of "psychotherapy notes." HIPAA defined these notes as that by a mental health professional documenting or analyzing the

contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. (But are still a part of it). The definition excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date (45CFR 164.501) (p. 13).

Within HIPAA, mental health progress notes were predominantly designed to document information that the billing staff could use to process payment, and this is what BHPs document in IHCS to facilitate holistic care with their physical health teammates. Since they exclude most of the information about clinical process, the BHP's analysis and details about the client's sensitive information, these notes are not adequate for clinical supervision. Psychotherapy notes are richer documents that are more conducive to effective clinical supervision. However, the need for them to be separated from the rest of the chart (but still a part of it) allows support staff to release information without releasing sensitive chart details that could harm the client if released without discretion. Psychotherapy notes can help clinical supervisors better decide which client's therapy session should be more deeply explored via a process recording.

Supervisees often document between 10 and 30 sessions a week. Clinical supervisors read these notes, cosign them and glean information about their supervisees' learning issues, quality of care and indications of countertransference (the supervised clinician's feelings about their client that can be an obstacle to care or an opportunity for enrichment) (Freud, 1910) (Greenberg & Mitchell, 1983) and projective identification (when a client reenacts a personal issue within the therapeutic relationship outside the awareness of the client) (Ogden,

1977). Clinical supervisors often have four to five supervisees at a time. This can lead to an avalanche of paperwork review that can feel overwhelming and bureaucratically useless, unless useful information that enhances the clinical supervision process is inside the notes. Having supervisees write psychotherapy notes, instead of progress notes, promotes this. Supervisees are often directed to read their supervisor's clinical documentation. They would, also, learn more by reading the supervisor's more detailed psychotherapy notes.

For clarification, here are three different mental health notes for the same fictional session (with fictional clients):

As the exemplar notes indicate, the progress note is too sparse to alert a supervising clinician that more focus, depth, and understanding is needed with this case. The psychotherapy note is much richer and allows the clinician to be alerted to potential learning problems, countertransference, and problems with the quality of care that the supervisee provides. Social workers who do not supervise may not be aware that supervisees can tend to focus on cases that are going well instead of problematic cases (Jacobs, David & Meyer, 1995, p. 47). Supervisees are often highly anxious about their clinical work being judged and may have only had past non-clinical supervisors who were punitive and belittling.

It is not uncommon for a supervisee to write a progress note like the exemplar of Ms. U's parent guidance session that states briefly what happens but almost obfuscates the issues involved. A supervisor would be curious about the progress note's emphasis on Ms. U's poor executive functions, the possibility of her having borderline personality disorder, and her preference to not be called by her first name but would be clearer about how to proceed in clinical supervision if the exemplar psychotherapy note was read instead. With the process recording exemplar there is information about how racial and class differences may be affecting the work, and how countertransference and projective identification might be in play. The intense focus of a process recording would more likely be assigned to this case and optimally promote the supervisee's learning.

Figure 1 | Progress Note

<u>Pt:</u> <u>Shantaya Untaya</u>	<u>Collateral:</u> <u>Kwane Untaya</u>	<u>Date:</u> 01/30/2014
<u>Meds:</u> Adderall (takes regularly as Rx)	<u>Meds:</u> None Rx at <u>IHCS</u>	<u>Start/Stop:</u> 3:17/3:45
<u>Modality:</u> Parent Guidance (<u>Shantaya</u> not present)	<u>PsychTests:</u> None	

Tx Plan Goal #6: Discussed parenting skills and began to address how Ms. U dealt with a recent parenting issue. Tx used Love & Logic Parent Ed model emphasizing accountability and natural consequences.

Dx (MO's): PTSD, R/O Borderline PD

Sx (MO's): poor executive functions, low impulse control,

Progress/Prognosis: Ms. Untaya (*prefers to not be called by her first name*) is making slow progress. She may not be ready to parent Shantaya without external support when Shantaya's MATGRMO dies. She encouraged Tx to not give up on her.

Tx Signature: _____
Date: 02/01/2014

Figure 2 | Psychotherapy Note

Psychotherapy Note
 Parent Guidance with Ms. Kwane Untaya (31 yo) (for Shantaya Untaya (13 yo))
 2nd of 8 planned PG sessions Ms. U,
 16th of 30 planned individual sessions with SU,
 7th of 12 planned family therapy sessions with SU & GS (Ms. U may join in March.)

02/01/2014

D: Ms. U was 17 minutes late to her session and started by focusing on the different types of cars she and the therapist (tx) have. Tx encouraged her to use our remaining time today to work together and figure out what happened at her daughter's birthday party. (This is the first birthday that Ms. U attended in 9 years, is the first since the family was told that Ms. U's MO, (Gertrude Smith, Shantaya's GRMO and primary parenting figure since 3 yo) has untreatable Stage III ovarian cancer, and the first where she has been "clean & sober" for more than 6 months.)
 Instead, Ms U. continued to insist that we talk about "the light green, eco-car out in the parking lot – not a dark, black powerful car." When Tx set limits and tried to refocus on her being late to her daughter's birthday party and unexpectedly bringing her boyfriend (who was high), Ms. U alluded to her being very dark skinned compared to her daughter and this Tx and to her Caucasian mother.
 Ms. U ended the session early and left with the mixed message that she does not want me to give up on her, and that she thinks she is going to meet with my supervisor and ask for a therapist who can work with "people like me." She added that she might ask the supervisor to assign a new therapist for her daughter.

A: Ms. U needs her Tx to work more on building a strong therapeutic relationship. She may need a clinician who is not also her daughter's therapist and her family's family therapist.

P: Nonjudgmentally encourage Ms. U to assert what she needs from her parent guidance worker/therapist. Continue to encourage the use of the same parenting program that Shantaya is used to (Love & Logic Parenting), but allow more room for MS. U to alter it so it can incorporate her own style.

Signature: _____ Date: ____/____/____
 Sup Co-signature: _____ Date: ____/____/____

Figure 3 | Process Recording 1st page

Verbatim Process	PT's Feelings/ Affects/ Behavior	My Gut Level Thoughts & Feelings	Analysis of Interventions/ Major Themes/ Issues/ Hunches	Diversity Issues	Theory	Supervisor's Comments/ Questions/ Reflections
<p>Third Parent Guidance Session 17th late Ms. U: I think I figured out that you drive the light green, eco-car in the parking lot am I right? TX: Kwame' we have about 30 min. left to today's session, I'd like us to focus on what happened at Shantaya's birthday party. Ms. U: I know you are not flexible about time. ... Most people do a little socializing before they get down to business. ... So you want to know about Shame's birthday party. Okay, ask away! TX: I heard from Shantaya, I wanted to hear your side of the story. Ms. U: And I want to know if that is your light green eco-car, why not a dark black powerful car? 7 second pause, with a long stare.</p>	<p>Embarrassed? Angry. Moved on? Scary? Stubborn?</p>	<p>Annoyed I need to set appropriate limits and expectations. OK, now we can get done what is needed.</p>	<p>Projecting blame for being late onto me. Relationship Building.</p>	<p>Where I come from showing up on time is a sign of respect. Ms. U comes from a different subculture.</p>	<p>Anal Stage?</p>	
<p>Ms. U: I never gave you permission to call me by my first name. You have her bee gee bees, don't you? My mother and my daughter --- you've already taking their side. They talk like you, they look more (wipes away tear) ... you take what I say with suspicion, I think I want to talk to your supervisor I don't think you can work with people like me.</p>	<p>Clarifying where she sees our relationship. Tears = suppressed anger?</p>	<p>The stare freaks me out. Is she going to be violent? What are her bee ...? I do feel nervous.</p>	<p>Limit setting, clarifying purpose of parent guidance. I was so caught up I did not respond to her tears.</p>	<p>Is Hee Bee Gee Bee a black culture term I am not familiar with?</p>	<p>She is projecting her suspiciousness on to me.</p>	

Figure 4 | Process Recording 2nd page

Verbatim Process	PT's Feelings/ Affects/ Behavior	My Gut Level Thoughts & Feelings	Analysis of Interventions/ Major Themes/ Issues/ Headers	Diversity Issues	Theory	Supervisor's Comments/ Questions/ Reflections
<p>TX: I do work better with people who show up on time. Here's my supervisor's card. Please feel free to call.</p> <p>Ms. U: You want to ...? ... Don't give up too easily on me and Shantaya. ... You need to toughen up.</p> <p>TX: Sometimes there is simply a personality conflict between a therapist and a client. There is no judgment here. I'm sure my supervisor can find a different counselor who will be less likely to have a personal...</p> <p>Ms. U: Shut up bitch! You give up too easy. Maybe I'll tell your supervisor that I want Shantaya to have a different therapist too!</p> <p>Ms. U gets up and leaves, and slams the door behind her.</p>	<p>Surprised look on her face.</p> <p>Fighting fur TX, but fighting.</p> <p>Listened with a stare</p> <p>Pure anger, threatening to take away what she knows I value.</p>	<p>What happened? This isn't me. I am so cold and uncaring. why?</p> <p>A really sick feeling. I was a bitch. Why? What happened? Very worried that I just blew up Shantaya's Therapy.</p>	<p>I am screwing up and making things worse.</p> <p>Cold. I need to warm up to her.</p> <p>I don't want to lose Shantaya. Her GrMo is dying. She needs me. Jealous of my good relationship with Shantaya?</p>	<p>Is she from a subculture where you have to earn calling her by her first name?</p>	<p>Masterson? BPD?</p>	

The supervisor might not be alerted to this need if the agency restricts documentation to progress notes.

Method: Exploring Teaching Strategies That Address Ethical Dilemmas

At the very beginning of clinical supervision, the supervisor emphasizes that supervision needs to be a space where the supervisee can talk about anything related to their work. Discussing countertransference, sexual attraction, the effects of racial/ethnic/gender differences, applying a variety of theories and strategies, and ethical dilemmas are specifically identified as areas that are essential for effective clinical supervision (Cohen, 2004). However, given young clinicians' anxiety over being judged by their supervisor and their lack of familiarity with professional ethical issues, it is important to ask frequently about these issues, to role model their discussion in the supervisor's presentation of their own cases during individual supervision, group supervision and case conference and by introducing supervisees to systematic approaches to resolving ethical issues.

When the overall agency faces an ethical dilemma, the clinical supervisor needs to go beyond their typical supervision strategies. Supervisees need to learn how to research the literature to better understand legal and ethical issues, know how to professionally seek a variety of perspectives to inform how they will attempt to resolve the issue, and determine if this is an issue they can quietly resolve in their supervised practice. At the micro level, does the client understand the NPP? Does the client know what will be in the notes that other team members can see? At the mezzo level, is it simply a matter of management not being fully informed? Or, are there intra-agency political issues involved that may need to be understood and addressed in order to advocate optimally to the agency administration? Or has it reached a point where macro level advocacy (outside the agency) is the only ethical route left? Part of this process includes developing the supervisees' skills in effective, professional advocacy—even if it is

decided that a quieter, in-house approach is needed.

Training starts with the supervisor asking supervisees to read broad ethics articles. Two of these include Topazian, Hook, & Mueller's (2013) article on the ethical duty to speak up to prevent patient harm, and Mattison's (2000) article on "applying the person-in-situation construct to ethical decision making." Articles like these introduce supervisees to their ethical role as a clinician and a strategy that is consistent with social work values that encourages the regular application of a process that requires self-awareness and knowledge of professional ethical concerns with the day-to-day ethical issues in clinical practice. Over their careers, students and post-graduate supervisees also need to use this foundation to deal with more complex and serious issues. The CA Society for Clinical Social Work has used Mattison's article as a guide for its ethics committee members for years (M. Montgomery, personal communication from CSCSW ethics committee chair, (March 15, 2012)).

Another author who helps supervisees understand the ethical resolution process is Reamer. Reamer (2013) explains:

No precise formula for resolving ethical dilemmas exists. Reasonable, thoughtful social workers can disagree about the ethical principles and criteria that ought to guide ethical decisions in any given case. But ethicists generally agree on the importance of approaching ethical decisions systematically, by following a series of steps to ensure that all aspects of the ethical dilemma are addressed. Following a series of clearly formulated steps allows social workers to enhance the quality of the ethical decisions they make. In my experience, social workers attempting to resolve ethical dilemmas find these steps helpful (pp. 77–78).

Reamer's very comprehensive framework should help the clinician find a path outside ethical quagmires that McAuliffe and Sudbery (2005)

describe when they state, “ethical dilemmas occur when the social worker sees herself as faced with a choice between two equally unwelcome alternatives which may involve a conflict of moral principles, and it is not clear which choice will be the right one. Ethical dilemmas, then, are difficult situations where often no “right” answer can be found” (p. 23).

Mattison (2000) also captures this sense of ambivalence even after an ethical dilemma is resolved. She clarifies, “Typically, the more troubling ethical decisions involve choosing from among possible choices of action, each of which offers potential benefits (good/good) or those in which each of the options at hand appears unattractive or undesirable (bad/bad). In either case, any option is never entirely satisfying” (p. 203).

It is the supervisor’s role to both give structure and support to guide his/her supervisee towards an ethical resolution that the supervisee and supervisor can live with, and to provide support to hold the ambivalence and “not knowing” that is a component of ethical decision-making.

The supervisor must be able to live with their supervisee’s ethical resolution because they are responsible for their supervisees’ work and this includes legal liability and risk to their licensure status. Reamer (2013) clarifies, “These claims usually cite the legal concept of *respondeat superior*, which means ‘let the master respond,’ and the doctrine of vicarious liability. That is, supervisors may be found liable for actions or inactions in which they were involved only vicariously or indirectly (and they) had some degree of control” (pp. 196–197).

The research in the supervision then focuses on the specific issue. Many graduate students, and even postgraduate clinicians, have not thought that they might need to protect their client’s confidentiality from administrative directives.

The following quotes are from articles my supervisees in an IHCS college counseling center found useful in their journey toward resolving the ethical dilemmas in that IHCS. They were eager to discuss and process how these related to their situation in their group supervision. The

predominant lesson learned by the supervisees is in brackets and in italics after each quote.

1. “BHPs are increasingly entering the world of primary care, and they are often struggling to satisfy the ethical standards of their profession as they manage relationships in this new world” (Reiter & Runyan, 2013, p. 20). [*We are not alone; others are struggling with this transition.*]
2. “BHPs are very susceptible to ethical violations in primary care. They must take special care to maintain fidelity to the ethical standards, and a patient-centered focus, while also being flexible to the unique demands of primary care” (Reiter & Runyan, 2013, p. 27). [*There are no easy black and white answers. If we get dogmatic we need to seek support/consultation to better appreciate the dilemma.*]
3. “Including (the patient’s history and full diagnostic formulation) in the patient’s general medical record might constitute a breach of privacy should patients (and non-BHP colleagues) not understand the terms used or why (bio-psycho-social) history—beyond what is needed to help the staff manage current medical conditions—is being communicated” (Benefield et al., 2006, p. 276). [*We need to write our notes with a broader audience in mind. We don’t just write for our supervisor and ourselves; our clients and our non-BHP colleagues can read these progress notes!*]
4. “(The client’s) sensitive information ... that does not immediately impact the patient’s current care should be omitted from the (BHP’s) progress

- notes); instead this information should be included in a separate patient file and stored with the mental health practitioner's secure files" (Benefield et al., 2006, p. 275). [*Working here, we can become inured to how sensitive our client's information is to them. We need to keep this in the front of our mind when we write our progress notes. But we also need to remember the details and share them with our supervisors so we can better understand our clients' needs.*]
5. "BHPs balance the protection of patient privacy with the necessary disclosure of information to other clinicians for care coordination. In the name of efficiency, ... patients who agree to collaborative care understand that sharing appropriate patient information with other clinicians on the treatment team is a customary part of practice. In documenting patient information in the medical record, which can be easily accessed by various medical personnel, (BHPs) in the (IHCS) communicate the necessary information to facilitate seamless integrated team care of behavioral health issues while being sensitive to and protective of patient information that is not relevant to medical care" (Nash, Khatri, Cubic, & Baird, 2013, p. 335). [*Our clients benefit from collaborative care. In our efforts to protect privacy, confidentiality, and client self-determination, we will also need to appreciate efficiency and collaboration.*]
 6. "(Information releases are) designed to be analogous to speed bumps, not roadblocks to care, adherence to the regulations requires thoughtful evaluation of what is necessary for the well-coordinated care of the patient" (Benefield et al., 2006, p. 276). [*Social workers value comprehensive informed consent when releasing client information to protect the therapeutic relationship. PCPs value timeliness and efficiency more than comprehensive informed consent because they are protecting the client's health and see clients every 15 minutes.*]
 7. "The primary goals of (HIPAA are) ... working to improve health care consumers' trust in the privacy of their personal information while creating integrated and fluid health care delivery systems" (Benefield et al., 2006, p. 274). [*HIPAA is more complex than we thought it would be. If we keep its intent in mind, it will help us serve the client.*]
 8. "The regulations known as HIPAA are the legislative grandchildren spawned by well warranted concerns for the privacy of patients' personal health information (PHI) and the noble desire to create a more integrated health care delivery system. These regulations provide for the proper assembly and secure maintenance of patient records. Additionally, patients are given greater control over and access to their personal information. Health care professionals are charged with using greater sensitivity and clarity when charting their patients' status and progress" (Benefield et al., 2006, p. 276). [*It is easy for us to see HIPAA as a bureaucratic obstacle. It is important that we understand that its intent is client empowerment and improved client care.*]

The graduate students spoke of these eight above quotes from the administration's, the medical provider's, their clients', and "how they would feel if they were the client's" perspectives in individual and group supervision. The clinical supervisor needs to encourage multiple perspectives taking in order to facilitate their ability to not resort to all or nothing thinking.

Discussion Through Case

Example: An IHCS/Confidentiality Case Over Three Years

Three second year MSW students each year and two post MSW associates were supervised and taught micro and mezzo level advocacy within a college counseling center where the Vice President of Student Affairs created a corporate culture which encouraged university administrators to be skeptical of the clinical director's reports of increased students' mental health needs and acuity (Varlotta, 2012). This management philosophy underlied the Health Center's Chief Administrative Officer's (COA) decision to change the HIPAA NPP to one where all staff including receptionists, dieticians, medical assistants, x-ray technicians and ophthalmologists, as well as people outside of the IHCS (coaches, team physicians, exercise physiotherapists) would have access to all notes—including from BHPs. The CAO changed the external staff component of the new NPP to be more in compliance with HIPAA after the mental health staff advocated through education. This educational advocacy was done for our clients and to uphold our professions' standards and had an internal political cost.

Working in an IHCS where the administration plans to implement confidentiality in an "expanded, cutting edge, efficient" manner that is inconsistent with the community's standard of care (e.g., Kaiser Health, Native American Health Center), required all clinicians—including supervisees—to research the legal and ethical issues more deeply than in more traditional settings. It was supportive and growth promoting to involve student supervisees' field instructors, to assign professional article searches and readings, and to require presentations on the

issue in group supervision. Though more work, and a detour from traditional clinical supervision, this research—in such a setting—is empowering and clarifies that ethical decisions are not decided in a top down manner, but are resolved through honest self-reflection, information gathering and thoughtful deliberation. It helped that the graduate students' field instructors were aware of the agency's challenges and addressed them in their classroom setting and in assigned papers.

It is imperative that the supervisor dispels groupthink amongst the supervisees. A space needs to be created where each supervisee learned how to resolve the agency's ethical dilemma in a way that was consistent with their understanding of what best meets their clients' needs, while staying within the structure of the clinical social work profession's values and the agency's mandates. In this specific case, some supervisees a.) Only entered progress notes in the chart and hand wrote the more extensive psychotherapy notes that were then kept in a thrice-locked cabinet, b.) Others always wrote progress notes for the IHCS team to read, but—when needed—added psychotherapy notes that our electronic health record e-locked and only allowed the supervisee and the IT director to unlock, and c.) A third smaller group predominantly wrote progress notes, but—when needed—wrote the e-locked psychotherapy notes instead of a progress note. There were administrative consequences for all three solutions.

Administrators wanted the chart to be completely electronic and did not want to provide lock boxes that supervisees could put their handwritten psychotherapy notes into. The supervisees who went this route purchased their own lock boxes and gave their supervisor the second key. They then, over time, allied with others who wanted material kept separate from the electronic chart—psychologists who wanted primary testing material and art therapists who wanted client's art kept separate. The administration was unhappy with all three of these groups keeping some material out of the electronic chart, but eventually stopped demanding that primary testing information and

client art be scanned into the electronic chart. They eventually defined the supervisees' hand written psychotherapy notes as process recordings and agreed they should, therefore, not be in the chart. This meant the supervisees often wrote two notes for one session, and at their supervisor's discretion might also need to do a genuine process recording. It also meant that the psychotherapy note did not meet the HIPAA standard of being a part of the chart, but with restricted access.

The second group received feedback from administration that their e-locked psychotherapy notes appeared in the chart as locked, and that it hurt trust and teamwork when team members did not have full access to all notes. The supervisor informed the primary care physicians about the type of information that was in these e-locked notes (e.g., trauma details) and they no longer asked for access. However, receptionists and medical assistants complained, "the therapists must think they are special, nobody else can lock a note." This continued to be a source of friction with administration. They were concerned that the use of e-locked psychotherapy notes slowed down the process of integration into a fully integrated health care system and threatened to take that e-capability away from the therapists. The PCP's provided quiet support for the therapists who write locked psychotherapy notes along with progress notes by pointing out that they (PCPs) can also e-lock notes (when they relate to HIV/AIDS) and by emphasizing that in both cases the staff who were complaining did not need the information in the e-locked notes to serve the student client efficiently.

The third strategy only lasted one month. Administration insisted that a note that was available to all had to be written in the chart for each service, so unlocked progress notes had to accompany any e-locked psychotherapy note.

This struggle between competing values can become personalized in agencies, and can put the supervisor's employment at risk if they advocate too loudly and passionately. However, if the supervisor advocates too quietly the supervisees can believe they are acquiescing and not advocating

for client needs. The clinical supervisor is often an agency employee with influence, but little formal power (Kotter, 2010) and needs to advocate for these issues on a mezzo level quietly, respectfully and behind closed doors. The need to advocate effectively while teaching supervisees how to identify and resolve the ethical issues themselves is a complex balance. On a micro level, the supervisor should discuss their own challenges and difficulties in explaining the NPP to a variety of students (from recently raped and in shock, to those with severe OCD) and how they discuss with clients what they will put in the chart that the entire Student Health & Counseling Services staff can read.

In this IHCS, as a consequence for this advocacy, the clinical supervisor's contract was not extended into the next academic year (along with four other clinicians who advocated for these issues on a mezzo level) and the college counseling center shifted to supervising pre-doctoral and post-doctoral psychology students instead of second year MSW student interns and graduated MSWs working toward licensure. Since the agency was a state university in California it could not require a 'gag order' that would prevent me from presenting this case. But, since the author would like to teach at this university he has not been explicit about its identity.

Implications for the Profession & Conclusion

Clinical social work supervision needs to be considered in IHCS's deciding how to develop their NPP and implement HIPAA. To assure quality of care and supervisee learning, IHCS's flexibility in allowing psychotherapy notes to be written and read only by mental health clinicians will promote the agency's mission. In this time of transition to more agencies becoming IHCS, micro and mezzo level advocacy skills are indicated and should be used by all mental health clinicians. However, in agencies where there are other agendas, the supervisor needs to identify when lawyers, union grievance and whistleblower procedures are necessary. NASW and Society for Clinical Social Work Code of Ethics need to be revised to strengthen clinical

supervisors' ability to assure quality patient care and strong learning opportunities. Myles Montgomery, LCSW, JD, the Ethics Chair of the California Society of Clinical Social Work, while revising the Code of Ethics in 2014 stated, "After the Great Recession agencies have started to do things they have never done before in the name of efficiency and cost savings. Clinical supervisors are often in the crucible, where they have an important role in pushing against policies that hurt clients. Our Code of Ethics needs to protect them in their efforts to protect the clients" (M. Montgomery, personal communication, July 14, 2014).

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