Sustaining Appropriate Clinical Boundaries in Home and Community Care

with Jan Heumann

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Summary

Due to the home and community-based location of their work, community support staff and other in-home care providers have unique challenges in maintaining appropriate clinical boundaries with their clients. In this session participants will explore numerous potential pitfalls that can ensnare well-meaning professionals. The Code of Ethics for Psychiatric Rehabilitation Practitioners will be used to demonstrate how an ethics code can be beneficial in guiding practice.

Notes

Transcript

Presenter

Jan Heumann holds a Bachelors degree in Recreational Therapy and Masters degree in Counseling Psychology. As a 28-year veteran in mental health, her experience includes work as a Recreational Therapist, a Psychosocial Rehabilitation Program Supervisor, Community Support Supervisor, Program Director at a Community Mental Health Center, and Training Director for a state-wide University of Missouri Extension project. She is currently the Clinical Director for New Horizons Community Support Services in Columbia, a position she has held for ten years.

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References

Codes of Ethics

US Psychiatric Rehab Association http://www.uspra.org/i4a/pages/index.cfm?pageid=3361

National Association of Social Workers http://www.socialworkers.org/pubs/code/default.asp

National Board for Certified Counselors http://nbcc.org/extras/pdfs/ethics/nbcc-codeofethics.pdf

Background Checks (MO)

Family Care Safety Registry *www.dhss.mo.gov/FCSR*

Missouri Check https://secure6.pointinspace.com/~kurtz/index2

CaseNet https://www.courts.mo.gov/casenet/base/welcome.do

Glossary

Boundary Violation—when a helping professional uses their relationship with their client to get their own needs met.

Code of Ethics—document designed to provide guidance to what is acceptable behavior. Codes of ethics also set forth values, principles and standards for professional behavior.

Dual Relationship—when a helping professional has more than one role with a client (e.g. community support worker and scout leader for client's child)

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Thom Pancella: Hello, and welcome to this MIMHTraining presentation on Sustaining Appropriate Clinical Boundaries in Home and Community Care. I'm Thom Pancella with the Missouri Institute of Mental Health. With me today is Jan Heumann. Jan holds a Bachelor's degree in Recreational Therapy, and a Master's degree in Counseling Psychology. She's a 28-year veteran in mental health, and her experience includes work as a Recreational Therapist, a Psychosocial Rehabilitation Program Supervisor, a Community Support Supervisor, a Program Director at a community mental health center, and Training Director for a statewide University of Missouri Extension project. Currently, she is the Clinical Director for New Horizons Community Support Services in Columbia, Missouri, and that's a position she's held for about ten years. Jan, thanks for joining us today.

Jan Heumann: Thanks so much, Thom; thanks for having me.

TP: So why is this topic—Sustaining Appropriate Clinical Boundaries—why is this important for home-based care providers?

JH: Well first I think that the topic is appropriate for all professionals who work in home—in helping professions. People have to constantly have this topic in front of them, thinking about issues that will arise. In particular with home -based care providers, whether they be case managers, home health workers, nurses, in-home therapists, I think that the

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problems that occur for—or the issues that come up for them are maybe just a little bit different than for someone who sits in an office, behind a desk, with a client.
For example, a very typical issue for a case manager is that they would go in home with a client to pick them up for a psychiatry appointment and bring them into an office. Well, let's say that when they get to the house or the apartment of the client that the person is still in their pajamas. So what do they do? Do they go into the apartment with a client in their pajamas? Do they assist them in dressing if they're in a hurry? Do they cancel an appointment instead, knowing full well that if they do that the receptionist and the physician and their supervisor is gonna be on them about canceling a very expensive appointment? What do they do if the client offers them coffee? Or breakfast? Or whatever, while they're getting ready? These are things that don't happen in an office, but they do occur in home.

TP: So what would constitute a—what's a boundary violation?

JH: Well, a boundary violation is pretty simply defined as when a helping professional uses their relationship with their client to get their own needs met. And this can happen, really, in kind of an accidental way, or it could be intentional. Some examples of kind of an accidental boundary violation would be—a very typical sort of a situation, again for a case manager, often times they have to go with a consumer to get their medications picked up at a

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pharmacy. And so, you get to the pharmacy and find out that the consumer has co-payments that have been stacking up, and the pharmacy's been kind enough to charge those, but it kind of reaches a level with the pharmacy where they say, "You've reached the cap on what you can charge and you're gonna have to make a payment on your co-pays today." But the client doesn't have the money. So, the case manager reaches into her pocket and pays that co-payment. Now, 'accidental' I say—is it a heinous crime that the case manager did what needed to be done to get the client their medication? Of course not. But it may lead to problems later on in the relationship, that may lead to some dependency issues, that may lead to some expectations on the part of that client for what the agency is going to continue to provide for them.

On the other hand, sometimes boundary violations are more intentional. An example of this might be having a client who works in, let's say, an oil change business, and as a job perk gets coupons for oil changes. But the client doesn't have a car, so he gives those coupons to his case manager, and the case manager uses them, knowing full well that it was a benefit gained from the client that would not be a normal job perk, and that probably he wouldn't even want to tell his co-workers or supervisor about this and keeps it secret, and uses that for his own gain.

So, again, it goes back to that definition, when the professional uses their relationship for the client—with the client—for their personal gain.

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TP: If the client gave the certificate or the coupon to the case manager, then wouldn't that be the client's responsibility—the client's fault?

JH: Ah, I'm glad you asked that, Thom. Actually, boundary violations are never a client's fault. And furthermore, they're really never the client's responsibility to fix. It's the professional's responsibility to pick up when there's been a boundary violation, and the professional's responsibility to make some sort of adjustment in the way they're doing business, such that that can be repaired.

TP: So how would a boundary violation be different from an ethics violation?

JH: Well, a boundary violation is actually a type of an ethics violation. Most in-home workers that we deal with in mental health are Bachelor's-level staff, and professionals report to—or are responsible to follow a code of ethics, a professional code of ethics—licensed professionals, registered professionals, certified professionals. Often times, in-home staff with Bachelor's degrees have never had exposure to an Ethics course in college, for example, and they're not licensed, certified or registered, so they do not have a code of ethics for their profession. Chances are, the agency that they work for has a code of ethics, and particularly if it's a lot of in-home workers are on contract somehow with a state agency, and might have a code of conduct in the code of state regulations—something like this.

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Again, thank you for your time. And thank you for your time Jan.

JH: Thanks so much Thom.

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But particularly a code of ethics they do not respond to or are not responsible to adhere to, and so a boundary violation really being a type of an ethics violation I think is kind of the more common type of way that I find that in-home staff need some assistance.

TP: Well, it sounds a little complicated, but let's get into some of the nuts and bolts. How do boundary violations come up?

JH: Well, I think there are lots of ways for boundary violations to come up. I've kind of broken it down into a few categories. The first one I think of as expediency issues. Sometimes, it's just faster to do it the wrong way. The example that I said earlier about the case manager at the pharmacy with the client is an example of, 'it's faster to do it this way.' Possibly—probably, the agency that this person works for has some sort of routine set up, some sort of procedure for how to assist consumers when they don't have enough money to pay their medication co-pays. It may be that there's a community agency that they go to to ask for assistance; it may be that the agency pays that co-pay for them; it may mean another level of advocacy at the pharmacy to charge it one more time, and to set up a payment plan, something that. But it's just easier in the moment to just go ahead and make that payment. So that's an example of an expediency issue.
Another way that I think that boundary violations arise I call, "Falling in Love and Falling in Like." That has to do with

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the fact that clients, consumers—they're people. They're people first; they have attractive qualities; they have things about them that we like as friend—as friend qualities, as human beings, people to spend time with—interests and things like this. And sometimes staff fall in love, or fall in like—in a friendship sort of a way are attracted to their clients; and then make some mistakes. Of course the biggest and baddest—we might as well get right out here—is having sex with clients. And I think all of these kinds of issues occur under this category of Falling in Love and Falling in Like, because staff are getting their own needs met through their client—their social needs; their love needs; their need to be liked—those kinds of things.

Another category that I always talk about is this category I call, "I Never Meant to Hurt You." This is really about the impact of ignorance in your practice or practicing over your head; practicing in a way that is not consistent or in line with your education, and your credentials, and your experience. Again, kind of classic example from the outpatient mental health world is a community support worker who has a weekly appointment set up with a client where, in essence, what they're doing is sitting down, talking, listening—having a therapy session; when in fact, the case manager/community support worker is not qualified to be doing therapy. And so what happens is they get in over their heads. There's actually a lot of evidence that bad therapy—which I guess we can just say is Boneheaded And Dumb—BAD Therapy—is harmful to clients. And so, when people practice over their heads, bad things can happen.

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the folks?

JH: Yes. I think kind of—when all else fails, one thing that we found to be helpful in several agencies that I've been at is just making a list—in addition to your code of ethics—make a list of those kinds of things that come up repeatedly for your staff. For example, don't give consumers your personal telephone number; that leads to problems in the evening and on the weekends where boundaries need to be set and a client has an expectation that they should be able to call at anytime. So maybe that's one thing that maybe you would want to put on your list. Some employees tell me, "No, that's standard procedure at our agency, and it's considered to be okay." So this making a list issue really has to be done agency by agency.

Some other examples might be don't loan money to consumers, don't borrow money from consumers, don't do personal errands when you're out with consumers. So all of these kinds of lists, if nothing else, you've made very clear that there are certain items that are forbidden. And if nothing else you can use it in personnel actions with problem staff.

TP: Well thank you for your time; it's been a very important topic and very helpful to us.

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TP: So if there isn't an existing code of ethics, is there a way to kind of formulate one?

JH: There should be many places that an employee or a supervisor can go to find a code of ethics. I do think that most helping professionals would have something in personnel policy, some sort of code of conduct or something in either personnel policy or just the larger policy and procedure for the agency. In addition, if the employee is a state employee or employed by an agency that contracts with the state—Department of Mental Health, Health and Senior Services, Family Services, whatever—they should be able to find something in the Code of State Regulations about ethical code, code of conduct, etc.
In addition to that, there are numerous codes of ethics that guide certain professionals—whether the person is registered or licensed may be immaterial, they can still get guidance and answers about some of their questions from the profession's code of ethics. So I would just point to the USPRA Code of Ethics—the United States Psychiatric Rehab Association; the Code of Ethics for Licensed Clinical Social Workers or National Certified Counselors—would be some examples. There are other professions—the nursing profession I assume would have a code of ethics available probably on their website as well.

TP: Well our audiences tend to come from a variety of different levels of professions—the supervisors, there might be front line staff; could you share some final thoughts with

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The last category of how things like this arise, I would just call, "I Just Never Thought…" This is an issue of not really thinking through the impact of what you're doing; not being able to foresee the kinds of consequences that your actions will have. Those issues—some of the examples mentioned earlier of clients developing dependency on a case manager or particular staff person, or on an agency, when in fact what a major portion of our job is in home care is to assist people to be as independent as they possibly can be so that they can grow, so that they can rehabilitate.

TP: So, who's most likely to commit these violations? Who does it?

JH: Well, often times we might think that there's a certain bad person that would commit boundary violations. In fact I think that everybody commits boundary violations. In particular, people who are uninformed, unaware, insufficiently trained—brand new staff, inexperienced staff—everybody commits boundary violations.
Thom, I think the second type of person who commits boundary violations I call "The Problem Staff." These are people who just really don't get it. They tend to be argumentative when you're talking about examples of boundary violations in the office; they are arguing and always have an answer for you as to why their way of doing things is better than your way of doing things. Or sometimes they're just quiet, and you really can't get a sense of what it is that's going on inside their head; I worry about those

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people, too. An example of an issue that I've dealt with several times is with young staff who have kind of a culturally-appropriate, age-appropriate social activity of going out to bars after work and on the weekends. And, especially in a small town, being inadvertently—not that it was planned—but inadvertently being at the same bar with some of their clients. And I've had staff argue and argue and argue that I shouldn't be able to dictate what they do in their time off; they weren't drinking with the client; the client was on the other side of the bar, etc. In fact in an outpatient mental health agency it is highly likely that consumers who are using alcohol will have that become a therapeutic issue in their treatment, and thus, if a staff member is drinking in the same bar with them then the client has new issues to bring up with that therapist about, "how dare they?" So it gets in the way of their doing their job, and that becomes a problem.
The last type of staff that I think commits boundary violations again kind of has all of us included at one time or another. This I call "The Impaired Staff." This is good staff under stress: people who are going through a divorce; people who have lost a loved one and are still coming to work; people who have enormous family problems or just, you know, tragedies—just normal life events that come up that stress us out. When those things happen we are more vulnerable to committing boundary violations.

TP: So is there—can they remedy them? Or can they avoid the problems?

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be consequences for them in your personnel code about not reporting—observing something, knowing something happened and not reporting—being as bad as if they had done it themselves.
Last, I think that it's really important to educate your clients about what is appropriate staff behavior. If no one else brings it to your attention as the supervisor, the client will.
Other things that you can do when you know that you—or you suspect that you—have a staff member that needs some help—treat all staff fairly. Know what your personnel policy says about working with staff who are in trouble, and consistently use your personnel requirements for disciplinary action. Model that you're "not kidding around about this ethics thing!" I think you do that by sort of hosting those informal discussions, and by making other staff aware of the fact that there are disciplinary interventions for people who violate the boundary code, the ethics code.
I also like to remind people to know their limits about some of those things, and to know their lawyer, because sometimes with supervisory staff that aspect of some—termination of someone's employment is out of their hands. The will have to go through a certain number of steps to set up evidence that the person really should no longer be retained as an employee, but maybe the actual firing is in someone else's hands. So people really do need to know what their limits are in terms of that final step. And when necessary, staff who don't conform to a code of ethics or a professional code of conduct, need to be fired.

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professionals and other in-home care providers to be able to give references. But I do think that it's important to call previous employers.

Another thing I think that is important is to make sure that the people that are doing your interviewing are experienced interviewers; if not, to put some experienced interviewers in the room. I've found that new staff who are not real experienced at interviewing—sometimes they focus on and pick up things that are really insignificant and they get kind of stuck on those things. So, if you've got someone really good in your office who can size people up easily and seems to be on target with those kinds of impressions, it's a good thing to get that person in the room for the interviews.

Of course the reality is, with one or two interviews, you don't really know who you're hiring. So, if a bad one slips in, I think we have to trust our instincts. In helping professions, maybe we're too nice sometimes; we believe people can change; we believe people deserve a second chance. Sometimes we let that go a little bit too far. I think it's important to use your code of ethics in working with staff when you think that something that you've observed or that's been reported is a little too nebulous, and you just can't really figure out if this is a problem—get that code of ethics out and look at it and see if maybe there's something in there about attitude, about ability to work with clients and other values of the profession that might fit.

It's important to create an atmosphere where staff can report—and we talked about that a little bit—and to educate your staff about the importance of reporting; that there may

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JH: You bet. There are lots of things that we can do to remedy and avoid boundary violations.

TP: For example?

JH: Well, the place that I really like to start, especially with new staff, is to make sure that they understand the concept of Dual Relationships. A Dual Relationship is when any helping professional has more than one role with the client. An example would be—maybe an in-home home health provider and the Girl Scout leader of that family's children; another example—a community support worker and a friend—so having two different roles with the client. And where this gets to be a problem is when those roles sort of overlap, and that social role comes into the professional role. So, for example, with the case manager and friend—a friend; what is it that you expect from a friend? What would you expect, you know, in your role with a friendship? You would normally expect that your friend would be there for you—probably anytime you needed them, right? You expect to be able to talk about things mutually; share the deep dark secrets, both portions of the friendship would expect to be able to do that. You would expect that your friend would be there for you unconditionally, pretty much. Whereas, community support worker, works an 8-hour shift generally; there are on-call staff who respond after hours, and so if you make this mistake of describing your relationship with your client as a friendship, then you begin to have, potentially, some expectations on the part of the client that you will be

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there for them in the way that a friend is. And then, again, that's not the client's fault that they have those expectations; you set it up, and so it's your responsibility to work your way out of that.
Another thing that we like to talk about is the importance of understanding power dynamics in helping professionals—or helping professions. And this—really I'm not talking about like power over a client, but just the understanding that because we are in the role of the helping professional, people come to us for certain things. They want assistance with certain things. So we have things that we have access to that our client does not have access to. Maybe it would be coupons for disabled bus fare; maybe it would be access to free goods in the community, such as furniture or clothing or food pantries—things like that. And the client does not have access to those things without the assistance of the agency. We have the power of the pen; we write down a person's mental status, how they're responding to certain treatment, etc. So we do have some things that people come to us for, and that, in essence, creates some power dynamics in that relationship. And of course those differences—those assets we have, those things we have to give to clients—those in and of themselves are not a problem. The problem in the power difference in a relationship only comes into play when we exploit that power. And I've already given some examples of how someone could exploit the relationship with a client.

TP: Well some of what you said sounds like it's appropriate

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some people garden, some people participate in art, some people are spectators of art, music—those kinds of things—but really trying to balance all of that pain with some beauty.

TP: That talks a lot about the avoidance of the problems. What if a supervisor, a co-worker, another agency person recognizes that there may be a problem staff person; is there anything that they can do?

JH: Yeah, I think so. First of all, even before having somebody there is the importance—in that screening process of hiring new employees—really using all of the things that are available to us to do pre-screening—pre-employment screening—using the Family Care Safety Registry, for example; calling the Division of Health and Senior Services; using CaseNet to check people's criminal background, or a new site called MissouriCheck.com; asking applicants about their criminal history and then matching that up to the information that you get on those sites, on those reviews. It's really important to call previous employers. I think this is something that in some agencies has kind of fallen out of favor because what you often find is that previous employers don't give references; a lot of people have policies nowadays to not give references. I hope that that is kind of in the process of changing; I know there's been a lot of talk about background checks for teachers, and the ability of school districts to pass on personnel information when they have had to let go a teacher that had problems, and I hope that some of that opens up our ability as mental health

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for clinical supervision for lots and lots of staff, but in fact they're also responsible for 20 billable hours of service per week themselves, then they really don't have a lot of time to be supervisors.
So I think all of those things important, and ways that help set up the proper atmosphere for avoiding boundary violations.

TP: Well, that sounds good; is there anything else?

JH: Oh, sure, there's lots of things we can do, and all of this is kind of in that set-up phase. I think it's really important to encourage staff—we talked about Impaired Staff (under stress)—to encourage staff health and well-being. Things like modeling and teaching the importance of life balance—you can't work all day; you know, you need to have some other things in your life to help balance out. You need to check in with Impaired Staff about the importance of physical exercise. In-home care providers tend—and all helping professionals tend—to be sort of receptacles for a lot information that is filled with trauma and hard stuff. And it's important, I think, that stuff gets kind of stored in our cells, and it's important to exercise in order to work that out, and to get rid of it, and sort of put it away physically. It's important to drink water, instead of to be plying ourselves constantly all day long with caffeinated beverages.
So some simple things like this. Also the importance of quality sleep. The importance of balancing all that pain with some beauty, no matter—everybody gets it a different way—

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for formal training, but some of it could be more informal—in kind of a group session, group conversations, isn't it?

JH: Yes, that's a good point. I think a lot of this is really ripe for just informal discussion. It takes some of the defensiveness away; and it also opens up and it gives staff the idea that these things are relatively normal; we all fall in holes every once in a while. And nobody's—unless a really big abuse or neglect issue comes up as a boundary violation—people aren't going to get fired for paying a co-payment for a client for example—trying to do the right thing. So it's important to discuss these things in casual informal ways, yes.

TP: And I know a lot of organizations, a lot of professional associations are using codes—formalized Codes of Ethics—does that help?

JH: Oh, yes, absolutely. I want people to refer to their professional code of ethics. However, just—some of the ones that I have looked at—I know the USPRA Code of Ethics, the United States Psychiatric Rehab Association Code is 11 pages long; the Code of Ethics for Clinical Social Workers is 15 pages; Professional Counselors is about 10 pages; so—and even our own agency Code of Ethics is I think 4 1/2 pages out of, oh, about 4 or 500 that new staff read, so I really think it's important to realize that people are not going to remember specifically what's in their code of ethics. It has to be something that is used, dusted off,

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brought up off the bookshelf from time to time, and maybe take some opportunities to discuss a boundary issue that somebody's struggling with, and get out the code of ethics and take a look at it.

TP: Well, what are some of the things that you'd find in a code of ethics?

JH: It's a guideline, not a rulebook, so you're not really going to be finding that you, for example, it's not going to say something like, "community support worker must not ever drink in the same bar as a client." But it is going to give some guidance to what is acceptable behavior. Codes of ethics also set forth some values, principles and standards for professional behavior. And they also allow for conflicts in the different values of the professions, so that you can kind of weigh one ethical principle against another to decide which is more important in a particular case, because it isn't always real clear cut. For example, most ethical codes will talk about the importance of doing—not doing harm to a client, yet also talk about the importance of believing in a client's ability to be independent, and supporting their independence. So, which is more important? Allowing a person to make a mistake in order to learn and grow, or making sure that they don't get hurt? So sometimes it'll help to be able to kind of think through those and weigh them. A code of ethics really guides very complex, complicated decision-making, where there really aren't any simple answers.

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Some of the standard things that you'll find in a code of ethics is—the Philosophical Principles that are important to the profession, the Values of the profession, and then the Standards of the profession.

TP: You said that it is possible to avoid these boundary violations. How would people do that?

JH: Well, again, I think there are many ways. First of all, I think it's really important for agencies to create that sort of informal discussion that we talked about, and to allow people to sort of confess when they think maybe they have stepped in some mud or made a mistake—encourage that instead of punish it. Also I think it's really important to insure that staff who work in homes have immediate access, or close to immediate access to their supervisors. Unfortunately, our supervisors aren't sitting on our shoulders whispering the right thing to do in our ear, and so I think having—we have so many means of electronic communication now—most people carry pagers and have cell phones—people need to have those on and they need to really be accessible to staff when they're in trouble. That includes having someone in addition to—if the direct supervisor isn't available—having someone else in the chain of command sort of, to touch base with.
It's also important for supervisors to have some open door time, where they're not constantly scheduled; I think it's important to really let supervisors be supervisors. If you have people who are—on paper—supposed to be responsible