North Carolina Board of Licensed Clinical Mental Health Counselors

The Board Insider

Winter 2024

Volume 12

In this Issue...

Board Office Hours

The Board Office is closed to visitors; board staff is currently working remotely, so please email or leave a voicemail.

Monday	8:30–5 pm
Tuesday	8:30–5 pm
Wednesday	8:30–5 pm
Thursday	8:30–5 pm
Friday	8:30–5 pm
Saturday	*Closed*
Sunday	*Closed*

Message From the Board Chair

Dr. Mark Schwarze
LCMHCS, NCC, LCAS, CCS
Board Chair

On behalf of the North Carolina Board of Licensed Clinical Mental Health Counselors (NCBLCMHC), we welcome you to the winter edition of the Board Insider.

So many exciting things are underway at the NCBLCMHC. Our Impaired Professionals Program is now launched and receiving referrals. This program will allow counselors who find themselves impaired and unable to effectively work with clients to receive the help they need to get them back to work safely. The Board was given statutory authority to develop and implement this program back in 2018. We have chosen the North Carolina Professionals Health Program (NCPHP) as the program to manage this process. Find out more about NCPHP at their website at www.ncphp.org.

Additionally, we are continuing to move forward with developing our Supervision Improvement Plan (SIP). Some areas of focus include increasing supervision capacity, improving supervision quality, and reviewing supervisor and supervisee administrative tasks. We encourage all current LCMHCs who are eligible to consider upgrading their license to an LCMHCS on their next renewal cycle. This does not involve any additional costs outside of renewal fees.

Finally, the Board office is busy with application reviews and interviews for the hiring of an additional ethics investigator. This additional investigator will help with the important work of managing and investigating ethics complaints coming to the office. This is an important aspect of our primary mission of protecting the public.

I would also like to congratulate our Executive Director, Melonie Davis on her recent election to the office of Secretary for the American Association of State Counseling Boards. This position places Melonie and the NCBLCMHC in the national dialogue of licensure regulation and counseling topics that affect us all.

Please reach out to me or Melonie with any concerns or suggestions. We have committed to being an open and transparent board and staff. Thanks for all that you do.

Warmly,
Dr. Mark Schwarze
Board Chair, NCBLCMHC

Mark J Schwarze

NCBLCMHC Mission

The mission of the Board under NC GS Article 24 section 90-329 states that it is declared to be the public policy of this State that the activities of persons who render counseling services to the public be regulated to insure the protection of the public health, safety, and welfare.

NCBLCMHC Headquarters: 2-C Terrace Way, Greensboro, NC 27403
Toll free: 844-622-3572 or 336-217-6007 | **Email:** LCMHCinfo@ncblcmhc.org
ncblcmhc.org

Meet the Board

Dr. Mark Schwarze
Board Chair
LCMHCS
Congressional District 5

Dr. Yasmin Gay
Vice Chair
LCMHCS
Congressional District 6

Gussie Tate
Secretary/Treasurer
Congressional District 7

Edward "Neal" Carter
Public Member
Congressional District 1

Dr. Levette Scott
LCMHC
Congressional District 2

2024 AASCB Annual Conference

Board members photographed with AASCB Past President, and former N.C. Board member Dr. Denauvo Robinson. Dr. Robinson received the Past President Life Membership award and AASCB Board Service award.

Photographed right to left: Dr. Bruce Garris, Dr. Denauvo Robinson, Dr. Mark Schwarze, Dr. Nicole Stargell

Awareness Months

Awareness is Prevention

JANUARY

A new year is the perfect opportunity to shift your focus from the holidays to your own personal well-being. Take time to give special care to your own mental health and wellness.

FEBRUARY

February is Teen Dating Violence Awareness Month. Raising awareness and promoting prevention of dating violence among teenagers to highlight the importance of healthy relationships during adolescence.

MARCH

March is Self-injury Awareness Month. Non-suicidal self-injury is defined as any deliberate act of harm to one's body without suicidal intent (Nock, 2009). This month is dedicated to spreading information, understanding the risks, and drawing attention to those who may struggle with self-harm.

What You Need to Know About Reciprocity!

The North Carolina Board of Licensed Clinical Mental Health Counselors recently announced we have entered into reciprocity agreements with Kentucky, South Carolina, and Tennessee. These are three separate agreements that were announced at one time. Reciprocal licensing agreements allow licensees to apply for licensure in another state and are often shorter applications due to the agreeing states accepting each other's licensing requirements.

All applicants must submit verification of an active, independent license in good standing; pass the LCMHC jurisprudence assessment for Northarolina; consent to a criminal background check; pay the $238 application fee; and provide two letters of good character (optional for South Carolina applicants).

For North Carolina licensees interested in applying for reciprocity in Kentucky, South Carolina, and Tennessee, please visit those states' websites to access their application and forms.

Licensees from Kentucky, South Carolina, and Tennessee who wish to apply for license by reciprocity will be required to create an account in the Counselor Gateway on our website, ncblcmhc.org.

Each state has the authority to set their own application fee, and their processing time frames may be different from NCBLCMHC's application processing time frame of four to six weeks. For additional information on each state's requirements, fees, and application processing, we encourage you to visit each state board's licensing website for additional information.

Kentucky

South Carolina

Tennessee

FAQs: Let's Talk About Supervision

Q. I have been asked to provide supervision and I am currently an LCMHCS. What do I need to send to the Board?

A. Please submit a Board-approved supervision contract. We can only accept the Board-approved form on our website. We cannot accept any other form. You can email a scanned copy to the supervision inbox (supervision@lcmhc org) or fax it to the Board office using the fax number on the form.

Q. I am not an LCMHCS or an LCMHC, but I have been asked to provide supervision. What do I need to submit to the Board to begin supervision?

A. If this is your initial request to provide supervision, you must submit the Board-approved supervision contract, verification of your active mental health license, an official transcript, and clinical supervision training. we will accept forty-five (45) hours of continuing education in the knowledge and competency of counseling supervision, or three (3) semester hours of graduate-level (or above) coursework in counseling supervision from an NBCC Approved Continuing Education Provider.

Q. I've submitted our supervision contract. What's next?

A. The Board will review your contract, and you and the supervisee will receive an email notification of approval or an email advising of what's needed to cure the deficiency in order for the contract to be approved. You cannot begin supervision until you receive the approval email from the Board.

Q. My supervisee and I did not submit a contract, but I have been providing supervision. Can I have the contract retroactively approved or backdated?

A. No, as of Jan. 31, 2024, NCBLCMHC is no longer retroactively approving supervision contracts. The contract effective date is the date the contract was received in the Board office, or the date all required documents are received in the Board office if the contract is submitted with missing information.

Q. What other documentation are supervisors required to submit? Are Qualified Supervisors (QS) and Licensed Clinical Mental Health Counselor Supervisors (LCMHCS) required to submit the same documentation?

A. Qualified Supervisors and Licensed Clinical Mental Health Supervisors are required to submit the same documentation. In addition to the Supervision Contract, QS and LCMHCS are required to submit Quarterly Supervision Reports (available on the website) and submit Final Supervision Reports within two weeks of the termination of supervisory relationship. QS and LCMHCS are also required to be available for consultation with the Board or its committees regarding the supervisee's competence as per the Supervision Contract and Quarterly Supervision Report.

Q. Who is responsible for submitting supervision reports?

A. The Board will accept the supervision contract from either the LCMHC Associate or proposed supervisor. Quarterly Supervision Reports and Final Supervision Reports must be submitted to the Board directly from the supervisor. The Board does not allow LCMHC Associates to self-submit their own Quarterly or Final Supervision Report.

Q. Who keeps track of supervised professional practice hours?

A. It is the responsibility of the supervisor and supervisee to keep a log of supervised professional practice hours. Supervised professional practice hours should be tracked and reported on the Final Supervision Report at the conclusion of supervision. Please note that the Board reserves the right to request supervision logs.

Mark Your Calendars 2024

Jan. 26–27
Board meeting

Feb. 17
Deadline: Receipt of application material to be reviewed at April 2024 Board meeting

March 1
Board Hearings

April 18–19
Board meeting

NOTE: In order for an applicant to be licensed at the Board of Directors meeting, all application supporting documents should be in the office prior to the deadline(s) listed above.

Please visit ncblcmhc.org/boardinfo/calendar to view the full board calendar.

NCBLCMHC Holiday Schedule 2024 (January–March)

MLK Jr. Holiday	Monday, Jan. 15
Presidents' Day	Monday, Feb. 19
Spring Holiday	Friday, March 29

Does your license expire this June?

SAVE TIME BY RENEWING ONLINE!

The 2024 license renewal window opens on Jan. 1

Licensure renewal procedures apply to LCMHC Associates, LCMHCs, and LCMHC Supervisors. Renewals may be submitted as early as Jan. 1 of the renewal year. All licensees shall complete requirements before renewal can be issued.
Deadline for receipt of renewal is June 20 of the renewal year.

Click Here to Renew Now

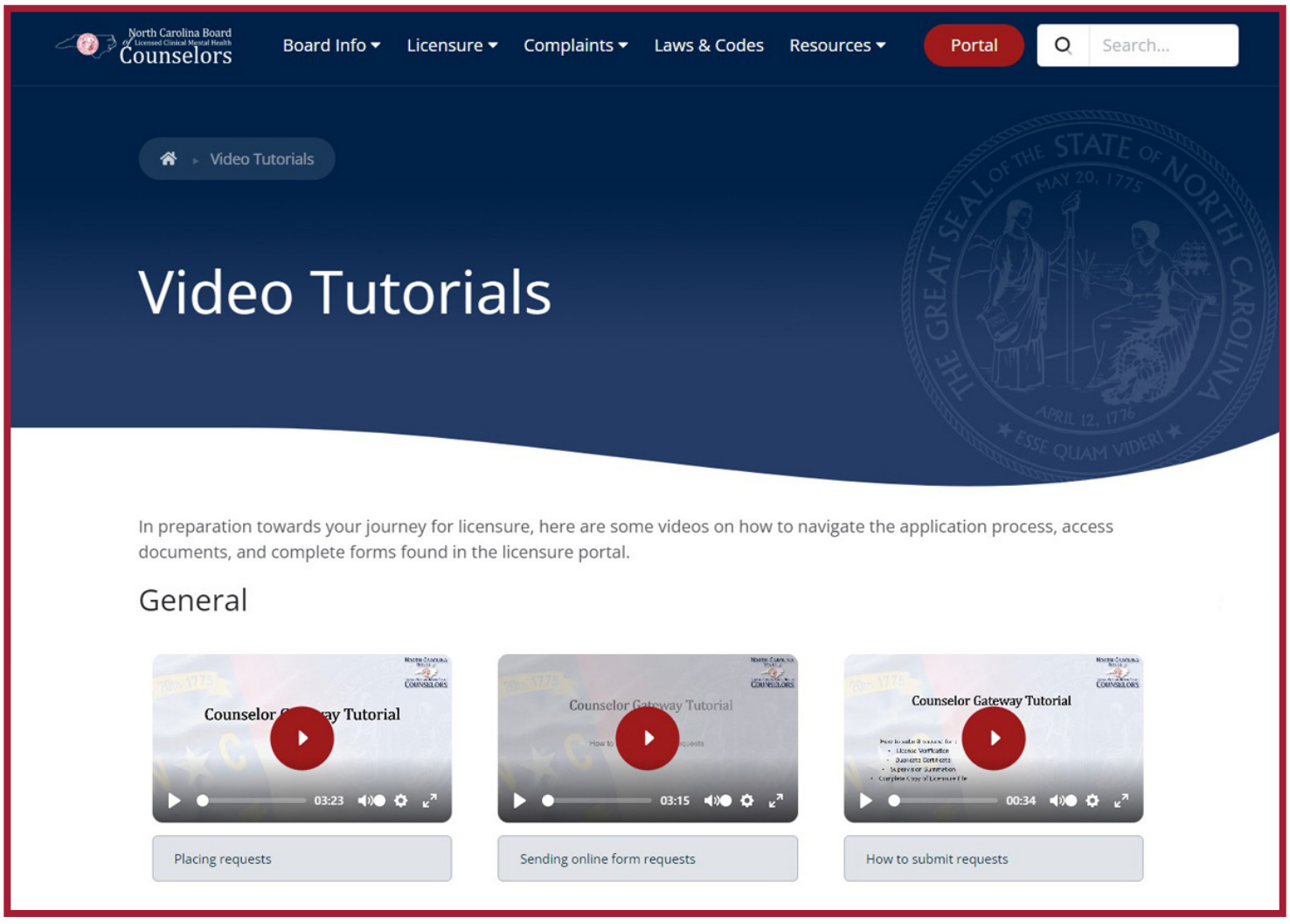
Tip: Add a recurring event to your phone's calendar to remind you when renewals are due.

Be sure to keep your contact information updated to avoid missing important emails from the board.

Accessing your Counselor Gateway

Check the status of your renewal, view your supervision documents, and manage your contact information via the Counselor Gateway Online Portal.
https://portal.ncblcmhc.org/

To watch video tutorials on how to navigate the application process, access documents, and complete forms, visit www.ncblcmhc.org/Resources/Tutorials



Tell Me No Lies and Keep Your Hands to Yourself: A Call Back to Effective Clinical Supervision

Nick Dejesus, LCMHCS

Ethics Consultant & Board Investigator

Clinical supervision is a core professional competence, and the North Carolina Board of Licensed Clinical Mental Health Counselors ("the Board") is now focusing on ensuring supervisor competence and effective supervision practice. Approximately 10% of complaints filed each year to the Board highlight supervision practices that have less to do with harmful supervision than bad or inadequate supervision practices. Notably, problems arising from clinical supervision, including inadequate supervision, are the seventh-most frequently reported reason for disciplinary actions by licensing boards (ACA, 2014). There are many reasons that bad or harmful clinical supervision is an essential topic for discourse, not the least of which is potential harm to clients and supervisees. The supervisee is in an inextricably vulnerable relationshipan evaluative, hierarchical relationship where the supervisor holds the supervisee's professional career in his or her hands (Bernard & Goodyear, 2014; Koenig & Spano, 2003). Thus, the supervisee is at risk of harm should a supervisor act in unethical or harmful ways.

Ellis (2001) attempted to clarify the topic by offering a unified framework—a continuum of two constructs: harmful clinical supervision and bad clinical supervision. Ellis defined harmful supervision as supervisory practices that result in psychological, emotional, and/or physical harm or trauma to the supervisee (e.g., the supervisor's sexual intimacy, sexual harassment, or sexual improprieties with a supervisee; aggressive and abusive behavior; violation of the supervisee's boundaries; microaggressions). Ellis defined bad supervision as ineffective supervision that does not traumatize or harm the supervisee and that is characterized by one or more of the following: the supervisor's disinterest and lack of investment in supervision, the supervisor's failure to provide timely feedback or evaluation of the supervisee's skills, the supervisor's inattention to the supervisee's concerns or struggles, the supervisor does not consistently work toward the supervisee's professional growth or training needs, or the supervisor does not listen and is not open to the supervisee's opinions or feedback.

Bernard and Goodyear's (2014) definition of clinical supervision—perhaps the most widely accepted one (Falender & Shafranske, 2004)—states that clinical supervision is:

"an intervention that is provided by a more senior member of a profession to a more junior colleague or colleagues who typically (but not always) are members of that same profession. This relationship is evaluative and hierarchical, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the junior person(s), monitoring the quality of professional services offered to the clients she, he, or they see, and serving as a gatekeeper for the particular profession the supervisee seeks to enter. (p. 9)

Drawing on this definition of clinical supervision (Bernard & Goodyear, 2014), bad or inadequate clinical supervision occurs when the supervisor is unable, or unwilling, to meet the criteria for minimally adequate supervision, to enhance the professional functioning of the supervisee, to monitor the quality of the professional services offered to the supervisee's clients, or to serve as a gatekeeper to the profession. In addition, inadequate supervision may include but is not limited to, the behaviors and descriptors delineated in Ellis's (2001) definition of bad supervision.

So, what does this mean for counselor supervisors and supervisees in North Carolina? This means that with the growing number of licensees in our state, along with the increasing number of complaints regarding issues in the supervisor-supervisee relationship, this is a call back to effective clinical supervision. But where do we start? We start with exploring what is being highlighted in the ethical complaints that can be characterized by Ellis's (2001) definition of bad or inadequate supervision.

What supervisees in N.C. are reporting:

- My supervisor never observed any of my sessions yet marked me as "average or below" on my final supervision report.
- My supervisor did not adequately keep track of my supervision sessions, nor did they have supervision logs, which resulted in an inaccurate report of my supervision hours.
- Free, in-house supervision was a part of my employment contract. Still, now that I have left the practice, the supervisor is not cooperating or accurately reporting my hours or ratings.

Other complaint indicators:

- No interest in cultural background, only discusses strengths, focuses only on diagnosis, supervising my supervisor.

What supervisors in N.C. are reporting:

- My supervisee has not paid me for supervision; therefore, I will withhold submitting final supervision reports to the Board.
- My supervisee lacks core knowledge of diagnosis and clinical documentation.
- My supervisee is not open to constructive feedback and only discusses cases in which the supervisee is doing well with the client.

Other complaint indicators:

- Lacks professionalism, is not committed, oblivious to interpersonal process.

This information from supervisors and supervisees provides the Board with documented inadequacies occurring in clinical supervision in North Carolina. When investigating complaints regarding issues in clinical supervision, it is often noted that the problems are not discussed between the supervisor and supervisee. Additionally, these complaints highlight the lack of awareness in identifying inadequate supervision earlier in the supervisory relationship and process instead of at the end when it is time to complete the final supervision report.

Supervisees are often unaware of what constitutes inadequate or harmful clinical supervision (Ellis, 2001). For example, given that many supervisors did not use consent or contract for supervision or did not monitor their sessions, supervisees may be uninformed about their rights, what constitutes minimally adequate supervision, and the supervisor's responsibilities (Thomas, 2007). The lack of knowledge may compromise their ability to identify the extent to which the supervision they are receiving is inadequate or harmful. However, the current data provided by thirty-four (34) supervision experts suggested that inadequate supervision subsumes harmful supervision (i.e., harmful supervision is, by definition, inadequate supervision). As such, inadequate supervision can induce up to a moderate level of harm before crossing the threshold of clearly harmful supervision (Ellis et al., 2014).

One question elicited here is how the field will balance a supervisee-protective stance and a supervisor-protective stance. The issue is complex. For example, issues of supervisee incompetence are likely a contributing or complicating factor (Falender, Collins, & Shafranske, 2009). Yet, we need to be cognizant not to victimize the victim, assuming that the fault lies with the supervisee versus the supervisor. At the same time, it seems prudent not to condemn or label a supervisor as inadequate or harmful before further investigation.

In addition, an important distinction is warranted—inadequate versus ineffective clinical supervision. As in the counseling literature (Barlow, 2010; Dimidjian & Hollon, 2010), the adequacy of supervision is related to, yet independent from, the efficacy of supervision. They are distinct constructs. That is, it is conceivable to receive adequate yet ineffective supervision, whereas the inverse seems less plausible (effective and inadequate supervision). Nevertheless, these constructs deserve further investigation.

Finally, all licensees are encouraged to reflect on their own supervisory experiences as a supervisee and, if applicable, as a supervisor. Supervisors are encouraged to critically examine their supervision practices with a keen eye on minimally adequate supervision and harmful supervision behaviors. Worthington (1987) stated that "A good theory of lousy supervisor behaviors is missing" (p. 203). Over 25 years later, progress is slowly being made (Goodyear et al., 2005).

References

American Counseling Association. (2014). *Supervision guidelines*. Alexandria, VA: Author.

Bernard J. M., Goodyear R. K. (2014). The fundamentals of clinical supervision (5th ed.). New York, NY: Pearson.

Ellis M. V. (2001). Harmful supervision, a cause for alarm: Commentary on Nelson & Friedlander (2001) and Gray et al. (2001). *Journal of Counseling Psychology*, *48*, 401-406.

Ellis, M. V., Berger, L., Hanus, A. E., Ayala, E. E., Swords, B. A., & Siembor, M. (2014). Inadequate and Harmful Clinical Supervision: Testing a Revised Framework and Assessing Occurrence. *The Counseling Psychologist*, *42*(4), 434-472.

Falender C. A., Shafranske E. P. (2004). Clinical supervision: A competency-based approach. Alexandria, VA: American Counseling Association.

Koenig T. L., Spano R. N. (2003). Sex, supervision, and boundary violations: Pressing challenges and possible solutions. *Clinical Supervisor*, *22*, 1-19.

Thomas J. T. (2007). A consent through contracting for supervision: Minimizing risks, enhancing benefits. *Counselor Education and Supervision*, *38*, 221-231.

Worthington E. L. Jr. (1987). Changes in supervision as counselors and supervisors gain experience: A review. *Professional Psychology: Research and Practice*, *18*, 189-208.

Don’t Miss Important Messages About Your License!

All LCMHCAs shall only provide counseling while under the supervision of a qualified clinical supervisor with a supervision contract approved by the board. You must receive approval of the supervision contract prior to rendering counseling services. At least one contract is required per supervisor. You may have multiple supervisors, but a separate contract is needed for each of the supervisors. Notification must be given to the board within two weeks of termination of or a change in supervision contract. If not receiving supervision, it shall be the responsibility of the LCMHCA to report such to the board. A Final Report is to be filed at conclusion or termination of supervision. If you have multiple supervisors, a Final Report is required from each supervisor.

SUPERVISION MUST CONTINUE UNTIL THE LCMHCA/APPLICANT RECEIVES THE LCMHC LICENSE.

ATTENTION:

Effective Jan. 31, 2024, the NCBLCMHC will not retroactively approve supervision contracts or supervision hours earned without an approved supervision contract on file. Please be advised, if you are currently receiving or providing supervision and you have not received written approval from the board, you will need to submit all required documentation no later than Jan. 31, 2024.

Please visit

www.ncblcmhc.org/Licensure/Current/LCMHCA

to review important information regarding supervised professional practice.

What's New

The NCBLMHC is pleased to announce that you can now find us on Instagram.

We hope you will connect with us for updates and important news from the Board.

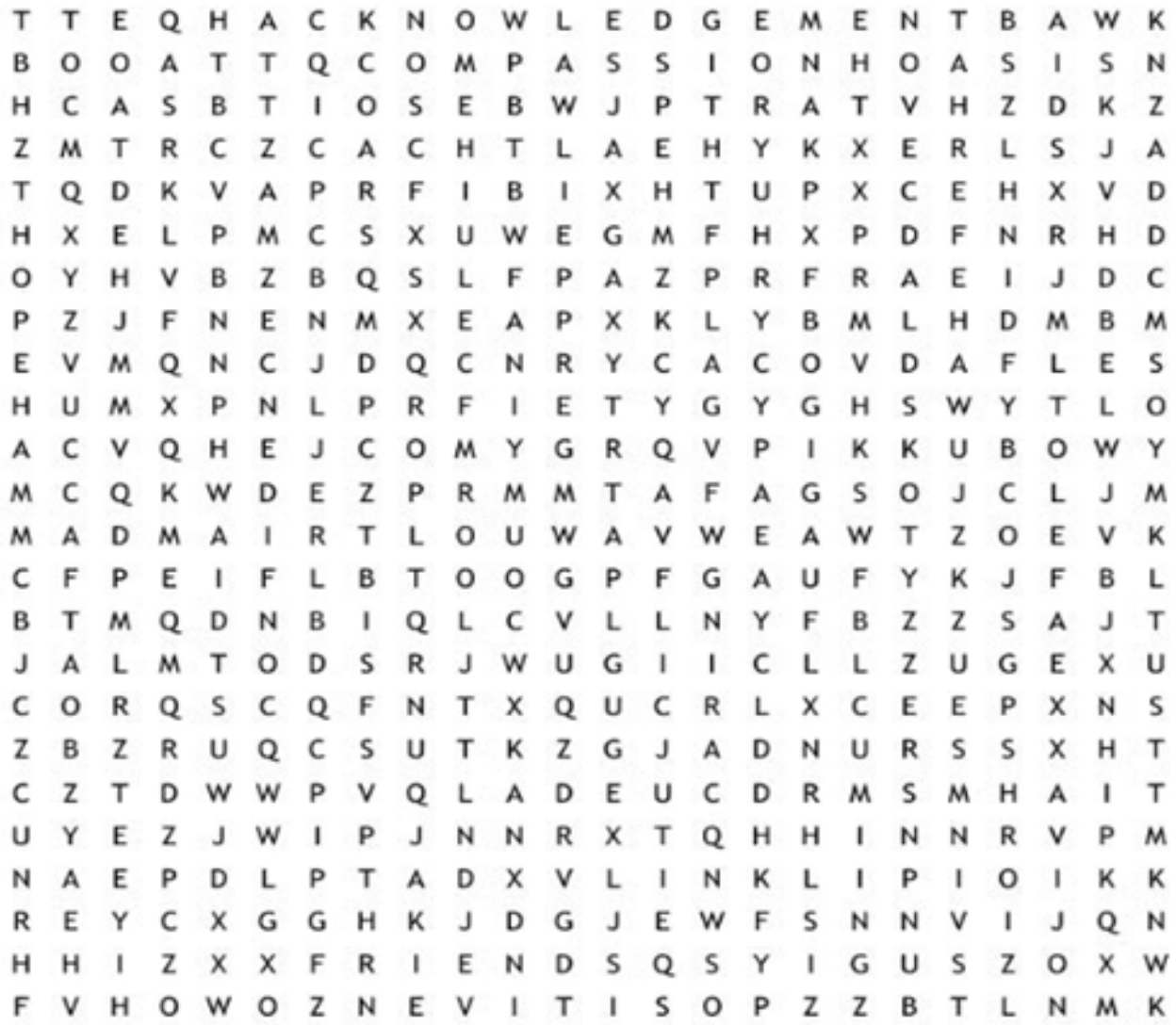
This information-only page will help you stay up to date on important changes, announcements, and deadlines.

Please be reminded the best way to contact the Board is to email lcmhcinfo@ncblcmhc.org or call us at (336)217-6007.

@NCBLCMHC

Just for Fun!

Puzzles are a healthy way to relieve stress, reduce anxiety, improve focus, and relax. Decompress with this word find.



Self Awareness
Confidence
Acknowledgement
Compassion
Sharing

Positive
Health
Hope
Happy
Friends

Mindful
Caring
Faith
Self Advocacy
Oasis

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