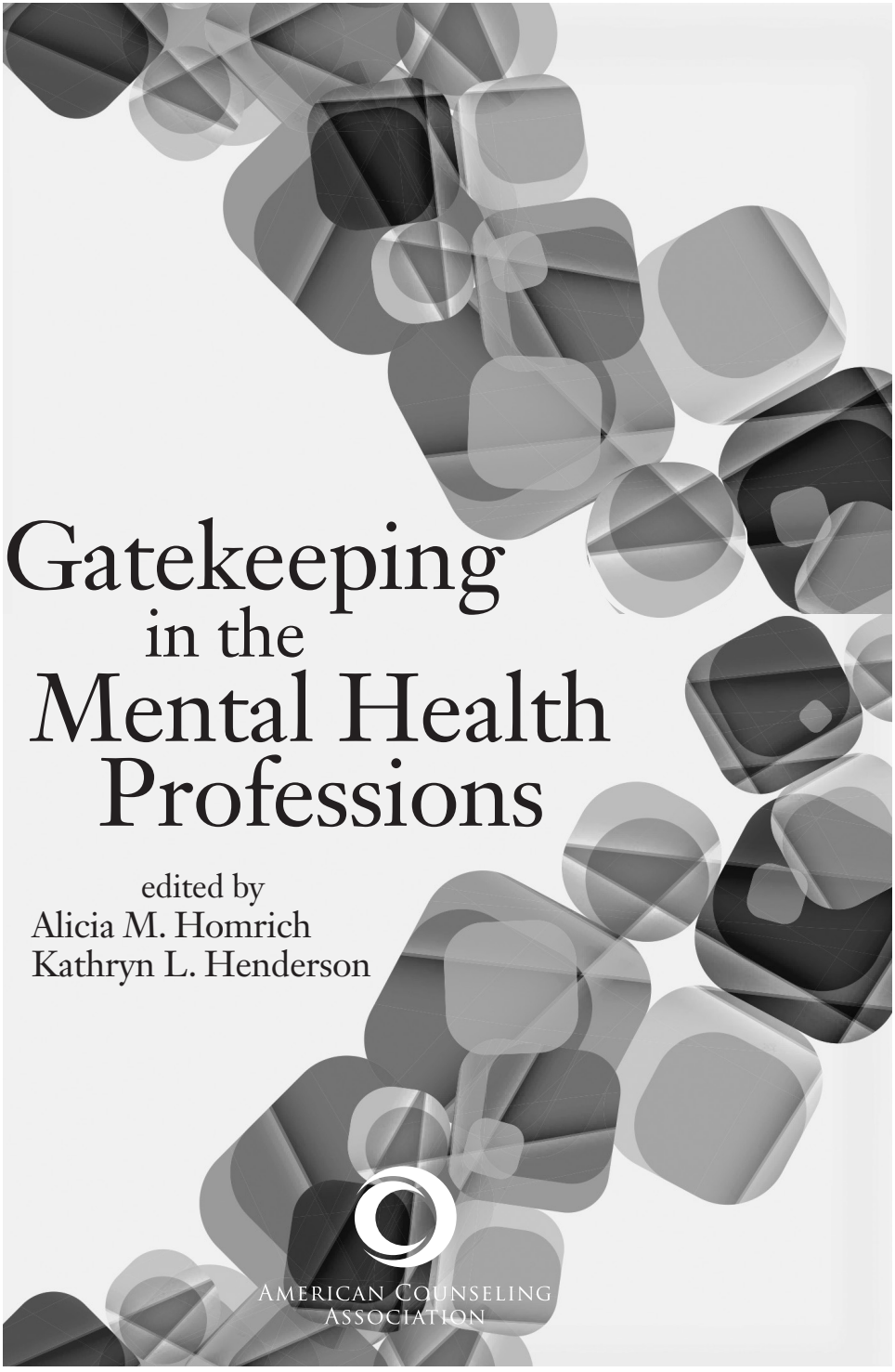
Gatekeeping in the Mental Health Professions

edited by
Alicia M. Homrich
Kathryn L. Henderson

American Counseling Association

Wiley



6101 Stevenson Avenue, Suite 600 | Alexandria, VA 22304 | www.counseling.org

Gatekeeping in the Mental Health Professions

American Counseling Association
6101 Stevenson Avenue, Suite 600 | Alexandria, VA 22304

Associate Publisher | Carolyn C. Baker

Senior Production Manager | Bonny E. Gaston

Digital and Print Development Editor | Nancy Driver

Copy Editor | Beth Ciha

Cover and text design by Bonny E. Gaston

Library of Congress Cataloging-in-Publication Data

Names: Homrich, Alicia M., editor. | Henderson, Kathryn L., editor. | American Counseling Association, issuing body.
Title: Gatekeeping in the mental health professions / Alicia M. Homrich, Kathryn L. Henderson, editors.
Description: Alexandria, VA : American Counseling Association, [2018] | Includes bibliographical references and index.
Identifiers: LCCN 2018007027 | ISBN 9781556203282 (pbk. : alk. paper)
Subjects: | MESH: Counseling—education | Mentoring—methods | Mental Health Services—standards | Clinical Competence—standards | United States
Classification: LCC RC466 | NLM WM 18 | DDC 362.2/04256—dc23 LC record available at https://lccn.loc.gov/2018007027

To mentors, who we often want to be when we become professionals, and the careers they model of integrity and compassion, who do the hard work with the students who need it the most.

—KLH

• • •

To clinical faculty and supervisors, the frontline gatekeepers for our respective professions, for your courage and commitment to developing future ethical, effective clinical professionals and redirecting those who are unable to attain expected standards. Thank you for protecting the quality of the mental health community and those who seek our expertise to pursue their fullest potential.

—AMH

Table of Contents

Preface

The term *gatekeeper* is a metaphor for those who monitor or oversee the progress of others while simultaneously controlling admission or access to an entity. In the context of career preparation programs, the gatekeeper is an experienced member of a profession who oversees the academic and clinical development of individuals preparing to enter the field while upholding professional standards for the welfare of future clients. Allowing qualified individuals to successfully progress through training and pass through "gates," such as graduation and licensure, implies that those individuals have met minimal clinical training standards.

Gatekeeping is the inherent responsibility of educators and supervisors in the mental health professions. Jurisdictional regulatory and licensing boards, accrediting bodies, and professional associations mandate gatekeeping in laws, rules, standards, and ethics codes. The health professions are increasingly being held accountable for developing standards and enacting practices that fulfill quality assurance expectations that protect the public and safeguard clients. The effects of *gateslipping* can be life threatening and/or result in long-term psychological injury. Passing unqualified students for graduation or endorsing incapable supervisees for licensure endangers the welfare of others. Ignoring gatekeeping mandates risks harming a trainee or other colleagues who may be affected by his or her actions, compromises the integrity of the clinical professions, and diminishes the trustworthiness and reputation of mental health training programs and related agencies. Gatekeeping is also a very challenging professional responsibility. The literatures in each of the allied professions—counseling, social work, psychology, and marriage and family therapy—reflect the challenges of the gatekeeper's role.

The goal of this book is to support faculty and supervisors to engage effectively in the tasks and challenges of the gatekeeping process. The book has been written with the intention of bringing together the developing body of professional performance standards for trainees from multiple behavioral health fields. It is accompanied by suggested standards for best practices across the myriad gatekeeping tasks and processes. This book aims to be a guidebook for clinical faculty and supervisors that supports the development of gatekeeping practices and policies found in the current literature. This volume can also be useful in training new supervisors and doctoral students preparing to assume the role of gatekeeper. The philosophical foundations supporting gatekeeping are examined, along with suggestions for best practices and tools and templates that can be used with trainees.

A trainee's fitness in the domains of academic and clinical ability can be readily established through the use of evaluative measures that assess commonly held standards for performance. However, evaluating trainee competency in the domains of interpersonal behavior, intrapersonal functioning, and professional conduct to determine readiness to practice is much more subjective. This critical domain of trainee development—the heart of the gatekeeping focus—is less clearly defined and lacks common agreement within and across the mental health professions; thus, it is typically the area of greatest concern for clinical educators and supervisors.

Chapters in this book discuss the following topics addressing gatekeeping in terms of the professional conduct and personal behavior of students and supervisees.

Chapter 1 provides an introduction to gatekeeping by reviewing the foundational principles that guide gatekeeping practices. It begins the discussion of ethical principles and legal concepts pertinent to gatekeeping that are woven throughout the book as they pertain to various practices or stages of the process.

Chapter 2 defines the lexicon that is specifically relevant to the practice of gatekeeping, offering a compilation and background review of key terminology. Professional terminology is introduced that should be avoided, along with the background or history of the word usage and current recommended language for practice. General legal perspectives, such as due process and liability, are applied to the practice of gatekeeping, in addition to vocabulary and definitions found in other guiding documents in the clinical professions.

The challenge of addressing problematic trainees, a concern of every faculty member and supervisor, is the focus of Chapter 3. The author of this chapter proposes the development of policies, systems, and strategies for assisting students and supervisees who are exhibiting problematic behavior in their developmental process as clinical professionals.

Recognizing that training is a developmental process and that all trainees have unique personal identities, Chapter 4 encourages

gatekeepers to be sensitive to and respectful of the broader contextual factors that may overlay trainee functioning. This chapter represents one of the inherent tensions in gatekeeping: upholding professional standards and the duty to protect future clients while simultaneously being sensitive to trainees' developmental processes and caring for their individual experiences and differences.

Chapter 5 offers descriptions of the roles and responsibilities faculty and supervisors have in gatekeeping activities as defined by professional standards. This chapter considers the various mandates for training practitioners, including licensure laws, accreditation standards, and codes of ethics from the mental health professions.

An important aspect of efficacious gatekeeping is garnering active support and participation from multiple constituencies. Chapter 6 describes the multiple institutional influences that interact to support or hinder the gatekeeping process. This chapter identifies potential stakeholders and suggests methods of collaboration essential to successful gatekeeping.

How does a clinical program or agency site inform students and supervisees about expectations for personal behavior and professional conduct? Chapter 7 identifies procedures for clearly advising prospective trainees about graduate program or agency expectations, standards, and gatekeeping policies at various points of contact, starting with admissions.

Chapter 8 reviews the literature from the mental health professions about trainee problems of professional competency. Empirical research on the personal behavior and professional conduct of trainees is reviewed in order to assist programs in constructing their own set of expectations and standards for trainee performance.

Once programs identify expectations or standards for trainee behavior, they must undertake the process of evaluating the meeting of those behavioral standards. Chapter 9 suggests methods for assessing and evaluating trainee conduct and behavior and offers a review of formal measures currently available in the field.

Chapter 10 describes best practices for intervening when trainees demonstrate problems with professional competency. In some situations, trainees may struggle with change, may be incapable of meeting required standards of behavior and conduct, or may be unwilling to comply with standards. A range of possible strategies and interventions is offered in this chapter, including formal remediation plans and accompanying remedial interventions.

Throughout the gatekeeping process, documentation is critical for legal and ethical reasons. Chapter 11 suggests best practice procedures in documenting, such as verifying that published procedures were followed, documenting subsequent actions taken, and verifying trainee actions and reactions. Examples of documentation formats are illustrated in this chapter.

Avoiding the need to engage in gatekeeping processes, the situation preferred by most professors and supervisors, can lie in prevention efforts. Chapter 12 offers strategies for preempting the development of problematic behavior in trainees and for curtailing problems through education, relationship building, and other early intervention approaches, including the admissions process.

The appendices offer a detailed review of ethics codes from several professions that directly address gatekeeping functions. Sample documentation and forms that may be adapted for use in practice are also included for readers of this book. These include sample correspondence and examples of evaluation and prevention strategies.

In sum, this book aims to be a practical resource to assist educators and supervisors in the practice of gatekeeping and to give doctoral students and future supervisors a foundational understanding of the gatekeeping process. As a fundamental responsibility of faculty and supervisors, gatekeeping represents an ethical imperative to address the struggles and challenges trainees may experience in their development, which could lead to harming clients. The ethical mandate speaks not only to protecting the clinical professions and the public from harm but also to providing trainees with transparent feedback regarding their competence and their likelihood of success as professional clinicians. During their time of struggle and challenge, effective feedback and remedial support from gatekeepers can offer trainees an opportunity, should they choose to accept it, to achieve success and develop into competent, ethical, and professionally effective clinicians.

About the Editors

Alicia M. Homrich, PhD, is a professor in the Graduate Studies in Counseling program (accredited by the Council for Accreditation of Counseling and Related Educational Programs) at Rollins College in Winter Park, Florida. She is a licensed psychologist and licensed marriage and family therapist in the State of Florida, a national certified counselor, and a qualified supervisor. Dr. Homrich has been researching, publishing, and presenting on the topic of gatekeeping for more than 15 years. Her goals for publishing this book are to encourage faculty and supervisors to support optimal clinical trainee development by engaging in gatekeeping processes during pre- and postgraduate training, to safeguard clients, and to uphold the practice standards of the clinical professions.

• • •

Kathryn L. Henderson, PhD, is an assistant professor in the Department of Counseling and Applied Behavioral Studies at the University of Saint Joseph (accredited by the Council for Accreditation of Counseling and Related Educational Programs) in West Hartford, Connecticut. Dr. Henderson is a licensed professional counselor in Texas and a national certified counselor. Dr. Henderson has researched, published, and presented on student remediation and gatekeeping for more than 8 years. She is an advocate of early intervention and transparency in the gatekeeping process and views counselor self-care and wellness as cornerstones of ethical practice.

About the Contributors

Kyle D. Baldwin, EdD, is the clinical practice and assessment coordinator and a clinical professor of counseling in the Graduate Studies in Counseling program (accredited by the Council for Accreditation of Counseling and Related Educational Programs) at Rollins College in Winter Park, Florida. She is a licensed mental health counselor, national certified counselor, master addictions counselor, certified clinical mental health counselor, clinical sexologist, and qualified supervisor. Dr. Baldwin's research interests include counselor wellness and counselor education and supervision.

Theresa A. Coogan, PhD, is a counselor educator and educational consultant in Raleigh, North Carolina. She is a licensed/certified school counselor in Massachusetts and New York, a national certified school counselor, and national certified counselor. Dr. Coogan has worked as a counselor educator and program director for school counselor training for 10 years. She recently started an educational consulting business serving kindergarten–Grade 12 and higher education clients providing professional and curriculum development as well as program evaluation, gatekeeping, and accreditation compliance.

Leigh D. DeLorenzi, PhD, is an assistant professor in the Graduate Studies in Counseling program (accredited by the Council for Accreditation of Counseling and Related Educational Programs) at Rollins College in Winter Park, Florida, and a licensed mental health counselor in the State of Florida. Dr. DeLorenzi began researching and writing on the professional, interpersonal, and intrapersonal conduct behaviors of helping professionals in 2013. She has developed and implemented gatekeeping-focused assessment systems for graduate programs to streamline and simplify the gatekeeping process from preadmission to graduation.

Roxane L. Dufrene, PhD, is an associate professor in the Counselor Education Program at the University of New Orleans (accredited by the Council for Accreditation of Counseling and Related Educational Programs) in Louisiana. She is a licensed professional counselor and licensed marriage and family therapist in the State of Louisiana as well as a national certified counselor. Dr. Dufrene has been researching and presenting on the topic of remediation for more than 10 years.

Page L. Thanasiu, PhD, is an assistant professor of counselor education at Stetson University (accredited by the Council for Accreditation of Counseling and Related Educational Programs) in DeLand, Florida. She is a licensed mental health counselor and qualified supervisor in the State of Florida. At the national level, she is credentialed as a registered play therapist supervisor and a national certified counselor. Dr. Thanasiu has been supporting master's-level students through remediation and gatekeeping processes for the past 10 years and truly appreciates the opportunity to join trainees on their developmental journey.

Acknowledgments

A special thanks to Dr. Burt Bertram, who has been a longtime advocate and supporter for this project. Without his encouragement and professional mentorship, this book would not have been written.

We would also like to acknowledge the work of Michelle Sullivan, a graduate assistant at Rollins College, who offered invaluable support as an early copy editor and research assistant. A huge thank-you for your help with this project!

Chapter 1 Introduction to Gatekeeping

Alicia M. Homrich

The term *gatekeeping* is thought to have first originated in the arena of communications wherein an editor or editorial board determined which information or news stories would be pursued and which would be shelved (Kerl & Eichler, 2005). Gatekeeping was a point of control that advanced or deterred progression through the publication process. This activity is akin to the credentialing process, through which an individual prepares for and applies for entry into a profession, documenting satisfactory achievement of the requisite training in knowledge and skills and the professional qualities necessary to be recognized as a full practitioner. In all cases, approval of an individual to enter a profession is sanctioned by appointed senior practitioners with professional experience and the credentials to make such a determination. Within the context of the allied mental health professions, multiple scholars have defined the term *gatekeeping* as the ongoing responsibility of faculty members and clinical supervisors to monitor trainee progress and appropriateness to enter professional practice.

The Purposes of Gatekeeping

The two primary purposes of gatekeeping are to protect the integrity of the clinical professions and to prevent harm to clientele receiving services from incompetent clinicians (Brear, Dorrian, & Luscri, 2008). A secondary goal of gatekeeping is to consider the best interests of others, be it the trainee, the training community, the clinical or educational

setting, or the population at large (Brear & Dorrian, 2010). Bodner (2012) noted that an additional responsibility of gatekeeping is to uphold professional standards, including the principles of beneficence, nonmaleficence, fidelity, personal dignity, and justice, as described in most ethics codes of the clinical professions.

The charge to the professions' gatekeepers is to enforce gatekeeping policies and procedures in order to reduce the incidence of advancing poorly or marginally suited trainees through graduate training and onto licensure in a clinical profession without intervention. This phenomenon was defined by Gaubatz and Vera (2002) as *gateslipping*. They found that clinical training programs that implemented formalized gatekeeping practices "reduce the number of deficient students who slip through programs' gates (i.e., graduate without remedial attention)" (p. 296). Thoughtful gatekeeping practices protect the public and the clinical professions from inept practitioners.

The Role of the Gatekeeper

Gatekeepers are the persons responsible for ethically monitoring trainees' progression through gatekeeping checkpoints prior to endorsing them for independent professional practice. In the clinical professions, educators and supervisors serve in this role both before and after trainees receive a degree. Gatekeeping is one responsibility expected of supervisors and/or faculty members who have oversight of trainees. Gatekeeping is an aspect of the assessment and evaluation processes incumbent on every supervisor and professor who has a role in preparing future clinicians. Gizara and Forrest (2004) described gatekeepers as quality control agents for the clinical training experience because they determine the readiness and fit of candidates for their particular profession. Gatekeepers institute evaluative procedures, deliver feedback aimed at improvement, provide trainees with the opportunity to respond to and address concerns, and take responsibility for deciding whether and when to permit trainees to continue to the next phase of the training process or to stop their progression for the purpose of remediating behaviors of concern (Gaubatz & Vera, 2002; Ziomek-Daigle & Christensen, 2010). Gatekeepers act to "ensure that those who graduate are capable of interacting with clients, colleagues, and the community in an ethical and competent manner" (J. Miller & Koerin, 2002, p. 1) and "control the access of impaired, unethical or incompetent counselors to clients, thereby protecting clients who are likely to be at a highly vulnerable stage of their lives" (Bhat, 2005, p. 399). The trainee's ability and/or willingness to achieve the requisite competencies of a given clinical profession predicts his or her progression through the various gatekeeping checkpoints across the training process (see Figure 1.1).

Most educators and supervisors in clinical programs are energized by the prospect of training individuals to become competent, ethically

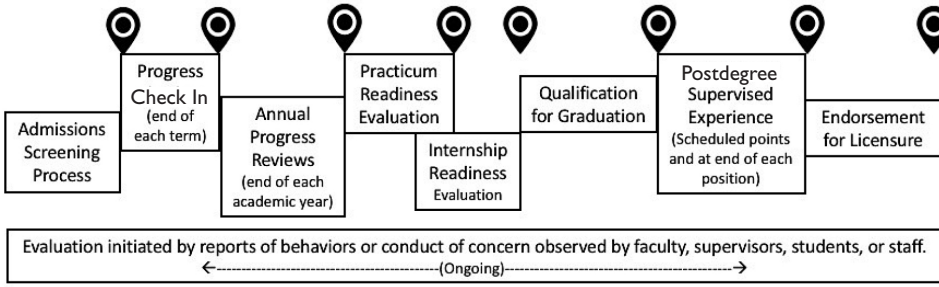


Figure 1.1 • Gatekeeping Checkpoints

Use these points for evaluating personal behavior and professional conduct to determine continuation of clinical training.

practicing professionals. This enthusiasm and commitment applies to training programs across the behavioral health fields, including the professions of mental health counseling; marriage and family therapy; psychology; social work; and specialized practice fields such as school counseling, school psychology, rehabilitation counseling, or neuropsychology. Whether professors in academic programs, faculty supervising students in practicum or internship courses, field site clinicians engaged in supervisory experiences with graduate students, or supervisors of postdegree trainees obtaining experience in fulfillment of licensure requirements, clinical trainers have one thing in common: the opportunity to influence the development of clinical knowledge, skills, and professionalism in novice members of the profession. In legal terms, this role is known as the respondeat superior (see On the Legal Side 1.1): the professional responsible for the actions of trainees (Wheeler & Bertram, 2015).

Inherent in the position of respondeat superior are multiple professional obligations. According to Saccuzzo (1997), these duties include monitoring the training and supervisory processes to:

1. protect the welfare of current and future clients (patients) from harm by ensuring that they receive effective treatment, that their rights are protected, and that they are treated with dignity and respect;
2. protect the welfare of the student or supervisee;
3. protect the well-being of other trainees or colleagues who may be affected by the individual student or supervisee;
4. protect the integrity of the clinical professions by graduating and endorsing for licensure only those practitioners who demonstrate the competencies necessary to be effective practitioners; and
5. protect the trustworthiness and reputation of the program, institution, or agency (although not a direct duty of respondeat superiors, this secondary influence is often the concern of administrators and other affiliates of the institution, such as alumni).

On the Legal Side 1.1

A Latin term, *respondeat superior* means "let the master answer or respond." This legal doctrine holds that a person such as an employer or a supervisor is legally responsible for the wrongful acts of those over which he or she has charge, such as an employee or supervisee. Essentially, when the respondeat superior premise is invoked in a legal proceeding, a plaintiff will look to hold both the employer and the employee liable. There is no national standard for respondeat superiors. Because states create their own standards for the doctrine, different jurisdictions use different tests to prove the responsibility of the respondeat superior (Cornell Law School Legal Information Institute, 2017). Clinical supervisors of predegree and prelicensed counselors can be identified as respondeat superiors, which means that they can be held legally responsible for the actions of their supervisees (Saccuzzo, 1997; Wheeler & Bertram, 2015).

These responsibilities also converge to inform the direction of activities and procedures known as gatekeeping.

The Process of Gatekeeping

Clinical trainees are expected to progress through a series of gates or checkpoints, as illustrated in Figure 1.1, that are carefully placed across the training experience to substantiate attainment or demonstration of competencies in three domains: acquired knowledge, execution of clinical skill, and demonstration of personal behaviors or professional conduct appropriate for a practicing clinician. Fundamental to this process are the procedures of monitoring and evaluating trainee development to ascertain whether expected levels of performance have been achieved to support continued advancement toward graduation, licensure, and eventual independent professional practice (Brear et al., 2008; Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2015). The process of gatekeeping also incorporates engagement in activities that support trainee development or remedy stalled progress. Gatekeeping may also involve stopping a trainee from graduating or gaining licensure in his or her chosen profession (Koerin & Miller, 1995) because of an inability or lack of willingness to meet standards or professional expectations. Multiple processes are involved in gatekeeping and are the topics featured in this book.

The Mandate for Gatekeeping

All clinical professions reference the obligation of preventing inept practitioners from entering into the profession primarily to protect clients from harm. This mandate is identified by multiple governing bodies within each professional group and extends to all members of the profession. In the realm of preprofessional preparation, the

gatekeeping obligation is typically fulfilled by clinical faculty and supervisors serving as respondeat superiors accountable for overseeing the training process and trainees. The responsibilities of gatekeeping include monitoring, evaluating, and determining which trainees can appropriately enter the given profession while remediating or stopping those who cannot. Where and how this mandate is explained or defined across the clinical professions varies.

Professional Associations' Codes of Ethics

General expectations for gatekeeping are addressed in the ethics codes of the four primary clinical professions: the American Counseling Association (ACA), American Psychological Association (APA), National Association of Social Workers (NASW), and American Association for Marriage and Family Therapy (AAMFT).

Above all, professional ethics uphold the standards of beneficence and nonmaleficence: striving to do no harm and protect the rights and welfare of those with whom counselors and therapists interact, especially clients. Standards in professional ethics also identify some criteria for professional demeanor and behavior for members of their respective organizations beyond the competencies of having the knowledge and skills to practice effectively. Most ethical standards delineate or infer that students and supervisees will adhere to the same ideals as professional members. Chapter 7 provides examples of these expectations.

The general tenets of ethics codes stipulate the role of the gatekeeper for members who are educators or supervisors; however, the amount of detail varies considerably across the four major mental health professions. For example, the APA *Ethical Principles of Psychologists and Code of Conduct* (APA, 2017c) states in Standard 7.04(2) that psychologists do not disclose personal information about trainees except when

> the information is necessary to evaluate or obtain assistance for students whose personal problems could reasonably be judged to be preventing them from performing their training- or professionally related activities in a competent manner or posing a threat to the students or others.

Other APA standards address timely assessment and feedback processes; however, they do not specifically address the role or responsibility of respondeat superiors in training positions to protect clients or the profession from inappropriate trainees via the gatekeeping process. Bodner (2012) extrapolated the ethical principles that she believed apply to gatekeeping practices in psychology.

The *NASW Code of Ethics* (NASW, 2017) details the obligation of social workers to address their own impairment or the impaired, incompetent, or unethical conduct of colleagues—as do all clinical professions' ethics codes; however, the ethical standards are very vague in reference to trainees and include only that "social workers who

function as educators or field instructors for students should evaluate students' performance in a manner that is fair and respectful" (Standard 3.02[b]). Descriptions of "fair and respectful" are undefined and left to the assumptions of the members.

The 2015 revision of AAMFT's *Code of Ethics* (AAMFT, 2015) reveals standards that are similarly ambiguous when describing the role and expectations of gatekeepers. Standard 4.4 reads: "Oversight of Supervisee Competence. Marriage and family therapists do not permit students or supervisees to perform or to hold themselves out as competent to perform professional services beyond their training, level of experience, and competence." This standard is generally known as the scope of practice clause and is included in every ethics code as a principle that applies to all practicing professionals. Standard 4.5 reads: "Oversight of Supervisee Professionalism. Marriage and family therapists take reasonable measures to ensure that services provided by supervisees are professional." This standard does not offer an explanation or definition of behaviors that qualify as "professional," which could be interpreted broadly in a gatekeeping proceeding.

The *ACA Code of Ethics* (ACA, 2014a) offers the most comprehensive ethical guidelines for supervisors and educators engaged in training by describing key components of the gatekeeping process, including monitoring, evaluating, protecting clients, and determining continuation in the profession. This code is unique in specifying that trainees are obligated to follow the *ACA Code of Ethics* and includes an entire section of standards that support gatekeepers by defining expectations for professional behavior:

Section F: Supervision, Training, and Teaching

F.1. Counselor Supervision and Client Welfare

F.1.a. Client Welfare A primary obligation of counseling supervisors is to monitor the services provided by supervisees. Counseling supervisors monitor client welfare and supervisee performance and professional development. To fulfill these obligations, supervisors meet regularly with supervisees to review the supervisees' work and help them become prepared to serve a range of diverse clients. Supervisees have a responsibility to understand and follow the *ACA Code of Ethics.*

F.4. Supervisor Responsibilities

F.4.a. Informed Consent for Supervision Supervisors are responsible for incorporating into their supervision the principles of informed consent and participation. Supervisors inform supervisees of the policies and procedures to which supervisors are to adhere and the mechanisms for due process appeal of individual supervisor actions. The issues unique to the use of distance supervision are to be included in the documentation as necessary.

F.5. Student and Supervisee Responsibilities

F.5.a. Ethical Responsibilities Students and supervisees have a responsibility to understand and follow the *ACA Code of Ethics.* Students and supervisees have the same obligation to clients as those required of professional counselors.

F.6. Counseling Supervision Evaluation, Remediation, and Endorsement

F.6.a. Evaluation Supervisors document and provide supervisees with ongoing feedback regarding their performance and schedule periodic formal evaluative sessions throughout the supervisory relationship.

F.6.b. Gatekeeping and Remediation Through initial and ongoing evaluation, supervisors are aware of supervisee limitations that might impede performance. Supervisors assist supervisees in securing remedial assistance when needed. They recommend dismissal from training programs, applied counseling settings, and state or voluntary professional credentialing processes when those supervisees are unable to demonstrate that they can provide competent professional services to a range of diverse clients. Supervisors seek consultation and document their decisions to dismiss or refer supervisees for assistance. They ensure that supervisees are aware of options available to them to address such decisions.

F.8. Student Welfare

F.8.d. Addressing Personal Concerns Counselor educators may require students to address any personal concerns that have the potential to affect professional competency.

F.9. Evaluation and Remediation

F.9.a. Evaluation of Students Counselor educators clearly state to students, prior to and throughout the training program, the levels of competency expected, appraisal methods, and timing of evaluations for both didactic and clinical competencies. Counselor educators provide students with ongoing feedback regarding their performance throughout the training program.

F.9.b. Limitations Counselor educators, through ongoing evaluation, are aware of and address the inability of some students to achieve counseling competencies. Counselor educators do the following:

1. assist students in securing remedial assistance when needed,
2. seek professional consultation and document their decision to dismiss or refer students for assistance, and
3. ensure that students have recourse in a timely manner to address decisions requiring them to seek assistance or to dismiss them and provide students with due process according to institutional policies and procedures. (pp. 12–15)

The *ACA Code of Ethics* is much more specific and helpful in providing guidance to faculty and supervisors than most codes across the clinical professions, as illustrated above. Appendix A provides excerpts from ethics codes that guide gatekeeping processes in additional professional specialties: the *ASCA Ethical Standards for School Counselors* (American School Counselor Association, 2016), the *AMHCA Code of Ethics* (American Mental Health Counselors Association [AMHCA], 2015), and the *Code of Professional Ethics for Rehabilitation Counselors* (Commission on Rehabilitation Counselor Certification, 2017).

A general limitation of ethics codes with regard to gatekeeping is their lack of specificity, which is typically considered to be acceptable because ethics codes are intended to be aspirational standards applicable to multiple contexts. Although considered foundational descriptions for ideal professional functioning, codes of ethics are only enforceable among members of the particular professional association who have

agreed to abide by the code as a condition of membership. Nevertheless, codes of ethics are considered to reflect standards for best practice and have at times been relied on in court cases and licensure board hearings to define expectations for practicing clinicians, even if the individuals appearing in those proceedings are not members of their professional group. Also, some state licensure laws reference the ethics code of a given profession as the legal standard for practice. APA, for example, proposed a model state licensure act in 2010 that included adoption of its ethics code as the standard for conduct for psychologists (APA, 2011). Similarly, of the 52 jurisdictions that license mental health counselors, 19 have adopted the *ACA Code of Ethics* as the standard for ethical practice and professional conduct (ACA, 2014b), and other states have adopted the *AMHCA Code of Ethics* (AMHCA, 2015) as the benchmark criteria for licensees' practice.

As demonstrated by the differences among the ethics codes of the mental health professions, there is significant disparity, which contributes to the confusion of identifying expected actions of the gatekeeper. Only the counseling profession addresses this role in detail in its ethics code, which provides guidelines for easy reference. The directives for other professional groups are inconsistent and not necessarily identified elsewhere in the standards of those particular professions.

Accrediting Bodies for Training Programs

Professional accrediting bodies such as the Commission on Accreditation for Marriage and Family Therapy Education, CACREP, APA's Commission on Accreditation, and the Council on Social Work Education (CSWE) accreditation program also define specific academic standards for clinical training programs. The role of accrediting bodies is important in clinical education because the process of accreditation

> assures the educational community and the general public that an institution or a program has clearly defined and appropriate objectives and maintains conditions under which their achievement can reasonably be expected. . . . through the development of principles and guidelines for assessing educational effectiveness. (APA, 2017a, para. 1)

Although not all training programs are professionally accredited, the highest standards for training are influential in defining the ideals of academic gatekeeping as well as licensing. In the domain of gatekeeping, there is variation across these major accrediting bodies in terms of defining and specifying processes required of accredited programs to ensure the protection of clients and the profession. Along with codes of ethics, program accreditation standards for the professions of counseling and psychology offer the most specificity and guidance for the gatekeeping mandate in clinical training programs.

In counselor education, CACREP (2015) establishes the standards for training for accredited counseling programs. Of the four accredit-

ing bodies named previously, CACREP's standards are the only ones that designate and define the gatekeeping process as a function of clinical training:

> Gatekeeping [is] the ethical responsibility of counselor educators and supervisors to monitor and evaluate an individual's knowledge, skills, and professional dispositions required by competent professional counselors and to remediate or prevent those that are lacking in professional competence from becoming counselors. (p. 45)

The CACREP standards for accreditation also offer a related definition for this particular area of student functioning: "Professional dispositions [are] the commitments, characteristics, values, beliefs, interpersonal functioning, and behaviors that influence the counselor's professional growth and interactions with clients and colleagues" (p. 47). This definition is less explicit than that of gatekeeping but offers the importance of personal and professional functioning as a critical factor in student development worthy of evaluation, feedback, remediation, and, if found to be problematic and unchangeable, dismissal from the training program.

The APA Commission on Accreditation (2015) mentions policies and procedures that provide for student performance evaluation, feedback, advisement, retention, and termination decisions and for due process and grievance procedures for students. The APA Commission on Accreditation also designates that newly admitted students receive written policies and procedures regarding program and institution requirements and expectations regarding students' performance and continuance in the program and procedures for terminating students. Another foundational gatekeeping practice is also addressed by this accrediting body:

> Feedback and Remediation. Students receive, at least annually and as the need is observed for it, written feedback on the extent to which they are meeting the program's requirements and performance expectations. Such feedback should include:
>
> a. timely, written notification of any problems that have been noted and the opportunity to discuss them;
> b. guidance regarding steps to remediate any problems (if remediable);
> c. substantive, written feedback on the extent to which corrective actions have or have not been successful in addressing the issues of concern. (Standard III.C.3.)

Psychology trainees are also expected to conduct professional activities with respect and sensitivity for human and cultural diversity; maintain professional conduct, including self-reflection and responsiveness to feedback and supervision; and fulfill expectations for the communication and interpersonal skills of students and interns. These are some of the characteristics of trainees that align with the interpersonal, intrapersonal, and professional standards considered in gatekeeping efforts. To support faculty and supervisors in their training role, APA (2012) has published a website of resources that includes *A Practical Guidebook*

for the Competency Benchmarks. This document and the accompanying website offer a toolkit of resources and guidance for evaluating trainees, communicating feedback, and remediating professionalism and related competencies.

NASW's CSWE, the program accreditation body for training in social work, includes as its first competency the expectation for trainees to demonstrate ethical and professional behavior. Although limited in definition, the accreditation standards (CSWE Commission on Accreditation, 2015) also identify the requirement for students (a) to demonstrate their abilities to use self-awareness, self-reflection, and self-regulation to manage personal values and maintain professionalism in practice situations; and (b) to demonstrate professional demeanor in their behavior, appearance, and communication. The CSWE standards also prescribe a process for student development that includes evaluating students' professional performance, informing students of policies and criteria for evaluation, and terminating students from training programs for problems with professional performance. Designated faculty and field personnel are expected to oversee organized procedures for the ongoing assessment of student outcomes according to this accrediting body.

The Commission on Accreditation for Marriage and Family Therapy Education (2017) accreditation standards call for the evaluation of student performance but do not address the processes or criteria for evaluation in graduate training programs. The standards also reference a code of conduct but do not require programs to have one. The definition in the glossary is "Codes of Conduct are shared statements regarding a commitment to ethical, legal and professional beliefs, values, and behavior that serve as foundational standards for making decisions and taking actions" (p. 44). AAMFT-approved supervisor training standards (AAMFT, 2014) discuss the provision of supervision in significant detail and provide instruction on the processes for evaluating supervisees; managing difficulties in supervision, including remediation; and, when necessary, advising family therapy trainees out of the profession. However, not all faculty in family and relationship therapy programs are required to be approved supervisors, so they may not have training on these best practices.

State Regulatory Boards

Saccuzzo (1997) noted a similar dilemma across the regulations of state licensure boards, observing that licensure laws are vague in delineating the specific criteria for supervision and often fail to define standards for who is qualified to provide supervision in the clinical professions. One reason for this is that the majority of training and supervision occurs during the predegree period. Licensure boards establish minimal requirements for coursework in content areas and the quantity of supervised experience prior to graduation, with some

offering more specific direction than others; however, state-level licensing bodies generally do not legislate detailed requirements within the academic realm. Licensure laws designate only the entry requirements of licensure applicants (e.g., the type and level of degree: master's or doctorate), single line descriptions of required courses, and slightly more detail about the conditions of practicum experiences. For specific information about individual state licensure requirements, access the following directories of regulatory boards:

- Counseling (https://www.counseling.org/knowledge-center/licensure-requirements/state-professional-counselor-licensure-boards)
- Psychology (www.asppb.net/?page=BdContactNewPG)
- Marriage and family therapy (https://www.aamft.org/iMIS15/AAMFT/Content/directories/MFT_licensing_boards.aspx)
- Social work (http://aswbsocialworkregulations.org/licensingWebsitesReportBuilder.jsp)

Regulatory boards are responsible for defining postdegree, prelicensure experience requirements in greater detail, including the gatekeeping responsibilities of postdegree clinical supervisors for monitoring, evaluating, and screening for problematic trainees to determine which applicants can appropriately enter the given profession. Like ethics codes, laws and rules for the same license vary across states and may differ across the four allied clinical professions within a state. The absence of detail regarding the process by which supervisors determine endorsement for licensure typically boils down to checking a box on a form as the final gate checkpoint affirming that a supervisee is or is not considered to be in good standing or has or has not met the minimum standards of performance in professional activities as measured against general prevailing peer performance, or similar wording that is ill defined and does not necessarily confirm whether any gatekeeping procedures occurred.

Some states require that postdegree supervisors complete minimal training requirements to become qualified or approved supervisors prior to supervising postdegree clinicians who are obtaining experience to meet licensure requirements. These states may offer or require supervision training workshops that include knowledge of supervisee assessment, understanding of jurisdictional expectations in terms of the amount and frequency of supervision, and expected content to be covered in supervisory meetings (such as a review of case files or recordings of sessions). State regulatory boards may also require licensed or certified supervisors to attend continuing education workshops on supervision at assigned intervals to maintain their status as supervisors of postdegree license seekers. Most state licensing bodies rely on standards of practice assumed to be known by the licensed supervisor

through either predegree training or ethics education through his or her professional association.

It is recommended that both pre- and postdegree supervisors seek ongoing education, training, and consultation to enhance their skills as effective supervisors, which includes the role of gatekeeper. Seeking information and consultation is particularly helpful when determining whether to endorse a questionable trainee for continuation toward licensure. Professional associations, conferences, and the professional literature are sources for knowledge and collegial support for postdegree supervisors who hold membership in the given association. Some professional associations also have specialty divisions or interest groups for the study of clinical supervision, such as the Association for Counselor Education and Supervision (https://www.acesonline.net/), AAMFT's approved supervisor training program (https://www.aamft.org/Documents/Approved_Supervisor_Handbook_2014.pdf), or APA's Clinical Supervision Essentials series of books and videos (www.apa.org/pubs/books/clinical-supervision.aspx).

Defining Competency

The health professions, including mental health, are increasingly being held accountable for practices that fulfill quality assurance expectations to protect the public or risk facing legal repercussions for improper supervision or training (Custer, 1994; Frame & Stevens-Smith, 1995; Hutchens, Block, & Young, 2013; Polychronis & Brown, 2016; Saccuzzo, 1997). Safeguarding clients from practitioners who do not meet minimal standards of professional competence is especially critical in the health professions because the consequences of poor practice can be life threatening and/or result in long-term psychological injury. For this reason, higher education has moved toward a competency-based approach to training that can be demonstrated through outcomes—the training of competent professionals (e.g., clinical mental health practitioners). (See sidebar, What Would You Do? 1.1.)

In 2002, APA initiated a multiyear effort and convened a task force to identify and gain consensus about essential competencies for clinical practice, define competencies as standards for training programs, and develop methodologies for evaluating competencies that fittingly define the profession of psychology (APA, 2006). No other clinical behavioral health profession has undertaken such a broad effort, although expectations and standards have been generated by the professional organizations of all clinical fields, such as training program accreditation standards, ethics codes, and a growing body of research and knowledge that includes competency assessment methods and models.

The task force identified specific competencies within three domains of training considered critical to the development of competent clinical practitioners:

1. Attainment of requisite *knowledge*, primarily through academic learning and clinical experience, that can be applied in a clinical setting
2. Acquisition of *clinical skills* based in empirical evidence as therapeutic, accompanied by the ability to apply those skills effectively and ethically as appropriate to the client situation or setting
3. The ability to develop and maintain *personal behavior and professional conduct* expected of clinicians in the practice of their profession

What Would You Do? 1.1

You work as a school counselor at a high school that hosts school counseling trainees from a local university. Your unit of four counselors works together as a team to supervise master's-level counseling interns in their last year of their graduate program. In other words, all four of you work together collectively supervising three school counseling interns. You notice that one of the students, Roy, is very engaged in the internship experience but spends a lot of time kidding with the high school students and giving advice instead of using counseling skills to understand their concerns and facilitate their personal development of problem solving. His relationship with the students is more social than clinical or professional, and the students view Roy as a buddy. You have a conversation with Roy about your concerns and the professional boundaries differentiating personal and professional relationships. He expresses understanding and appreciation for the feedback, but his interactions with the student clients do not change. You believe that he has some clinical skills but is not applying them and continues to be chummy with the teens with whom he works; thus, you are unable to assess his skill level and are concerned about his professionalism.

You express your concerns to the supervisory team. They acknowledge that they have also witnessed this behavior but seem less concerned. It is time for your team to complete Roy's midpoint evaluation. The other team members minimize your growing concerns about Roy's consistent avoidance of his professional role, failure to engage appropriately with clients, and minimal demonstration of counseling skills. You believe that this information should be not only reported to his faculty supervisor but reflected in the evaluation ratings of Roy's professional conduct and interpersonal behavior. Your colleagues brush you off, stating that they do not want to interfere with the completion of this last stage of Roy's degree.

What would you do?

What would you say to your colleagues about your understanding of gatekeeping?

What standards would you refer to in your discussion? What steps would you take if you could not convince your colleagues to fulfill their gatekeeping obligation?

These domains are analogous to a three-legged stool representing professional knowledge, skills, and conduct (see Figure 1.2). It is important to acknowledge these three domains as essential to the training process because other non-human-service-oriented academic fields (e.g., chemistry or history) only address the first two domains and do not address behavior as an academic or training standard. In the clinical health professions, particularly mental health, personal functioning and professional conduct are essential components of competent practice and, hence, degree completion. Personal and professional conduct requirements must be modeled, taught, assessed, and evaluated as acceptable in order for a trainee to be considered suitable for the clinical profession. Furthermore, all three domains are fundamental and interconnected; criteria not required of other non-human-service majors hold a vital, interlocked relationship in clinical work that needs to be conveyed to and supported at the administrative levels of institutions of higher learning.

Two of the three domains are more straightforward to evaluate using standardized procedures. Knowledge achievement is generally determined by educational institutions or their departments with oversight from accreditation bodies. Knowledge acquisition can be evaluated by multiple quantitative and widely acceptable qualitative methods that result in the assignment of grades and is measured by standardized exams required for licensure.

Essential clinical skills are described in terms of observable demonstration of proficiencies as well as through client outcomes. Although they are not as objectively defined as academic knowledge areas, there is a generally accepted consensus about the fundamental clinical skills required to demonstrate competence, many of which are supported by research and/or theory within the behavioral health professions (Barber, Sharpless, Klostermann, & McCarthy, 2007; Bernard & Goodyear, 2014; Hatcher et al., 2013; L'Abate, 2008; Perosa, 2010; Spruill, Rozensky,

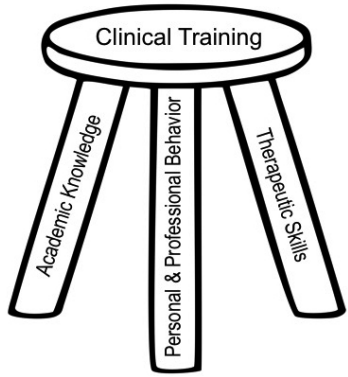


Figure 1.2 • Three Domains of Clinical Training

Stigall, Vasquez, & Bingham, 2004; Tweed, Graber, & Wang, 2010). Clinical skills are assessed using a range of standardized qualitative and quantitative instruments that are available to supervisors, several of which are discussed in Chapter 9. The relatively unambiguous establishment of criteria in these two domains—academic achievement and clinical skills—supports foundational training standards and provides clarity in the assessment of students and supervisees. Also, acquisition of knowledge and its application through skill demonstration are generally represented in most mental health fields of study.

Standards for the domain of personal behavior and professional conduct are, however, nebulous and must be gathered from multiple sources across each clinical profession—some professions identify many expectations, whereas other professions identify fewer expectations or use less definition. Despite the efforts of APA and other clinical professional associations to identify and define essential components of performance as a professional, expectations for personal and professional behavior remain vague, substantiated by limited empirical evidence, and lacking in broad consensus. This dilemma is due in part to the difficulty of identifying and defining common qualities expected of clinical trainees. Currently, training programs are expected to create their own criteria for professional behavior—a daunting task. In addition, the lack of a specific collection of personal and professional competencies hampers the construction of assessment instruments and evaluation processes that are reliable, valid, and widely accepted. The lack of consistent standards and measurement methods is the greatest challenge to the gatekeeping process and has long been lamented in the literature across the clinical professions. Several authors have described the problems created by the lack of a consistent, universal definition of gatekeeping and the related constructs that are the responsibility of the gatekeeper (Brear et al., 2008; Elman & Forrest, 2007; Forrest, Elman, Gizara, & Vacha-Haase, 1999; Homrich, 2009). Given that grounds for dismissing students from graduate programs lay primarily in the categories of ethical misconduct, emotional problems that impact professional behavior, and interpersonal skills deficits versus academic or clinical skills deficits (Crawford & Gilroy, 2012), defining gatekeeping criteria and developing assessment instruments that address these criteria should be considered a priority of the clinical professions.

Although not a recommended form of policymaking, many of the standards for trainee behavior developed within the mental health professions have been created in response to legal challenges that have forced the clarification of ethical standards, program policies, and the definitions of what constitutes academic requirements (Hutchens et al., 2013; *Keeton v. Anderson-Wiley*, 2011; McAdams, Foster, & Ward, 2007; *Ward v. Polite*, 2012), as discussed in Chapter 2. Learning from court rulings arising from vaguely defined criteria has contributed to clarifying

professional benchmarks and procedures for responding to problematic behavior. Regrettably, amending practices by repairing errors, or allowing the courts to determine what defines gatekeeping practices, is risky and contributes to the continued avoidance of gatekeeping practices by faculty and supervisors (Wayne, 2004). Fortunately, the general history of case law up to the present demonstrates that courts prefer not to interfere with the academic judgment of faculty in evaluating behavior as part of academic performance when fair proceedings have occurred and due process principles have been followed (Gilfoyle, 2008). Essentially, case law supports faculty and supervisors in determining what is acceptable trainee performance, including personal behavior and professional conduct competencies (see On the Legal Side 1.2).

The APA Task Force report (APA, 2006) acknowledged that the profession of psychology, although at the forefront of the assessment of professional competence among the allied clinical professions, lags behind other health care professions such as medicine "in terms of the breadth and use of summative assessment approaches and in the extent to which multiple models of formative assessment has been standardized in professional education and training programs" (p. 88). This explains why Corey, Corey, Corey, and Callanan (2015) admonished professional organizations to

> develop specific guidelines pertaining to students' successful completion of a program: NASW for social worker students, AAMFT or [International Association of Marriage and Family Counselors] for students in marital and family therapy programs, APA for students in clinical and counseling psychology, and ACA for students in counselor education programs. Faculty in these respective professional training programs would then have the backing of their professional associations in determining evaluation procedures to be used when decisions regarding retaining or dismissing students are made. (p. 315)

This dilemma is due in part to the nature of training clinical mental health professionals: The process is multidimensional and iterative because it includes overlapping domains of academic development, clinical skill development, interpersonal functioning, and intrapersonal professional identity development (Gibson, Dollarhide, & Moss, 2010). Nonetheless, the lack of official standards for personal behavior and professional conduct creates challenges for supervisors and educators who uphold their obligations as gatekeepers. This is especially true when one is faced with a problematic supervisee who is academically competent and skilled yet lacking in interpersonal abilities or professional conduct. Models of gatekeeping from individual programs have been presented in the literature (Baldo, Softas-Nall, & Shaw, 1997; Bemak, Epp, & Keys, 1999; Frame & Stevens-Smith, 1995; Lamb et al., 1987; Lumadue & Duffey, 1999); however, they lack empirical validation, their efficacy has not been established in a definitive manner,

On the Legal Side 1.2

The primary legal issue pertinent to gatekeeping is due process. Due process is a right protected in the Fourteenth Amendment of the U.S. Constitution (Cobb, 1994; Knoff & Prout, 1985; Wayne, 2004), which holds states governable by the Bill of Rights; thus, denial of due process can be charged against institutions that receive federal or state funding (Gilfoyle, 2008).

Due process claims involving student dismissals have been interpreted at length by the courts (Gilfoyle, 2008; Olkin & Gaughen, 1991). Case law essentially serves as a guide for implementing due process rights. Of particular importance is the precedent of the court's respect for faculty expertise in determining academic decisions (Forrest et al., 1999; Frame & Stevens-Smith, 1995; Kerl, Garcia, McCullough, & Maxwell, 2002; Knoff & Prout, 1985; Lamb & Swerdlik, 2003; Olkin & Gaughen, 1991). In essence, Gilfoyle (2008) stated that the courts grant faculty "substantial leeway" in academic decisions regarding student evaluations and dismissals (p. 202).

A landmark legal case from the 1970s involving a medical student established the important precedent affirming the evaluation of clinical and interpersonal skills as an academic prerogative and has implications for gatekeeping in the clinical professions. In the case *Board of Curators of the University of Missouri v. Horowitz* (1978), Horowitz sued after being dismissed from medical school, despite high grades, because of poor interpersonal relationships with colleagues and patients, poor personal hygiene, and poor clinical skills. The case was eventually brought to the U.S. Supreme Court, which upheld the dismissal decision (Cole & Lewis, 1993; Enochs & Etzbach, 2004; Frame & Stevens-Smith, 1995; Gilfoyle, 2008; Kerl et al., 2002; Knoff & Prout, 1985; Wayne, 2004). Knoff and Prout (1985) summarized the importance of the *Horowitz* case as distinguishing the dismissal as academic in nature rather than disciplinary and upholding the evaluation of "students' interpersonal skills and attitudes within the academic domain" (p. 794); these conclusions regarding the importance of *Horowitz* were also emphasized by Cobb (1994) and Wayne (2004). For the mental health professions, the *Horowitz* case affirms the evaluation of personal and professional behavior as appropriate for academic purposes and hence within the purview of gatekeeping.

Three court cases directly involving counseling graduate programs also present important legal considerations for gatekeeping. The 1986 case *Harris v. Blake and the Board of Trustees of the University of Northern Colorado* involved a single faculty member in a counseling graduate program (Baldo et al., 1997; Bhat, 2005; Frame & Stevens-Smith, 1995; Lumadue & Duffey, 1999). The court upheld a dismissal decision over claims of denial of due process and discrimination after the dismissed student received a counseling degree from another institution. Lessons from this case applicable to gatekeeping include having a faculty committee responsible for remedial decisions rather than one faculty member deciding alone (Baldo et al., 1997; Bhat, 2005). Also, the case illustrates the value of having a

(Continued)

On the Legal Side 1.2 *(Continued)*

dismissal policy and procedure in place that defines problematic behaviors along with the importance of requiring signatures on any accompanying remediation documentation.

Another pertinent legal consideration for remediation is found in a court case against Louisiana Tech University (Baldo et al., 1997; Bhat, 2005; Custer, 1994; Enochs & Etzbach, 2004; Frame & Stevens-Smith, 1995; Kerl et al., 2002; Lumadue & Duffey, 1999) that alleged that the counseling program did not provide adequate training and was liable for graduating an impaired professional. The case was settled in 1994 for $1.7 million before Louisiana Tech University was included in the case as a defendant (Custer, 1994). This case shows the potential liability for graduate programs, highlighting the importance of actively addressing students with problematic behaviors and preventing the endorsement of problematic professionals (Enochs & Etzbach, 2004; Frame & Stevens-Smith, 1995; Kerl et al., 2002; Lumadue & Duffey, 1999).

A final court case that involved remediation was examined by McAdams et al. (2007). In the 2005 case *Plaintiff v. Rector and Board of Visitors of The College of William and Mary*, a student sued for being dismissed from the counseling program. Prior to the student's dismissal, remediation had been attempted. In this case, the faculty were charged by the plaintiff with due process violations and conspiracy, among a total of six charges. After 3 years in litigation, the case against the college was dismissed, and the dismissal was upheld on appeal. Many lessons from this experience were articulated by McAdams et al. and expanded on by McAdams and Foster (2007), including the following: using an assessment tool that clearly defines deficient behaviors, specifying remedial interventions in behavioral terms, holding regular meetings with students, documenting the occurrence of meetings, and requiring signatures on all remediation documentation.

An additional court case involved Southwest Texas State University. In 1998, the counselor education faculty at Southwest Texas State University were sued by a student attempting to force enrollment in an advanced fieldwork course. The student had not fulfilled the requirements of a remediation plan (Kerl et al., 2002). Prior to the lawsuit, the faculty had implemented the program's review policy, called the Professional Counseling Performance Evaluation, to address the student's problematic behaviors. The court ruled in the university's favor on all counts, indicating that due process had been afforded to the student and that faculty had followed established policies and procedures consistent with professional standards, a ruling that Kerl et al. (2002) directly attributed to the implementation of the Professional Counseling Performance Evaluation. Enochs and Etzbach (2004) also noted the role in this case of having a formal policy in place regarding student expectations and remediation and dismissal procedures about which students are informed on admission to a program.