



CLINICAL SUPERVISION AND PROFESSIONAL DEVELOPMENT OF THE SUBSTANCE ABUSE COUNSELOR, MODULE 2

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Course Author: John H. Tinsley, PhD
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— Maya Angelou

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ABOUT THE INSTRUCTOR

Dr. John H. Tinsley is a former assistant professor of Medical Physiology at the Texas A&M University System College of Medicine. He received his Ph.D. from Texas A&M University, College Station, Texas; M.S. from the University of North Carolina; and his B.S. from the University of Oklahoma.

He has been teaching, training, consulting and conducting research in the fields of Medical Physiology and Behavioral Biology for over twenty-nine years. Dr. Tinsley has authored over twenty-five professional and refereed articles, including invited reviews. He has been a member of the American Society for Physiology, and work done in 2001 led to an international award from The European Society on Microcirculation. Dr. Tinsley has received research funding from the Veteran's Administration, American Heart Association, and Scott and White Hospital. In addition, he has served on numerous review committees for national grant-funding agencies and scientific journals.

Supervision Methods, Counselor Wellbeing, and Performance

Assessment: Current Evidence

Module 2 of TIP 52 addresses the practical dimensions of clinical supervision — specific methods and techniques, managing the supervisory relationship including conflict and resistance, identifying counselor impairment and burnout, and evaluating supervisee performance. These are the operational skills that distinguish effective supervision from supervisory relationships that exist on paper but fail to produce professional growth. Recent research has focused on two areas this module covers directly: the occupational trauma and burnout that substance abuse counselors experience, and the challenge of measuring whether supervision actually produces competent clinical practice.

The secondary traumatic stress experienced by addiction professionals — a topic this module addresses through its discussion of counselor impairment and burnout — was the subject of a 2026 mixed-methods synthesis analyzing nine studies. The review found that addiction treatment professionals experience "considerable levels of secondary traumatic stress" that transforms their "worldviews, emotions, and beliefs about themselves and others." The researchers identified three thematic experiences: overwhelming exposure to client trauma ("Opening Pandora's Box"), the tension between professional distance and empathic connection ("Defensive practice versus connecting and boundaries"), and growth through witnessing client resilience ("New paths in personal and professional development"). Critically, the review identified that "support from colleagues, supervision, and continuous education were identified as critical factors in reducing negative consequences" (Gkremou et al., 2026). For supervisors implementing the methods described in this module, this finding positions supervision as a protective factor against occupational harm. The supervision session is one of the few structured spaces where a counselor can process the emotional impact of working with traumatized, substance-using clients without the pressure to maintain a therapeutic stance. When supervisors neglect this supportive function — focusing exclusively on case management, administrative compliance, or skill development — they miss the opportunity to address the secondary traumatic stress that, left unmanaged, leads to the impairment and burnout this module describes. The three-theme framework from the Gkremou et al. synthesis can serve as a practical assessment tool: supervisors can periodically explore with their supervisees which of these three experiences — overwhelming exposure, boundary tension, or professional growth — is currently dominant, and adjust the supervision focus accordingly.

How a supervisor responds when burnout is identified matters as much as whether it is identified at all. The Gkremou et al. synthesis found that supervision serves as a critical protective factor, but this function operates only when the supervisor creates conditions in which the supervisee can acknowledge distress without fearing professional consequences. A counselor who discloses that client trauma narratives are intruding on their personal life, or that they have begun dreading certain sessions, is taking a significant professional risk — particularly if the same supervisor who hears this disclosure also writes their performance evaluation. Supervisors who respond to burnout disclosures with immediate corrective action, however well-intentioned, may inadvertently teach supervisees that honesty about emotional strain triggers unwanted intervention. The more effective response, consistent with the Gkremou et al. finding that peer support and continuous education reduce negative consequences, is to normalize the experience first — acknowledging that secondary traumatic stress is an occupational reality, not a personal deficiency — and then collaboratively exploring adjustments to caseload composition, session spacing, or self-care practices. This sequencing preserves professional competence while addressing the clinical risk that unmanaged burnout poses to client care.

The workforce retention consequences of supervision quality were quantified in a 2025 study of 167 addiction professionals, which found that professionals with negative supervisor relationships are more likely to leave, that inconsistent supervision increases turnover, and that "poor supervision and training can lead to poor work performance" (Aristy, 2025). For the evaluation techniques described in this module, this data reinforces that the evaluative function must be exercised carefully. Performance feedback that damages the supervisory relationship — even when clinically accurate — may drive counselor attrition rather than improvement. The supervision methods this module describes must balance honest performance assessment with relational support, recognizing that the supervisory relationship is itself a retention mechanism. Supervisors who can deliver direct, specific, behaviorally-anchored feedback within a relationship characterized by trust, consistency, and genuine investment in the supervisee's development are more likely to produce both clinical improvement and workforce stability than those who prioritize either function at the expense of the other.

The tension between the evaluative and supportive functions of supervision — a central concern of this module — is often framed as an inherent contradiction, but the Aristy data suggests it is more accurately understood as a sequencing challenge. Supervisors who establish a strong supportive alliance before introducing rigorous evaluative feedback create a relational context in which honest assessment is experienced as investment rather than threat. The supervisee whose supervisor has consistently advocated for manageable caseloads and responded to clinical struggles with curiosity rather than judgment is far more likely to receive performance feedback as useful information. This does not mean delaying evaluation — the gatekeeping function requires ongoing assessment from the beginning. It means that evaluative conversations occur within a relationship that has already demonstrated its supportive dimensions. When supervisors attend to this sequencing deliberately, the two functions reinforce each other: the supervisee trusts the evaluation because the relationship is supportive, and the relationship deepens because the evaluation is honest.

The challenge of assessing supervisee performance with rigor has been addressed through validated measurement tools. A 2023 study developed and validated a 12-item fidelity scale across 1,089 audio recordings from 238 substance use treatment providers in 60 community clinics. Community-based providers scored significantly lower on advanced MI competencies than research-setting providers, confirming that training alone does not produce consistent clinical proficiency. The authors concluded that "follow-up coaching by trained supervisors may be needed" (Naar et al., 2023). For supervisors using the performance assessment approaches described in this module, the MI fidelity scale represents a shift from impression-based evaluation to measurement-based supervision. Rather than relying on subjective impressions of whether a supervisee is "doing MI correctly," supervisors can use standardized instruments to identify specific skill domains requiring attention, track improvement over time, and anchor feedback in observable behavioral indicators. This approach also addresses the supervisory challenge of managing resistance — when feedback is linked to specific, measurable behaviors documented through direct observation, supervisees are less likely to experience it as personal criticism and more likely to engage with it as professional development.

The practical mechanics of measurement-based supervision deserve attention because the concept is straightforward but the implementation is not. Using a validated fidelity scale like the one Naar et al. developed requires supervisors to review recorded sessions, score specific behavioral indicators, and translate scores into actionable feedback — a process that demands time and training many community-based supervisors lack. Yet the alternative — evaluation based on supervisee self-report and supervisory impression — is precisely what produces the competence-fidelity gap the Naar et al. data

documents. Supervisors can bridge this gap incrementally: even reviewing one recorded session per month with a structured rating tool provides more reliable data than weekly verbal check-ins. The key shift is from asking "How do you think that session went?" to "Let us listen to this segment together and look at what happened." This moves evaluation from the domain of opinion into the domain of shared observation, which fundamentally changes the supervisory conversation.

The expansion of the addiction treatment workforce to include non-traditional providers has created new demands on supervisors implementing TIP 52's methods. A 2025 study documented the training and supervision of community members delivering substance use disorder interventions in American Indian communities, finding that "additional training and supervision during the open trial was needed to ensure proper treatment delivery" — initial workshops alone were insufficient (Skewes et al., 2025). For supervisors, this underscores that the developmental model applies regardless of the supervisee's professional background: new practitioners require intensive, structured support that gradually shifts as competence develops. A 2023 evaluation of brief training formats — the type most counselors access for continuing education — assessed whether short-format training produced measurable practice changes (Cambron et al., 2023). Together, these findings frame the supervision methods in this module as the essential mechanism for translating workforce training into workforce competence — a distinction that determines whether new clinical knowledge actually reaches clients.

Clinical Supervision and Professional Development of the Substance Abuse Counselor

A Treatment
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TIP
52



Clinical Supervision and Professional Development of the Substance Abuse Counselor

Treatment Improvement Protocol (TIP) Series

52

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Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

1 Choke Cherry Road
Rockville, MD 20857

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Quality Improvement and Workforce Development Branch, Division of Services Improvement, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

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Consensus Panel

Note: The information given indicates each participant's affiliation as of 2007, when the panel was convened, and may no longer reflect the individual's current affiliation.

Chair, Part 1 and Part 2 Consensus Panels

David J. Powell, Ph.D. (Chair)

President

International Center for Health Concerns, Inc.

East Granby, Connecticut

Part 1 Consensus Panel Members

Bruce Carruth, Ph.D.

KAP Expert Content Director

The CDM Group, Inc.

Bethesda, Maryland

Bettye Harrison

Opioid Treatment Program Accreditation Director

CARF International

Tucson, Arizona

Sharon Hartman, M.B.A., LSW

Director of Professional Training and Education

Caron Treatment Centers

Wernersville, Pennsylvania

Pamela Mattel, M.S.W., LCSW-R, ACSW, CASAC

Executive Deputy Director

BASICS, Inc.

New York, New York

John Porter, M.S.

Northwest Frontier Addiction Technology Transfer Center

Wilsonville, Oregon

Part 2 Consensus Panel Members

Bruce Carruth, Ph.D.

KAP Expert Content Director

The CDM Group, Inc.

Bethesda, Maryland

Charles F. Gressard, Ph.D., LPC, NCC

Associate Professor, School of Education

College of William & Mary

Williamsburg, Virginia

Pamela Mattel, M.S.W., LCSW-R, ACSW, CASAC

Executive Deputy Director

BASICS, Inc.

New York, New York

What Is a TIP?

Treatment Improvement Protocols (TIPs) are developed by the Center for Substance Abuse Treatment (CSAT), part of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). Each TIP involves the development of topic-specific best-practice guidelines for the prevention and treatment of substance use and mental disorders. TIPs draw on the experience and knowledge of clinical, research, and administrative experts of various forms of treatment and prevention. TIPs are distributed to facilities and individuals across the country. Published TIPs can be accessed via the Internet at <http://store.samhsa.gov>.

Although each consensus-based TIP strives to include an evidence base for the practices it recommends, SAMHSA recognizes that behavioral health is continually evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. If research supports a particular approach, citations are provided.

Foreword

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

The Treatment Improvement Protocol (TIP) series fulfills SAMHSA's mission to improve prevention and treatment of substance use and mental disorders by providing best practices guidance to clinicians, program administrators, and payers. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates debates and discusses their particular area of expertise until they reach a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of behavioral health services. We are grateful to all who have joined with us to contribute to advances in the behavioral health field.

Pamela S. Hyde, J.D.

Administrator

Substance Abuse and Mental Health Services Administration

H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM

Director

Center for Substance Abuse Treatment

Substance Abuse and Mental Health Services Administration

How This TIP Is Organized

This TIP is divided into three parts:

- *Clinical Supervision and Professional Development of the Substance Abuse Counselor, Part 1.*
- *Clinical Supervision and Professional Development of the Substance Abuse Counselor: An Implementation Guide for Administrators, Part 2.*
- *Clinical Supervision and Professional Development of the Substance Abuse Counselor: A Review of the Literature, Part 3.*

Parts 1 and 2 are presented in this publication; Part 3 is available only online at <http://store.samhsa.gov>.

Part 1 of the TIP is for clinical supervisors and consists of two chapters. Chapter 1 presents basic information about clinical supervision in the substance abuse treatment field. It covers:

- Central principles of clinical supervision and guidelines for new supervisors, including the functions of a clinical supervisor.
- The developmental levels of counselors and clinical supervisors.
- Information on cultural competence, ethical and legal issues such as direct and vicarious liability, dual relationships and boundary issues, informed consent, confidentiality, and supervisor ethics.
- Information about monitoring clinical performance of counselors, the various methods commonly used for observing counselors, the methods and techniques of supervision and administrative supervision, and practical issues such as balancing one's clinical and administrative duties, finding the time to do clinical supervision, documentation, and structuring clinical supervision sessions.

Chapter 2 presents the “how to” of clinical supervision. Chapter 2 contains:

- Representative vignettes of clinical supervision scenarios.
- Master supervisor notes and comments that help you understand the thinking behind the supervisor's approach in each vignette.
- “How-to” descriptions of specific techniques.

It is strongly recommended that you read chapter 1 before reading chapter 2.

Part 2 is an implementation guide for program administrators and consists of two chapters. Chapter 1 lays out the rationale for the approach taken in chapter 2 and will help administrators understand the benefits and rationale behind providing clinical supervision for their program's substance abuse counselors. Chapter 2 provides tools for making the tasks associated with implementing a clinical supervision system easier.

The following topics are addressed in Part 2:

- How to develop a model for clinical supervision and implement a clinical supervision program.
- Key issues for administrators to consider, including assessing organizational structure and readiness.
- Legal and ethical issues to consider.
- Cultural competence issues.
- Providing professional development for clinical supervisors.

Part 3 of this TIP is a literature review on the topic of clinical supervision and is available for use by clinical supervisors, interested counselors, and administrators. Part 3 consists of three sections: an analysis of the available literature, an annotated bibliography of the literature most central to the topic, and a bibliography of other available literature. It includes literature that addresses both clinical and administrative concerns. To facilitate ongoing updates (which will be performed every 6 months for up to 5 years from first publication), the literature review will be available only online at <http://store.samhsa.gov>.

Clinical Supervision and Professional Development of the Substance Abuse Counselor

Part 2: A Guide for Administrators

Clinical Supervision and Professional Development

Chapter 1

Clinical supervision should be an essential part of all substance abuse treatment programs. Every counselor, regardless of skill level and experience, needs and has a right to supervision. In addition, supervisors need and have a right to their own clinical supervision. For more on the essential nature of clinical supervision, see Appendix B, *New York State Office of Alcoholism and Substance Abuse Services Clinical Supervision Statement*. Unfortunately, many agencies place a higher priority on administrative tasks (such as case recordkeeping and crisis management), than on clinical supervision. This guide for administrators will assist in developing a rationale for and designing a clinical supervision system for your substance abuse treatment organization. Part 2 provides strategies and tools for implementing effective supervision along with advice on allocating resources for best results.

Benefits and Rationale

A successful clinical supervision program begins with the support of administrators. You communicate the value, benefits, and integral role of clinical supervision in quality care, staff morale and retention, and overall professional development within the context of the organization's mission, values, philosophy of care, and overall goals and objectives. Being able to discuss specific benefits of clinical supervision will increase the likelihood of internal support, enhance your organization's ability to deliver quality supervision, and add marketability for funding opportunities.

Administrative Benefits

Clinical supervision enables organizations to measure the quality of services. It ensures that employees follow agency policies and procedures and comply with regulatory accreditation standards while promoting the mission, values, and goals of the organization. Supervision provides administrators with tools to evaluate job performance, maintain communication between administrators and counselors, facilitate conflict resolution, and hold personnel accountable for quality job performance. Clinical supervision is a risk-management tool that increases an organiza-

tion's ability to respond to risk, thereby reducing overall liability. It also addresses human resource issues, including staff satisfaction and retention of personnel. Finally, supervision provides marketing benefits by improving the overall reputation of the agency in the community and among other service providers.

Clinical Services Benefits

The goal of clinical supervision is to continuously improve quality client care. Supervision by trained and qualified supervisors helps staff understand and respond more effectively to all types of clinical situations and prevent clinical crises from escalating. It specifically addresses assessment, case conceptualization, treatment strategies, and discharge planning. Supervision aids in addressing the unique needs of each client. It provides a mechanism to ensure that clinical directives are followed and facilitates the implementation and improvement of evidence-based practices (EBPs). "Quality supervision will become a major factor in determining the degree to which EBPs are adopted in community settings" (CSAT, 2007, p. 12). Clinical supervision also enhances the cultural competence of an organization by consistently maintaining a multicultural perspective. "Supervision encourages supervisees to examine their views regarding culture, race, values, religion, gender, sexual orientation, and potential biases" (CSAT, 2007, p. 27).

CSAT's Technical Assistance Publication (TAP) 21-A, *Competencies for Substance Abuse Treatment Clinical Supervisors*, defines supervision as a "social influence process that occurs over time in which the supervisor participates with supervisees to ensure quality care. Effective supervisors observe, mentor, coach, evaluate, inspire, and create an atmosphere that promotes self-motivation, learning, and professional development" (CSAT, 2007, p. 3). Also, supervision can improve client outcomes (Carroll, Ball, Nich, Martino, Frankforter, Farentinos, et al., 2006). Finally, supervision increases staff members' sensitivity and responsiveness to diversity issues among staff, with clients, and between staff and clients.

Clinical Supervision and Professional Development

Professional Development Benefits

Quality clinical supervision has been shown to increase staff retention through professional skills development and increased competency (Bernard & Goodyear, 2004). Supervision provides the forum for expanding current clinical practices, intellectual stimulation, emotional support, and improvement in critical thinking (see CSAT, 2007). Supervision is part of an organization's career ladder, as it supports staff in obtaining and maintaining professional credentials. It also provides information and guidance about key contextual factors that may influence their work performance such as culture, lifestyles, and beliefs.

Workforce Development Benefits

Supervision by trained and qualified supervisors is an essential tool in the recruitment and retention of personnel, as counselors often rate training and development as critical factors in their selection of employment. In addition, supervision has been shown to improve staff morale and motivation by making staff feel valued and appreciated (Bernard & Goodyear, 2004). It also assists in promoting counselor wellness, and promotes the overall development of the substance abuse treatment field by upgrading the credentials, knowledge, skills, and attitudes of personnel.

Program Evaluation and Research Benefits

Implementation of program evaluation and/or research is often misunderstood by counselors and viewed as more work that is unrelated to quality client care. Supervision can mediate in this area by providing staff with the rationale for the initiative, connecting it to client outcomes, and communicating achievements and challenges to the evaluators. Clinical supervision can also provide the mechanism for data gathering and information retrieval in support of the new projects and programmatic innovations.

Key Issues for Administrators in Clinical Supervision

Administrative and Clinical Tasks of Supervisors

Supervisors wear many hats. In most organizations, the administrative and clinical supervisor is the same person (see also the section that follows, Administrative and Clinical Supervision, p. 89). Most clinical supervisors still carry a client caseload (albeit reduced somewhat from that of a line counselor), perform administrative duties, write grant proposals, serve as project managers, and supervise the clinical performance of counselors. Each role involves different expectations and goals. It is important for administrators to be aware of each of these roles and for supervisors to be prepared to perform effectively in administrative, organizational, and clinical roles.

Kadushin (1976) outlines multiple administrative tasks for a clinical supervisor: staff recruitment and selection; orientation and placement of employees; work planning and assignments; monitoring, coordinating, reviewing, and evaluating work; staff communication both up and down the chain of command; advocating for client and clinician needs; acting as a buffer between administrators and counselors; and acting as a change agent and community liaison. Munson states, "As part of their administrative responsibilities, supervisors are often required to manage program transitions and modifications. Departments and programs can be altered, restructured and merged" (1979, p. 72).

Assessing Organizational Structure and Readiness for Clinical Supervision

In implementing a clinical supervision program, an important first step will be to evaluate the agency's preparedness to support the functions of clinical supervision by identifying the agency's culture and organizational structure. Organizational readiness scales and attitude inventories can be helpful in the

process of assessing and adopting EBPs. You need to assess the following:

- How decisions are made within the organization (centralized versus decentralized, vertical or horizontal).
- How authority is defined and handled (top down, bottom up, through the chain of command, or ad hoc).
- How power is defined and handled (reward, coercion, legitimate power through status, prestige, titles, expert power through skills and experience, or referent power through respect for an individual—or all of the above).
- How information is communicated (structured/formal/informal, on a need-to-know basis, bidirectional feedback and communication).
- How the organizational structure influences supervisory relationships, process, and outcome.
- The overall cultural proficiency of the organization.

The following organizational issues should be considered by an agency before a clinical supervision system is implemented:

- *Organizational context.* How consistently do staff adhere to agency philosophy and culture? To what extent will clinical supervisors teach and support this philosophy?
- *Clinical competence.* What specific knowledge, skills, and attitudes are expected of substance abuse counselors? What is each counselor's baseline competence and learning style? What is the level of cultural competence of staff?
- *Motivation.* How should the staff's motivation and morale be characterized?
- *Supervisory relationships.* What is the nature of relationships between administrators and front-line workers? How healthy or unhealthy are those relationships?
- *Environmental variables.* To what extent do administrators expect supervisors to proactively teach ethical and professional values? Do staff have a common set of goals? How does the organization promote professional development? How is progress toward those goals monitored and supported? What is the cultural, racial, religious, gender, and sexual orientation mix of the clients served by the organization?

- *Methods and techniques.* How familiar is the organization with individual, group, and peer supervision? How familiar is the organization with case progress note review, case consultation methods, direct observation, live supervision, audio- or videotaping, and role playing?

Assessing an organization's readiness for a clinical supervision system may also include such questions as: "What stage of readiness for implementing a clinical supervision system are the board of directors, other administrative staff and clinical supervisory staff (if any), direct care staff, and support personnel? What are some of the organizational, administrative, and clinical barriers to implementing a clinical supervision system?" Potential barriers include lack of familiarity with supervision methods and techniques, the need for further training of supervisors, and lack of technical equipment such as video cameras. It is helpful to develop a timeframe for addressing the most important barriers. What would you as an administrator like to see happen and who should be part of the process for implementing clinical supervision? (See Tools 1 and 2 in chapter 2.)

Administrative and Clinical Supervision

This section is a comprehensive look at the issues facing supervisors in their dual roles. In the substance abuse treatment field, one of the major challenges facing supervision is the reality that most supervisors perform both administrative and clinical supervisory functions. The numerous conflicts and ambiguity that result from these roles can pose serious problems for administrators, supervisors, and supervisees. Determining the distinction between the roles of clinical and administrative supervision can be difficult because there are no uniform definitions of these functions. Most writing on administrative supervision is in the context of the evaluative and record-keeping functions of a supervisor.

To the extent possible, administrative supervision should be distinguished from clinical supervision. Bradley and Ladany (2001) state that administrative supervisors "help the supervisee function effectively as a part of the organization," with an emphasis on

Clinical Supervision and Professional Development

“organizational accountability, case records, referrals, and performance evaluations” (p. 5). In contrast, clinical supervisors focus on the services received by the client, including the therapeutic relationship, assessment, interventions, and client welfare. While these tasks may be seen as substantially different, many are complementary. Therefore, you and the supervisors need to be mindful of the different roles and of the inherent ethical, relational, and role conflict issues. Best supervision practices will work to keep the dual roles as clear as possible.

Legal and Ethical Issues for Administrators

You play a vital role in clarifying legal and ethical issues for your organization, especially for clinical supervisors and counseling personnel. You are invaluable in providing information and support for supervisors and staff.

You and your supervisors need to define and document (in writing) the legal and ethical standards for the agency. You can draw from the staff's professional codes of ethics as well as accepted best practices. All personnel should be consistently and continually trained in the agency's legal and ethical standards, as well as in changing case law and legislation affecting clinical practice. You need to reinforce your support for supervisors who face situations where legal and ethical issues may arise. You should help supervisors develop a process for ethical decisionmaking as supervisors as well as a process for teaching ethical decisionmaking to counselors.

Among the key issues for you and your supervisors are the following:

- *Direct and vicarious liability.* Important factors affecting liability include the supervisor's power of control; the counselor's duty to perform a clinical service; the time, place, and purpose of the service; the motivation for responding the way the counselor responded; and the supervisor's expectations for action. Critical legal questions for administrators are: Did you make a reasonable effort to supervise? Was there any dereliction of duty? Did treatment create any harm, wrongdoing, or damage to the client, the organization, or the community? Did you and the supervisor give appropriate advice concerning the counselor's actions? Were

tasks assigned to staff that were outside their scope of competence?

Confidentiality. Has the organization adhered to all laws of confidentiality (i.e., the Health Insurance Privacy and Portability Act [HIPAA], 42 CFR, Part 2)? To what extent has the organization balanced the counselor's and client's right to privacy and performance review? Has the organization adhered to its duty to warn, to report, and to protect?

- *Informed consent and due process.* This requires that supervisees and clients be fully informed as to the approach and procedures of the agency's actions (see Tools 4 and 19). Have the clients and counselors been informed about treatment parameters and supervision requirements? Have all required forms and documents been read and signed by all relevant parties? Is there a fair process that encourages conflict resolution and ensures the person a process of appeals?
- *Supervisor and counselor scope of competence.* Are supervisors and counselors operating within their scope of practice and competence? Are supervisors and counselors meeting minimal standards of competence regarding cultural and contextual awareness, knowledge, and skills? Are they effectively working within the wider client systems and networking appropriately with wider community services and institutions?
- *Dual relationships.* A dual relationship exists when a supervisor and supervisee or counselor and client have an additional relationship outside the primary professional relationship. Guidelines for supervisory relationships prohibit supervising current or former clients (a difficult issue in the substance abuse field where it is not uncommon for an agency to hire and supervise former clients in recovery). Do any supervisors have current or former romantic or sexual partners, business associates, family members, or friends among their supervisees? Is the distinction clear between the teaching and supervisory roles when students are being supervised? Are supervisors mindful of crossing over from the supervisory relationship to social activities with supervisees that may impair objectivity? Do supervisors avoid excessive self-disclosure in supervision and avoid comments or actions that might be interpreted as sexual? Do you and your supervisors respect and recognize professional boundaries in all aspects of

your relationships? When in doubt, do you consult with colleagues?

You should provide comprehensive legal and ethical orientation to all employees, review codes of ethics at the time of hire, and require employees to sign a statement that they will abide by these codes. You will want to review agency adherence to these codes periodically under the umbrella of a quality assurance or compliance program. Clinical supervisors should be proactive and provide documentation that describe and conceptualize client problems addressing potential legal and ethical dilemmas, document all clinical directives given, and offer counselors a written summary of recommendations. Finally, you should review liability insurance coverage and suggest that supervisors and counselors maintain their own personal professional liability and malpractice insurance.

For further legal and ethical issues, the reader is referred to the forms in this section.

Diversity and Cultural Competence

An important responsibility for supervisors is to continually improve their cultural competence in order to teach and support staff. Cultural competence is gained through education and training, supervised clinical work, and ongoing exposure to the population being served. All potential supervisors should be required to receive training in cultural competence. It is the supervisor's responsibility to initiate discussions of differences in race, ethnicity, gender, religion, socioeconomic status, sexual orientation, or disability regarding both clinical work with clients and supervisory and team relationships. This promotes the acceptance of diversity and cultural issues as appropriate topics of discussion and allows the supervisor the opportunity to model culturally competent behaviors.

To appreciate the importance of cultural competence, counselors must first recognize "the power of their own cultural assumptions to influence their thinking and their interactions with others" (Bernard & Goodyear, 2004, p. 118). From there, supervisors can help supervisees understand how their own diversity

variables affect their interactions with clients.

Administrators should be watchful for problems that can arise in the supervisory relationship when supervisors are of a different race, culture, or ethnicity than their supervisees. Fong and Lease (1997) have identified four areas that might present challenges:

1. *Unintentional racism.* Well-intentioned supervisors who are unaware of how their racial identity affects their relationships with supervisees may avoid talking about race or culture.
2. *Power dynamics.* The power differential in the supervisory relationship may be exaggerated in dyads where the supervisor is part of the dominant group and the supervisee is a member of a minority group.
3. *Trust and vulnerability.* Supervisees who are in a vulnerable position are, at the same time, encouraged to trust their supervisors, when they may have little reason to do so.
4. *Communication issues.* Differing communication styles among cultural groups can result in misunderstandings.

An excellent exercise for you and your supervisors is to evaluate how supervisors measure up to multicultural supervision competencies. Bradley and Ladany (2001) list the following in what they term the "supervisor-focused personal development" domain:

- "Supervisors actively explore and challenge their own biases, values, and worldview and how these relate to conducting supervision;
- Supervisors actively explore and challenge their attitudes and biases toward diverse supervisees;
- Supervisors are knowledgeable about their own cultural background and its influence on their attitudes, values, and behaviors;
- Supervisors possess knowledge about the background, experiences, worldview, and history of culturally diverse groups; and
- Supervisors are knowledgeable about alternative helping approaches other than those based in a North American and Northern European context" (pp. 80–81).

Developing a Model for Clinical Supervision

An organization must develop a model for clinical supervision that best fits its needs. What are its underlying needs, goals, and objectives? What models are available to assist in reaching your organizational goals? The model should be selected in light of the organization's mission, philosophy of treatment, and orientation. You need to assess the organization's readiness for implementing a supervision system and barriers that might impede the process. What are the organization's capacities for implementation? Once implemented, how will the program's quality be evaluated? How will continuous quality improvement strategies be incorporated into the supervision model? And if the program is successful, how will it be sustained?

An effective model for clinical supervision will keep the target clear: ensuring that the client receives better treatment as a result of the clinical supervision system. In addition:

- It will begin with the supervisors' unique management or leadership style, their levels of proficiency in supervision, the organization's philosophy about clinical supervision, and the specialized client needs for clinical services.
- It will improve counselor competence, make work more manageable, encourage staff to stretch beyond their current capabilities, build mastery and growth, and meet the needs of the client, counselor, agency, and credentialing bodies.
- It will encourage supervisees to grow professionally in their understanding of culture, race, religion, gender, and sexual orientation as these issues are present clinically.

Implementing a Clinical Supervision Program

TAP 21-A (CSAT, 2007) describes the importance of using a clearly articulated process for implementing a new model of clinical supervision in both State and local agency settings as follows: "If agencies are to improve their supervisory practices by adding activities identified as clinical supervision competencies, a set of guidelines is needed to support the develop-

ment of an implementation plan" (p. 7). To ensure a smooth transition to the new supervision program, an agency will need to perform the following tasks: [d]efining or clarifying the rationale, purpose and methods for delivering clinical supervision; [e]nsuring that agency management fully understands and supports the changes that need to be made; [p]roviding training and support in supervisory knowledge and skill development; and [o]rienting clinicians to the new supervision rationale and procedures" (p. 7). These tasks are part of an implementation process whereby the changes are introduced over a limited period of time that allows for procedures to be developed and tested and clinicians to provide feedback and adjust to the supervisory process. "The broad goal is to create a continuous learning culture within the agency that encourages professional development, service improvement, and a quality of care that maximizes benefits to the agency's clients" (p. 8).

More detailed guidelines for implementing and phasing a clinical supervision system into existing processes include:

1. You need to be clear as to the organization's goals of supervision, viewing supervision as a way of supporting and reaching the agency's mission.
2. You should be familiar with the skills and competencies outlined in TAP 21-A (CSAT, 2007) and other experience and/or credentialing requirements. The competence of the designated supervisors is central to the successful design and implementation of the program. In some cases, agencies will need to invest in additional training for potential clinical supervisors. Ask yourself the following about your supervisors:
 - Has the supervisor had formal training and is he or she credentialed in counseling, substance abuse, and clinical supervision?
 - At what level of supervision proficiency are the clinical supervisors?
 - Has the supervisor received supervision of his or her clinical skills?
 - What is the supervisor's relationship with staff?
 - What is his or her level of cultural proficiency and ability to work with culturally diverse clients?
3. It is essential that a clear statement of support from senior administration be provided both verbally and in writing to all levels of administra-

- tion, counselors, and support staff. This statement should provide a rationale (see p. 95) for implementing clinical supervision. The importance of this step cannot be overemphasized.
4. The next step in implementing a clinical supervision system is to create a Change Team from within your organization to spearhead the effort. Selecting the appropriate agency representatives to be the link between you and the supervision system will ensure internal communication and support. The Team should comprise individuals committed to quality care and the supervision process. They need to be somewhat familiar with the process of supervision and have a clinical background. Supervisors need to have a thorough understanding of the agency's model and techniques of supervision. The Change Team leader will ensure participation and followup with the organization's clinical supervisors. Planning specific steps to ensure sustainability of the system is integral to long-term success.
 5. You, the Change Team, and clinical supervisors should read and understand the importance of the standards outlined in TAPs 21 (CSAT, 2006) and 21-A (CSAT, 2007). Each counselor should have a copy of TAP 21 (*Addiction Counseling Competencies—The Knowledge, Skills, and Attitudes of Professional Practice* [CSAT, 2006]). It is important for clinical supervisors to meet with the Change Team to discuss the skills and competencies in TAP 21-A, and to identify both the organization's strengths and areas needing improvement. The Team should draft formal policies and procedures to articulate expectations and guidelines.
 6. An all-staff meeting should feature the organization's view of clinical supervision and how it will implement the supervision system. The formal policy and procedure should be distributed and discussed. All clinical staff involved in the system should attend this briefing, presented by the Change Team leader and key clinical supervisors.
 7. Provide necessary training, time, and funding for supervisors. Because the training requirement for credentialing as clinical supervisors is typically participation in a 30-hour class on supervision, you need to ensure that all supervisors receive training before proceeding to comprehensive implementation.
 8. If the organization is sizable or the clinical staff is large, it is sometimes helpful to initiate a pilot supervision system in selected units of the organization. This is an issue that can be addressed by the Change Team. If organizational staff are particularly resistant to implementing the supervision program, it may be helpful to demonstrate the efficacy of a quality supervision program via a pilot program.
 9. Supervisors should prioritize discussing the supervisory agreement or contract with each supervisee and invest time to determine the training needs and goals for each counselor. This is the beginning of an Individual Development Plan (IDP), outlining the counselor's knowledge, skills, attitudes, and cultural competence. It is essential that the supervisor observe the counselor in action before rating her or his abilities. Rating scales provide the baseline from which to begin supervision. Both supervisors and counselors should develop and complete rating scales and IDPs. Dialog on areas of agreement and disagreement at the outset form a vital part of the supervision process. This discussion also provides the supervisor with an opportunity to praise staff members for their strengths.
 10. Supervisors should schedule formal, frequent, and regular individual supervisory sessions. These sessions, similar to individual sessions with clients, need to be respected and protected from unnecessary interruptions or distractions. The supervisory sessions should be documented and follow the prescribed focus outlined in the IDP.
 11. To begin direct observation, design an implementation strategy (assuming the organization has recognized the value of direct observation; see Part 1, chapter 1), and establish a weekly rotation schedule for the observation of each counselor over the next 3 months. Initially, the clinical supervisor can provide direct observation feedback to counselors individually and then move toward a group supervision model whenever practical and possible to promote team building and efficiency. To help with sustainability, the supervisor should discuss supervision at every opportunity. Staff needs to see that supervision will be conducted on a regular basis, and that frequency will be determined by the agency's needs and those of the individual counselor and team.

Clinical Supervision and Professional Development

12. Provide feedback and review the IDP. Through the observation, the supervisor and counselor can discuss the strengths and challenges of the counselor's performance. The developing IDP should outline in detail the areas for improvement and how these changes will be further observed and monitored. Learning goals evolve as continued observation leads to further suggestions for improving performance.
13. Supervisors should document their direct observation using various forms that exist for this purpose. The documentation should include times of meetings and observation, a brief statement of the content of the clinical session observed, review procedures (audio or video tape), feedback provided, and mentoring and teaching offered.
14. Incentive plans can be developed to encourage counselors to become seriously involved in their professional development.
15. Create a sustainable treatment team. Over time, some staff will leave and others will join the team. It is important for you and your supervisors to work with the team to create an atmosphere of learning that supports the agency's commitment to clinical supervision. This means including the clinical supervision policy and procedures in the orientation of new staff. It definitely means that the team will continue to meet for supervision on a regular basis.
16. Develop a system of supervision of clinical supervisors, particularly for those who are new to their role. Supervisors need to continually build and improve their supervisory skills as well as have a forum to discuss staff challenges. Some agencies have created supervisory peer groups where the supervisors present and receive feedback on their supervision, other agencies hire a consultant to provide supervision, while some regional coalitions have established monthly forums.

Some of the primary elements in a supervision of supervisors system include:

- *Direct observation.* This may best be done by periodically (e.g., once a calendar quarter) videotaping a supervision session and having the supervisor's supervisor review the videotape. They then discuss what occurred during the supervision, with the supervisor's supervisor providing feedback and recommendations.

- *Competencies.* It is important that the supervisors of supervisors be Level 3 counselors and preferably Level 3 supervisors (see Figures 5 and 6 in Part 1, chapter 1). They need to be certified clinical supervisors and to have had supervision as supervisors themselves so they have experience with this type of supervision. Administrators should give them the responsibility and authority to perform this task and to require that tapes be provided for review in a timely fashion. Supervisors should develop the competencies sufficient to attain their credentials as a certified clinical supervisor.
- *Record-keeping system.* A logging system should maintain records on the initial counselor-supervisor sessions and the supervision of supervisors sessions.
- *Recruiting personnel.* If your agency does not have an internal person to provide the supervisor's supervision, it is recommended that you contract for such services with external sources. Over time, the external supervisor should train an internal person to assume this role.

Phasing in a Clinical Supervision System

The steps below have been found to be helpful in phasing in clinical supervision systems in an orderly manner. Although the list is provided sequentially, the needs of an agency will determine the timeframe and selection of objectives.

Phase I: Organization and Creation of a Structure

- Assess and describe the agency culture (including assets and deficits), selecting assets to build on and/or deficits for remediation regarding clinical supervision.
- Assess the facility's policies and procedures to determine the feasibility and practicality of a clinical supervision system (i.e., presence of clinical supervisory staff, availability of direct observation technology, etc.).
- Examine job descriptions to determine staff scope of practice and competence.

- Reach consensus among the Change Team about the definition of clinical supervision and its key components for that agency.
- Publicize this consensus statement to all personnel, introducing staff to the new supervisory model and clearly communicating expectations for the delivery and outcomes of clinical supervision before program implementation.
- With all personnel, discuss and introduce clinical supervision policies and procedures.
- Review the organization's cultural competence as it relates to the client populations served.
- Develop documentation and accountability systems.

Phase II: Implementation

- Implement a supervisory contract, including informed consent, with all staff to improve the supervisory working alliance.
- Assess the quality of the supervisory relationship and devise interventions to strengthen the learning alliance.
- Conduct counselor assessments to establish competency baselines.
- Design initial supervisory goals and measurable objectives for each counselor.
- Use strengths-based approaches where appropriate and possible in clinical supervision, supporting counselors' positive actions with clients.
- Develop a system of supervision of supervision. Some programs use the same taping and monitoring systems for supervisors that are used between counselors and clients, with supervisors expected to videotape their supervision sessions at least once a month, and receive supervision of their supervision by the team of supervisors and/or their supervisor.

Phase III: Establishing a Training Plan and Learning Goals

- Complete a written IDP for each counselor.
- Provide focused, on-the-job training.
- Identify clinical supervision quality indicators to monitor the quality assurance program for the agency.
- Periodically review job descriptions and evaluation procedures to ensure that counselor competencies

are sound. Review the counselor's ability to perform the TAP 21 competencies, the activities and functions performed by a substance abuse counselor that form the basis of the standards required in many States for credentialing. Also see the Northwest Frontier Addiction Technology Transfer Center Performance Rubric at <http://www.attcnetwork.org/documents/Final.CS.Rubrics.Assessment.pdf>.

Phase IV: Improving Performance

Proficiency in the Addiction Counseling Competencies (CSAT, 2006) and the International Certification and Reciprocity Consortiums 12 Core Functions should be the subject of continuous assessment and professional development during clinical supervision. Additional specific performance concerns include:

- Continually align the clinical supervision goals to the agency's mission, values, and approach;
- Create risk management policies and practices and monitor adherence;
- Address the cultural competence of personnel in supervision;
- Consistently address a deepening of counselor knowledge, skills, and attitudes about legal and ethical issues;
- Use formative and summative evaluation and feedback procedures to inform the clinical supervision process;
- Develop quality improvement plans for the agency, including clinical supervisory procedures;
- Overtly address and encourage counselor and staff wellness programs;
- Invest in counselor and staff training; and
- Foster your staff from within, continually seeking individuals with the potential to become tomorrow's supervisors.

Documentation and Record Keeping

Overseeing documentation and record keeping is an essential administrative task, as maintaining a supervisory record has multiple purposes for administrators, supervisors, and counselors. One of the primary purposes of documentation is to serve as the legal record for the delivery of supervision: a reasonable effort was made to supervise. The supervisory

record is also important in developing a thoughtful plan for both quality client care and professional development. The supervisory record serves to:

- Improve client care.
- Model good record-keeping procedures for personnel.
- Afford and enhance ethical and legal protection.
- Provide a reliable source of data in evaluating the competencies of counselors.
- Provide information concerning staff ability to assess and treat clients.
- Reflect staff understanding of the dynamics of behavior and the nature and extent of the problems treated.
- Assess staff cultural competence and proficiency.
- Provide information about the clinical supervisor's ability to assess counselor competencies and the nature of the clinical supervisory relationship.
- Provide information about the clinical supervisor's clinical and supervisory competence.

A good clinical supervision record should include the following elements:

- Requirements for counselor credentialing (certification/licensure) and the extent to which each counselor meets those requirements.
- The counselor's regularly updated resume and a brief summary of his or her background and clinical expertise.
- A copy of the informed consent document, signed by the supervisor and the supervisee.
- A copy of the clinical supervision contract, signed by the supervisor and the supervisee.
- The IDP, updated minimally twice a year and preferably every 3 months.
- A copy of the formative and summative evaluations the supervisor has given to the supervisee and all relevant updates to these evaluations.
- A log of clinical supervision sessions, dates, times; a brief summary of key issues discussed; recommendations given by the supervisor and actions taken by the counselor; documentation of cancelled or missed sessions by either the supervisor or supervisee; and actions taken by the supervisor when supervision sessions are missed.
- A brief summary of each supervision session, including specific examples that support learning goals and objectives.

- A risk management review summary, including concerns about confidentiality, duty to warn situations, crises, and the recommendations of the supervisor concerning these situations.

The entire documentation record can be brief and in summary form. (See Tools 10–12 in Part 2, chapter 2, including checklists and summary statements to reduce the volume of work for the supervisor.)

Evaluation

Although training in how to conduct productive and constructive evaluations of personnel is rare, evaluation of personnel is a critical administrative task of supervisors and administrators. The goals of evaluation include, but are not limited to, reviewing job performance; assessing progress toward professional development goals; eliciting future learning goals; assessing fitness for duty and scope of competence; and providing feedback to staff on adherence to agency policies, procedures, and values.

There are a number of issues that shape the feedback process, including:

- How does the agency define a “good” counselor? What knowledge, skills, and attitudes are critical? What level of cultural competence is needed?
- How does a supervisor measure general affective qualities, such as counselor's empathy, respect, genuineness, concreteness for clients?
- What standardized tools will be used to support the evaluation? There are few evaluation instruments with psychometric validity or reliability.

The IDP can be the basis for evaluation. Each counselor should have a development plan that takes into consideration her or his counseling developmental level (see Stoltenberg, McNeill, & Delworth, 1998), learning needs and styles, job requirements, client needs, and the agency's overall goals and objectives. A sample IDP is provided in chapter 2 (Tool 15).

How do administrators and supervisors evaluate personnel and assess job performance? There are two forms of evaluation: formative and summative. Formative evaluation focuses on progress, is regularly provided, and gives feedback to the employee regarding his or her attainment of the knowledge, skills, and attitudes necessary to the job. It addresses the

question, “Are you going in the right direction?” The quality of the supervisory relationship determines the success of the formative evaluation process.

Summative evaluation is a formal process that rates employees’ overall ability to do their job and their fitness for duty. It answers the question, “Does the employee measure up?” In substance abuse counseling, summative evaluation takes into account many variables: the range and number of clients seen, the issues and problems addressed by the counselor, the general themes in training and supervision, skill development, self-awareness, how learning goals have been translated into practice, and the employee’s strengths, expertise, limitations, and areas for future development. Summative evaluation also addresses the nature of the supervisory relationship and goals for future training.

The best evaluations occur when there is open exchange of information and ideas between the supervisor and counselor, where specific examples are gleaned from the ongoing supervisory documentation, and expectations are again reviewed and agreed upon. Some organizations have moved to 360-degree assessments, with input from many layers of the organization. Tool 13 in chapter 2 is a counselor evaluation of a supervisor. The quality and quantity of feedback from a supervisor is an important part of supervision, according to supervisees (Bernard & Goodyear, 2004). Formalized feedback and evaluation is designed to review the ongoing, frequent feedback provided over time in a supervisory system (see Tool 14).

Conducting an evaluation involves exercising authority and power. When supervisors evaluate counselors, they are also evaluating themselves and their effectiveness as supervisors with particular supervisees. The evaluation process brings up many emotions for both parties. In providing feedback, supervisors should:

Provide positive, as well as constructive, feedback:

- Differentiate between data-based and qualitative judgments about job performance.
- State observations clearly and directly.
- Prioritize key areas for review rather than flood the counselor with an all-inclusive review.

Supervisees prefer:

- Clear explanations.
- Written feedback whenever possible.
- Feedback matched to their counseling development level.
- Encouragement, support, and opportunities for self-evaluation.
- Specific suggestions for change.

Feedback should be:

- Frequent.
- As objective as possible.
- Consistent.
- Credible.
- Balanced.
- Specific, measurable, attainable, realistic, and timely: SMART.
- Reduced to a few main points.

Supporting Clinical Supervisors in Their Jobs

Being a supervisor in any setting is a difficult job. The supervisor represents the concerns of administrators, counselors, and clients. Supervisors advocate on behalf of those above and below them in the organization chart. Hence, it is imperative that you provide support for the clinical supervisor in the agency and in the job.

To show support for clinical supervision, review the organization’s receptivity to supervision: Is its climate for change, tolerance, and commitment conducive to efficient implementation of a clinical supervision system? Also, assess the magnitude of the proposed supervision system and the critical factors needed for success. “The agency structure and the supervisory program within it define the parameters of the supervisory relationship. Decision-making processes, autonomy within units, communication norms, and evaluative structures are all relevant to the supervisory function” (Holloway, 1995, p. 98).

To assess the organization’s receptivity to supervision, you should address the following issues:

1. To what degree does the organization value accountability and have clear expectations of its personnel?

2. How is supervision tied to an employee's ongoing performance improvement plan or performance incentive program?
3. To what extent does the organization have efficient and effective systems in place to manage day-to-day operations?
4. To what extent does the organization view itself as a learning environment, encouraging inquisitiveness, creativity, innovation, and professional development?
5. To what extent does the organization value upward and downward communication and relationships by creating opportunities for staff to be heard? Does the organization understand that the learning alliance and relationship is key to successful supervision?
6. In what ways is the organization a dynamic, growing organism that values everyone's contribution?
7. To what extent does the organization "provide diversity training and other experiences that empower [a counselor] to become an advocate for the organization's target population and an agent of organizational change" ? (CSAT, 2007, p. 31)
8. How does the organization view teamwork, and what structures are in place to support the team-building process?
9. How do lines of authority and communication operate in the organization? How do formal and informal decisionmaking processes that influence the supervisors' functions work?
10. To what extent do administrators know about and understand the process and practices of clinical supervision? What training do they need in this regard?
11. What is the common ground in understanding the relationship between the administrative and clinical functions of the supervisor?
12. If the organization does not have trained and motivated clinical supervisors, what is your plan for recruiting new supervisors and/or training current supervisors who will be able to take on this new responsibility?
13. Are the job descriptions and roles clear, current, and accurate for all personnel?
14. How much supervision of their supervision will the supervisors receive from administrators or other consultants?

You support clinical supervision when you help supervisors build an organizational climate in which they can do quality work. This entails the following factors:

1. Allocating time for clinical supervision. Since supervision is not (in most cases) a revenue-generating activity, administrators may tend to minimize the importance of quality clinical supervision and fail to provide the needed time to "make a reasonable effort to supervise." A matrix presented in Part 1, chapter 1 gives guidelines to supervisors for organizing their time and providing quality supervision.
2. Making clinical supervision an agency priority. You can support the clinical supervisor with a clear statement of the importance of supervision and provide the resources needed to perform this function. This might include the acquisition of taping equipment, provision of one-way mirrors, etc. Staff need to hear unequivocally that supervision is a necessity and a requirement for all personnel, regardless of years of experience, academic background, skill and counselor developmental levels, and status within the organization. Supervisors also need supervision.
3. Supporting creative methods for supervision. As this TIP advocates for direct methods of supervision through one-way mirrors, video/audio taping, and live observation, you can state clearly that "at our agency we observe." Other methods for clinical supervision might include group or peer supervision models (see Part 1, chapter 1).
4. Building and supporting a record-keeping process for clinical supervision. This entails providing time and tools for the documentation related to clinical supervisory and administrative functions. Supervisory notes need to be integrated with clinical notes and human resource files. One good documentation system is the Focused Risk Management Supervision System (FoRMSS; Falvey, Caldwell, & Cohen, 2002). Assisting in organizing the supervisory process by investing in activities that will increase productivity over time, setting and adhering to priorities, and increasing coping skills repertoire to manage multiple tasks through cross-training and team building. You also need to periodically review job descriptions, personnel strengths and aptitudes, and cultural competence, and reorganize work-

loads accordingly. You should periodically review the purpose and function of every meeting and seek to streamline meeting times for economy and efficiency.

5. Assisting supervisors in implementing agency priorities, such as the adaptation of EBP to fit the agency's goals and objectives. Hence, if an organization is implementing an EBP, it is imperative that supervisors also be trained in how to supervise that practice, perhaps even before counselors are trained.
 6. Assisting supervisors in other personnel functions, such as working with impaired professionals and providing an employee assistance program (EAP) as a resource to supervisors and supervisees. You and your supervisors need to work together when staff are involved in ethical or legal issues that might impair the organization's function and credibility, and the supervisor needs to keep the administrator informed of all actions taken throughout the process.
 7. Supporting supervisors in developing cultural competence within the organization. This entails hiring culturally competent clinical supervisors and staff and providing personnel training on cultural issues. It also requires supporting supervisors in developing and improving cultural competence in counselors.
- Creating IDPs with all supervisors. Even as every client needs a treatment plan and every staff member needs an IDP, every clinical supervisor also needs an IDP. Supervisors' IDPs are jointly developed and monitored by the clinical supervisor and his or her supervisor.
 - Helping supervisors develop a professional identity as a supervisor. This entails encouraging the supervisor to be credentialed as a clinical supervisor. They should also receive ongoing training required for recertification.
 - Providing time for them to work with a mentor (either someone within the organization or an outside consultant).
 - Requiring an annual minimum number of clinical supervision training hours.
 - Offering time and resources for supervisors to participate in State or local support groups for supervisors.
 - Providing job performance evaluations on a regular and timely basis.

Professional Development of Supervisors

You both support clinical supervisors in their function and monitor their professional development and performance by:

- Building a system to monitor, evaluate, and provide feedback to clinical supervisors. Supervision of one's supervision is lacking in many organizations. Every clinical supervisor is entitled to and needs to have some form of supervision of their supervision, either live or online.

Chapter 2

Introduction

Your clinical supervision system needs to match the unique issues and contextual factors of your agency, and your agency needs to have a clear vision of what it wishes to accomplish with its clinical supervision system and actively determine and understand the processes by which it will get there. The tools presented in this chapter are designed to make the tasks associated with implementing a clinical supervision system easier. You will want to take advantage of the experience of well-established supervision programs and adapt the tools that have worked for them to suit the specific needs of your program.

The resources presented in this chapter are organized to be parallel to Part 2, chapter 1. These tools should be considered as prototypes and, in some cases, might even be used as is, provided they fit the context of your organization. These tools can be used by both clinical supervisors and administrators as part of a comprehensive clinical supervision system.

The Change Book: A Blueprint for Technology Transfer (Addiction Technology Transfer Center [ATTC] National Office, 2004) provides the basis for the organizational change process presented here. You may wish to consult with colleagues who have implemented a clinical supervision system for their organizations, especially if the agency is similar to yours. Managing organizational change is very similar to working with a client in a clinical setting. Your understanding of the recovery process and of the counselor's personal qualities and skills that facilitate recovery are invaluable resources as you apply the tools presented in this chapter.

Assessing Organizational Readiness

You will need to determine the state of readiness of your organization and its personnel to implement a clinical supervision system. This assessment should include agency contextual variables, competence of supervisory staff, clinical competence of counseling staff and organizational integrity, motivation of personnel, the nature of your relationships with staff, environmental variables (such as current or recent organizational changes, financial issues, accreditation, and legislative mandates), and the best methods and techniques to be used (see Tool 1). Tool 2 will help in assessing organizational readiness to change and identifying and prioritizing barriers to change. Just as a clinician might assess a client's stage of readiness to change, these principles can be applied to implementing a clinical supervision system or other types of organizational change. Tool 3 will help you reach agreement with staff on the goals of supervision.

Tool 1. Initial Organizational Assessment
Organizational Context

Conditions	Not at All 1	A Little 2	Possibly 3	Very Likely 4	Definitely
Staff have a common set of goals. A goal of the organization is that clinical supervision is valued and should be provided.					
Administrators model a norm of collegiality. Although a supervisee's performance evaluation implies a hierarchy, the organization demonstrates an openness ensuring that each person will be respected and treated as a valuable member of the team.					
The organization promotes professional development. Continuous education and professional growth are promoted for supervisors as well as counselors.					
Progress toward goals is monitored actively and does not wait for outcome evaluation. Ongoing monitoring is valued. Obstacles are identified and handled as an organizational challenge, instead of allowing a situation to deteriorate and be judged as demonstrating a lack of competence of particular staff members.					
Support for clinical supervision is appropriately generous. Allotment of time and resources is critical.					
Priority Focus _____ Secondary Focus _____ <i>Source: Based on Bernard & Goodyear, 1998; Adapted from Porter & Gallon, 2006.</i>					

Tool 2. Organizational Stage of Readiness To Change Implementing a Clinical Supervision Program in Your Agency	
Stages of Change	
Precontemplation	Unaware of issue
Contemplation	Considering the issue
Preparation	Designing a plan of action
Action	Implementing the action plan
Maintenance	Maintaining the change

	Stage of Readiness	Incentives to Change	Obstacles to Change	Resources for Change
Board of Directors				
Administration				
Supervisors				
Direct Care Staff				
Support Staff				

Primary Group—Focus of Change	Expected Outcome and Timeframe

Secondary Group—Focus of Change	Expected Outcome and Timeframe

This part of Tool 2 is designed for use by administrators and supervisors to identify the current barriers in the organization to implementing a comprehensive supervision system. Administrators and supervisors should fill this out separately, and then discuss answers in an executive team meeting.

Tool 2. Organizational Stage of Readiness To Change Implementing a Clinical Supervision Program in Your Agency			
Current Barriers to Change			
Organizational	Administrative	Clinical	Other

List the most important barriers to address within the next 3 months.

What would you like to have happen?

Who do you need to help participate in the change?

Source: Adapted from Porter & Gallon, 2006.

Tool 3. Goals for Supervision**Organizational Context**

How does the organization support counselors and supervisors in achieving the organization's mission statement? What steps are needed to gain consensus between administration and direct service personnel to achieve the mission statement? What are the specific steps we can take as administrators to achieve this goal of consensus regarding the philosophy of the organization and its relationship to clinical work?

GOAL: _____

Cultural Competence

What cultural and contextual factors are unique to this agency? What factors need to be addressed in clinical supervision?

GOAL: _____

Clinical Competence

What specific knowledge, skills, and attitudes do we expect from our counselors? How do we acknowledge and address the individual counselor's baseline competence and learning style?

GOAL: _____

Motivation

How can we ensure that the clinical supervisor will help motivate counselors to participate in clinical supervision and perform clinical tasks?

GOAL: _____

Supervisory Relationship

How can we support and validate the supervisory relationship both informally and formally?
Do we believe that the supervisory relationship is an important variable in the supervisory process? How can we support and validate the supervisory relationship both informally and formally?

GOAL: _____

Ethics and Professional Values

How much do we expect that clinical supervisors will proactively teach ethics and professional values?

GOAL: _____

Source: Adapted from Mattel, 2007

Clinical Supervision and Professional Development

Legal and Ethical Issues of Supervision

Legal and ethical considerations should be paramount as you implement a supervision system. The goal is to know how to operate within the boundaries of legal and ethical codes and regulations for the protection of all parties, including the agency, administration, staff, and clients. Legal and ethical issues of supervision include direct and vicarious liability, confidentiality, informed consent and due process, supervisor and supervisee scope of competence and practice, and dual relationships (see discussion of these issues in Part 2, chapter 1).

The Association for Counselor Education and Supervision (ACES) has standards for counseling supervisors that can serve as guidelines for the substance abuse field (available online at <http://www.acesonline.net/members/supervision/>). ACES also has ethical guidelines for supervisors that address issues such as protecting client welfare and rights, supervisory roles, and program administration roles. The National Board for Certified Counselors, Inc., has a Code of Ethics pertaining to the practice of professional counseling and clinical supervision. This code, like the ACES code, is reproduced in TAP 21-A (*Competencies for Substance Abuse Treatment Clinical Supervisors* [CSAT, 2007]). Other professions also have similar guidelines, such as the Association of State and Provincial Psychology Boards (reprinted in Falvey, 2002b), the National Association of Social Workers (NASW, *Guidelines for Clinical Social Work Supervision*, 1994), and the American Association for Marriage and Family Therapy (*AAMFT Supervisor Designation: Standards and Responsibilities Handbook*, 1999).

Informed consent is important for several reasons: (1) clients are entitled to know and agree to what processes support quality treatment, who will be reviewing information about them, and how this information will be used; (2) counselors are entitled to know how their work will be evaluated, the process of the supervision, and how this information will be used to support both quality care and their professional development; and (3) the administration is entitled to know that supervisory processes are articulated to support quality care and address legal and ethical standards.

Tool 4 is one of a number of sample informed consent for supervision forms that are available.

Tool 4. Informed Consent Template

The consent should include:

The purpose of supervision: the structure and mutual understanding of supervision

- Goals of supervision
- How goals will be evaluated and the specific timeframes
- Specific expectations of the supervisor and the supervisee
- Integration of theoretical models

Professional disclosure: information about the supervisor that includes credentials and qualifications and approach to supervision

- Educational background
- Training experiences
- Theoretical orientation
- Clinical competence with various issues, models, techniques, populations
- Sense of mission or purpose in the field
- Educational plans and professional goals

Supervision process: methods and format of supervision

- Individual, group, peer, dyadic
- Method of direct observation
- Permission to record sessions on audio- or videotape

Due Process: includes written procedures to be followed when a grievance or complaint has been made against the administration, the supervisor, or the counselor. It ensures that all sides are heard and that the complaint and response to the complaint receive due consideration. In this case, informed consent means that all parties are aware of the process for lodging a complaint.

Tool 4. Informed Consent Template (continued)**Ethical and legal issues: policies, regulations, and laws regarding supervisory and therapeutic relationships**

- Number of supervisees for which the supervisor will be responsible
- Emergency and back-up procedures (e.g., supervisor accessibility)
- Ethical codes of conduct
- Process for discussing ethical dilemmas
- Confidentiality regarding information discussed in supervision
- Confidentiality issues when more than one supervisee is involved
- Dual roles and relationships
- Process for addressing supervisee issues (e.g., burnout, countertransference)

Statement of agreement

Signed acknowledgement by all parties that they understand and agree to comply with the contract

Source: Adapted from Falvey, 2007.

Selection and Competencies of Supervisors

When hiring or appointing a person as a clinical supervisor, you will need to understand the scope of practice and competence of a supervisor. Consult TAP 21-A (CSAT, 2007) and the International Certification and Reciprocity Consortium [IC&RC] Role Delineation Study for Clinical Supervisors (2000).

Administrators can use checklists such as Tool 5 to determine the competencies of a potential clinical supervisor.

Tool 5. Checklist for Supervisor Competencies

Competencies	Poor	Below Average	Average	Above Average	Excellent
Knowledge					
Has knowledge of theory and intervention strategies					
Has knowledge of screening, assessment, and diagnostic standards					
Understands cultural and ethnic issues					
Has knowledge of resources in the community					
Has knowledge of current ethical guidelines and legal issues					
Practice					
Demonstrates mastery of intervention techniques					
Is timely and thorough in documentation					
Is able to develop rapport					
Is able to conceptualize problems					
Can respond to multicultural issues					
Is able to formulate treatment goals					

Clinical Supervision and Professional Development

Tool 5. Checklist for Supervisor Competencies (continued)					
Competencies	Poor	Below Average	Average	Above Average	Excellent
Personal					
Demonstrates ethical behavior					
Demonstrates use of good judgment and counseling skills					
Is interpersonally competent					
Is able to identify own strengths and weaknesses					
Is able to accept and learn from feedback					
Is an asset to the profession					
Source: Adapted from Campbell, 2000. Permission pending.					

Other sources to consult on the same topic include:

- Bernard and Goodyear, 2004: Evaluation Questionnaires and Scales (pp. 316–339).
- Falvey, 2004b: Ethical Mandates for Professional Competence, Standards for Clinical Supervisor Competence (pp. 25, 28).
- Powell and Brodsky, 2004: ACES Supervision Interest Network, Competencies of Supervisors (pp. 327–332).
- Campbell, 2000 (pp. 257–285).

Substance Abuse Policy

As an administrator, you have ultimate responsibility for enforcing policies and procedures for maintaining a safe workplace. Under provisions of the Drug-Free Workplace Act of 1988, all agencies receiving Federal and/or State funds are required to have a substance abuse policy. This policy should state how the organization maintains a safe workplace so as to provide the highest quality service to its clients. The procedures should address how the agency will deal with issues related to alcohol and drugs in the workplace, fitness-for-duty concerns, testing of employees, drug-related convictions, searches, and violations of policies. Tool 6 is a sample substance abuse policy. Other administrative issues can be addressed, such as gambling and tobacco in the workplace, pornography in the workplace, and abuse of Internet access and use in the workplace. Tool 6 is an example of a substance abuse policy.

Tool 6. Sample Policy on Substance Abuse
This organization is committed to maintaining a safe workplace and to providing high-quality service to its clients. Successful attainment of these goals depends on the establishment and maintenance of a workplace that is free from the adverse effects of drug use and alcohol abuse. Alcohol 1. The use, possession, or being under the influence of alcohol while on duty or on the premises is strictly forbidden. This prohibition precludes an employee from consuming alcohol at meal times during work hours, even off premises. 2. Employees are prohibited from working with the smell of alcohol on their breath, regardless of when or where alcohol was consumed. Drugs 1. The use, possession, being under the influence of, manufacture, sale, dispensation, or distribution of illegal or unauthorized drugs or drug paraphernalia while on duty or on the premises is forbidden. 2. An employee's involvement with illegal or unauthorized drugs off duty and/or off premises may result in discipline, up to and including discharge, where such involvement may have an adverse effect on the organization's reputation.

Part 2, Chapter 2

Tool 6. Sample Policy on Substance Abuse

- Employees who are taking prescribed medications must keep them in a secure location, completely inaccessible to anyone but themselves, while on the premises. It is expected that employees will follow all safety precautions associated with consumption of that drug (i.e., regarding operating machinery or driving vehicles).

Fitness for Duty

- Employees are required to be fit for duty.
- An employee is unfit for duty if, while on duty or on the premises, he or she is under the influence of or affected by illegal or unauthorized alcohol and/or has an impermissible level of illegal or legally prescribed drugs or alcohol in his or her system and/or is affected to a degree that the employee cannot perform work because of the legally prescribed drugs.
- Unfitness for duty can be determined through a variety of means, separately or in conjunction with each other, depending on the circumstances, such as direct observation and/or drug and/or alcohol testing.
- An employee will be terminated if he or she is unfit for duty because of drugs and/or alcohol.

Testing of Employees

- Reasonable Suspicion.* An employee may be required to submit to drug and/or alcohol testing whenever there is reason to believe because of physical, behavioral, or performance indicators, that the employee is under the influence of or is affected by illegal or legally prescribed drugs and/or alcohol while on duty or on the premises.
- Post-Accident.* An employee may be tested for drugs and/or alcohol after any accident that could have been caused by human error or carelessness. An accident is defined as an event resulting in medical treatment by a professional or property damage in excess of \$500.
- Medication Control.* If prescribed medication or controlled substances dispensed by the organization disappear or cannot otherwise be accounted for, all employees who may have had access to such medication or substances will be tested for illegal drugs.
- Positive Test Result.* An employee who tests positive for an illegal drug or unauthorized or illegally obtained legal drug and/or alcohol is unfit for duty and may be disciplined.

Drug-Related Convictions

An employee who is convicted of a drug-related offense occurring in or out of the workplace is in violation of this policy. A conviction includes a guilty plea, a plea of nolo contendere, or any court-supervised program or court-imposed sentence.

Searches

The organization reserves the right to search an employee, his or her possessions, work area, or vehicle while on the premises to determine if illegal drugs or alcohol are present.

Failure to Cooperate

An employee who refuses to provide a specimen at the date and time requested, who refuses to provide written consent to testing, who provides a false or tampered specimen, or refuses to consent to a search of his or her person, possessions, work area, or vehicle may be discharged.

Supervision Guidelines

Supervision guidelines describe the organization's commitment to clinical supervision, working terms, principles of supervision at that organization, and required documentation of clinical sessions and clinical supervision. The guidelines should clearly state the frequency of supervision, ongoing feedback procedures, and commitment to ongoing professional development. Tool 7 is an example of such a document.

Clinical Supervision and Professional Development

Tool 7. Clinical Supervision Policy and Procedure

Underlying Principles

Clinical supervision is a powerful tool for managing and ensuring continuous improvement in service delivery. Clinical supervision is comprised of balancing four distinct functions: administrative, evaluative, supportive, and clinical. Fundamental structures include a positive working relationship, client-centered approach, commitment to professional development, and accountability. The following principles ensure high-quality clinical supervision:

- A safe, trusting working relationship that promotes a learning alliance.
- A counselor-centered program with a culturally and contextually responsive focus.
- Active promotion of professional growth and development.
- Shared clinical responsibility ensuring that the client's treatment goals are addressed.
- A rigorous process that ensures ethical and legal responsibility.
- An individualized approach based on the learning needs and style of the supervisee.
- Congruence with the values and philosophy of the agency.

Terms

A healthy **working relationship** is built on shared vision and goals, clear expectations, and the belief in the good intentions of staff members. It demonstrates reciprocal communication where all parties provide comprehensive, timely information that is respectful. Each person is responsible for providing relevant information critical to his or her job function and the mission of the agency. The working relationship recognizes the importance of the chain of command throughout all agency levels. The agency expects that this chain of command supports structure, appropriate boundaries, and decisionmaking at all levels. The chain of command is followed to ensure effective and efficient communication.

Trust is central to the working relationship. This is manifested in several ways: (1) people are accountable to their work and job responsibilities, (2) confidentiality is maintained, (3) decisions are respected, and (4) misunderstandings are pursued to clarify miscommunication, seek to understand the other person, air emotions, and reach resolution.

The **learning alliance** is based on the belief that the supervisee has specific learning needs and styles that must be attended to in supervision. The relationship between supervisor and supervisee is best formulated and maintained when this frame of reference is predominant. Supervisees participate in a mutual assessment based on a combination of direct and indirect observations.

Guidelines for Clinical Supervision

The principles of clinical supervision are made explicit by a clear contract of expectations, ongoing review and feedback, and a commitment to professional development.

Clear contract of expectations

It is critical that both the supervisor and supervisee share their expectations about the process, method, and content of clinical supervision. This can advance the development and maintenance of a trusting, safe relationship. The following information should be discussed early in the working relationship:

- Models of supervision and treatment.
- Supervision methods and content.
- Frequency and length of supervisory meetings.
- Ethical, legal, and regulatory guidelines.
- Access to supervision in emergencies.
- Alternative sources of supervision when the primary supervisor is unavailable.

The supervisee will be provided with a job description that outlines essential duties and performance indicators. Additionally, each supervisee will receive an assessment of core counseling skills based on the TAP 21 competencies and other appropriate standards.

Documentation

Supervisory sessions are recorded as notes that indicate the focus of the session, the issues discussed, solutions suggested, and agreed upon actions. Supervisors will maintain a folder for each of their supervisees. The folder will contain the IDP, clinical supervision summaries, and personnel actions (e.g., memos, commendations, other issues). Supervisees are allowed full access to the folders.

Tool 7. Clinical Supervision Policy and Procedure (continued)

Clinical supervision frequency

Each supervisee will receive 4 hours of supervision monthly. A combination of individual and group supervision may be used. Supervisors are to ensure that a minimum of 50 percent of this time is devoted to clinical, as opposed to administrative, supervision.

Ongoing review and feedback

The supervisee will be given an annual performance evaluation that reviews both job expectations and the clinical skills learning plan. Written records of the supervisee will be reviewed on a regular basis. Supervisees will be given specific written feedback regarding their strengths and areas for improvement. The supervision system operates through direct observation of clinical work. This ensures that direct, focused feedback will be provided, increases the degree of trust and safety, and provides an accurate evaluation of skills development progress. Observations will be pre-arranged and take the form of sitting in on a session, co-facilitating, or videotaping. The supervisee will present a case at a minimum of once per month.

Commitment to ongoing professional development

The supervisee's learning plan should document goals, objectives, and methods to promote professional development. The plan should be completed within the first 6 months of employment and updated annually. Ongoing supervision should focus on achieving the identified goals. The agency supports supervisees' participation in training to achieve their professional development goals.

Source: Adapted from unpublished Basics, Inc. materials

The Supervision Contract

A supervision contract protects the rights of the agency, the supervisor, and supervisee. A written contract between supervisor and supervisee, stating the purpose, goals, and objectives of supervision is important. Tool 8 is a template for supervision contracts. In addition to the contract, for the purposes of informed consent, it is useful to have a supervision consent form signed by both the supervisor and supervisee, indicating the supervisee's awareness and agreement to be supervised (see Tool 4).

Tool 8. Supervision Contract Template

This document serves as a description of the supervision provided by (supervisor name, credentials, title) to (supervisee, credentials, title).

Primary Purpose, Goals, and Objectives

- Monitor and ensure client welfare
- Facilitate professional development
- Evaluate job performance

Provision

- (Frequency) of individual supervision at (day and time)
- (Supervision model and case review format) will be used
- Clients of the counselor will give informed consent for supervision of their case
- Counselor will have a minimum of (amount) of supervision for every (number) of client contact hours
- All client cases will be reviewed on a rotating basis based on need

Documentation

- (Form name) will be used to document the content and progress of the supervision
- Informal feedback will be provided at the end of each session
- Written formal evaluation will be provided (frequency)
- Supervision notes will be shared (at the supervisor's discretion or at request of counselor)

Clinical Supervision and Professional Development

Tool 8. Supervision Contract Template (continued)

Duties and Responsibilities

The supervisor at a minimum will:

- Review all psychosocial histories, progress notes, treatment plans, and discharge plans.
- Question the counselor to justify approach and techniques used.
- Present and model appropriate clinical interventions.
- Intervene directly if client welfare is at risk.
- Ensure that ethical guidelines and legal statutes are upheld.
- Monitor proficiencies in working with community resources and networking with community agencies.

The counselor at a minimum will:

- Uphold all ethical guidelines and legal statutes.
- Be prepared to discuss all client cases.
- Discuss approaches and techniques used and any boundary issues or violations that occur.
- Consult supervisor or designee in emergencies.
- Implement supervisor directives.
- Adhere to all agency policies and procedures.

Procedural Consideration

- The Individual Development Plan's goals and objectives will be discussed and amended if necessary.
- The quality of the supervisory relationship will be discussed and conflicts resolved.
- If conflicts cannot be resolved, (name) will be consulted.
- In the event of an emergency, the counselor is to contact the supervisor. If unavailable, contact (alternate's name, title, and other relevant back-up information).
- Crises or emergency consultations will be documented.
- Due process procedures (as explained in the agency's policy and procedure handbook) have been reviewed and will be discussed as needed.

Supervisor's Scope of Competence

- Title/date of credentials/licensure.
- Formal supervisory training and credentials.
- Years providing supervision.
- Current supervisory responsibilities.

This agreement is subject to revision at any time on request of either person. Revision will be made only with consent of the counselor and approval of the supervisor. We agree to uphold the directives outlined in this agreement to the best of our ability and to conduct our professional behavior according to the ethical principles and codes of conduct of our professional associations.

Supervisor_____ Title_____ Date_____

Supervisee_____ Title_____ Date_____

This agreement is in effect from (current date) to (annual date of review or termination)

Source: Mattel, 2007

Another sample supervision contract form can be found in Campbell (2000), p. 285.

The Initial Supervision Sessions

An initial supervision sessions checklist documents the topics to be covered in initial sessions by the supervisor and supervisee. The goal is that as part of establishing the supervisory relationship, the supervisor and supervisee should discuss the basic issues in substance abuse counseling and in supervision. For new supervisors and for administrators to monitor the implementation of supervision, a checklist, such as Tool 9, can ensure that the important issues are discussed. The example below can aid in setting a preliminary structure for supervision, clarifying goals and expectations, and incorporating feedback so as to promote a sense of openness, trust, and safety. It is understood that not all of these topics can be covered in the first few sessions, but these topics are important considerations in initiating clinical supervision.

Documentation and Recordkeeping

Documentation is unquestionably a crucial risk-management tool for clinical supervisors and is no longer optional in supervision. Legal precedents suggest that organizations are both ethically and legally responsible for quality control of their work, and the supervision evaluation, documentation, and record-keeping systems are a useful and necessary part of that professional accountability. However, in contrast with the myriad clinical forms and documentation required, there is a paucity of tools for documentation in supervision. Most organizations rely on the personal style and records of individual supervisors, and do not have an organization-wide standardized system of record keeping for supervision. Documenting supervision should not be burdensome, but it should be systematic and careful. Key components of what should be documented and how it should be documented are provided in the following paragraphs.

A record of supervision sessions needs to be maintained that documents: when supervision was conducted, what was discussed, what recommendations were provided by the supervisor, and what actions resulted. A supervisor should maintain a separate file on each counselor supervised, including:

- Caseloads.
- Notes on particular cases.
- Supervisory recommendations and impressions.
- The supervision contract.
- A brief summary of the supervisee's experience, training, learning needs, and learning styles.
- The individual development plan.
- A summary of all performance evaluations.
- Notations of supervision sessions, particularly concerning duty-to-warn situations, cases discussed, and significant decisions made.
- Notations of canceled or missed supervision sessions.
- Significant issues encountered in supervision and how they were resolved.

By far, the most comprehensive documentation system for clinical supervisors is Falvey's FoRMSS system (2002a), which includes emergency contact information, supervisee profiles, a log sheet for supervision, an initial case overview, a supervision record, and a termination summary that records the circumstances of client termination, client status at termination, and any followup or referrals needed. The FoRMSS system alerts supervisors to potential clinical, ethical, or legal risks associated with cases.

Records of supervision must be retained for the period required by the State and pertinent accreditation bodies. The American Psychological Association's guidelines (2007) recommend retaining clinical and supervisory records for at least 7 years after the last services were delivered. Organization policy may differ from this. Administrators should check with local and State statutes regarding record-keeping requirements. It is prudent for an organization and supervisor to retain supervision records for at least as long as required by the State and accreditation bodies.

Clinical Supervision and Professional Development

Tool 9. Initial Supervision Sessions Checklist

Education, Training, and Clinical Experience

- ☐ Educational background
- ☐ Training experience
- ☐ Setting(s), number of years
- ☐ Theoretical orientation
- ☐ Clinical competence with various issues, models, techniques, populations, presenting problems, treatment modalities
- ☐ Sense of mission and purpose in the field
- ☐ Educational plans and professional goals of the supervisee
- ☐ Training and awareness of cultural and contextual issues in counseling
- ☐ Training and awareness of community networking in counseling

Philosophy of Supervision

- ☐ Philosophy of therapy and change
- ☐ Purpose of supervision

Previous Supervision Experiences

- ☐ Previous supervision experiences (e.g., format, setting)
- ☐ Strengths and weaknesses as counselor and as supervisee
- ☐ Supervisee's competence with stages of counseling process
- ☐ Supervisee's level of development in terms of case planning, notes, collateral support, and networking
- ☐ Supervisory competence with various issues, models, techniques, populations, therapy groups, and modalities
- ☐ Methods for managing supervisor-supervisee differences

Supervision Goals

- ☐ Goals (personal and professional)
- ☐ Process of goal evaluation and timeframe
- ☐ Requirements for which supervisee is seeking supervision (e.g., licensure, professional certification)
- ☐ Requirements to be met by supervision (e.g., total hours, individual or group supervision)

Supervision Style and Techniques

- ☐ Specific expectations the supervisee or supervisor has of the parties involved (e.g., roles, hierarchy)
- ☐ Type of supervision that would facilitate clinical growth of the supervisee
- ☐ Preferred supervision style (didactic, experiential, collegial)
- ☐ Parallels between therapy and supervision models
- ☐ Supervision focus (e.g., counselor's development, cases)
- ☐ Manner of case review (e.g., crisis management, in-depth focus)
- ☐ Method (e.g., audio- or videotaping, direct observation)

Theoretical Orientation

- ☐ Models and specific theories in which supervisee and supervisor have been trained, practice, and or conduct supervision
- ☐ Extent to which these models have been used clinically
- ☐ Populations, presenting problems, and/or family forms with which the models have been most effective
- ☐ Interest in learning new approaches

Tool 9. Initial Supervision Sessions Checklist (continued)**Legal and Ethical Considerations**

- ____ Ultimate responsibility for clients discussed in supervision in different contexts (e.g., licensed vs. unlicensed counselor, private practice vs. public agency)
- ____ Number of cases for which the supervisor will be responsible
- ____ Emergency and back-up procedures
- ____ Awareness of professional ethical codes
- ____ Confidentiality regarding the information discussed in supervision
- ____ Confidentiality issues when more than one supervisee is involved
- ____ Specific issues in situations where dual relationships exist (e.g., former client)
- ____ Process for addressing supervisee issues (e.g., burnout, countertransference)

Other

What do we need to know about each other that we have not already discussed?

Source: Adapted from Falvey, 2002b. Permission pending.

Tools 10–12 are sample documentation forms. (See also Campbell, 2000.)

Tool 10. Supervision Note Sample
Professional Development Plan Current Focus

Goal/TAP Competencies	Objective	Date of Expected Completion

Supervision Content

Issue	Discussion	Recommendation/ Action	Followup

Progress on Professional Development Plan Objectives

Other _____

Supervisor _____ Counselor _____ Date _____

Source: Porter and Gallon, 2006.

Clinical Supervision and Professional Development

Tool 11. Current Risk-Management Review

Case: _____

Date: _____

ISSUES

- ☐ Informed Consent
- ☐ Parental Consent
- ☐ Confidentiality
- ☐ Recordkeeping
- ☐ Records Security
- ☐ Child Abuse/Neglect
- ☐ Risk of Significant Harm
- ☐ Duty to Warn
- ☐ Medical Exam Needed

- ☐ Supervisee Expertise
- ☐ Supervisor Expertise
- ☐ Institutional Conflict
- ☐ Dual Relationship
- ☐ Sexual Misconduct
- ☐ Releases Needed
- ☐ Voluntary/Involuntary Hospitalization
- ☐ Utilization Review Discharge/Termination

Discussion:

Recommendation:

Action:

Signature _____ Date _____

Title _____

Source: Based on Falvey, 2002b.

Tool 12. Supervisory Interview Observations		
STATEMENTS/BEHAVIORS	STATEMENTS/BEHAVIORS	COMMENTS
Step 1 SET AGENDA Decrease anxiety Involve counselor		
Step 2 GIVE FEEDBACK Empower Individualize		
Step 3 TEACH and NEGOTIATE Share agenda Clarify knowledge, skills, attitude Identify learning steps Agree upon methods of learning		
Step 4 SECURE COMMITMENT Clarify expectations Clarify responsibility Create mutual accountability		

LOOK FOR	OBSERVATIONS, BEHAVIORS, NOTES
SUMMARY OBSERVATIONS	
Interview structure followed?	
Time managed effectively?	
Established nurturing and supportive environment?	
Stayed on course?	
Resistance? Power struggle?	
Agreement secured?	
Followup plan created?	
NOTES:	
Source: Based on Porter & Gallon, 2006.	

Clinical Supervision and Professional Development

Evaluation of Counselors and Supervisors

Evaluation of counselors and supervisors is both formative (ongoing and evolving over time) and summative (periodic and formal). Nowhere else in supervision does the power differential between the supervisor and supervisee become more evident than in the evaluation process. Feedback and evaluation are necessary and important in an organization's risk-management procedures. Agencies need a formal procedure and criteria for staff evaluation. When supervisors conduct supervisee evaluations, counselors need to understand there is a level of subjectivity in the process. There is no psychometrically valid tool to assess counselor competence. An element of the supervisor's judgment is always involved.

Most evaluation guidelines and tools identify general areas of competence to assess—knowledge, skills, and attitudes—but specific criteria for making an evaluation are left to the individual supervisor and the organization. It is important that the evaluation of staff be closely linked to job descriptions, the supervision contract, and the specific needs of the agency. Levels of competence and fitness for duty should be established by the individual organization, with consideration given to the credentialing and accreditation requirements of the agency. Supervisee triads also offer another option to assist in the evaluation process. A grievance and appeals process should be defined. Finally, supervisors need to be reminded that they are the gatekeepers for the agency, providing feedback, remediation as needed, and dismissal of personnel if indicated.

Tools 13 and 14 aid the supervisee in evaluating the supervisor and the supervisor in assessing the counselor.

Tool 13. Counselor Evaluation of the Supervisor

This evaluation form gives the supervisor valuable feedback while it gives the counselor a sense of responsibility and involvement in the design and development of supervision.

Use a 7-point rating scale where:

1 = strongly disagree

4 = neither agree nor disagree

7 = strongly agree

	Rating
1. Provides useful feedback regarding counselor behavior	
2. Promotes an easy, relaxed feeling in supervision	
3. Makes supervision a constructive learning process	
4. Provides specific help in areas needing work	
5. Addresses issues relevant to current clinical conditions	
6. Focuses on alternative counseling strategies to be used with clients	
7. Focuses on counseling behavior	
8. Encourages the use of alternative counseling skills	
9. Structures supervision appropriately	
10. Emphasizes the development of strengths and capabilities	
11. Brainstorms solutions, responses, and techniques that would be helpful in future counseling situations	
12. Involves the counselor in the supervision process	
13. Helps the supervisee feel accepted and respected as a person	
14. Appropriately deals with affect and behavior	
15. Motivates the counselor to assess counseling behavior	

Tool 13. Counselor Evaluation of the Supervisor (continued)	
This evaluation form gives the supervisor valuable feedback while it gives the counselor a sense of responsibility and involvement in the design and development of supervision.	
Use a 7-point rating scale where: 1 = strongly disagree 4 = neither agree nor disagree 7 = strongly agree	
	Rating
16. Conveys a sense of competence	
17. Helps to use tests constructively in counseling	
18. Appropriately addresses interpersonal dynamics between self and counselor	
19. Can accept feedback from counselor	
20. Helps reduce defensiveness in supervision	
21. Encourages expression of opinions, questions, and concerns about counseling	
22. Prepares the counselor adequately for the next counseling session	
23. Helps clarify counseling objectives	
24. Provides an opportunity to discuss adequately the major difficulties the counselor is facing with clients	
25. Encourages client conceptualization in new ways	
26. Motivates and encourages the counselor	
27. Challenges the counselor to perceive accurately the thoughts, feelings, and goals of the client	
28. Gives the counselor the chance to discuss personal issues as they relate to counseling	
29. Is flexible enough to encourage spontaneity and creativity	
30. Focuses on the implications and consequences of specific counseling behaviors	
31. Provides suggestions for developing counseling skills	
32. Encourages the use of new and different techniques	
33. Helps define and achieve specific, concrete goals	
34. Gives useful feedback	
35. Helps organize relevant case data in planning goals and strategies with clients	
36. Helps develop skills in critiquing and gaining insight from counseling tapes	
37. Allows and encourages self-evaluation	
38. Explains the criteria for evaluation clearly and in behavioral terms	
39. Applies criteria fairly in evaluating counseling performance	
40. Addresses cultural issues of supervisee in a helpful manner.	
41. Discusses cultural and contextual issues of the client, family, and wider systems that open up new resources and avenues for support.	
Source: Adapted from Powell and Brodsky, 2004.	

Clinical Supervision and Professional Development

Clinical Supervision and Professional Development of the Substance Abuse Counselor

Part 2: A Guide for Administrators

Clinical Supervision and Professional Development

Chapter 1

Clinical supervision should be an essential part of all substance abuse treatment programs. Every counselor, regardless of skill level and experience, needs and has a right to supervision. In addition, supervisors need and have a right to their own clinical supervision. For more on the essential nature of clinical supervision, see Appendix B, *New York State Office of Alcoholism and Substance Abuse Services Clinical Supervision Statement*. Unfortunately, many agencies place a higher priority on administrative tasks (such as case recordkeeping and crisis management), than on clinical supervision. This guide for administrators will assist in developing a rationale for and designing a clinical supervision system for your substance abuse treatment organization. Part 2 provides strategies and tools for implementing effective supervision along with advice on allocating resources for best results.

Benefits and Rationale

A successful clinical supervision program begins with the support of administrators. You communicate the value, benefits, and integral role of clinical supervision in quality care, staff morale and retention, and overall professional development within the context of the organization's mission, values, philosophy of care, and overall goals and objectives. Being able to discuss specific benefits of clinical supervision will increase the likelihood of internal support, enhance your organization's ability to deliver quality supervision, and add marketability for funding opportunities.

Administrative Benefits

Clinical supervision enables organizations to measure the quality of services. It ensures that employees follow agency policies and procedures and comply with regulatory accreditation standards while promoting the mission, values, and goals of the organization. Supervision provides administrators with tools to evaluate job performance, maintain communication between administrators and counselors, facilitate conflict resolution, and hold personnel accountable for quality job performance. Clinical supervision is a risk-management tool that increases an organiza-

tion's ability to respond to risk, thereby reducing overall liability. It also addresses human resource issues, including staff satisfaction and retention of personnel. Finally, supervision provides marketing benefits by improving the overall reputation of the agency in the community and among other service providers.

Clinical Services Benefits

The goal of clinical supervision is to continuously improve quality client care. Supervision by trained and qualified supervisors helps staff understand and respond more effectively to all types of clinical situations and prevent clinical crises from escalating. It specifically addresses assessment, case conceptualization, treatment strategies, and discharge planning. Supervision aids in addressing the unique needs of each client. It provides a mechanism to ensure that clinical directives are followed and facilitates the implementation and improvement of evidence-based practices (EBPs). "Quality supervision will become a major factor in determining the degree to which EBPs are adopted in community settings" (CSAT, 2007, p. 12). Clinical supervision also enhances the cultural competence of an organization by consistently maintaining a multicultural perspective. "Supervision encourages supervisees to examine their views regarding culture, race, values, religion, gender, sexual orientation, and potential biases" (CSAT, 2007, p. 27).

CSAT's Technical Assistance Publication (TAP) 21-A, *Competencies for Substance Abuse Treatment Clinical Supervisors*, defines supervision as a "social influence process that occurs over time in which the supervisor participates with supervisees to ensure quality care. Effective supervisors observe, mentor, coach, evaluate, inspire, and create an atmosphere that promotes self-motivation, learning, and professional development" (CSAT, 2007, p. 3). Also, supervision can improve client outcomes (Carroll, Ball, Nich, Martino, Frankforter, Farentinos, et al., 2006). Finally, supervision increases staff members' sensitivity and responsiveness to diversity issues among staff, with clients, and between staff and clients.

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Professional Development Benefits

Quality clinical supervision has been shown to increase staff retention through professional skills development and increased competency (Bernard & Goodyear, 2004). Supervision provides the forum for expanding current clinical practices, intellectual stimulation, emotional support, and improvement in critical thinking (see CSAT, 2007). Supervision is part of an organization's career ladder, as it supports staff in obtaining and maintaining professional credentials. It also provides information and guidance about key contextual factors that may influence their work performance such as culture, lifestyles, and beliefs.

Workforce Development Benefits

Supervision by trained and qualified supervisors is an essential tool in the recruitment and retention of personnel, as counselors often rate training and development as critical factors in their selection of employment. In addition, supervision has been shown to improve staff morale and motivation by making staff feel valued and appreciated (Bernard & Goodyear, 2004). It also assists in promoting counselor wellness, and promotes the overall development of the substance abuse treatment field by upgrading the credentials, knowledge, skills, and attitudes of personnel.

Program Evaluation and Research Benefits

Implementation of program evaluation and/or research is often misunderstood by counselors and viewed as more work that is unrelated to quality client care. Supervision can mediate in this area by providing staff with the rationale for the initiative, connecting it to client outcomes, and communicating achievements and challenges to the evaluators. Clinical supervision can also provide the mechanism for data gathering and information retrieval in support of the new projects and programmatic innovations.

Key Issues for Administrators in Clinical Supervision

Administrative and Clinical Tasks of Supervisors

Supervisors wear many hats. In most organizations, the administrative and clinical supervisor is the same person (see also the section that follows, Administrative and Clinical Supervision, p. 89). Most clinical supervisors still carry a client caseload (albeit reduced somewhat from that of a line counselor), perform administrative duties, write grant proposals, serve as project managers, and supervise the clinical performance of counselors. Each role involves different expectations and goals. It is important for administrators to be aware of each of these roles and for supervisors to be prepared to perform effectively in administrative, organizational, and clinical roles.

Kadushin (1976) outlines multiple administrative tasks for a clinical supervisor: staff recruitment and selection; orientation and placement of employees; work planning and assignments; monitoring, coordinating, reviewing, and evaluating work; staff communication both up and down the chain of command; advocating for client and clinician needs; acting as a buffer between administrators and counselors; and acting as a change agent and community liaison. Munson states, "As part of their administrative responsibilities, supervisors are often required to manage program transitions and modifications. Departments and programs can be altered, restructured and merged" (1979, p. 72).

Assessing Organizational Structure and Readiness for Clinical Supervision

In implementing a clinical supervision program, an important first step will be to evaluate the agency's preparedness to support the functions of clinical supervision by identifying the agency's culture and organizational structure. Organizational readiness scales and attitude inventories can be helpful in the

process of assessing and adopting EBPs. You need to assess the following:

- How decisions are made within the organization (centralized versus decentralized, vertical or horizontal).
- How authority is defined and handled (top down, bottom up, through the chain of command, or ad hoc).
- How power is defined and handled (reward, coercion, legitimate power through status, prestige, titles, expert power through skills and experience, or referent power through respect for an individual—or all of the above).
- How information is communicated (structured/formal/informal, on a need-to-know basis, bidirectional feedback and communication).
- How the organizational structure influences supervisory relationships, process, and outcome.
- The overall cultural proficiency of the organization.

The following organizational issues should be considered by an agency before a clinical supervision system is implemented:

- *Organizational context.* How consistently do staff adhere to agency philosophy and culture? To what extent will clinical supervisors teach and support this philosophy?
- *Clinical competence.* What specific knowledge, skills, and attitudes are expected of substance abuse counselors? What is each counselor's baseline competence and learning style? What is the level of cultural competence of staff?
- *Motivation.* How should the staff's motivation and morale be characterized?
- *Supervisory relationships.* What is the nature of relationships between administrators and front-line workers? How healthy or unhealthy are those relationships?
- *Environmental variables.* To what extent do administrators expect supervisors to proactively teach ethical and professional values? Do staff have a common set of goals? How does the organization promote professional development? How is progress toward those goals monitored and supported? What is the cultural, racial, religious, gender, and sexual orientation mix of the clients served by the organization?

- *Methods and techniques.* How familiar is the organization with individual, group, and peer supervision? How familiar is the organization with case progress note review, case consultation methods, direct observation, live supervision, audio- or videotaping, and role playing?

Assessing an organization's readiness for a clinical supervision system may also include such questions as: "What stage of readiness for implementing a clinical supervision system are the board of directors, other administrative staff and clinical supervisory staff (if any), direct care staff, and support personnel? What are some of the organizational, administrative, and clinical barriers to implementing a clinical supervision system?" Potential barriers include lack of familiarity with supervision methods and techniques, the need for further training of supervisors, and lack of technical equipment such as video cameras. It is helpful to develop a timeframe for addressing the most important barriers. What would you as an administrator like to see happen and who should be part of the process for implementing clinical supervision? (See Tools 1 and 2 in chapter 2.)

Administrative and Clinical Supervision

This section is a comprehensive look at the issues facing supervisors in their dual roles. In the substance abuse treatment field, one of the major challenges facing supervision is the reality that most supervisors perform both administrative and clinical supervisory functions. The numerous conflicts and ambiguity that result from these roles can pose serious problems for administrators, supervisors, and supervisees. Determining the distinction between the roles of clinical and administrative supervision can be difficult because there are no uniform definitions of these functions. Most writing on administrative supervision is in the context of the evaluative and record-keeping functions of a supervisor.

To the extent possible, administrative supervision should be distinguished from clinical supervision. Bradley and Ladany (2001) state that administrative supervisors "help the supervisee function effectively as a part of the organization," with an emphasis on

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“organizational accountability, case records, referrals, and performance evaluations” (p. 5). In contrast, clinical supervisors focus on the services received by the client, including the therapeutic relationship, assessment, interventions, and client welfare. While these tasks may be seen as substantially different, many are complementary. Therefore, you and the supervisors need to be mindful of the different roles and of the inherent ethical, relational, and role conflict issues. Best supervision practices will work to keep the dual roles as clear as possible.

Legal and Ethical Issues for Administrators

You play a vital role in clarifying legal and ethical issues for your organization, especially for clinical supervisors and counseling personnel. You are invaluable in providing information and support for supervisors and staff.

You and your supervisors need to define and document (in writing) the legal and ethical standards for the agency. You can draw from the staff's professional codes of ethics as well as accepted best practices. All personnel should be consistently and continually trained in the agency's legal and ethical standards, as well as in changing case law and legislation affecting clinical practice. You need to reinforce your support for supervisors who face situations where legal and ethical issues may arise. You should help supervisors develop a process for ethical decisionmaking as supervisors as well as a process for teaching ethical decisionmaking to counselors.

Among the key issues for you and your supervisors are the following:

- *Direct and vicarious liability.* Important factors affecting liability include the supervisor's power of control; the counselor's duty to perform a clinical service; the time, place, and purpose of the service; the motivation for responding the way the counselor responded; and the supervisor's expectations for action. Critical legal questions for administrators are: Did you make a reasonable effort to supervise? Was there any dereliction of duty? Did treatment create any harm, wrongdoing, or damage to the client, the organization, or the community? Did you and the supervisor give appropriate advice concerning the counselor's actions? Were

tasks assigned to staff that were outside their scope of competence?

Confidentiality. Has the organization adhered to all laws of confidentiality (i.e., the Health Insurance Privacy and Portability Act [HIPAA], 42 CFR, Part 2)? To what extent has the organization balanced the counselor's and client's right to privacy and performance review? Has the organization adhered to its duty to warn, to report, and to protect?

- *Informed consent and due process.* This requires that supervisees and clients be fully informed as to the approach and procedures of the agency's actions (see Tools 4 and 19). Have the clients and counselors been informed about treatment parameters and supervision requirements? Have all required forms and documents been read and signed by all relevant parties? Is there a fair process that encourages conflict resolution and ensures the person a process of appeals?
- *Supervisor and counselor scope of competence.* Are supervisors and counselors operating within their scope of practice and competence? Are supervisors and counselors meeting minimal standards of competence regarding cultural and contextual awareness, knowledge, and skills? Are they effectively working within the wider client systems and networking appropriately with wider community services and institutions?
- *Dual relationships.* A dual relationship exists when a supervisor and supervisee or counselor and client have an additional relationship outside the primary professional relationship. Guidelines for supervisory relationships prohibit supervising current or former clients (a difficult issue in the substance abuse field where it is not uncommon for an agency to hire and supervise former clients in recovery). Do any supervisors have current or former romantic or sexual partners, business associates, family members, or friends among their supervisees? Is the distinction clear between the teaching and supervisory roles when students are being supervised? Are supervisors mindful of crossing over from the supervisory relationship to social activities with supervisees that may impair objectivity? Do supervisors avoid excessive self-disclosure in supervision and avoid comments or actions that might be interpreted as sexual? Do you and your supervisors respect and recognize professional boundaries in all aspects of

your relationships? When in doubt, do you consult with colleagues?

You should provide comprehensive legal and ethical orientation to all employees, review codes of ethics at the time of hire, and require employees to sign a statement that they will abide by these codes. You will want to review agency adherence to these codes periodically under the umbrella of a quality assurance or compliance program. Clinical supervisors should be proactive and provide documentation that describe and conceptualize client problems addressing potential legal and ethical dilemmas, document all clinical directives given, and offer counselors a written summary of recommendations. Finally, you should review liability insurance coverage and suggest that supervisors and counselors maintain their own personal professional liability and malpractice insurance.

For further legal and ethical issues, the reader is referred to the forms in this section.

Diversity and Cultural Competence

An important responsibility for supervisors is to continually improve their cultural competence in order to teach and support staff. Cultural competence is gained through education and training, supervised clinical work, and ongoing exposure to the population being served. All potential supervisors should be required to receive training in cultural competence. It is the supervisor's responsibility to initiate discussions of differences in race, ethnicity, gender, religion, socioeconomic status, sexual orientation, or disability regarding both clinical work with clients and supervisory and team relationships. This promotes the acceptance of diversity and cultural issues as appropriate topics of discussion and allows the supervisor the opportunity to model culturally competent behaviors.

To appreciate the importance of cultural competence, counselors must first recognize "the power of their own cultural assumptions to influence their thinking and their interactions with others" (Bernard & Goodyear, 2004, p. 118). From there, supervisors can help supervisees understand how their own diversity

variables affect their interactions with clients.

Administrators should be watchful for problems that can arise in the supervisory relationship when supervisors are of a different race, culture, or ethnicity than their supervisees. Fong and Lease (1997) have identified four areas that might present challenges:

1. *Unintentional racism.* Well-intentioned supervisors who are unaware of how their racial identity affects their relationships with supervisees may avoid talking about race or culture.
2. *Power dynamics.* The power differential in the supervisory relationship may be exaggerated in dyads where the supervisor is part of the dominant group and the supervisee is a member of a minority group.
3. *Trust and vulnerability.* Supervisees who are in a vulnerable position are, at the same time, encouraged to trust their supervisors, when they may have little reason to do so.
4. *Communication issues.* Differing communication styles among cultural groups can result in misunderstandings.

An excellent exercise for you and your supervisors is to evaluate how supervisors measure up to multicultural supervision competencies. Bradley and Ladany (2001) list the following in what they term the "supervisor-focused personal development" domain:

- "Supervisors actively explore and challenge their own biases, values, and worldview and how these relate to conducting supervision;
- Supervisors actively explore and challenge their attitudes and biases toward diverse supervisees;
- Supervisors are knowledgeable about their own cultural background and its influence on their attitudes, values, and behaviors;
- Supervisors possess knowledge about the background, experiences, worldview, and history of culturally diverse groups; and
- Supervisors are knowledgeable about alternative helping approaches other than those based in a North American and Northern European context" (pp. 80–81).

Developing a Model for Clinical Supervision

An organization must develop a model for clinical supervision that best fits its needs. What are its underlying needs, goals, and objectives? What models are available to assist in reaching your organizational goals? The model should be selected in light of the organization's mission, philosophy of treatment, and orientation. You need to assess the organization's readiness for implementing a supervision system and barriers that might impede the process. What are the organization's capacities for implementation? Once implemented, how will the program's quality be evaluated? How will continuous quality improvement strategies be incorporated into the supervision model? And if the program is successful, how will it be sustained?

An effective model for clinical supervision will keep the target clear: ensuring that the client receives better treatment as a result of the clinical supervision system. In addition:

- It will begin with the supervisors' unique management or leadership style, their levels of proficiency in supervision, the organization's philosophy about clinical supervision, and the specialized client needs for clinical services.
- It will improve counselor competence, make work more manageable, encourage staff to stretch beyond their current capabilities, build mastery and growth, and meet the needs of the client, counselor, agency, and credentialing bodies.
- It will encourage supervisees to grow professionally in their understanding of culture, race, religion, gender, and sexual orientation as these issues are present clinically.

Implementing a Clinical Supervision Program

TAP 21-A (CSAT, 2007) describes the importance of using a clearly articulated process for implementing a new model of clinical supervision in both State and local agency settings as follows: "If agencies are to improve their supervisory practices by adding activities identified as clinical supervision competencies, a set of guidelines is needed to support the develop-

ment of an implementation plan" (p. 7). To ensure a smooth transition to the new supervision program, an agency will need to perform the following tasks: [d]efining or clarifying the rationale, purpose and methods for delivering clinical supervision; [e]nsuring that agency management fully understands and supports the changes that need to be made; [p]roviding training and support in supervisory knowledge and skill development; and [o]rienting clinicians to the new supervision rationale and procedures" (p. 7). These tasks are part of an implementation process whereby the changes are introduced over a limited period of time that allows for procedures to be developed and tested and clinicians to provide feedback and adjust to the supervisory process. "The broad goal is to create a continuous learning culture within the agency that encourages professional development, service improvement, and a quality of care that maximizes benefits to the agency's clients" (p. 8).

More detailed guidelines for implementing and phasing a clinical supervision system into existing processes include:

1. You need to be clear as to the organization's goals of supervision, viewing supervision as a way of supporting and reaching the agency's mission.
2. You should be familiar with the skills and competencies outlined in TAP 21-A (CSAT, 2007) and other experience and/or credentialing requirements. The competence of the designated supervisors is central to the successful design and implementation of the program. In some cases, agencies will need to invest in additional training for potential clinical supervisors. Ask yourself the following about your supervisors:
 - Has the supervisor had formal training and is he or she credentialed in counseling, substance abuse, and clinical supervision?
 - At what level of supervision proficiency are the clinical supervisors?
 - Has the supervisor received supervision of his or her clinical skills?
 - What is the supervisor's relationship with staff?
 - What is his or her level of cultural proficiency and ability to work with culturally diverse clients?
3. It is essential that a clear statement of support from senior administration be provided both verbally and in writing to all levels of administra-

- tion, counselors, and support staff. This statement should provide a rationale (see p. 95) for implementing clinical supervision. The importance of this step cannot be overemphasized.
4. The next step in implementing a clinical supervision system is to create a Change Team from within your organization to spearhead the effort. Selecting the appropriate agency representatives to be the link between you and the supervision system will ensure internal communication and support. The Team should comprise individuals committed to quality care and the supervision process. They need to be somewhat familiar with the process of supervision and have a clinical background. Supervisors need to have a thorough understanding of the agency's model and techniques of supervision. The Change Team leader will ensure participation and followup with the organization's clinical supervisors. Planning specific steps to ensure sustainability of the system is integral to long-term success.
 5. You, the Change Team, and clinical supervisors should read and understand the importance of the standards outlined in TAPs 21 (CSAT, 2006) and 21-A (CSAT, 2007). Each counselor should have a copy of TAP 21 (*Addiction Counseling Competencies—The Knowledge, Skills, and Attitudes of Professional Practice* [CSAT, 2006]). It is important for clinical supervisors to meet with the Change Team to discuss the skills and competencies in TAP 21-A, and to identify both the organization's strengths and areas needing improvement. The Team should draft formal policies and procedures to articulate expectations and guidelines.
 6. An all-staff meeting should feature the organization's view of clinical supervision and how it will implement the supervision system. The formal policy and procedure should be distributed and discussed. All clinical staff involved in the system should attend this briefing, presented by the Change Team leader and key clinical supervisors.
 7. Provide necessary training, time, and funding for supervisors. Because the training requirement for credentialing as clinical supervisors is typically participation in a 30-hour class on supervision, you need to ensure that all supervisors receive training before proceeding to comprehensive implementation.
 8. If the organization is sizable or the clinical staff is large, it is sometimes helpful to initiate a pilot supervision system in selected units of the organization. This is an issue that can be addressed by the Change Team. If organizational staff are particularly resistant to implementing the supervision program, it may be helpful to demonstrate the efficacy of a quality supervision program via a pilot program.
 9. Supervisors should prioritize discussing the supervisory agreement or contract with each supervisee and invest time to determine the training needs and goals for each counselor. This is the beginning of an Individual Development Plan (IDP), outlining the counselor's knowledge, skills, attitudes, and cultural competence. It is essential that the supervisor observe the counselor in action before rating her or his abilities. Rating scales provide the baseline from which to begin supervision. Both supervisors and counselors should develop and complete rating scales and IDPs. Dialog on areas of agreement and disagreement at the outset form a vital part of the supervision process. This discussion also provides the supervisor with an opportunity to praise staff members for their strengths.
 10. Supervisors should schedule formal, frequent, and regular individual supervisory sessions. These sessions, similar to individual sessions with clients, need to be respected and protected from unnecessary interruptions or distractions. The supervisory sessions should be documented and follow the prescribed focus outlined in the IDP.
 11. To begin direct observation, design an implementation strategy (assuming the organization has recognized the value of direct observation; see Part 1, chapter 1), and establish a weekly rotation schedule for the observation of each counselor over the next 3 months. Initially, the clinical supervisor can provide direct observation feedback to counselors individually and then move toward a group supervision model whenever practical and possible to promote team building and efficiency. To help with sustainability, the supervisor should discuss supervision at every opportunity. Staff needs to see that supervision will be conducted on a regular basis, and that frequency will be determined by the agency's needs and those of the individual counselor and team.

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12. Provide feedback and review the IDP. Through the observation, the supervisor and counselor can discuss the strengths and challenges of the counselor's performance. The developing IDP should outline in detail the areas for improvement and how these changes will be further observed and monitored. Learning goals evolve as continued observation leads to further suggestions for improving performance.
13. Supervisors should document their direct observation using various forms that exist for this purpose. The documentation should include times of meetings and observation, a brief statement of the content of the clinical session observed, review procedures (audio or video tape), feedback provided, and mentoring and teaching offered.
14. Incentive plans can be developed to encourage counselors to become seriously involved in their professional development.
15. Create a sustainable treatment team. Over time, some staff will leave and others will join the team. It is important for you and your supervisors to work with the team to create an atmosphere of learning that supports the agency's commitment to clinical supervision. This means including the clinical supervision policy and procedures in the orientation of new staff. It definitely means that the team will continue to meet for supervision on a regular basis.
16. Develop a system of supervision of clinical supervisors, particularly for those who are new to their role. Supervisors need to continually build and improve their supervisory skills as well as have a forum to discuss staff challenges. Some agencies have created supervisory peer groups where the supervisors present and receive feedback on their supervision, other agencies hire a consultant to provide supervision, while some regional coalitions have established monthly forums.

Some of the primary elements in a supervision of supervisors system include:

- *Direct observation.* This may best be done by periodically (e.g., once a calendar quarter) videotaping a supervision session and having the supervisor's supervisor review the videotape. They then discuss what occurred during the supervision, with the supervisor's supervisor providing feedback and recommendations.

- *Competencies.* It is important that the supervisors of supervisors be Level 3 counselors and preferably Level 3 supervisors (see Figures 5 and 6 in Part 1, chapter 1). They need to be certified clinical supervisors and to have had supervision as supervisors themselves so they have experience with this type of supervision. Administrators should give them the responsibility and authority to perform this task and to require that tapes be provided for review in a timely fashion. Supervisors should develop the competencies sufficient to attain their credentials as a certified clinical supervisor.
- *Record-keeping system.* A logging system should maintain records on the initial counselor-supervisor sessions and the supervision of supervisors sessions.
- *Recruiting personnel.* If your agency does not have an internal person to provide the supervisor's supervision, it is recommended that you contract for such services with external sources. Over time, the external supervisor should train an internal person to assume this role.

Phasing in a Clinical Supervision System

The steps below have been found to be helpful in phasing in clinical supervision systems in an orderly manner. Although the list is provided sequentially, the needs of an agency will determine the timeframe and selection of objectives.

Phase I: Organization and Creation of a Structure

- Assess and describe the agency culture (including assets and deficits), selecting assets to build on and/or deficits for remediation regarding clinical supervision.
- Assess the facility's policies and procedures to determine the feasibility and practicality of a clinical supervision system (i.e., presence of clinical supervisory staff, availability of direct observation technology, etc.).
- Examine job descriptions to determine staff scope of practice and competence.

- Reach consensus among the Change Team about the definition of clinical supervision and its key components for that agency.
- Publicize this consensus statement to all personnel, introducing staff to the new supervisory model and clearly communicating expectations for the delivery and outcomes of clinical supervision before program implementation.
- With all personnel, discuss and introduce clinical supervision policies and procedures.
- Review the organization's cultural competence as it relates to the client populations served.
- Develop documentation and accountability systems.

Phase II: Implementation

- Implement a supervisory contract, including informed consent, with all staff to improve the supervisory working alliance.
- Assess the quality of the supervisory relationship and devise interventions to strengthen the learning alliance.
- Conduct counselor assessments to establish competency baselines.
- Design initial supervisory goals and measurable objectives for each counselor.
- Use strengths-based approaches where appropriate and possible in clinical supervision, supporting counselors' positive actions with clients.
- Develop a system of supervision of supervision. Some programs use the same taping and monitoring systems for supervisors that are used between counselors and clients, with supervisors expected to videotape their supervision sessions at least once a month, and receive supervision of their supervision by the team of supervisors and/or their supervisor.

Phase III: Establishing a Training Plan and Learning Goals

- Complete a written IDP for each counselor.
- Provide focused, on-the-job training.
- Identify clinical supervision quality indicators to monitor the quality assurance program for the agency.
- Periodically review job descriptions and evaluation procedures to ensure that counselor competencies

are sound. Review the counselor's ability to perform the TAP 21 competencies, the activities and functions performed by a substance abuse counselor that form the basis of the standards required in many States for credentialing. Also see the Northwest Frontier Addiction Technology Transfer Center Performance Rubric at <http://www.attcnetwork.org/documents/Final.CS.Rubrics.Assessment.pdf>.

Phase IV: Improving Performance

Proficiency in the Addiction Counseling Competencies (CSAT, 2006) and the International Certification and Reciprocity Consortiums 12 Core Functions should be the subject of continuous assessment and professional development during clinical supervision. Additional specific performance concerns include:

- Continually align the clinical supervision goals to the agency's mission, values, and approach;
- Create risk management policies and practices and monitor adherence;
- Address the cultural competence of personnel in supervision;
- Consistently address a deepening of counselor knowledge, skills, and attitudes about legal and ethical issues;
- Use formative and summative evaluation and feedback procedures to inform the clinical supervision process;
- Develop quality improvement plans for the agency, including clinical supervisory procedures;
- Overtly address and encourage counselor and staff wellness programs;
- Invest in counselor and staff training; and
- Foster your staff from within, continually seeking individuals with the potential to become tomorrow's supervisors.

Documentation and Record Keeping

Overseeing documentation and record keeping is an essential administrative task, as maintaining a supervisory record has multiple purposes for administrators, supervisors, and counselors. One of the primary purposes of documentation is to serve as the legal record for the delivery of supervision: a reasonable effort was made to supervise. The supervisory

record is also important in developing a thoughtful plan for both quality client care and professional development. The supervisory record serves to:

- Improve client care.
- Model good record-keeping procedures for personnel.
- Afford and enhance ethical and legal protection.
- Provide a reliable source of data in evaluating the competencies of counselors.
- Provide information concerning staff ability to assess and treat clients.
- Reflect staff understanding of the dynamics of behavior and the nature and extent of the problems treated.
- Assess staff cultural competence and proficiency.
- Provide information about the clinical supervisor's ability to assess counselor competencies and the nature of the clinical supervisory relationship.
- Provide information about the clinical supervisor's clinical and supervisory competence.

A good clinical supervision record should include the following elements:

- Requirements for counselor credentialing (certification/licensure) and the extent to which each counselor meets those requirements.
- The counselor's regularly updated resume and a brief summary of his or her background and clinical expertise.
- A copy of the informed consent document, signed by the supervisor and the supervisee.
- A copy of the clinical supervision contract, signed by the supervisor and the supervisee.
- The IDP, updated minimally twice a year and preferably every 3 months.
- A copy of the formative and summative evaluations the supervisor has given to the supervisee and all relevant updates to these evaluations.
- A log of clinical supervision sessions, dates, times; a brief summary of key issues discussed; recommendations given by the supervisor and actions taken by the counselor; documentation of cancelled or missed sessions by either the supervisor or supervisee; and actions taken by the supervisor when supervision sessions are missed.
- A brief summary of each supervision session, including specific examples that support learning goals and objectives.

- A risk management review summary, including concerns about confidentiality, duty to warn situations, crises, and the recommendations of the supervisor concerning these situations.

The entire documentation record can be brief and in summary form. (See Tools 10–12 in Part 2, chapter 2, including checklists and summary statements to reduce the volume of work for the supervisor.)

Evaluation

Although training in how to conduct productive and constructive evaluations of personnel is rare, evaluation of personnel is a critical administrative task of supervisors and administrators. The goals of evaluation include, but are not limited to, reviewing job performance; assessing progress toward professional development goals; eliciting future learning goals; assessing fitness for duty and scope of competence; and providing feedback to staff on adherence to agency policies, procedures, and values.

There are a number of issues that shape the feedback process, including:

- How does the agency define a “good” counselor? What knowledge, skills, and attitudes are critical? What level of cultural competence is needed?
- How does a supervisor measure general affective qualities, such as counselor's empathy, respect, genuineness, concreteness for clients?
- What standardized tools will be used to support the evaluation? There are few evaluation instruments with psychometric validity or reliability.

The IDP can be the basis for evaluation. Each counselor should have a development plan that takes into consideration her or his counseling developmental level (see Stoltenberg, McNeill, & Delworth, 1998), learning needs and styles, job requirements, client needs, and the agency's overall goals and objectives. A sample IDP is provided in chapter 2 (Tool 15).

How do administrators and supervisors evaluate personnel and assess job performance? There are two forms of evaluation: formative and summative. Formative evaluation focuses on progress, is regularly provided, and gives feedback to the employee regarding his or her attainment of the knowledge, skills, and attitudes necessary to the job. It addresses the

question, “Are you going in the right direction?” The quality of the supervisory relationship determines the success of the formative evaluation process.

Summative evaluation is a formal process that rates employees’ overall ability to do their job and their fitness for duty. It answers the question, “Does the employee measure up?” In substance abuse counseling, summative evaluation takes into account many variables: the range and number of clients seen, the issues and problems addressed by the counselor, the general themes in training and supervision, skill development, self-awareness, how learning goals have been translated into practice, and the employee’s strengths, expertise, limitations, and areas for future development. Summative evaluation also addresses the nature of the supervisory relationship and goals for future training.

The best evaluations occur when there is open exchange of information and ideas between the supervisor and counselor, where specific examples are gleaned from the ongoing supervisory documentation, and expectations are again reviewed and agreed upon. Some organizations have moved to 360-degree assessments, with input from many layers of the organization. Tool 13 in chapter 2 is a counselor evaluation of a supervisor. The quality and quantity of feedback from a supervisor is an important part of supervision, according to supervisees (Bernard & Goodyear, 2004). Formalized feedback and evaluation is designed to review the ongoing, frequent feedback provided over time in a supervisory system (see Tool 14).

Conducting an evaluation involves exercising authority and power. When supervisors evaluate counselors, they are also evaluating themselves and their effectiveness as supervisors with particular supervisees. The evaluation process brings up many emotions for both parties. In providing feedback, supervisors should:

Provide positive, as well as constructive, feedback:

- Differentiate between data-based and qualitative judgments about job performance.
- State observations clearly and directly.
- Prioritize key areas for review rather than flood the counselor with an all-inclusive review.

Supervisees prefer:

- Clear explanations.
- Written feedback whenever possible.
- Feedback matched to their counseling development level.
- Encouragement, support, and opportunities for self-evaluation.
- Specific suggestions for change.

Feedback should be:

- Frequent.
- As objective as possible.
- Consistent.
- Credible.
- Balanced.
- Specific, measurable, attainable, realistic, and timely: SMART.
- Reduced to a few main points.

Supporting Clinical Supervisors in Their Jobs

Being a supervisor in any setting is a difficult job. The supervisor represents the concerns of administrators, counselors, and clients. Supervisors advocate on behalf of those above and below them in the organization chart. Hence, it is imperative that you provide support for the clinical supervisor in the agency and in the job.

To show support for clinical supervision, review the organization’s receptivity to supervision: Is its climate for change, tolerance, and commitment conducive to efficient implementation of a clinical supervision system? Also, assess the magnitude of the proposed supervision system and the critical factors needed for success. “The agency structure and the supervisory program within it define the parameters of the supervisory relationship. Decision-making processes, autonomy within units, communication norms, and evaluative structures are all relevant to the supervisory function” (Holloway, 1995, p. 98).

To assess the organization’s receptivity to supervision, you should address the following issues:

1. To what degree does the organization value accountability and have clear expectations of its personnel?

2. How is supervision tied to an employee's ongoing performance improvement plan or performance incentive program?
3. To what extent does the organization have efficient and effective systems in place to manage day-to-day operations?
4. To what extent does the organization view itself as a learning environment, encouraging inquisitiveness, creativity, innovation, and professional development?
5. To what extent does the organization value upward and downward communication and relationships by creating opportunities for staff to be heard? Does the organization understand that the learning alliance and relationship is key to successful supervision?
6. In what ways is the organization a dynamic, growing organism that values everyone's contribution?
7. To what extent does the organization "provide diversity training and other experiences that empower [a counselor] to become an advocate for the organization's target population and an agent of organizational change" ? (CSAT, 2007, p. 31)
8. How does the organization view teamwork, and what structures are in place to support the team-building process?
9. How do lines of authority and communication operate in the organization? How do formal and informal decisionmaking processes that influence the supervisors' functions work?
10. To what extent do administrators know about and understand the process and practices of clinical supervision? What training do they need in this regard?
11. What is the common ground in understanding the relationship between the administrative and clinical functions of the supervisor?
12. If the organization does not have trained and motivated clinical supervisors, what is your plan for recruiting new supervisors and/or training current supervisors who will be able to take on this new responsibility?
13. Are the job descriptions and roles clear, current, and accurate for all personnel?
14. How much supervision of their supervision will the supervisors receive from administrators or other consultants?

You support clinical supervision when you help supervisors build an organizational climate in which they can do quality work. This entails the following factors:

1. Allocating time for clinical supervision. Since supervision is not (in most cases) a revenue-generating activity, administrators may tend to minimize the importance of quality clinical supervision and fail to provide the needed time to "make a reasonable effort to supervise." A matrix presented in Part 1, chapter 1 gives guidelines to supervisors for organizing their time and providing quality supervision.
2. Making clinical supervision an agency priority. You can support the clinical supervisor with a clear statement of the importance of supervision and provide the resources needed to perform this function. This might include the acquisition of taping equipment, provision of one-way mirrors, etc. Staff need to hear unequivocally that supervision is a necessity and a requirement for all personnel, regardless of years of experience, academic background, skill and counselor developmental levels, and status within the organization. Supervisors also need supervision.
3. Supporting creative methods for supervision. As this TIP advocates for direct methods of supervision through one-way mirrors, video/audio taping, and live observation, you can state clearly that "at our agency we observe." Other methods for clinical supervision might include group or peer supervision models (see Part 1, chapter 1).
4. Building and supporting a record-keeping process for clinical supervision. This entails providing time and tools for the documentation related to clinical supervisory and administrative functions. Supervisory notes need to be integrated with clinical notes and human resource files. One good documentation system is the Focused Risk Management Supervision System (FoRMSS; Falvey, Caldwell, & Cohen, 2002). Assisting in organizing the supervisory process by investing in activities that will increase productivity over time, setting and adhering to priorities, and increasing coping skills repertoire to manage multiple tasks through cross-training and team building. You also need to periodically review job descriptions, personnel strengths and aptitudes, and cultural competence, and reorganize work-

loads accordingly. You should periodically review the purpose and function of every meeting and seek to streamline meeting times for economy and efficiency.

5. Assisting supervisors in implementing agency priorities, such as the adaptation of EBP to fit the agency's goals and objectives. Hence, if an organization is implementing an EBP, it is imperative that supervisors also be trained in how to supervise that practice, perhaps even before counselors are trained.
 6. Assisting supervisors in other personnel functions, such as working with impaired professionals and providing an employee assistance program (EAP) as a resource to supervisors and supervisees. You and your supervisors need to work together when staff are involved in ethical or legal issues that might impair the organization's function and credibility, and the supervisor needs to keep the administrator informed of all actions taken throughout the process.
 7. Supporting supervisors in developing cultural competence within the organization. This entails hiring culturally competent clinical supervisors and staff and providing personnel training on cultural issues. It also requires supporting supervisors in developing and improving cultural competence in counselors.
- Creating IDPs with all supervisors. Even as every client needs a treatment plan and every staff member needs an IDP, every clinical supervisor also needs an IDP. Supervisors' IDPs are jointly developed and monitored by the clinical supervisor and his or her supervisor.
 - Helping supervisors develop a professional identity as a supervisor. This entails encouraging the supervisor to be credentialed as a clinical supervisor. They should also receive ongoing training required for recertification.
 - Providing time for them to work with a mentor (either someone within the organization or an outside consultant).
 - Requiring an annual minimum number of clinical supervision training hours.
 - Offering time and resources for supervisors to participate in State or local support groups for supervisors.
 - Providing job performance evaluations on a regular and timely basis.

Professional Development of Supervisors

You both support clinical supervisors in their function and monitor their professional development and performance by:

- Building a system to monitor, evaluate, and provide feedback to clinical supervisors. Supervision of one's supervision is lacking in many organizations. Every clinical supervisor is entitled to and needs to have some form of supervision of their supervision, either live or online.

Chapter 2

Introduction

Your clinical supervision system needs to match the unique issues and contextual factors of your agency, and your agency needs to have a clear vision of what it wishes to accomplish with its clinical supervision system and actively determine and understand the processes by which it will get there. The tools presented in this chapter are designed to make the tasks associated with implementing a clinical supervision system easier. You will want to take advantage of the experience of well-established supervision programs and adapt the tools that have worked for them to suit the specific needs of your program.

The resources presented in this chapter are organized to be parallel to Part 2, chapter 1. These tools should be considered as prototypes and, in some cases, might even be used as is, provided they fit the context of your organization. These tools can be used by both clinical supervisors and administrators as part of a comprehensive clinical supervision system.

The Change Book: A Blueprint for Technology Transfer (Addiction Technology Transfer Center [ATTC] National Office, 2004) provides the basis for the organizational change process presented here. You may wish to consult with colleagues who have implemented a clinical supervision system for their organizations, especially if the agency is similar to yours. Managing organizational change is very similar to working with a client in a clinical setting. Your understanding of the recovery process and of the counselor's personal qualities and skills that facilitate recovery are invaluable resources as you apply the tools presented in this chapter.

Assessing Organizational Readiness

You will need to determine the state of readiness of your organization and its personnel to implement a clinical supervision system. This assessment should include agency contextual variables, competence of supervisory staff, clinical competence of counseling staff and organizational integrity, motivation of personnel, the nature of your relationships with staff, environmental variables (such as current or recent organizational changes, financial issues, accreditation, and legislative mandates), and the best methods and techniques to be used (see Tool 1). Tool 2 will help in assessing organizational readiness to change and identifying and prioritizing barriers to change. Just as a clinician might assess a client's stage of readiness to change, these principles can be applied to implementing a clinical supervision system or other types of organizational change. Tool 3 will help you reach agreement with staff on the goals of supervision.

Tool 1. Initial Organizational Assessment
Organizational Context

Conditions	Not at All 1	A Little 2	Possibly 3	Very Likely 4	Definitely
Staff have a common set of goals. A goal of the organization is that clinical supervision is valued and should be provided.					
Administrators model a norm of collegiality. Although a supervisee's performance evaluation implies a hierarchy, the organization demonstrates an openness ensuring that each person will be respected and treated as a valuable member of the team.					
The organization promotes professional development. Continuous education and professional growth are promoted for supervisors as well as counselors.					
Progress toward goals is monitored actively and does not wait for outcome evaluation. Ongoing monitoring is valued. Obstacles are identified and handled as an organizational challenge, instead of allowing a situation to deteriorate and be judged as demonstrating a lack of competence of particular staff members.					
Support for clinical supervision is appropriately generous. Allotment of time and resources is critical.					
Priority Focus _____ Secondary Focus _____ <i>Source: Based on Bernard & Goodyear, 1998; Adapted from Porter & Gallon, 2006.</i>					

**Tool 2. Organizational Stage of Readiness To Change
Implementing a Clinical Supervision Program in Your Agency**

Stages of Change

Precontemplation	Unaware of issue
Contemplation	Considering the issue
Preparation	Designing a plan of action
Action	Implementing the action plan
Maintenance	Maintaining the change

	Stage of Readiness	Incentives to Change	Obstacles to Change	Resources for Change
Board of Directors				
Administration				
Supervisors				
Direct Care Staff				
Support Staff				

Primary Group—Focus of Change	Expected Outcome and Timeframe

Secondary Group—Focus of Change	Expected Outcome and Timeframe

This part of Tool 2 is designed for use by administrators and supervisors to identify the current barriers in the organization to implementing a comprehensive supervision system. Administrators and supervisors should fill this out separately, and then discuss answers in an executive team meeting.

Tool 2. Organizational Stage of Readiness To Change Implementing a Clinical Supervision Program in Your Agency			
Current Barriers to Change			
Organizational	Administrative	Clinical	Other

List the most important barriers to address within the next 3 months.

What would you like to have happen?

Who do you need to help participate in the change?

Source: Adapted from Porter & Gallon, 2006.

Tool 3. Goals for Supervision**Organizational Context**

How does the organization support counselors and supervisors in achieving the organization's mission statement? What steps are needed to gain consensus between administration and direct service personnel to achieve the mission statement? What are the specific steps we can take as administrators to achieve this goal of consensus regarding the philosophy of the organization and its relationship to clinical work?

GOAL: _____

Cultural Competence

What cultural and contextual factors are unique to this agency? What factors need to be addressed in clinical supervision?

GOAL: _____

Clinical Competence

What specific knowledge, skills, and attitudes do we expect from our counselors? How do we acknowledge and address the individual counselor's baseline competence and learning style?

GOAL: _____

Motivation

How can we ensure that the clinical supervisor will help motivate counselors to participate in clinical supervision and perform clinical tasks?

GOAL: _____

Supervisory Relationship

How can we support and validate the supervisory relationship both informally and formally?
Do we believe that the supervisory relationship is an important variable in the supervisory process? How can we support and validate the supervisory relationship both informally and formally?

GOAL: _____

Ethics and Professional Values

How much do we expect that clinical supervisors will proactively teach ethics and professional values?

GOAL: _____

Source: Adapted from Mattel, 2007

Clinical Supervision and Professional Development

Legal and Ethical Issues of Supervision

Legal and ethical considerations should be paramount as you implement a supervision system. The goal is to know how to operate within the boundaries of legal and ethical codes and regulations for the protection of all parties, including the agency, administration, staff, and clients. Legal and ethical issues of supervision include direct and vicarious liability, confidentiality, informed consent and due process, supervisor and supervisee scope of competence and practice, and dual relationships (see discussion of these issues in Part 2, chapter 1).

The Association for Counselor Education and Supervision (ACES) has standards for counseling supervisors that can serve as guidelines for the substance abuse field (available online at <http://www.acesonline.net/members/supervision/>). ACES also has ethical guidelines for supervisors that address issues such as protecting client welfare and rights, supervisory roles, and program administration roles. The National Board for Certified Counselors, Inc., has a Code of Ethics pertaining to the practice of professional counseling and clinical supervision. This code, like the ACES code, is reproduced in TAP 21-A (*Competencies for Substance Abuse Treatment Clinical Supervisors* [CSAT, 2007]). Other professions also have similar guidelines, such as the Association of State and Provincial Psychology Boards (reprinted in Falvey, 2002b), the National Association of Social Workers (NASW, *Guidelines for Clinical Social Work Supervision*, 1994), and the American Association for Marriage and Family Therapy (*AAMFT Supervisor Designation: Standards and Responsibilities Handbook*, 1999).

Informed consent is important for several reasons: (1) clients are entitled to know and agree to what processes support quality treatment, who will be reviewing information about them, and how this information will be used; (2) counselors are entitled to know how their work will be evaluated, the process of the supervision, and how this information will be used to support both quality care and their professional development; and (3) the administration is entitled to know that supervisory processes are articulated to support quality care and address legal and ethical standards.

Tool 4 is one of a number of sample informed consent for supervision forms that are available.

Tool 4. Informed Consent Template

The consent should include:

The purpose of supervision: the structure and mutual understanding of supervision

- Goals of supervision
- How goals will be evaluated and the specific timeframes
- Specific expectations of the supervisor and the supervisee
- Integration of theoretical models

Professional disclosure: information about the supervisor that includes credentials and qualifications and approach to supervision

- Educational background
- Training experiences
- Theoretical orientation
- Clinical competence with various issues, models, techniques, populations
- Sense of mission or purpose in the field
- Educational plans and professional goals

Supervision process: methods and format of supervision

- Individual, group, peer, dyadic
- Method of direct observation
- Permission to record sessions on audio- or videotape

Due Process: includes written procedures to be followed when a grievance or complaint has been made against the administration, the supervisor, or the counselor. It ensures that all sides are heard and that the complaint and response to the complaint receive due consideration. In this case, informed consent means that all parties are aware of the process for lodging a complaint.

Tool 4. Informed Consent Template (continued)**Ethical and legal issues: policies, regulations, and laws regarding supervisory and therapeutic relationships**

- Number of supervisees for which the supervisor will be responsible
- Emergency and back-up procedures (e.g., supervisor accessibility)
- Ethical codes of conduct
- Process for discussing ethical dilemmas
- Confidentiality regarding information discussed in supervision
- Confidentiality issues when more than one supervisee is involved
- Dual roles and relationships
- Process for addressing supervisee issues (e.g., burnout, countertransference)

Statement of agreement

Signed acknowledgement by all parties that they understand and agree to comply with the contract

Source: Adapted from Falvey, 2007.

Selection and Competencies of Supervisors

When hiring or appointing a person as a clinical supervisor, you will need to understand the scope of practice and competence of a supervisor. Consult TAP 21-A (CSAT, 2007) and the International Certification and Reciprocity Consortium [IC&RC] Role Delineation Study for Clinical Supervisors (2000).

Administrators can use checklists such as Tool 5 to determine the competencies of a potential clinical supervisor.

Tool 5. Checklist for Supervisor Competencies

Competencies	Poor	Below Average	Average	Above Average	Excellent
Knowledge					
Has knowledge of theory and intervention strategies					
Has knowledge of screening, assessment, and diagnostic standards					
Understands cultural and ethnic issues					
Has knowledge of resources in the community					
Has knowledge of current ethical guidelines and legal issues					
Practice					
Demonstrates mastery of intervention techniques					
Is timely and thorough in documentation					
Is able to develop rapport					
Is able to conceptualize problems					
Can respond to multicultural issues					
Is able to formulate treatment goals					

Clinical Supervision and Professional Development

Tool 5. Checklist for Supervisor Competencies (continued)					
Competencies	Poor	Below Average	Average	Above Average	Excellent
Personal					
Demonstrates ethical behavior					
Demonstrates use of good judgment and counseling skills					
Is interpersonally competent					
Is able to identify own strengths and weaknesses					
Is able to accept and learn from feedback					
Is an asset to the profession					
Source: Adapted from Campbell, 2000. Permission pending.					

Other sources to consult on the same topic include:

- Bernard and Goodyear, 2004: Evaluation Questionnaires and Scales (pp. 316–339).
- Falvey, 2004b: Ethical Mandates for Professional Competence, Standards for Clinical Supervisor Competence (pp. 25, 28).
- Powell and Brodsky, 2004: ACES Supervision Interest Network, Competencies of Supervisors (pp. 327–332).
- Campbell, 2000 (pp. 257–285).

Substance Abuse Policy

As an administrator, you have ultimate responsibility for enforcing policies and procedures for maintaining a safe workplace. Under provisions of the Drug-Free Workplace Act of 1988, all agencies receiving Federal and/or State funds are required to have a substance abuse policy. This policy should state how the organization maintains a safe workplace so as to provide the highest quality service to its clients. The procedures should address how the agency will deal with issues related to alcohol and drugs in the workplace, fitness-for-duty concerns, testing of employees, drug-related convictions, searches, and violations of policies. Tool 6 is a sample substance abuse policy. Other administrative issues can be addressed, such as gambling and tobacco in the workplace, pornography in the workplace, and abuse of Internet access and use in the workplace. Tool 6 is an example of a substance abuse policy.

Tool 6. Sample Policy on Substance Abuse
This organization is committed to maintaining a safe workplace and to providing high-quality service to its clients. Successful attainment of these goals depends on the establishment and maintenance of a workplace that is free from the adverse effects of drug use and alcohol abuse. Alcohol 1. The use, possession, or being under the influence of alcohol while on duty or on the premises is strictly forbidden. This prohibition precludes an employee from consuming alcohol at meal times during work hours, even off premises. 2. Employees are prohibited from working with the smell of alcohol on their breath, regardless of when or where alcohol was consumed. Drugs 1. The use, possession, being under the influence of, manufacture, sale, dispensation, or distribution of illegal or unauthorized drugs or drug paraphernalia while on duty or on the premises is forbidden. 2. An employee's involvement with illegal or unauthorized drugs off duty and/or off premises may result in discipline, up to and including discharge, where such involvement may have an adverse effect on the organization's reputation.

Part 2, Chapter 2

Tool 6. Sample Policy on Substance Abuse

- Employees who are taking prescribed medications must keep them in a secure location, completely inaccessible to anyone but themselves, while on the premises. It is expected that employees will follow all safety precautions associated with consumption of that drug (i.e., regarding operating machinery or driving vehicles).

Fitness for Duty

- Employees are required to be fit for duty.
- An employee is unfit for duty if, while on duty or on the premises, he or she is under the influence of or affected by illegal or unauthorized alcohol and/or has an impermissible level of illegal or legally prescribed drugs or alcohol in his or her system and/or is affected to a degree that the employee cannot perform work because of the legally prescribed drugs.
- Unfitness for duty can be determined through a variety of means, separately or in conjunction with each other, depending on the circumstances, such as direct observation and/or drug and/or alcohol testing.
- An employee will be terminated if he or she is unfit for duty because of drugs and/or alcohol.

Testing of Employees

- Reasonable Suspicion.* An employee may be required to submit to drug and/or alcohol testing whenever there is reason to believe because of physical, behavioral, or performance indicators, that the employee is under the influence of or is affected by illegal or legally prescribed drugs and/or alcohol while on duty or on the premises.
- Post-Accident.* An employee may be tested for drugs and/or alcohol after any accident that could have been caused by human error or carelessness. An accident is defined as an event resulting in medical treatment by a professional or property damage in excess of \$500.
- Medication Control.* If prescribed medication or controlled substances dispensed by the organization disappear or cannot otherwise be accounted for, all employees who may have had access to such medication or substances will be tested for illegal drugs.
- Positive Test Result.* An employee who tests positive for an illegal drug or unauthorized or illegally obtained legal drug and/or alcohol is unfit for duty and may be disciplined.

Drug-Related Convictions

An employee who is convicted of a drug-related offense occurring in or out of the workplace is in violation of this policy. A conviction includes a guilty plea, a plea of nolo contendere, or any court-supervised program or court-imposed sentence.

Searches

The organization reserves the right to search an employee, his or her possessions, work area, or vehicle while on the premises to determine if illegal drugs or alcohol are present.

Failure to Cooperate

An employee who refuses to provide a specimen at the date and time requested, who refuses to provide written consent to testing, who provides a false or tampered specimen, or refuses to consent to a search of his or her person, possessions, work area, or vehicle may be discharged.

Supervision Guidelines

Supervision guidelines describe the organization's commitment to clinical supervision, working terms, principles of supervision at that organization, and required documentation of clinical sessions and clinical supervision. The guidelines should clearly state the frequency of supervision, ongoing feedback procedures, and commitment to ongoing professional development. Tool 7 is an example of such a document.

Tool 7. Clinical Supervision Policy and Procedure

Underlying Principles

Clinical supervision is a powerful tool for managing and ensuring continuous improvement in service delivery. Clinical supervision is comprised of balancing four distinct functions: administrative, evaluative, supportive, and clinical. Fundamental structures include a positive working relationship, client-centered approach, commitment to professional development, and accountability. The following principles ensure high-quality clinical supervision:

- A safe, trusting working relationship that promotes a learning alliance.
- A counselor-centered program with a culturally and contextually responsive focus.
- Active promotion of professional growth and development.
- Shared clinical responsibility ensuring that the client's treatment goals are addressed.
- A rigorous process that ensures ethical and legal responsibility.
- An individualized approach based on the learning needs and style of the supervisee.
- Congruence with the values and philosophy of the agency.

Terms

A healthy **working relationship** is built on shared vision and goals, clear expectations, and the belief in the good intentions of staff members. It demonstrates reciprocal communication where all parties provide comprehensive, timely information that is respectful. Each person is responsible for providing relevant information critical to his or her job function and the mission of the agency. The working relationship recognizes the importance of the chain of command throughout all agency levels. The agency expects that this chain of command supports structure, appropriate boundaries, and decisionmaking at all levels. The chain of command is followed to ensure effective and efficient communication.

Trust is central to the working relationship. This is manifested in several ways: (1) people are accountable to their work and job responsibilities, (2) confidentiality is maintained, (3) decisions are respected, and (4) misunderstandings are pursued to clarify miscommunication, seek to understand the other person, air emotions, and reach resolution.

The **learning alliance** is based on the belief that the supervisee has specific learning needs and styles that must be attended to in supervision. The relationship between supervisor and supervisee is best formulated and maintained when this frame of reference is predominant. Supervisees participate in a mutual assessment based on a combination of direct and indirect observations.

Guidelines for Clinical Supervision

The principles of clinical supervision are made explicit by a clear contract of expectations, ongoing review and feedback, and a commitment to professional development.

Clear contract of expectations

It is critical that both the supervisor and supervisee share their expectations about the process, method, and content of clinical supervision. This can advance the development and maintenance of a trusting, safe relationship. The following information should be discussed early in the working relationship:

- Models of supervision and treatment.
- Supervision methods and content.
- Frequency and length of supervisory meetings.
- Ethical, legal, and regulatory guidelines.
- Access to supervision in emergencies.
- Alternative sources of supervision when the primary supervisor is unavailable.

The supervisee will be provided with a job description that outlines essential duties and performance indicators. Additionally, each supervisee will receive an assessment of core counseling skills based on the TAP 21 competencies and other appropriate standards.

Documentation

Supervisory sessions are recorded as notes that indicate the focus of the session, the issues discussed, solutions suggested, and agreed upon actions. Supervisors will maintain a folder for each of their supervisees. The folder will contain the IDP, clinical supervision summaries, and personnel actions (e.g., memos, commendations, other issues). Supervisees are allowed full access to the folders.

Tool 7. Clinical Supervision Policy and Procedure (continued)

Clinical supervision frequency

Each supervisee will receive 4 hours of supervision monthly. A combination of individual and group supervision may be used. Supervisors are to ensure that a minimum of 50 percent of this time is devoted to clinical, as opposed to administrative, supervision.

Ongoing review and feedback

The supervisee will be given an annual performance evaluation that reviews both job expectations and the clinical skills learning plan. Written records of the supervisee will be reviewed on a regular basis. Supervisees will be given specific written feedback regarding their strengths and areas for improvement. The supervision system operates through direct observation of clinical work. This ensures that direct, focused feedback will be provided, increases the degree of trust and safety, and provides an accurate evaluation of skills development progress. Observations will be pre-arranged and take the form of sitting in on a session, co-facilitating, or videotaping. The supervisee will present a case at a minimum of once per month.

Commitment to ongoing professional development

The supervisee's learning plan should document goals, objectives, and methods to promote professional development. The plan should be completed within the first 6 months of employment and updated annually. Ongoing supervision should focus on achieving the identified goals. The agency supports supervisees' participation in training to achieve their professional development goals.

Source: Adapted from unpublished Basics, Inc. materials

The Supervision Contract

A supervision contract protects the rights of the agency, the supervisor, and supervisee. A written contract between supervisor and supervisee, stating the purpose, goals, and objectives of supervision is important. Tool 8 is a template for supervision contracts. In addition to the contract, for the purposes of informed consent, it is useful to have a supervision consent form signed by both the supervisor and supervisee, indicating the supervisee's awareness and agreement to be supervised (see Tool 4).

Tool 8. Supervision Contract Template

This document serves as a description of the supervision provided by (supervisor name, credentials, title) to (supervisee, credentials, title).

Primary Purpose, Goals, and Objectives

- Monitor and ensure client welfare
- Facilitate professional development
- Evaluate job performance

Provision

- (Frequency) of individual supervision at (day and time)
- (Supervision model and case review format) will be used
- Clients of the counselor will give informed consent for supervision of their case
- Counselor will have a minimum of (amount) of supervision for every (number) of client contact hours
- All client cases will be reviewed on a rotating basis based on need

Documentation

- (Form name) will be used to document the content and progress of the supervision
- Informal feedback will be provided at the end of each session
- Written formal evaluation will be provided (frequency)
- Supervision notes will be shared (at the supervisor's discretion or at request of counselor)

Clinical Supervision and Professional Development

Tool 8. Supervision Contract Template (continued)

Duties and Responsibilities

The supervisor at a minimum will:

- Review all psychosocial histories, progress notes, treatment plans, and discharge plans.
- Question the counselor to justify approach and techniques used.
- Present and model appropriate clinical interventions.
- Intervene directly if client welfare is at risk.
- Ensure that ethical guidelines and legal statutes are upheld.
- Monitor proficiencies in working with community resources and networking with community agencies.

The counselor at a minimum will:

- Uphold all ethical guidelines and legal statutes.
- Be prepared to discuss all client cases.
- Discuss approaches and techniques used and any boundary issues or violations that occur.
- Consult supervisor or designee in emergencies.
- Implement supervisor directives.
- Adhere to all agency policies and procedures.

Procedural Consideration

- The Individual Development Plan's goals and objectives will be discussed and amended if necessary.
- The quality of the supervisory relationship will be discussed and conflicts resolved.
- If conflicts cannot be resolved, (name) will be consulted.
- In the event of an emergency, the counselor is to contact the supervisor. If unavailable, contact (alternate's name, title, and other relevant back-up information).
- Crises or emergency consultations will be documented.
- Due process procedures (as explained in the agency's policy and procedure handbook) have been reviewed and will be discussed as needed.

Supervisor's Scope of Competence

- Title/date of credentials/licensure.
- Formal supervisory training and credentials.
- Years providing supervision.
- Current supervisory responsibilities.

This agreement is subject to revision at any time on request of either person. Revision will be made only with consent of the counselor and approval of the supervisor. We agree to uphold the directives outlined in this agreement to the best of our ability and to conduct our professional behavior according to the ethical principles and codes of conduct of our professional associations.

Supervisor_____ Title_____ Date_____

Supervisee_____ Title_____ Date_____

This agreement is in effect from (current date) to (annual date of review or termination)

Source: Mattel, 2007

Another sample supervision contract form can be found in Campbell (2000), p. 285.

The Initial Supervision Sessions

An initial supervision sessions checklist documents the topics to be covered in initial sessions by the supervisor and supervisee. The goal is that as part of establishing the supervisory relationship, the supervisor and supervisee should discuss the basic issues in substance abuse counseling and in supervision. For new supervisors and for administrators to monitor the implementation of supervision, a checklist, such as Tool 9, can ensure that the important issues are discussed. The example below can aid in setting a preliminary structure for supervision, clarifying goals and expectations, and incorporating feedback so as to promote a sense of openness, trust, and safety. It is understood that not all of these topics can be covered in the first few sessions, but these topics are important considerations in initiating clinical supervision.

Documentation and Recordkeeping

Documentation is unquestionably a crucial risk-management tool for clinical supervisors and is no longer optional in supervision. Legal precedents suggest that organizations are both ethically and legally responsible for quality control of their work, and the supervision evaluation, documentation, and record-keeping systems are a useful and necessary part of that professional accountability. However, in contrast with the myriad clinical forms and documentation required, there is a paucity of tools for documentation in supervision. Most organizations rely on the personal style and records of individual supervisors, and do not have an organization-wide standardized system of record keeping for supervision. Documenting supervision should not be burdensome, but it should be systematic and careful. Key components of what should be documented and how it should be documented are provided in the following paragraphs.

A record of supervision sessions needs to be maintained that documents: when supervision was conducted, what was discussed, what recommendations were provided by the supervisor, and what actions resulted. A supervisor should maintain a separate file on each counselor supervised, including:

- Caseloads.
- Notes on particular cases.
- Supervisory recommendations and impressions.
- The supervision contract.
- A brief summary of the supervisee's experience, training, learning needs, and learning styles.
- The individual development plan.
- A summary of all performance evaluations.
- Notations of supervision sessions, particularly concerning duty-to-warn situations, cases discussed, and significant decisions made.
- Notations of canceled or missed supervision sessions.
- Significant issues encountered in supervision and how they were resolved.

By far, the most comprehensive documentation system for clinical supervisors is Falvey's FoRMSS system (2002a), which includes emergency contact information, supervisee profiles, a log sheet for supervision, an initial case overview, a supervision record, and a termination summary that records the circumstances of client termination, client status at termination, and any followup or referrals needed. The FoRMSS system alerts supervisors to potential clinical, ethical, or legal risks associated with cases.

Records of supervision must be retained for the period required by the State and pertinent accreditation bodies. The American Psychological Association's guidelines (2007) recommend retaining clinical and supervisory records for at least 7 years after the last services were delivered. Organization policy may differ from this. Administrators should check with local and State statutes regarding record-keeping requirements. It is prudent for an organization and supervisor to retain supervision records for at least as long as required by the State and accreditation bodies.

Clinical Supervision and Professional Development

Tool 9. Initial Supervision Sessions Checklist

Education, Training, and Clinical Experience

- ___ Educational background
- ___ Training experience
- ___ Setting(s), number of years
- ___ Theoretical orientation
- ___ Clinical competence with various issues, models, techniques, populations, presenting problems, treatment modalities
- ___ Sense of mission and purpose in the field
- ___ Educational plans and professional goals of the supervisee
- ___ Training and awareness of cultural and contextual issues in counseling
- ___ Training and awareness of community networking in counseling

Philosophy of Supervision

- ___ Philosophy of therapy and change
- ___ Purpose of supervision

Previous Supervision Experiences

- ___ Previous supervision experiences (e.g., format, setting)
- ___ Strengths and weaknesses as counselor and as supervisee
- ___ Supervisee's competence with stages of counseling process
- ___ Supervisee's level of development in terms of case planning, notes, collateral support, and networking
- ___ Supervisory competence with various issues, models, techniques, populations, therapy groups, and modalities
- ___ Methods for managing supervisor-supervisee differences

Supervision Goals

- ___ Goals (personal and professional)
- ___ Process of goal evaluation and timeframe
- ___ Requirements for which supervisee is seeking supervision (e.g., licensure, professional certification)
- ___ Requirements to be met by supervision (e.g., total hours, individual or group supervision)

Supervision Style and Techniques

- ___ Specific expectations the supervisee or supervisor has of the parties involved (e.g., roles, hierarchy)
- ___ Type of supervision that would facilitate clinical growth of the supervisee
- ___ Preferred supervision style (didactic, experiential, collegial)
- ___ Parallels between therapy and supervision models
- ___ Supervision focus (e.g., counselor's development, cases)
- ___ Manner of case review (e.g., crisis management, in-depth focus)
- ___ Method (e.g., audio- or videotaping, direct observation)

Theoretical Orientation

- ___ Models and specific theories in which supervisee and supervisor have been trained, practice, and or conduct supervision
- ___ Extent to which these models have been used clinically
- ___ Populations, presenting problems, and/or family forms with which the models have been most effective
- ___ Interest in learning new approaches

Tool 9. Initial Supervision Sessions Checklist (continued)**Legal and Ethical Considerations**

- ____ Ultimate responsibility for clients discussed in supervision in different contexts (e.g., licensed vs. unlicensed counselor, private practice vs. public agency)
- ____ Number of cases for which the supervisor will be responsible
- ____ Emergency and back-up procedures
- ____ Awareness of professional ethical codes
- ____ Confidentiality regarding the information discussed in supervision
- ____ Confidentiality issues when more than one supervisee is involved
- ____ Specific issues in situations where dual relationships exist (e.g., former client)
- ____ Process for addressing supervisee issues (e.g., burnout, countertransference)

Other

What do we need to know about each other that we have not already discussed?

Source: Adapted from Falvey, 2002b. Permission pending.

Tools 10–12 are sample documentation forms. (See also Campbell, 2000.)

Tool 10. Supervision Note Sample
Professional Development Plan Current Focus

Goal/TAP Competencies	Objective	Date of Expected Completion

Supervision Content

Issue	Discussion	Recommendation/ Action	Followup

Progress on Professional Development Plan Objectives

Other _____

Supervisor _____ Counselor _____ Date _____

Source: Porter and Gallon, 2006.

Clinical Supervision and Professional Development

Tool 11. Current Risk-Management Review

Case: _____

Date: _____

ISSUES

- ☐ Informed Consent
- ☐ Parental Consent
- ☐ Confidentiality
- ☐ Recordkeeping
- ☐ Records Security
- ☐ Child Abuse/Neglect
- ☐ Risk of Significant Harm
- ☐ Duty to Warn
- ☐ Medical Exam Needed

- ☐ Supervisee Expertise
- ☐ Supervisor Expertise
- ☐ Institutional Conflict
- ☐ Dual Relationship
- ☐ Sexual Misconduct
- ☐ Releases Needed
- ☐ Voluntary/Involuntary Hospitalization
- ☐ Utilization Review Discharge/Termination

Discussion:

Recommendation:

Action:

Signature _____ Date _____

Title _____

Source: Based on Falvey, 2002b.

Tool 12. Supervisory Interview Observations		
STATEMENTS/BEHAVIORS	STATEMENTS/BEHAVIORS	COMMENTS
Step 1 SET AGENDA Decrease anxiety Involve counselor		
Step 2 GIVE FEEDBACK Empower Individualize		
Step 3 TEACH and NEGOTIATE Share agenda Clarify knowledge, skills, attitude Identify learning steps Agree upon methods of learning		
Step 4 SECURE COMMITMENT Clarify expectations Clarify responsibility Create mutual accountability		

LOOK FOR	OBSERVATIONS, BEHAVIORS, NOTES
SUMMARY OBSERVATIONS	
Interview structure followed?	
Time managed effectively?	
Established nurturing and supportive environment?	
Stayed on course?	
Resistance? Power struggle?	
Agreement secured?	
Followup plan created?	
NOTES:	
Source: Based on Porter & Gallon, 2006.	

Clinical Supervision and Professional Development

Evaluation of Counselors and Supervisors

Evaluation of counselors and supervisors is both formative (ongoing and evolving over time) and summative (periodic and formal). Nowhere else in supervision does the power differential between the supervisor and supervisee become more evident than in the evaluation process. Feedback and evaluation are necessary and important in an organization's risk-management procedures. Agencies need a formal procedure and criteria for staff evaluation. When supervisors conduct supervisee evaluations, counselors need to understand there is a level of subjectivity in the process. There is no psychometrically valid tool to assess counselor competence. An element of the supervisor's judgment is always involved.

Most evaluation guidelines and tools identify general areas of competence to assess—knowledge, skills, and attitudes—but specific criteria for making an evaluation are left to the individual supervisor and the organization. It is important that the evaluation of staff be closely linked to job descriptions, the supervision contract, and the specific needs of the agency. Levels of competence and fitness for duty should be established by the individual organization, with consideration given to the credentialing and accreditation requirements of the agency. Supervisee triads also offer another option to assist in the evaluation process. A grievance and appeals process should be defined. Finally, supervisors need to be reminded that they are the gatekeepers for the agency, providing feedback, remediation as needed, and dismissal of personnel if indicated.

Tools 13 and 14 aid the supervisee in evaluating the supervisor and the supervisor in assessing the counselor.

Tool 13. Counselor Evaluation of the Supervisor

This evaluation form gives the supervisor valuable feedback while it gives the counselor a sense of responsibility and involvement in the design and development of supervision.

Use a 7-point rating scale where:

1 = strongly disagree

4 = neither agree nor disagree

7 = strongly agree

	Rating
1. Provides useful feedback regarding counselor behavior	
2. Promotes an easy, relaxed feeling in supervision	
3. Makes supervision a constructive learning process	
4. Provides specific help in areas needing work	
5. Addresses issues relevant to current clinical conditions	
6. Focuses on alternative counseling strategies to be used with clients	
7. Focuses on counseling behavior	
8. Encourages the use of alternative counseling skills	
9. Structures supervision appropriately	
10. Emphasizes the development of strengths and capabilities	
11. Brainstorms solutions, responses, and techniques that would be helpful in future counseling situations	
12. Involves the counselor in the supervision process	
13. Helps the supervisee feel accepted and respected as a person	
14. Appropriately deals with affect and behavior	
15. Motivates the counselor to assess counseling behavior	

Tool 13. Counselor Evaluation of the Supervisor (continued)	
This evaluation form gives the supervisor valuable feedback while it gives the counselor a sense of responsibility and involvement in the design and development of supervision.	
Use a 7-point rating scale where: 1 = strongly disagree 4 = neither agree nor disagree 7 = strongly agree	
	Rating
16. Conveys a sense of competence	
17. Helps to use tests constructively in counseling	
18. Appropriately addresses interpersonal dynamics between self and counselor	
19. Can accept feedback from counselor	
20. Helps reduce defensiveness in supervision	
21. Encourages expression of opinions, questions, and concerns about counseling	
22. Prepares the counselor adequately for the next counseling session	
23. Helps clarify counseling objectives	
24. Provides an opportunity to discuss adequately the major difficulties the counselor is facing with clients	
25. Encourages client conceptualization in new ways	
26. Motivates and encourages the counselor	
27. Challenges the counselor to perceive accurately the thoughts, feelings, and goals of the client	
28. Gives the counselor the chance to discuss personal issues as they relate to counseling	
29. Is flexible enough to encourage spontaneity and creativity	
30. Focuses on the implications and consequences of specific counseling behaviors	
31. Provides suggestions for developing counseling skills	
32. Encourages the use of new and different techniques	
33. Helps define and achieve specific, concrete goals	
34. Gives useful feedback	
35. Helps organize relevant case data in planning goals and strategies with clients	
36. Helps develop skills in critiquing and gaining insight from counseling tapes	
37. Allows and encourages self-evaluation	
38. Explains the criteria for evaluation clearly and in behavioral terms	
39. Applies criteria fairly in evaluating counseling performance	
40. Addresses cultural issues of supervisee in a helpful manner.	
41. Discusses cultural and contextual issues of the client, family, and wider systems that open up new resources and avenues for support.	
Source: Adapted from Powell and Brodsky, 2004.	

Clinical Supervision and Professional Development

Tool 14. Counselor Competency Assessment <i>Based on TAP 21, Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice (CSAT, 2006)</i>				
Competency Area	Needs Improvement	Able to Perform Skill	Proficient	Consistent Mastery
Understand Substance Use Disorders - Models and theories - Recognize complex context of substance abuse				
Treatment Knowledge - Philosophies - Practices - Outcomes				
Application to Practice - DSM-IV-TR - Repertoire of helping strategies - Familiar with medical and pharmacological resources				
Diversity and Cultural Competence - Understand diversity - Use client resources - Select appropriate strategies				
Clinical Evaluation - Screening - Assessment				
Assess Co-Occurring Disorders - Symptomatology - Course of treatment				
Treatment Planning - Based on assessment - Individualized - Ensure mutuality - Reassessment - Team participation				
Referral and Followup - Evaluate referrals - Ongoing contact - Evaluate outcome				
Case Management				

Tool 14. Counselor Competency Assessment (continued) <i>Based on TAP 21, Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice (CSAT, 2006)</i>				
Competency Area	Needs Improvement	Able to Perform Skill	Proficient	Consistent Mastery
Group Counseling • Group theory • Describe, select, and use appropriate strategies • Understand and work with process and content • Facilitate group growth				
Family, Couples Counseling • Theory and models • Understand characteristics and dynamics • Describe, select, and use appropriate strategies				
Individual Counseling • Theory of individual counseling • Describe, select, and use appropriate strategies • Understand functions and techniques of individual counseling				
Client, Family, and Community Education • Culturally relevant • Provide current information • Teach life skills				
Documentation • Knowledge of regulations • Prepare accurate, concise notes • Write comprehensive, clear psychosocial narrative • Record client progress in relation to treatment goals • Discharge summaries				
Professional and Ethical Responsibilities • Adhere to code of ethics • Apply to practice • Participate in supervision • Participate in performance evaluations • Ongoing professional education				
Source: Porter & Gallon, 2006.				

Clinical Supervision and Professional Development

Other useful resources are:

- Bernard and Goodyear, 2004: Supervision Instruments (pp. 317–326).
- Campbell, 2000: Generic Rating Sheet and Evaluation Form, Supervisee's Basic Skills and Techniques (p. 263); Sample Generic Supervisee Evaluation Form (p. 275).
- Powell and Brodsky, 2004: Evaluation of the Counselor, adapted from Stoltenberg and Delworth, 1987 (p. 351).
- Powell and Brodsky, 2004: Counselor Assessment Forms (p. 373–379).
- Northwest Frontier Addiction Technology Transfer Center Performance Rubric available online at <http://www.attcnetwork.org/documents/Final.CS.Rubrics.Assessment.pdf>.

Individual Development Plan

After the supervisor and counselor have agreed on goals, they should formulate an individual development plan (IDP) or professional development plan. It should address the expectations for supervision, the counselor's experience and readiness for the position, procedures to be used to observe and assess the counselor's competencies, and the counselor's professional development goals. Some IDP formats follow the 12 Core Functions taking into account the stage of development of the counselor. Other formats might use the competencies in TAP 21. Tool 15 outlines the generic knowledge, skills, and attitudes to be addressed as part of one's professional development plan. Whatever format is adopted, the IDP should provide the counselor with a road map for learning goals.

Tool 15. Professional Development Plan				
Staff _____ Position _____ Date _____				
Practice Dimension: _____				
Competency number and page from TAP 21: _____				
Present level of competence from TAP 21 Rating Form:				
Understands	2 Developing	3 Competent	4 Skilled	5 Master
1 = Understands 2 = Developing 3 = Competent 4 = Skilled 5 = Master		Comprehends the tasks and functions of counseling Applies knowledge and skills inconsistently Consistent performance in routine situations Effective counselor in most situations Skillful in complex counseling situations		
Describe the counselor's strengths and challenges for this rating: _____				

Expected level of competency to be achieved with this learning plan:				
Understands	2 Developing	3 Competent	4 Skilled	5 Master
Describe the goal for this learning plan in observable terms: _____				

Tool 15. Professional Development Plan (continued)

List the Knowledge, Skills, and Attitudes relevant to achieving the target competency.

Knowledge _____

Skills _____

Attitudes _____

State the performance goal in specific behavioral terms: _____

What activities will the counselor complete in order to achieve the stated goal? _____

How will progress be evaluated? How will proficiency be demonstrated? _____

Supervisor Signature _____ Date _____

Counselor Signature _____ Date _____

UPDATE

Date of "re-observation" _____

Demonstration of knowledge and skills successful? _____ Yes _____ No

If "No," demonstration needs the following correction and followup demonstration rescheduled:

Supervisor Signature _____ Date _____

Counselor Signature _____ Date _____

Source: Adapted from Porter & Gallon, 2006.

Outline for Case Presentations

Counselors often need to be taught how to present cases in supervision. The counselor needs to think about the goals he or she would like to achieve for the client and his or her particular concerns about the case. It is possible to use the case presentation format for a variety of purposes: to explore the client's clinical needs, to aid in case conceptualization, to process relational issues in counseling (transference and countertransference), to identify and plan how to use specific clinical strategies, and to promote self-awareness for the counselor. In the beginning, the supervisor should structure the case presentation procedures to ensure consistency and conformity to agency guidelines. Tool 16 can be adapted to the particular theoretical model of the agency and the specific needs of the supervisee and organization.

Tool 16. Sample Case Consultation Format

Name of presenter: _____

Date: _____

Identifying data about the client (age, marital status, number of marriages, number and ages of children, occupation, employment status)

Presenting problem: _____

Short summary of the session: _____

Important history or environmental factors (especially cultural or diversity issues): _____

Tentative assessment or problem conceptualization (diagnosis): _____

Plan of action and goals for treatment (treatment plan): _____

Intervention strategies: _____

Concerns or problems surrounding this case (e.g., ethical concerns, relationship issues): _____

Source: Adapted from Campbell, 2000.

Audio- and Videotaping

To ensure competence, the agency should provide instruction on audio- and videotaping to all staff. Instruction should include the overall purpose of taping, how to inform the client about the taping procedure, how to use the recording equipment, the placement of taping devices, how to ensure client confidentiality and obtain signed releases, how to begin the actual session while recording, and how to process the tapes after recording. Tool 17 provides helpful hints for successful audio- and/or videotaping.

Tool 17. Instructions for Audio and Videotaping

1. **Use quality equipment.** Check the sound quality, volume, and clarity. It is best to use equipment with separate clip-on microphones unless you are in a sound studio with a boom microphone. Clip-on microphones are inexpensive and easy to obtain.
2. **Buy good quality tapes.** It is not necessary to buy top-of-the-line tapes, but avoid the cheapest. Better tapes give better sound and picture and can be reused.
3. **Placement of equipment matters.** Use a tripod for the video camera. Check the angle of camera, seating, volume, and the stability of the picture.

Tool 17. Instructions for Audio and Videotaping (continued)

4. **Check the background sound and volume.** Choose a quiet, private place to do this, both to protect confidentiality and to improve recording quality. Do not use an open space, an office with windows facing the street, or a place subject to interruption. Loud air-conditioning fans, ringing phones and pagers, street noise, and office conversations all disrupt the quality of taping.
5. **Know how to use the equipment.** Conduct a dry run. Be sure to check the placement of chairs, video camera angles, and picture quality before you begin. If the supervisee is especially anxious or unfamiliar with the equipment, have him or her make a practice tape. Be sure those in the picture are the persons agreed on by the supervisor and supervisee.
6. **Protect the confidentiality** of the supervisee and the client. Choose a private, controlled space for taping. Keep the tapes in a locked cabinet and don't include identifying data on the outside of the tape. When finished with supervision, erase the tape completely before reusing; do not just tape over the previous session.
7. **Process with the supervisee any anxiety** or concern generated by taping. Three areas of potential anxiety are the technical aspects (equipment and room availability), concern for the client (confidentiality), and the effect of taping on the session (critical evaluation of performance by the supervisor).
8. **Explain taping**, its goals, and its purpose to the client at least one session before proceeding. Review with the client any concerns about confidentiality. Remember that the more comfortable and enthusiastic the supervisor and the supervisee are with the value of taping, the more comfortable the client will be. Sometimes just reassuring the client that the tape can be turned off at any point if the client is uncomfortable increases a sense of control and reduces anxiety. Usually after the first few minutes of taping, both the client and counselor forget its presence, and this option is rarely used. If the client appears resistant, a decision should be made as to the appropriateness of using this particular method of supervision in this situation.
9. **Get a written release** from the client. Be sure the release includes a description of the purpose of the tape, limits of confidentiality, identities of those viewing the tape, and assurance of erasure of the tape afterward. If the tape is to be used in group supervision or a staffing seminar, the client should be informed of that fact.
10. Before beginning the actual session, **check the equipment** by making a short practice tape covering background material on the client. Then, rewind the tape and play it to check sound, volume, camera angle, and picture. When satisfied, begin the actual session.

Source: Adapted from Campbell, 2000.

Further, it is essential that an organization provide documentation to protect the confidentiality of information and to preserve patients' rights. This is especially important if direct observation of clinical sessions is to occur using audio or videotaping. Tool 18 explains the benefits and procedures of taping and can be read by the counselor to the client. The consent form, Tool 19, should be signed and dated prior to taping.

Tool 18. Confidentiality and Audio- or Videotaping

Video recording of clinical processes will be conducted with the client's written, informed consent for each taping. Clients understand that no taping will occur without their consent. A process already in place will ensure the security and destruction of DVDs or erasure of VHS tapes.

The purpose of videotaping is to improve counselors' clinical skills through supervision and teaching.

Counselor benefits of videotaping include:

- Improving therapeutic skills.
- Improving treatment team cohesion.
- Improving assessment, treatment planning, and delivery of services.
- Improving clinical supervision.

Procedure:

The client's counselor will explain and fully disclose the reason, policy, and procedure for videotaping the client. Both will sign a specific videotaping release form. The counselor should also explain that refusal to be taped will not affect the client's treatment at the agency.

1. The client must be 18 years old to sign the consent. Those under 18 must have a parent's signature in addition to their own.
2. Respecting the client's concerns is always the priority. Should any client or family member show or verbalize concerns about taping, those concerns need to be addressed.
3. All taping devices will be fully visible to clients and staff while in use.
4. A video camera will be set up on a tripod, consistent with safety standards and in full view of each client. Clients will be notified when the camcorder is on or off.
5. The tape will be labeled when the session is completed, and no copies will be made.
6. Clinical review for supervision or training: The treatment team will review the tape and assess clinical skills for the purpose of improving clinical techniques.
7. The tape will be turned over to the Medical Records Department (if available) for sign out.
8. Tapes and DVDs will be stored in a locked drawer in the Medical Records Department. Within 2 weeks of taping, tapes will be erased and DVDs destroyed in the presence of two clinical staff members who attest to this destruction on a form to be kept for 3 years.
9. Tapes and DVDs may not be taken off premises.

Tool 19. Audio or Video Recording Consent

I, _____, consent to be recorded or filmed for supervision purposes. I also agree to allow the clinical staff to review the film as a resource to facilitate staff development for the enhancement of clinical procedures. I understand that any film in which I am a participant will be erased within 2 weeks of the date of filming. I understand that no copies will be made of such film.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

Appendix C: Advisory Meeting Panel

Note: The information given indicates each participant's affiliation as of 2007, when the panel was convened, and may no longer reflect the individual's current affiliation.

H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM

Director
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, Maryland

Mady Chalk, Ph.D.

Director
Division of Services Improvement
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, Maryland

Christina Currier

Public Health Analyst
Practice Improvement Branch
Division of Services Improvement
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, Maryland

Michael T. Flaherty, Ph.D.

Northeast Addiction Technology Transfer Center
Institute for Research, Education and Training in Addictions
Pittsburgh, Pennsylvania

Kevin Hennessy, Ph.D.

Science to Service Coordinator
Substance Abuse and Mental Health Services Administration/OPPB
Rockville, Maryland

Constance M. Pechura, Ph.D.

Senior Program Officer
Robert Wood Johnson Foundation

Princeton, New Jersey

Richard A. Rawson, Ph.D.

Pacific Southwest Addiction Technology Transfer Center
Los Angeles, California

Jack B. Stein, Ph.D.

Acting Deputy Director
Division of Epidemiology, Services, and Prevention Research
National Institute on Drug Abuse
National Institutes of Health
Bethesda, Maryland

Richard T. Suchinsky, M.D.

Associate Chief for Addictive Disorders
Mental Health and Behavioral Sciences Service
U.S. Department of Veteran Affairs
Washington, D.C.

Karl D. White, Ed.D.

Public Health Analyst
Practice Improvement Branch
Division of Services Improvement
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, Maryland

Mark Willenbring, M.D.

Director
Division of Treatment and Recovery Research
National Institute on Alcohol Abuse and Alcoholism
National Institutes of Health
Bethesda, Maryland

Appendix D: Stakeholders Meeting Participants

Note: The information given indicates each participant's affiliation during the time the panel was convened and may no longer reflect the individual's current affiliation.

H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM
Director
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, Maryland

Mirean Coleman, M.S.W., LICSW, CT
Senior Policy Associate
National Association of Social Workers (NASW)
Washington, DC

Tom Durham, Ph.D.
Executive Director
The Danya Institute
Silver Spring, Maryland

Anne M. Herron, M.S.W.
Director, Division of State and Community Assistance
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, Maryland

Ted Judson, M.Ed., ADC2, CCS
Certification and Contracts Officer
Navy Drug and Alcohol Counselor School
San Diego, California

Linda Kaplan
Special Expert
Division of Services Improvement
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, Maryland

Peter J. Martieau
Public Health Analyst
Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration
Rockville, Maryland

Jack Stein, M.S.W., Ph.D.
Director, Division of Services Improvement
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, Maryland

Bill Trefzger
Lead, Communication Services Team
Office of Communication
Substance Abuse and Mental Health Services Administration
Rockville, Maryland

Appendix E: Field Reviewers

Note that information given indicates each participant's affiliation as of 2008, when the review was conducted, and may no longer reflect the individual's current affiliation.

L. DiAnne Borders, Ph.D.

Excellence Professor
University of North Carolina at Greensboro
Greensboro, NC

Donny Brock

Treatment Director, Outpatient Division Head
Charleston Center
Charleston, SC

Patricia A Burke, M.S.W., LCSW

Private Practice
West Baldwin, ME

Charlotte M. Chapman

Director of Training
Mid-Atlantic Addiction Technology Transfer
Center
Richmond, VA

Thomas G. Durham, Ph.D.

Executive Director, The Danya Institute
Silver Spring, MD

Janet E. Falvey, Ph.D., NCC, ACS

Professor
University of New Hampshire
Durham, NH

Steven L. Gallon, Ph.D.

Northwest Frontier Addiction Technology
Transfer Center
Salem, OR

John Hamilton LMFT, LADC

Regional Network of Programs, Inc.
Fairfield, CT

Ted Judson, M.Ed., ADC2, CCS

Assistant Department Head
Navy Drug and Alcohol Counselor School
San Diego, CA

Hunter McQuisition, M.D.

Director, Division of Integrated Psychiatric
Services, Department of Psychiatry
The St. Luke's-Roosevelt Hospitals
New York, NY

Thomas A. Peltz, LMHC, CADAC I, CAS

Private Practice
Beverly Farms, MA

Annie Ramniceanu

Clinical Director
Spectrum Youth and Family Services
Burlington, VT

Sandra A. Rigazio-DiGilio, Ph.D.

Professor
Marriage and Family Therapy Program
University of Connecticut
Storrs, CT

**John (Jack) M. Schibik, Ph.D., LPC,
LCADC, CCS, CPS**

Kairos Counseling, Consulting Coaching
Services
Naples, Florida

Diane Shea, Ph.D.

Adjunct Professor
Holy Family University
Newtown, PA

Ernestine Winfrey

Executive Director
Good News Home for Women
Flemington, NJ

Appendix F— Acknowledgments

Numerous people contributed to the development of this TIP, including the TIP Consensus Panel (see page v), the Knowledge Application Program (KAP) Advisory Meeting Panel (see Appendix C), the SAMHSA Stakeholders Meeting attendees, (see Appendix D), and TIP Field Reviewers (see Appendix E).

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Appendix A: Clinical Supervision and Professional Development of the Substance Abuse Counselor, Module 2

Directions: To receive credits for this course, you are required to take a post test and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CEU Matrix – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions. Then, submit your test to us for processing. This can be done in the following manner:

Submit your test via the Internet. All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions found at the end of this appendix. Then, return to your browser and go to the Student Center located at:

<http://www.ceumatrix.com/studentcenter>

Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'View Lesson Quiz' and you will be presented with the electronic exam.

To take the exam, simply select from the choices of "a" through "e" for each multiple choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded and you will receive your results immediately. If your score is 80% or greater, you will receive a link to the course evaluation. You will also receive a link to the Certificate of Completion. This is the final step in the process, and you may save and / or print your Certificate of Completion.

If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

NOTE: THE EXAM QUESTIONS AND /OR ANSWERS MAY BE IN A DIFFERENT ORDER IN THE ONLINE EXAM

Clinical Supervision and Professional Development of the Substance Abuse Counselor,
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Answer the following questions by selecting the most appropriate response.

Quiz

1. It's fortunate that many agencies place a higher priority on record keeping and crisis management than on clinical supervision.
 - a. True
 - b. False

2. The goal of clinical supervision is to
 - a. Maintain an adequate number of counselors
 - b. Ensure that salaries are commensurate with skills
 - c. Continuously improve quality client care
 - d. Take over all administrative duties of the agency

3. Supervision encourages counselors to examine their views regarding:
 - a. Values
 - b. Race
 - c. Culture
 - d. Religion
 - e. All of the above

4. All but which of the following should be considered by an agency prior to implementation of a clinical supervision system?
 - a. Clinical competence
 - b. Environmental variables
 - c. Geographical location
 - d. Organizational context

5. Administrative supervision should be distinguished from clinical supervision when possible.
 - a. True
 - b. False

6. _____ refers to supervisees and clients being fully informed on the approach and procedures of the agency's actions.
 - a. Scope of confidence
 - b. Vicarious liability
 - c. Dual relationships
 - d. Informed consent

7. Clinical supervisors should be:
 - a. Proactive
 - b. Provide documentation concerning legal dilemmas
 - c. Offer counselors an oral summary of ethical recommendations
 - d. Document all clinical directives
 - e. All but (c)

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8. Supervisors may avoid talking to supervisees about race or culture due to:
 - a. Trust and vulnerability issues
 - b. Communication issues
 - c. Unintentional racism
 - d. Power dynamics
9. An organization must develop a model for clinical supervision that:
 - a. Provides appropriate income
 - b. Best fits its needs
 - c. Employs only supervisors with 10+ years of experience
 - d. Allows administrators to always be able to overrule supervisors
10. It is essential that a supervisor receives supervision of his or her clinical skills.
 - a. True
 - b. False
11. Supervisors should schedule _____ individual supervisory sessions.
 - a. formal
 - b. frequent
 - c. regular
 - d. all of the above
12. It is ok for an organization to bring in an external source if the organization does not have an internal person to provide the supervisor's supervision.
 - a. True
 - b. False
13. The recommended steps found to be helpful in phasing in clinical supervision systems include:
 - a. Creation of a structure
 - b. Improving performance
 - c. Direct observation
 - d. Implementation
 - e. All but c
14. _____ evaluation is a formal process that rates employees' overall ability to do their job and their fitness for duty.
 - a. Formative
 - b. Adaptive
 - c. Summative
 - d. Preemptive
15. _____ evaluation focuses on progress, is regularly provided, and gives feedback to the employee regarding knowledge, skills, and attitude.
 - a. Summative
 - b. Preemptive
 - c. Adaptive
 - d. Formative

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16. Evaluation feedback should be:

- a. Balanced
- b. Credible
- c. Frequent
- d. All of the above

17. Often allocating time for clinical supervision is overlooked because it is generally not a revenue-generating activity

- a. True
- b. False

18. An organizational _____ and _____ are necessary to implement a clinical supervision system.

- a. state of readiness, its personnel
- b. hierarchy, its financial stability
- c. location, its popularity
- d. philosophy, its design

19. _____ education should be promoted for both supervisors and counselors.

- a. Classroom
- b. Continuing
- c. Online
- d. No-cost

20. Informed consent is important for:

- a. client agreement on what processes support quality treatment
- b. counselors knowing how their work will be evaluated
- c. administration is entitled to know that supervisory processes support quality care
- d. all of the above

21. Due process includes written procedures to be followed when a complaint has been made against the administration or supervisor but not the counselor.

- a. True
- b. False

22. The _____ has ultimate responsibility for enforcing policies and procedures for maintaining a safe workplace.

- a. clinical supervisor
- b. counselor
- c. administrator
- d. agency owner

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23. A supervisor should maintain a file on each counselor that contains all of the following except _____.

- a. individual development plan
- b. salary compensation
- c. caseloads
- d. significant issues encountered
- e. supervision contract

24. It is important that the counselor evaluate the supervisor, not just the other way around.

- a. True
- b. False

25. Initially, the supervisor should allow the counselor to structure the case presentation procedures to insure conformity to agency guidelines.

- a. True
- b. False