

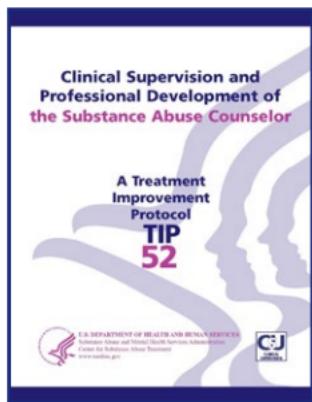
Quick Guide

For Clinical Supervisors

Based on TIP 52

***Clinical Supervision and
Professional Development***

***of the Substance
Abuse Counselor***



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Quick Guide

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Based on TIP 52
*Clinical Supervision and
Professional Development
of the Substance Abuse
Counselor*

This Quick Guide is based entirely on information contained in TIP 52, published in 2009. No additional research has been conducted to update this topic since publication of TIP 52.

WHY A QUICK GUIDE?

This Quick Guide provides succinct, easily accessible information to clinical supervisors about clinical supervision in the substance abuse treatment field. The Guide is based entirely on *Clinical Supervision and Professional Development of the Substance Abuse Counselor*, Number 52 in the Treatment Improvement Protocol (TIP) series.

Users of the Quick Guide are invited to consult the primary source, TIP 52, for more information on education and training in clinical supervision skills. To order a copy of TIP 52 or to access it online, see the inside back cover of this Guide.

DISCLAIMER

The opinions expressed herein are the views of the consensus panel members and do not necessarily reflect the official position of the Substance Abuse and Mental Health Services Administration (SAMHSA) or the U.S. Department of Health and Human Services (HHS). No official support of or endorsement by SAMHSA or HHS for these opinions or for the instruments or resources described is intended or should be inferred. The guidelines presented should not be considered substitutes for individualized client care and treatment decisions.

WHAT IS A TIP?

The TIP series provides professionals in behavioral health and related fields with consensus-based, field-reviewed guidelines on behavioral health treatment topics of vital current interest. TIPs have been published by SAMHSA since 1991.

TIP 52, *Clinical Supervision and Professional Development of the Substance Abuse Counselor:*

- Helps clinical supervisors understand their role in helping treatment providers grow professionally.
- Teaches the principles of clinical supervision.
- Provides awareness of evidence-based best practices and guidelines for new supervisors.
- Informs clinical supervisors of the ethical and legal issues that will confront them in their position.

INTRODUCTION

Clinical supervision is a profession with its own theories, practices, and standards. There are several definitions of supervision. According to Technical Assistance Publication (TAP) 21-A, *Competencies for Substance Abuse Treatment Clinical Supervisors*, clinical supervision is

a social influence process that occurs over time, in which the supervisor participates with supervisees to ensure quality of clinical care. Effective supervisors observe, mentor, coach, evaluate, inspire, and create an atmosphere that promotes self-motivation, learning, and professional development. They build teams, create cohesion, resolve conflict, and shape agency culture, while attending to ethical and diversity issues in all aspects of the process. Such supervision is key to both quality improvement and the successful implementation of consensus- and evidence-based practices. (p. 3)

Clinical supervision was only recently acknowledged as a discrete process with its own concepts and approaches. A clinical supervisor:

- Supervises the client, counselor, and organization.
- Has a legal and ethical responsibility to ensure quality client care, professional development for

counselors, and maintenance of program policies and procedures.

Functions of a Clinical Supervisor

- Be an advocate for the agency, counselor, and client.
- Serve as the primary link between the administration and front line staff, interpreting and monitoring compliance with agency goals, policies, and procedures.
- Communicate staff and client needs to administrators.

Central to the supervisor's function is the alliance between the supervisor and supervisee. Within the supervisory relationship, the supervisor's four roles are:

- **Teacher:** Assist with the development of counseling knowledge and skills by identifying learning needs, determining counselor self-awareness, and transmitting knowledge for practical use and professional growth.
- **Consultant:** Provide case consultation and review, monitor performance, counsel the counselor regarding job performance, and assess counselors. The supervisor provides alternative case conceptualizations, oversight of counselor work to achieve mutually agreed-on goals, and

professional gatekeeping for the organization and discipline (e.g., recognizing and addressing counselor impairment).

- **Coach:** Provide morale building, assess strengths and needs, suggest varying clinical approaches, model, cheerlead, and prevent burnout. This function is critical for entry-level counselors.
- **Mentor/Role Model:** Mentor and teach the supervisee through role modeling, facilitate the counselor's overall professional development, and train the next generation of supervisors.

Roles of the Clinical Supervisor



For more detailed information, see TIP 52, Part 1, Clinical Supervision and Professional Development of the Substance Abuse Counselor, Chapter 1, pages 3-4.

CENTRAL PRINCIPLES OF CLINICAL SUPERVISION

Clinical supervision can initially be costly for many financially strapped programs but is ultimately a cost-saving process that:

- Enhances the quality of client care.
- Improves counselors' efficiency.
- Increases workforce satisfaction, professionalization, and retention.
- Ensures that services provided uphold the profession's legal mandates and ethical standards.

The supervisory relationship is the crucible in which ethical practice is developed and reinforced. Clinical supervision:

- Is an essential part of all clinical programs.
- Enhances staff retention and morale.
- Is something to which every clinician has a need and a right, regardless of his or her level of skill and experience.
- Needs the full support of agency administrators.
- Is a set of skills that must be developed.
- Often requires balancing administrative and clinical supervision tasks.

- Is influenced by culture and other contextual variables; supervisors need to continually strive for cultural competence in their processes.
- Must be ongoing to ensure successful implementation of the evidence-based practices.
- Includes the responsibility to be gatekeepers for the profession.

For more detailed information, see TIP 52, Part 1, Clinical Supervision and Professional Development of the Substance Abuse Counselor, Chapter 1, pages 5–6.

GUIDELINES FOR NEW SUPERVISORS

The new supervisor faces changes, such as:

- Experiencing the loss of friendship with peers.
- Feeling out of one's comfort zone.
- Feeling lost with the new responsibilities.
- Feeling less effective in the new role.

Supervision can be emotionally draining because of additional staff-related interpersonal and human resources (HR) issues.

A good counselor does not necessarily possess all the skills needed to be a good supervisor; however, these skills can be acquired over time (see Resources on page 34 of TIP 52).

The new supervisor should learn as much as possible about:

- The organization's HR policies and procedures, such as hiring and firing, affirmative action requirements, and making evaluations.
- The new role, including one's own managerial voice and decisionmaking style.
- Methods to help staff reduce stress, address competing priorities, and resolve staff conflict and other interpersonal issues in the workplace.

Suggestions for new supervisors:

- Take time to learn about supervisees, their career goals, interests, developmental objectives, and perceived strengths.
- Work to establish a contractual relationship with supervisees, with clear supervisory goals and methods.
- Obtain training in supervisory procedures and methods.

- Find a mentor, either within or outside the organization.
- Shadow a respected supervisor to learn the ropes of the new job.
- Ask often and as many people as possible, “How can I improve my performance as a clinical supervisor?”
- Ask for regular, weekly meetings with the administrator for training and instruction.
- Seek supervision of one’s own supervision.

Problems and Resources

Supervisors may encounter a broad array of issues and concerns, from working within a system that does not fully support clinical supervision to working with resistant staff. The work setting is where the principles and practices of supervision are applied and where demands—such as financial solvency, profit, census, accreditation, and concerns over litigation—drive the organization. The supervisor must be practical when beginning in this role and determine how to make this work within his or her own unique work environment.

Working With Staff Who Are Resistant to Supervision

Some supervisees may resist supervision because they have:

- Been in the field longer than the supervisor.
- Completed their graduate training, and they believe they do not need supervision.
- Issues related to ageism, sexism, racism, or classism.

Particularly in the field of substance abuse treatment, tension may exist between those who believe that recovery from substance abuse is necessary for this counseling work and those who do not.

In addressing resistance, consistently communicate goals and expectations to staff. To resolve defensiveness and engage supervisees, honor resistance and acknowledge concerns. Resistance is an expression of ambivalence about change and not a personality defect of the counselor. Instead of arguing with or exhorting staff members, sympathize with their concerns.

To work with supervisees who are resistant:

- Try to understand the origins of any defensiveness.

- Address the resistance. Self-disclosure about experiences as a supervisee may be helpful in dealing with defensive, anxious, fearful, or resistant staff.
- Work to establish a healthy, positive supervisory alliance with staff.

Counselors not previously exposed to clinical supervision may need to be trained and oriented to the concept and why it is important for the agency.

Things a New Supervisor Should Know

- The reason for supervision is to ensure quality care. The primary goal of clinical supervision is to protect the client's welfare and ensure the integrity of clinical services.
- Developing the alliance between the counselor and the supervisor is the key to good supervision.
- Contextual factors such as culture, race, and ethnicity all affect the supervisory relationship.
- It is important to act human, have a sense of humor, and model the fact that everyone makes mistakes and can admit to and learn from them.
- Rely first on direct observation of counselors, and give specific feedback. Practice a model of counseling and of supervision and have a sense of purpose. Know the philosophical and theoretical foundations of that model.

- Make time to care for oneself spiritually, emotionally, mentally, and physically.
- Use this valuable opportunity to assist with the skills and professional development of staff and to advocate for the supervisee's, client's, and organization's best interests.

For more detailed information, see TIP 52, Part 1, Clinical Supervision and Professional Development of the Substance Abuse Counselor, Chapter 1, pages 6–8.

DEVELOPMENTAL STAGES OF COUNSELORS AND SUPERVISORS

Consider the level of training, experience, and proficiency of the counselors being supervised. Different supervisory approaches are appropriate for counselors at different stages of development. Although some of the characteristics of each level are shared by counselors and supervisors, others differ.

General cautions and principles about counselor development include the following:

- Learning clinical skills is an ongoing process. Be careful of counselors who think they “know it all.”

Shared Characteristics of Counselors and Supervisors at Levels 1, 2, and 3

- **Level 1 counselors and supervisors** may be anxious about their roles, overconfident of their skills, and focused on performing the right way.
- **Level 2 counselors and supervisors** may be confused about and frustrated with the level of complexity involved in their roles.
- **Level 3 counselors and supervisors** are generally objective. The counselor is able to focus intently on the client, integrate thinking and approach, and be highly responsible and ethical. The supervisor is highly motivated, able to provide an honest self-appraisal of his or her supervisory strengths and weaknesses, and comfortable with the evaluation process.

- The supervisory approach must be tailored to each counselor's individual learning style, personality, and developmental stage.
- There is a logical sequence to development. The number of years in the field does not necessarily correlate to the counselor's stage of development.
- Counselors have different learning needs; therefore, they require different supervisory approaches, depending on their respective developmental levels.

- The developmental level can be applied for different aspects of a counselor's overall competence (e.g., Level 2 mastery for individual counseling and Level 1 for couples counseling).

For more detailed information, see TIP 52, Part 1, Clinical Supervision and Professional Development of the Substance Abuse Counselor, Chapter 1, pages 9–11.

CULTURAL AND CONTEXTUAL FACTORS

Culture is a contextual factor that influences supervisory interactions. Others include race, ethnicity, age, gender, discipline, academic

Cultural competence “refers to the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time.”

U.S. Department of Health and Human Services (2003). *Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations.* (Rep. No. HHS Pub. No. SMA 3828). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

background, religious and spiritual practices, sexual orientation, disability, and recovery/nonrecovery status.

The competencies listed in TAP 21-A reflect the importance of culture in supervision:

- Initiate discussion of issues of culture, race, gender, sexual orientation, and the like in supervision to model the kinds of discussions counselors should have with their clients.
- Examine culturally influenced values, attitudes, experiences, and practices as a counselor. Consider how they affect dealings with supervisees and clients. Counselors should undergo a similar review.
- Use the following questions with supervisees:
 - What demographic variables do you use to identify yourself?
 - What struggles and challenges have you faced working with clients who were from other cultures?
- Attend continuing education classes, workshops, and conferences that address cultural competence and other contextual factors.
- Participate in multicultural activities and ceremonies to become more culturally sensitive; encourage counselors to do the same.

The supervisory relationship includes an inherent power differential. The potential for the misuse of power always exists, especially with supervisees and clients within multicultural contexts. The goal is to prevent institutional discrimination from affecting the quality of supervision.

For more detailed information, see TIP 52, Part 1, Clinical Supervision and Professional Development of the Substance Abuse Counselor, Chapter 1, pages 11–13.

ETHICAL AND LEGAL ISSUES

The clinical supervisor is responsible for upholding the highest standards of ethical, legal, and moral practices and for serving as a model of practice to staff. Part of the job is to help integrate solutions to everyday legal and ethical issues into clinical practice.

Underlying assumptions of incorporating ethical issues into clinical supervision include the following:

- Ethical decisionmaking is a continuous, active process.
- Ethical standards indicate what to do, but not always how to do it.

- It is imperative that all personnel learn how to “think ethically” and make sound legal and ethical decisions so they can respond appropriately to unique situations.
- The most complex ethical issues arise in the context of two ethical behaviors that conflict; for instance, when a counselor wants to respect a client’s privacy and confidentiality, but it is in the client’s best interest for the counselor to contact someone else about the client’s care.
- Therapy is conducted by fallible beings.
- Sometimes the answers to ethical and legal questions are elusive.

Direct Versus Vicarious Liability

Direct liability of the supervisor might include dereliction of supervisory responsibility, such as “not making a reasonable effort to supervise.” An example of “reasonable effort to supervise” in the behavioral health field is 1 hour of supervision for every 20–40 hours of clinical services. Other variables (such as the quality and content of clinical supervision sessions) also play a role in a reasonable effort to supervise.

In vicarious liability, a supervisor can be held liable for damages incurred as a result of negligence in the supervision process. Examples of negligence include:

- Providing inappropriate advice to a counselor about a client (for instance, discouraging a counselor from conducting a suicide screen on a depressed client).
- Failing to listen carefully to a supervisee's comments about a client.
- Assigning clinical tasks to inadequately trained counselors.

In legal texts, vicarious liability is referred to as *respondeat superior*.

The key legal questions to ask to determine whether negligence in the supervision process has occurred include:

- Did the supervisor conduct himself or herself in a way that would be reasonable for someone in his or her position?
- Did the supervisor make a reasonable effort to supervise?

Supervisory vulnerability increases when:

- The counselor has been assigned to too many clients.
- There is no direct supervision of a counselor's clinical work.
- A staff member is either inexperienced or poorly trained for assigned tasks.
- A supervisor is uninvolved or unavailable to aid the clinical staff.

Dual Relationships and Boundary Issues

Dual relationships can occur between supervisors and supervisees and between counselors and clients. A dual relationship occurs when a supervisor has a primary professional role with a supervisee and—earlier, simultaneously, or later—engages in another relationship with the supervisee that transcends the professional relationship. Examples include:

- Providing therapy for a current or former supervisee.
- Developing an inappropriate or unprofessional emotional relationship with either a current or former supervisee.
- Becoming an Alcoholics Anonymous sponsor for a former supervisee.

The degrees of actual or potential harm resulting from dual relationships vary and may not be apparent until later. The supervisor is responsible for:

- Weighing with the counselor the anticipated and unanticipated effects of dual relationships.
- Helping the supervisee's self-reflective awareness when boundaries become blurred, when he or she is getting close to a dual relationship, or when he or she is crossing the line in the clinical relationship.

Unequal status, power, and expertise between supervisor and supervisee can raise their own professional dilemmas. A clinical supervisor who evaluates a counselor's performance and serves as gatekeeper for training programs or credentialing bodies also might be involved in a dual relationship.

What makes a dual relationship unethical in supervision is the:

- Abusive use of power by either party.
- Likelihood that the relationship will impair or injure the supervisor's or supervisee's judgment.
- Risk of exploitation.

Examples of problematic dual relationships might include intimate relationships (sexual and non-sexual) and therapeutic relationships wherein the supervisor becomes the counselor's therapist.

Sexual involvement can include:

- Sexual attraction.
- Harassment.
- Consensual (but hidden) sexual relationships.
- Intimate romantic relationships.

Other common boundary issues include:

- Asking the supervisee to do favors.
- Providing preferential treatment.
- Socializing outside the work setting.
- Using emotional abuse to enforce power.

The most common basis for legal action against counselors (20 percent of claims) and the most frequently heard complaint by certification boards against counselors (35 percent) is some form of boundary violation or sexual impropriety.

Codes of ethics for most professions clearly advise that dual relationships between counselors and clients should be avoided. Dual relationships between supervisors and counselors are also addressed in the substance abuse counselor codes.

Informed Consent

Informed consent is key to protecting the counselor and/or supervisor from legal concerns.

Informed consent:

- Requires the recipient of any service or intervention to be sufficiently aware of what is to happen and of the potential risks and alternative approaches.
- Allows the recipient of services to make an informed and intelligent decision about participating in that service.

The supervisor must inform the supervisee about:

- The supervisory process.
- The feedback and evaluation criteria.
- Other expectations of supervision.

The supervision contract should clearly spell out these issues. Supervisors must ensure that the supervisee has informed the client about the parameters of counseling and supervision (such as the use of live observation, videotaping or audiotaping). A sample template for informed consent is provided on page 106 of TIP 52.

Confidentiality

Regardless of whether there is a *written* or *oral* contract between the supervisor and supervisee, there is an *implied* contract and duty of care because of the supervisor's vicarious liability.

Informed consent and concerns for confidentiality should occur at three levels:

- Client consent to treatment
- Client consent to supervision of the case
- Supervisee consent to supervision

With informed consent and confidentiality comes a duty not to disclose certain relational communication. Consultation with an attorney can determine the State codes of confidentiality and clinical privileging.

Limits of confidentiality of supervision session content should be stated in all organizational contracts with training institutions and credentialing bodies. Criteria for waiving client and supervisee privilege should be stated in institutional policies and discipline-specific codes of ethics and clarified by advice of legal counsel and courts.

In the substance abuse treatment field, confidentiality for clients is clearly defined by Federal law: 42 Code of Federal Regulations, Part 2 and the Health Insurance Portability and Accountability

Act. Important information about health information privacy can be found at <http://www.samhsa.gov/healthprivacy>.

Supervisors need to:

- Train counselors in confidentiality regulations.
- Adequately document their supervision, including discussions and directives.

Under duty-to-warn requirements (e.g., child abuse, suicidal or homicidal ideation), supervisors need to be aware of and take action as soon as possible in situations in which confidentiality may need to be waived. Organizations should have a policy stating how clinical crises will be handled.

New technology has given rise to new confidentiality concerns. Web sites now dispense information about substance abuse treatment and provide counseling services. With the growth in online counseling and supervision, concerns emerge regarding how to:

- Maintain confidentiality of information.
- Ensure the competence and qualifications of counselors providing online services.
- Establish reporting requirements and duty-to-warn when services are conducted across State and international boundaries.

New standards need to be written to address these evolving issues. The National Board for Certified Counselors has guidelines for counseling by Internet (<http://www.nbcc.org/Ethics>).

Supervisor Ethics

Supervisors need to adhere to the same standards and ethics as substance abuse counselors with regard to dual relationship and other boundary violations.

For more detailed information, see TIP 52, Part 1, Clinical Supervision and Professional Development of the Substance Abuse Counselor, Chapter 1, pages 13–17.

MONITORING PERFORMANCE

The goal of supervision is to ensure quality care for the client, which entails monitoring the clinical performance of staff. Essential to monitoring performance are:

- Educating supervisees in what to expect from clinical supervision.
- Regularly evaluating the counselor's progress in meeting organizational and clinical goals, as set forth in the Individual Development Plan (IDP), discussed below.

Just as a client has an IDP, counselors also need a plan to promote skill development.

Behavioral Contracting in Supervision

The written contract for supervision should:

- Outline realistic accountability for the supervisor and supervisee.
- Include:
 - The purpose, goals, and objectives of supervision.
 - The context in which supervision is provided.
 - Ethical and institutional policies that guide supervision and clinical practices.
 - Criteria and methods of evaluation and outcome measures.
 - Duties and responsibilities of the supervisor and supervisee.
 - Procedural considerations.
 - The supervisee's scope of practice and competence.
- State:
 - The rewards for contract fulfillment.
 - The length of supervision sessions.
 - Sanctions for noncompliance by either the supervisor or supervisee.

- Be compatible with the supervisee's developmental needs and address the obstacles to progress.

Individual Development Plan

An IDP includes the goals that the supervisor and the counselor wish to address over a certain period (e.g., 3 months). Each party should sign and keep a copy of the IDP.

A supervisor should have an IDP, based on the supervisory competencies listed in TAP 21-A, that addresses his or her training goals.

Evaluation of Counselors

Evaluation builds on a collaborative relationship between the supervisor and the counselor; it may not be easy for some supervisors. Counselors are not always comfortable asking for feedback. Also, most supervisors prefer to be liked, so they may have difficulty with giving clear, concise, and accurate evaluations to staff.

Formative evaluation is an ongoing status report of the counselor's skill development. It explores the questions:

- Are we addressing the skills or competencies on which you want to focus?

- How do we assess your current knowledge and skills and areas for growth and development?

Methods of evaluating performance should be discussed, clarified in the initial sessions, and included in the initial contract. Formative evaluations should focus on changeable behavior and, whenever possible, be separate from the overall annual performance appraisal process. The following should be used to determine the counselor's skill development:

- Written competency tools
- Direct observation
- Counselor self-assessments
- Client evaluations
- Work samples (files and charts)
- Peer assessments

Summative evaluation is a more formal rating of the counselor's overall job performance, fitness for the job, and job rating. It:

- Answers the question, "How does the counselor measure up?"
- Is typically completed annually.
- Focuses on the counselor's overall strengths, limitations, and areas for improvement.

Supervision is an inherently unequal relationship, with the supervisor usually having positional power over the supervisee. Therefore, procedures should be spelled out in advance, and the evaluation process should be mutual, flexible, and continuous.

Each counselor will react differently to feedback provided during the evaluation process. Research has shown:

- A correlation between a supervisee's confidence and efficacy and the quality and quantity of the supervisor's feedback.
- There is much variability in ratings of skills between supervisors, and often the supervisor's and supervisee's ratings differ or conflict.
- Good feedback is provided frequently, clearly, and consistently and is SMART (specific, measurable, attainable, realistic, and timely).

Direct observation of the counselor's work is the desired form of input for the supervisor. The least desirable feedback is unannounced observation by supervisors followed by vague, perfunctory, indirect, or hurtful delivery.

Addressing Burnout and Compassion Fatigue

Supervisors have the fiduciary responsibility to ensure counselors are healthy and whole and are responsible for helping counselors address their fatigue and burnout. This can be done by:

- Helping counselors develop a life outside of work (supported by having an organizational culture and policies that allow for appropriate use of time off and self-care).
- Reminding staff members to spend time with family and friends, exercise, relax, read, or pursue other interests.
- Normalizing the counselor's reactions to stress and compassion fatigue in the workplace (this response is a natural part of being an empathic and compassionate person and is not an individual failing or pathology).

Rest is good; self-care is important. Everyone needs relaxation and recreation. The benefits of a refreshing vacation often become lost after time passes. Longer term gain comes from finding what brings peace and joy. Help counselors remember why they are counselors. Ask:

- Why are you in the field?
- What gives you meaning and purpose in work?

Gatekeeping Functions

The gatekeeping function—managing problem staff members or individuals who should not be counselors—can be a difficult supervisory task. The supervisor must assess the counselor for fitness for duty and uphold professional standards.

In addition to technical counseling skills, the following are important therapeutic qualities that affect the outcomes of counseling:

- Insight
- Respect
- Genuineness
- Concreteness
- Empathy

Research consistently demonstrates that personal characteristics of counselors are highly predictive of client outcome. The essential questions are:

- Who should or should not be a counselor?
- What behaviors or attitudes are unacceptable?
- How would a clinical supervisor address these issues in supervision?

Unacceptable counselor behavior might include:

- Taking actions hurtful to the client.

- Violating boundaries either with clients or program standards.
- Engaging in illegal behavior.
- Demonstrating significant psychiatric impairment.
- Demonstrating consistent lack of self-awareness.
- Failing to adhere to professional codes of ethics.
- Consistently demonstrating attitudes that are not conducive to work with clients in substance abuse treatment.

When facing an impaired counselor, it is suggested that the supervisor:

- Have a model and policies and procedures in place when disciplinary action is undertaken.
- Consult with the organization's attorney and be familiar with State case law.
- Make contact with the State impaired counselor organization, if it exists.
- Have clear job descriptions and statements of scope of practice and competence that address such questions as:
 - How impaired must a counselor be before disciplinary action is needed?
 - How tired or distressed can a counselor be before a supervisor takes the counselor off-line for these or similar reasons?

- Seek administrative support and identify approaches to managing counselors experiencing burnout if interventions are needed. The Consensus Panel recommends that the supervisor's organization have an employee assistance program in place so the supervisor can refer staff members outside the agency.
- Learn the distinction between a supervisory referral, which usually occurs with a job performance problem, and a self-referral, which may include a recommendation by the supervisor.

The supervisor needs to:

- Provide oral and written evaluations of the counselor's performance and actions to ensure the staff member is aware of the behaviors that need to be addressed.
- Treat all supervisees the same, following agency procedures and timelines.
- Follow the organization's progressive disciplinary steps and document carefully what is said, how the person responds, and what actions are recommended.

It may be necessary to take action that is in the best interest of the clients and the profession, which may involve counseling the supervisee to seek employment in another field.

For more detailed information, see TIP 52, Part 1, Clinical Supervision and Professional Development of the Substance Abuse Counselor, Chapter 1, pages 17–20.

PRACTICAL ISSUES IN CLINICAL SUPERVISION

Distinguishing Between Supervision and Therapy

The goal of clinical supervision must always be to assist counselors with becoming better clinicians and not to resolve their personal issues. When personal issues emerge, the key questions to ask the supervisee are:

- How does this affect the delivery of quality client care?
- What is the effect on the client?

When personal issues threaten the quality of the therapeutic relationship between the supervisee and the client, the supervisor may need to transfer the case to a different counselor.

Problems related to negative countertransference (projecting unresolved personal issues onto a client or supervisee) often make for difficult therapeutic

relationships. Examples of signs of countertransference are:

- A feeling of loathing, anxiety, or dread at the prospect of seeing a specific client or supervisee.
- Unexplained anger or rage at a particular client.
- Distaste for a particular client.
- Mistakes in scheduling clients or missing appointments.
- Forgetting a client's name or history.

When countertransference issues between counselor and client arise, explore these questions with the counselor:

- How is this client affecting you? What feelings does this client bring out in you? What is your behavior toward the client in response to these feelings?
- What is happening in your life, but more particularly between you and the client, that might be contributing to these feelings? How does this affect your counseling?
- What strategies and coping skills can assist you in your work with the client?

Transference and countertransference also occur in the relationship between supervisee and supervisor. Examples of supervisee transference include:

- The supervisee's idealization of the supervisor.
- Distorted reactions to the supervisor based on the supervisee's reaction to the power dynamics of the relationship.
- The supervisee's need for acceptance by or approval from an authority figure.
- The supervisee's reaction to the supervisor's establishing professional and social boundaries with him or her.

Examples of supervisor countertransference include:

- The need for approval and acceptance as a knowledgeable and competent supervisor.
- Overly negative or positive responses to an individual supervisee (e.g., dislike, idealization).
- Sexual or romantic attraction to certain supervisees.
- Cultural countertransference (e.g., catering to or withdrawing from individuals of a specific cultural background in a way that hinders the counselor's professional development).

The supervisor should recognize clues to countertransference reaction, do careful self-examination, receive personal counseling, and receive supervision of the supervision he or she provides. In some cases, the supervisor may need to request a transfer for supervisees with whom countertransference is being experienced.

Let counselors know that countertransference is a normal part of being a counselor. Counselors should be rewarded in performance evaluations for raising these issues in supervision and demonstrating a willingness to work on them as part of professional development.

Balancing Clinical and Administrative Functions

A clinical supervisor may also be the administrative supervisor, responsible for overseeing managerial functions of the organization. Administrative supervisors often:

- Structure staff work.
- Evaluate personnel for pay and promotions.
- Define the scope of clinical competence.
- Perform tasks involving planning, organizing, coordinating, and delegating work.
- Select, hire, and fire personnel.
- Manage the organization.

Tips for juggling administrative and clinical functions include:

- Be clear about which functions are performed from an administrative perspective and which from a clinical perspective.
- Be aware of biases and values that may affect administrative opinions.
- Delegate administrative functions as feasible.
- Get input from others to ensure objectivity and perspective.

Finding the Time To Do Clinical Supervision

An implementation process for clinical supervision is to add components one at a time. For example:

Step 1: Schedule supervisory meetings with each counselor. Meet with each regularly to develop learning plans and review professional development.

Step 2: Plan to observe counselors in their work. Individual and group observations can be brief. For instance, rather than spending an hour observing an individual counselor, spend 20 minutes observing the counselor and 20 minutes providing feedback.

Step 3: Plan group supervision. Time can be maximized by teaching and training counselors who have common skill development needs.

Choice of modality (individual, group, peer, etc.) is influenced by:

- The supervisees' learning goals.
- The supervisees' experience, developmental levels, and learning styles.
- The supervisor's goals for the supervisees.
- The supervisor's theoretical orientation.
- The supervisor's own learning goals for the supervisory process.

To select an appropriate supervision modality, first pinpoint the immediate function of supervision. Different modalities fit different functions. For example, a supervisor might wish to conduct:

- *Group supervision* when the team is intact and functioning well.
- *Individual supervision* when specific skill development or countertransferential issues need additional attention.

Several alternatives to structure supervision are available.

Alternatives to Structure Supervision

Type of supervision	Characteristics of supervision
Peer supervision	<ul style="list-style-type: none">• May be particularly significant among well-trained, highly educated, and competent counselors.• Has received limited attention in the literature. However, the Consensus Panel believes it is a particularly effective method, especially for small group practices and agencies with limited funding for supervision.
Triadic supervision	<ul style="list-style-type: none">• Is a tutorial and mentoring relationship among three counselors, who, on a rotating basis, assume the roles of the supervisee, the commentator, and the supervision session facilitator.• Is supported by very little empirical or conceptual literature.
Individual supervision	<ul style="list-style-type: none">• Consists of a supervisor working one-on-one with a supervisee.• Is considered the cornerstone of professional skill development.• Is the most labor-intensive and time-consuming method.• May require individual supervision with a supervisor from the same discipline or graduate studies to fulfill credentialing requirements in a particular discipline or graduate study.

Alternatives to Structure Supervision (continued)

Type of supervision	Characteristics of supervision
Intensive supervision	<ul style="list-style-type: none">• Is helpful in working with a difficult client (such as one with a history of violence), a client using substances unfamiliar to the counselor, or a highly resistant client.• May be most beneficial, because of a number of factors, to focus for concentrated periods on the needs of one or two counselors.• Provides an opportunity to address specific staffing needs while still providing a reasonable effort to supervise all personnel.
Group clinical supervision	<ul style="list-style-type: none">• Is a frequently used and an efficient format for team building and staff growth.• Consists of one supervisor assisting counselor development with a group of supervisee peers.• Has a recommended group size of four to six persons, which allows for frequent case presentations by each member.

Sample Clinical Supervision Schedule

The plan below, based on a scenario in which a supervisor oversees one to five counselors, may be a useful structure for supervision:

- All counselors will receive at least 1 hour of supervision for every 20 to 40 hours of clinical practice.
- Direct observation is the backbone of a solid clinical supervision model.
- Group supervision is a viable means of engaging all staff members in dialog, sharing ideas, and promoting team cohesion.

Each week:

- One counselor will be observed in an actual counseling session that is followed by an individual supervision session.
- If the session is videotaped, the supervisee can be asked to cue the tape to the segment of the session he or she wishes to discuss with the supervisor.
- Afterwards, the observed counselor presents this session in group clinical supervision.

Sample Clinical Supervision Schedule

Week	Counselor A	Counselor B	Counselor C	Counselor D	Counselor E
Week 1	1 hour direct observation 1 hour individual supervision 1 hour group supervision of A's case (3 hours)	1 hour group	1 hour group	1 hour group	1 hour group
Week 2	1 hour group	3 hour group	1 hour group	1 hour group	1 hour group
Week 3	1 hour group	1 hour group	3 hour group	1 hour group	1 hour group
Week 4	1 hour group	1 hour group	1 hour group	3 hour group	1 hour group
Week 5	1 hour group	1 hour group	1 hour group	1 hour group	3 hour group

When it is a counselor's week to be observed or taped and meet for individual supervision, he or she will receive 3 hours of supervision:

- 1 hour of direct observation
- 1 hour of individual/one-on-one supervision
- 1 hour of group supervision when he or she presents a case to the group

Over the course of months, with vacation, holiday, and sick time, supervision should average out to approximately 1 hour per counselor per week.

Documenting Clinical Supervision

Document:

- Informal and formal evaluations procedures.
- Frequency of supervision, issues discussed, and the content and outcome of sessions.
- Due process rights of supervisees (such as the right to confidentiality and privacy and to informed consent).
- Risk management issues (how to handle crises, duty-to-warn situations, and breaches of confidentiality).

Supervisory documents and notes are:

- Open to management, administration, and HR personnel for performance appraisal and merit pay increases.
- Admissible in court proceedings.

Supervision notes, especially those related to work with clients, are kept separately and are intended for the supervisor's use in helping the counselor improve clinical skills and monitor client care. It is imperative to maintain accurate and complete notes on the supervision. Typically, HR accesses summative evaluations, and supervisory notes are maintained as formative evaluations.

Example of formative notes by a supervisor:

“The counselor responsibly discussed counter-transferential issues occurring with a particular client and was willing to take supervisory direction.”

“We worked out an action plan, and I will follow this closely.”

This wording avoids concerns by the supervisor and the supervisee about the confidentiality of supervisory notes. From a legal perspective, the supervisor needs to specify what was agreed on and a timeframe for following up.

Structuring the Initial Supervision Sessions

First tasks in clinical supervision include:

- Establishing a behavioral contract.
- Getting to know the supervisees.
- Outlining the requirements of supervision.

Before the initial supervision session:

- Send a supportive letter to the supervisee to express the agency's desire to provide him or her with a high-quality supervisory experience.
- Request that the supervisee think about what he or she would like to accomplish in supervision, what skills to work on, and which core functions used in the addiction counselor certification process he or she feels most comfortable performing.

A basic IDP for each supervisee should emerge from the initial supervision sessions.

For more detailed information, see TIP 52, Part 1, Clinical Supervision and Professional Development of the Substance Abuse Counselor, Chapter 1, pages 24–29.

METHODS AND TECHNIQUES OF CLINICAL SUPERVISION

A number of methods and techniques are available for clinical supervision, regardless of the modality used.

Methods and Techniques in Clinical Supervision

Method	Advantages	Disadvantages
Oral report	Informal Time efficient Spontaneous	Subjective Nonverbal cues missed Can drift into case management
Verbatim written report	Helps track use of treatment plan Enhances conceptualization and writing skills	Nonverbal cues missed Self-report bias
Case consultation/management	Helps organize information, decide on intervention	Validity of self-report is contingent on skill
Direct observation	Allows teaching of skills while protecting quality of care	May create anxiety

Methods and Techniques in Clinical Supervision (continued)

Method	Advantages	Disadvantages
Audiotaping	Technically easy and inexpensive Can explore rapport, pace, and interventions	Counselor may feel anxious Misses nonverbal cues
Videotaping	Rich medium enabling review of verbal/nonverbal information Provides documentation of clinical skills	Can be seen as intrusive to clinical process Counselor may initially feel anxious, self-conscious

For more detailed information, see TIP 52, Part 1, Clinical Supervision and Professional Development of the Substance Abuse Counselor, Chapter 1, pages 30–32.

ADMINISTRATIVE SUPERVISION

Documentation and time management are two of the most frequently voiced concerns of supervisors.

Documentation for Administrative Purposes

Supervisory documentation:

- Is a crucial risk-management tool.
- Can help promote the counselor's growth and professional development.
- May help justify disciplinary action.
- Is a critical link between work performance and service delivery.

Documentation is no longer optional for supervisors. Supervisors have a legal and ethical requirement to evaluate and document counselor performance. Records of supervision sessions should include:

- The signed supervisor-supervisee contract.
- A summary of the supervisee's experience, training, and learning needs.
- The current IDP.
- A summary of all performance evaluations.
- Notations of all supervisory sessions (as well as those cancelled or missed).

- Progressive discipline steps taken.
- Significant problems encountered in supervision and how they were resolved.
- Clinical recommendations provided to supervisees.
- Relevant case notes and impressions.

Several authors have proposed a standardized format for documenting supervision. See page 33 of TIP 52 for references.

Time Management

By some estimates, people waste about 2 hours every day performing tasks that are not of high priority. To identify priorities, ask:

- Why am I doing this; what is the goal of this activity?
- How can I best accomplish this task in the least amount of time?
- What will happen if I choose not to do this?

Develop systems for managing time-wasters (e.g., endless meetings held without notes or minutes, playing telephone or email tag). Effective supervisors find their time in the day when they are most productive. Time management is essential to scheduling supervisory tasks.

52 Clinical Supervision and Professional Development

For more detailed information, see TIP 52, Part 1, Clinical Supervision and Professional Development of the Substance Abuse Counselor, Chapter 1, pages 33–34.

Ordering Information

TIP 52

Clinical Supervision and Professional Development of the Substance Abuse Counselor

TIP 52-Related Product

Quick Guide for Administrators Based on TIP 52

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TIP 46: Substance Abuse: Administrative Issues in Outpatient Treatment

TAP 21: Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice

TAP 21-A: Competencies for Substance Abuse Treatment Clinical Supervisors

TAP 31: Implementing Change in Substance Abuse Treatment Programs

See the inside back cover for ordering information for all TIPs and related products.