Introduction to Clinical Supervision
Addiction Medicine Workbook

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Introduction:

After a period of school or community-based training, all counselors meet their first patient. At this point, most counselors recognize a need to work with and learn from more experienced practitioners in order to integrate their educational experience into the real life counselor-patient relationship. The knowledge gained in the classroom is essential to understanding human behavior, addiction and effective methods for intervention. However, the educational experience only partly prepares people for the actual practice of counseling. Counselors also may find themselves promoted based on their clinical work and can feel unprepared for a supervisory role.

Counselors will need to learn when and how to implement particular skills, create a therapeutic alliance with a diverse group of patients, manage their own emotional reactions to patients, manage paper work as well as patient demands, handle emergencies and maintain their own sense of hopefulness and self-efficacy in order to be effective with patients. It is not possible for even the best of training programs to completely prepare counselors for the demands of actual practice. Clinical supervision provides the counselor with a regularly scheduled time to talk with a more experienced clinician to focus on applying skills to specific patient situations.

Clinical Supervision:

There are many definitions of clinical supervision in the literature. Bernard and Goodyear (1998) propose the following:

> *Supervision is an intervention that is provided by a senior member of the profession to a junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of junior member(s), monitoring the quality of professional services offered to the clients she, he or they see(s), and serving as a gatekeeper of those who are to enter the particular profession.*

The definition includes the purpose of the supervisory relationship as well as establishing that there is a power differential. Clinical supervision includes monitoring and evaluative functions as well as acting as a "gatekeeper" for the profession. The counselor's relationship with their supervisor shares some similarities with that of the patient - counselor. In both relationships one person is responsible for helping to promote growth and change in the other person. The relationships also share in common the difference in power between parties that includes ethical guidelines for respecting boundaries and creating a "safe" relationship in which one can explore vulnerabilities as well as to celebrate successes.

According to Bernard and Goodyear (2004) clinical supervision has two main objectives. They include the fostering of professional development of the supervisee, and ensuring the welfare of patients. Supervisors work with the counselor to improve clinical skills with the goal of improving the counselor's ability to have a positive impact on patient care. They also monitor the quality of counselor

interactions to ensure that patients are making progress and are not harmed by the counselor.

Supervisors can be held accountable for the actions of supervisees through the legal concept of "vicarious liability". This simply means that the supervisor has responsibility for the actions of the supervisee to the extent that they are diligent in their supervisory responsibilities and do not neglect the supervisee's needs or ignore potentially harmful situations. Actions taken by the supervisee that may potentially cause harm to a patient need to be addressed adequately by the supervisor. An example of this type of situation is a case where the supervisor was aware that the counselor was using potentially harmful methods with a patient or providing treatment out of the scope of their practice. If the patient in this case was harmed by the treatment both the counselor and the supervisor may be held accountable.

An alternative definition of clinical supervision is offered by Powell and Brodsky (2004):

> *Clinical supervision is a disciplined tutorial process wherein principles are transformed into practical skills, with four overlapping foci: administrative, evaluative, clinical and supportive.*

In this definition Powell and Brodsky identify four areas that the supervisor focuses on with the counselor. Some of the areas can conflict with each other and this definition points to the complexity of the supervisory relationship. It has to be one of trust and mutual respect to allow for the support of the counselor and exploration of clinical material. It also involves the supervisor holding the counselor accountable for his/her performance through administrative and evaluative functions. Supervisors can set clear and specific parameters for performance expectations and provide evaluation of outcome on these parameters in a supportive and affirming way. Supervisors who bully or are verbally aggressive do not create the safety necessary for the exploration or establish effective methods for fair and purposeful evaluation.

Elements of Effective Clinical Supervision

The relationship in supervision is as important as the relationship with the patient in the counseling relationship. The same warmth, genuineness, acceptance and nonjudgmental attitudes that are effective in gaining an alliance with a patient work to gain the trust and alliance in a supervisory relationship. Gallon, Hausotter, and Bryan (2005) propose a list of important characteristics of a healthy supervisory relationship including:

- Bi-directional trust, respect and facilitation,
- A commitment to enthusiasm and energy for the relationship,
- An adequate amount of time committed to supervision,
- Sensitivity to supervisee's developmental needs,
- Encouragement of autonomy,
- Sense of humor,

- Comfort in disclosing perceived errors,
- Clarity of expectations, and regular feedback,
- A non-defensive supervisory style, and
- A clear understanding of the rights and responsibilities of both supervisor and supervisee.

Administrative vs. Clinical Supervision

The purpose of administrative supervision is to assure compliance with agency policies and procedures, productivity expectations, formats and models. Many clinical supervisors have both administrative and clinical supervisory responsibilities and it can be difficult to juggle both roles. Administrative supervision is more likely to result in disciplinary actions and clinical supervision requires trust and safety between both parties in order to be effective.

In some instances it is practical to separate the functions and have a clinical supervisor and a supervisor who looks after exclusively administrative functions. When this is not possible the clinical supervisor can help to navigate the dual functions of the relationship by acknowledging them and communicating clearly when he/she is performing one or the other. Steven Gallon (2002) proposed the following chart to compare the differences between counseling, clinical and administrative supervision:

	Counseling	**Clinical Supervision**	**Administrative Supervision**
Purpose	Personal Growth Behavior changes Decision-making Better self-understanding	Improve job performance	Assure compliance with agency policy and procedures
Outcome	Open-ended based on client needs	Enhanced proficiency in knowledge, skills and attitudes essential to effective job performance	Consistent use of approved formats, policies and procedures
Time Frame	Self-paced; longer-term	Short-term and on-going	Short-term and on-going
Agenda	Based on client needs	Based on service mission and design	Based on agency needs
Basic Process	Affective processes which includes listening, exploring, teaching	Assessing worker performance, negotiating learning objectives, and teaching/ learning specific skills	Clarifying agency expectations, policy and procedures, assuring compliance

An Integrated Model of Clinical Supervision

Clinical supervision models vary in philosophy and desired outcome. Some models are more focused on the counselor as change-agent and therefore pay more attention to counselor thoughts, feelings, behaviors and wellness. Others are more focused on increase in knowledge, and skill attainment and development. Some models, such as those used in clinical trials, focus on the fidelity of particular models or manualized treatments.

David Powell has written extensively about clinical supervision as it relates to addiction counselors. He advocates a developmental model of supervision that takes into account level of experience and the stage of professional development the counselor has achieved. Powell and other proponents of a developmental model argue that counselors will move through stages as they develop and they will need a different approach from a supervisor from an educational approach early in their career to a more egalitarian type of learning as they move towards increasing autonomy.

Powell states (1993) that supervisory models have tended to promote either skill development or emotional/ interpersonal dynamics and self-discovery of the worker. He uses an integrated model of clinical supervision influenced by the work of Stoltenberg and Delworth (1987). In Powell's model the developmental stage of counselor and supervisor are considered along with the acquisition and development of clinical skills as well as emotional growth and encouragement of self-awareness. In this model the role of supervision is to support a counselor's transition through the stages of professional development to confident and relatively autonomous practice.

Developmental Stages and Supervisory Interventions

Stoltenberg, McNeil and Delworth (1998) developed an Integrated Developmental Model of clinical supervision. The model has three levels of counselor development that include:

Level 1: These counselors are just entering into the field and are trying to take theoretical models and integrate them into their new experiences with patients. Counselors at this level can be very enthusiastic and idealistic. They may also be nervous about their lack of experience and the evaluation of their supervisor of their developing skill. The supervisory interventions that are recommended at this level include direct observation of actual practice through video-tape, audio-tape, in person, "bug-in-the-ear", or two-way mirror. Counselors at this level need feedback from more seasoned supervisors on specific interventions as well as "use of self" to develop an awareness in the moment of what skills are being utilized and why. An example of supervisor and counselor dialogue for this level of counselor development, after a directly observed patient interview:

Supervisor: "So tell me what you thought about how that interview went"
Counselor: **"**I think it went OK, but there were some times when I thought I was too quiet and I think it was uncomfortable for all of us."

Supervisor: "Let's look at a specific part of the session where you thought this was happening and we can go through it and see if there are interventions you might be able to use if that happens again. Tell me what the patient said first when you thought you got too quiet."
Counselor: "When I asked the patient 'Did you use any alcohol or other substances last week?', and he said 'no'; I didn't know what to say next and then it took me a while to ask another question."
Supervisor: "What was going on for you when that happened?"
Counselor: "Well, I wasn't sure what to say next and then I got nervous and I also started to worry about what he was thinking and what you were thinking and it seemed like a long time until I said 'How was that for you?'"
Supervisor: "I thought that even though it took a little time, it was an excellent next question and it got the patient talking about his cravings and that focused the session from there on. What was different about each of those questions that might explain how differently both you and the patient responded?"
Counselor: "Thinking back on it now I realize that the first question was a close-ended question and the next question I thought of was open-ended and it worked better to get the patient talking. It's good to look back on it because I don't think I would have thought about that if we didn't."
Supervisor: "So you realize now that while close-ended questions have a place, if you are stuck in a session it may be because you asked a close-ended question and asking a follow-up that is open-ended can work to get the patient talking."

In this short segment of conversation the supervisor is supportive and facilitates the counselor's own developing ability to evaluate the interview as a whole and to break it down into specific interventions. The supervisor works with the counselor to identify specific skills and also to begin to develop an awareness of self within the supervisory session and ultimately in the moment with the patient. The counselor will be able to use what he has learned in future sessions and is also growing in his ability to ask and answer these kinds of evaluative questions while in the session with patients.

Level 2: These counselors have one to two years of closely supervised experience and have gained increasing levels of confidence and comfort with a wide range of skills. They may begin to look for additional experiences with new or more challenging models of treatment. The supervisor may use direct observation techniques and the counselor at this level can be increasingly challenged to provide a rationale for intervention choices. They are more ready to identify personal feelings, transference and counter-transference in the context of an empathic and supportive supervisory relationship. Constructive criticism and feedback can be used in conjunction with exploring and eliciting an evaluation from the counselor. An example of supervisor and counselor dialogue at this level, in a regular supervision hour:

Supervisor: "What kinds of challenges are you facing with this particular patient?"
Counselor: "Things just aren't flowing like they usually do with other patients. I find that I get 'stuck' quite a bit in the session."
Supervision: Can you tell me a little more about that?"

Counselor: "Well we can be going along fine in a session and then there is some silence and I am not sure what it means or why, but I feel uncomfortable."
Supervision: "What is that like for you?"
Counselor: "I don't know, I just feel anxious and I start thinking that this guy is just playing along with me. All of the sudden I just feel like we aren't making any progress and I get a little irritated like he is wasting my time and maybe even laughing at me a little."
Supervisor: "So you are having a pretty strong reaction to this. What have you done with it in the sessions?"
Counselor: "I haven't really done anything. I just try to get around it and just change the topic."
Supervisor: "Well what do you think about that approach now that we are talking about it?"
Counselor: "I think I need to do something different. One of the things I was thinking about was bringing it up to the patient. I mean not like challenging him, but just asking what he thinks is going on when this happens again. I don't like the feeling of insecurity I get, and maybe it is because I am picking up on something that is going on with him. I have been thinking though that for some reason I really want this to work with this guy, more than with other patients and maybe that is affecting my work with him.
Supervisor: "It seems like you are saying that it might be important to first explore more about your own reactions until you are more certain of what it means and then also think about changing your approach in the session by using your experience to explore what is happening from the patient's point of view."

In this dialogue the level 2 counselor has much more experience to draw upon and is able to evaluate problems in the therapeutic relationship from his own and the patient's point of view. He is gently challenged by the supervisor who takes a facilitative role to explore his own reactions and to take a critical stance about his own interventions and also to propose a new approach. The counselor has learned to be aware of self in the interview as well as in the supervision, to trust that this type of exploration is safe and to use it to improve his performance in contacts with patients.

Level 3: At this level the counselor is more autonomous and the supervisory relationship is more egalitarian with both partners exploring interventions, models of treatment, use of self, emotional responses, transference and counter-transference reactions. The supervisor takes an empathic stance as a partner in the counselors continuing development of skill. The supervisor can help to identify signs of "burn-out", or compassion fatigue and work with the counselor to prevent it from progressing. An example of counselor and supervisor dialogue at this level of development in a regular supervision hour is as follows:

Supervisor: "How are things going for you?"
Counselor: "Pretty well, but I am struggling a little with an issue I'd like to talk about."
Supervisor: "Sure, what is going on?"

Counselor: "I have a patient I have been working with for a while and things were going well. I have been using a mostly cognitive approach and he has been doing really well with it and so I was surprised when he came in today and said he didn't think we were making any progress."
Supervisor: "That must have caught you off-guard. How did you feel?"
Counselor: "I felt a little upset actually. I like this patient and I was completely surprised that we were so far apart about how things were going. I talked with him more about it to try to understand it better and we decided that it may be because he is compliant with almost everyone in his life and so he was going along with me as well."
Supervisor: It seems like that is a big break-through in itself then. He was able to speak up to you when he doesn't do that with anyone else."
Counselor: "Yeah, I talked about that with him and by the end of the session he also felt pretty proud of himself and we have made a new plan that I think will work. It left me wondering though about how many of my other patients may be just going along."
Supervision: "Any ideas about how you might handle that?"
Counselor: "I think I will make it a point to check- in with each of my patients about how they feel things are going over the next few weeks."
Supervision: "It sounds like a good idea. I may make a more conscious effort to do that myself."

In this dialogue the counselor has clearly integrated theory, models of treatment, and specific interventions into his clinical practice and has an awareness of self and affect on the relationship that he is clearly able to articulate in supervision. The supervisor takes less of a teaching and coaching role and the two partners take a relaxed, respectful and collaborative approach with each other.

Parallel Process in Supervision

A concept that all supervisors should be aware of in supervision is "parallel process". What this means is that there is a possibility that what is happening in the supervisor-counselor interaction may mirror what is happening in the counselor-patient relationship. An example of this would be a supervisor who feels overwhelmed by the content that the counselor is sharing and confused by the vague or rambling quality of the counselor's presentation when this style is uncharacteristic of the counselor. The supervisor may suspect a parallel process in this case and ask questions of the supervisee like, "Are you confused by this?" or share their own experience and model a response while trying to clarify, "I am feeling overwhelmed and confused by all of the material, I wonder if you feel the same way with the client?"

Parallel process can inform the supervisor and supervisee of conflicts or problems in the counselor-patient relationship and awareness of the process can provide a means for resolution. A counselor who argues with or otherwise resists the supervisor's suggestions may mirror the relationship with a "resistant client". If aware that this process is repeating itself in the supervisory relationship the supervisor may draw attention by saying: "It seems to me that what is happening here with us is

similar to what happens in session, does it seem that way to you as well?" If the counselor responds that it does the supervisor can say something like, "This can offer us an opportunity to resolve the conflicts in the counseling. First we can work at resolving the impasse between us- How were you feeling when I made a suggestion about this case?" The work done to resolve the conflict in the supervisory relationship can serve as a model for the counselor to bring back to the relationship with the client. The supervisor can further use this situation to help the counselor build empathy for the patient.

Competency-based Clinical Supervision

One common approach to supervision encourages counselor competency through the development of knowledge, skills and attitudes. Supervisors work with counselors with individual development plans. This approach is also integrative as knowledge, skills and attitudes are targeted. Knowledge and skill development occur through supervision. Attitudes are addressed and influenced through a more exploratory process with the counselor.

The Center for Substance Abuse Treatment working with the National Curriculum Committee published *Addiction Counseling Competencies: The Knowledge, Skills and Attitudes of Professional Practice* Technical Assistance Publication (TAP) Series number 21 in 2006. The TAP identified four transdisciplinary foundations including Understanding Addiction; Treatment Knowledge; Application to Practice; and Professional Readiness. The TIP also identified eight practice dimensions with knowledge, skills and attitudes that substance abuse counselors need to master in order to practice competently. See the chart (Table A) for the dimensions and competencies.

Clinical supervisors and counselors can use these recommendations to develop a professional development plan with the goal of mastery in each of these dimensions. Steve Gallon, PhD. at the Northwest Frontier Addiction Technology Center and Dean Arrasmith PhD. developed a matrix for evaluation of counselors based on this tool. This tool is available at www.nfattc.com. Supervisors can use this tool to identify counselor strengths and weaknesses and to work towards mastery of all dimensions in the areas of knowledge, skill and attitude. The tool allows the supervisor to rate a counselor in each of the dimensions as; developing, proficient or exemplary.

Competency-based clinical supervision requires an integrated model with a focus on skill-building and emotional/ interpersonal dynamics. Each of the dimensions includes knowledge, skills and attitudes that are essential to mastery of the dimension of practice. Each of the dimensions has sub-categories or competencies and each competence area contains knowledge, skills and attitudes:

- Knowledge includes; awareness of theory, practice guidelines, epidemiology;
- Skills include; specific intervention methods, interpersonal skill
- Attitudes include; appreciation and respect for patients and co-workers.

Table A

Dimensions	Competencies
Clinical Evaluation • **Screening** • **Assessment**	**Screening:** • Establish Rapport • Gather Data • Recognize urgent problems • Identify impact of SUD on life • Determine Readiness • Review treatment options • Apply accepted criteria for diagnosis • Construct Initial Action Plan • Initiate Admission or Referral **Assessment:** • Select and use Comprehensive assessment tools • Analyze and interpret data • Seek supervision where needed • Document findings and recommendations
Treatment Planning	• Obtain and interpret assessment information • Present and explain findings • Provide patient and S.O.'s with clarification • Collaborate with client and S.O's to examine treatment implications • Confirm readiness • Formulate mutual and measurable treatment goals • Identify strategies • Coordinate treatment activities • Develop mutually acceptable plan of action • Inform of confidentiality, rights, and procedures • Reassess treatment plan at regular intervals
Referral	• Establish and maintain relationships with professionals, agencies and governmental entities • Assess and evaluate referral resources • Differentiate appropriateness of self vs. agency or counselor referral • Arrange referrals • Explain in clear and specific language the need for referral and work to ensure follow through • Exchange relevant information • Evaluate the outcome of the referral
Service Coordination • **Implementing Plan** • **Consulting** • **Continuing Assessment Planning**	**Implementing the Treatment Plan** • Initiate Collaboration with referral source • Review and interpret relevant screening and assessment information • Confirm eligibility for admission • Complete process for admission • Establish accurate treatment and recovery expectations

Dimensions	Competencies
	• Coordinate treatment activities **Consulting** • Summarize factors that may impede client progress to assure quality and change course of treatment • Understand terminology procedures and roles of other disciplines • Contribute as part of multidisciplinary team • Apply confidentiality regulations appropriately **Continuing Assessment and Treatment Planning** • Maintain ongoing contact with client and S.O.'s • Understand and recognize stages of change and other signs of progress • Assess treatment and recovery progress and make changes if necessary • Describe and document treatment process and progress • Use appropriate treatment outcome measures • Conduct continuing care, relapse prevention, and discharge planning functions • Document service coordination activities • Apply placement, continued stay and discharge criteria
Counseling • **Individual** • **Group** • **Families** • **Significant Others**	**Individual:** • Develop relationship with client characterized by warmth, respect, genuineness, and empathy. • Facilitate client's engagement with treatment process • Promote skills and attitudes that contribute to positive client change • Encourage and reinforce client progress • Work with client to discourage behaviors detrimental to progress • Recognize how, when and why to engage and work with S.O.'s • Promote client knowledge, skills and attitudes related to healthy lifestyle • Facilitate development of basic life skills needed to support recovery • Adapt counseling strategies to individual client needs • Apply crisis management skills • Facilitate practice strategies to sustain patient progress **Group:** • Describe select and use strategies for groups • Carry out the actions necessary to form a group • Facilitate patient movement into and out of group • Facilitate group growth • Understand concepts of process and content and be able to shift focus of group between the two

Dimensions	Competencies
	Families and Significant Others: • Understand the characteristics and dynamics of families, couples and S.O.'s affected by substance abuse • Know and appropriately use models of family treatment • Facilitate engagement of members of the family • Facilitate understanding of family members • Help families adopt behaviors to encourage and sustain recovery
Client, Family and Community Education	• Provide culturally relevant education • Sensitize others to issues of cultural identity, ethnic background, age, and gender • Describe warning signs, symptoms and course of substance use disorders • Describe affect on families • Describe continuum of care available • Describe principles and philosophy of prevention • Understand and describe health and behavior problems related to substance use • Teach life skills
Documentation	• Know accepted principles of records management • Protect client confidentiality when handling and releasing records • Prepare accurate and concise reports • Record treatment plans consistent with agency policies • Record progress of clients in relation to treatment goals • Prepare accurate and concise discharge summaries • Document treatment outcome using accepted methods and instruments
Professional and Educational Responsibilities	• Adhere to applicable professional codes of ethics • Adhere to Federal and State laws and agency rules and policies • Know and apply current research literature to practice • Recognize individual differences and how they affect patient behaviors • Use a range of supervisory options to process personal feelings • Conduct self-evaluations of professional performance to enhance self-awareness • Obtain appropriate continuing professional education • Participate in ongoing supervision and consultation • Develop and utilize strategies to maintain one's own physical and mental health

Supervisors and counselors can focus on particular dimensions or competencies and focus on an increase in knowledge or awareness through teaching and training

goals; and increase in skill through role-modeling, skill-based training, co-facilitated practice and attitude through experiential methods aimed at change in counselor thoughts, feelings, biases and opinion.

Twelve Core Functions

OASAS is a member of the International Certification and Reciprocity Consortium (IC&RC) and therefore counselors preparing for the CASAC exam will need to be knowledgeable about 12 core functions and they are another option for supervisors if choosing a competency based supervisory process. The Twelve Core Functions were developed by John Herdman (2001) for the IC&RC. The Twelve Core Functions and 46 Global Criteria are congruent with the TAP #21. The Twelve Core Functions are:

- Screening
- Intake
- Orientation
- Assessment
- Treatment Planning
- Counseling
- Case Management
- Crisis Intervention
- Client Education
- Referral
- Reports and Record Keeping
- Consultation

A clinical supervisor may use either of the competency based models or a combination of the two, but should be aware when supervising CASAC candidates that they will be responsible for knowledge about the 12 Core Functions.

Supervisee "Bill of Rights"

Munson (2002) proposes a Supervisee Bill of Rights as follows:

- A supervisor who supervises consistently and at regular intervals.
- Growth-oriented supervision that respects personal privacy.
- Supervision that is technically sound and theoretically grounded.
- Criteria that are made clear in advance, and evaluations based on actual observation of performance, and
- A supervisor who is adequately skilled in clinical practice and trained in supervisory methods.

Next Steps for Supervisors

Just as counselors go through stages and develop over time, supervisors develop with experience and training. All supervisors should have training specific to supervisory role, ethics, direct observation methods, theory and skills development.

It is helpful to attend an experiential workshop where it is possible to practice skills with others who are also learning clinical supervision process and skills. There are several excellent experiential trainings available through OASAS and local community providers. There is a listing of upcoming trainings available on the OASAS website www.oasas.state.ny.us and at www.ipdany.org.

It is important if you are a supervisor and have never experienced direct observation of your own clinical practice to seek out an opportunity to have this experience. Direct observation is the most accurate way to assess and intervene in clinical practice. Having one's work directly observed is likely to cause anxiety for counselor. It is helpful to have had experience in the role of the observed so that you can anticipate the counselor's reactions and create a safe environment for the counselor to receive feedback. After an initial period of anxiety or embarrassment about mistakes, most counselors report high levels of satisfaction with directly observed practice as it provides a rich learning environment.

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