Competencies for Substance Abuse Treatment Clinical Supervisors

TAP 21-A

21

Technical Assistance Publication Series

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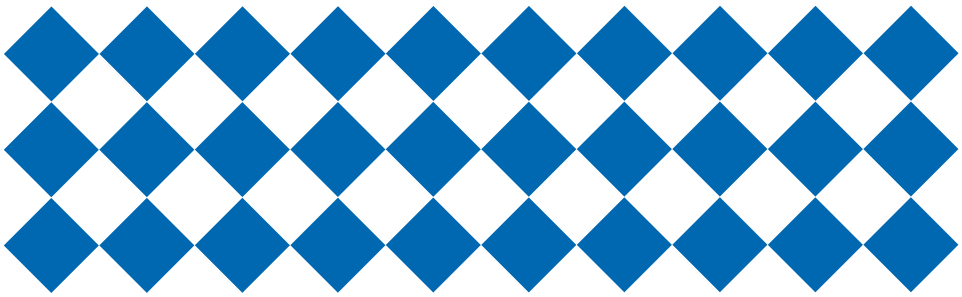

COMPETENCIES FOR SUBSTANCE ABUSE TREATMENT CLINICAL SUPERVISORS

Technical Assistance Publication (TAP) Series

21-A

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

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Contents

Clinical Supervision Competencies Task Force v

Section I: Introduction 1
Background 1
A Changing Profession 2
A Competency-Based Framework for Clinical Supervision 3
What This Document Is *Not* 4
Using This Document 5
Directions for Future Research 6
Bibliography 6

Section II: Implementation Guidelines 7
Why Have Implementation Guidelines? 7
What Needs To Be Implemented? 8
Bibliography 12

Section III: Foundation Areas 13
FA1: Theories, Roles, and Modalities of Clinical Supervision 15
FA2: Leadership 17
FA3: Supervisory Alliance 19
FA4: Critical Thinking 21
FA5: Organizational Management and Administration 23

Section IV: Performance Domains 25
PD1: Counselor Development 27
PD2: Professional and Ethical Standards 29
PD3: Program Development and Quality Assurance 31
PD4: Performance Evaluation 33
PD5: Administration 35

Section V: Integrated Bibliography 37

Section VI: Appendices 43
Appendix A: Clinical Supervision Certification—National Resources 45
Appendix B: Professional Codes of Ethics Specific to Clinical Supervision 47
Appendix C: Suggested Reading and Other Resources 55
Appendix D: Field Reviewers 59

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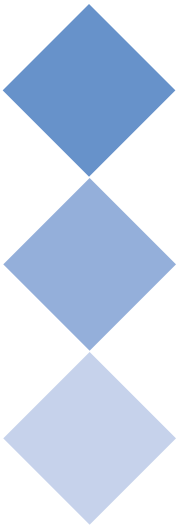
Section I:

Introduction



Background

In 1998, the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment (CSAT) published Technical Assistance Publication (TAP) 21, *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice*. TAP 21 has been widely distributed and is now a benchmark by which curricula are developed and educational programs and professional standards are measured in the U.S. substance use disorder treatment field. In 2006, CSAT produced a reformatted, revised version of TAP 21 (Center for Substance Abuse Treatment, 2006).

The TAP 21 counselor competencies describe what fully proficient counselors can do in clinical practice. Those competencies may be introduced in preemployment education and training settings, but they are often developed more fully on the job. It is typically the clinical supervisor's responsibility to mentor counselor development and facilitate the building of new knowledge and skills, not only during counselors' early years but throughout their careers. To that end, clinical supervisors in agencies specializing in the treatment of substance use disorders are expected to be knowledgeable and proficient in the addiction counseling competencies.

Clinical supervision itself is much discussed in the professional literature of several disciplines, including social work, psychology, and both mental health and substance use disorder counseling. Theories, process dynamics, and tools abound, but the functional responsibilities and essential skills of the substance use disorder treatment supervisor had not been synthesized into one document that could serve as a standard for the field. To remedy that situation, CSAT convened the Clinical Supervision Competencies Task Force (the Task Force) in fall 2005. The Task Force, composed of experts in substance abuse treatment and clinical supervision from across the country, was charged with developing this document, TAP 21-A, *Competencies for Substance Abuse Treatment Clinical Supervisors*. TAP 21-A is designed to accompany TAP 21, taking monitoring, assessment, and improvement of addiction counseling competencies to the next level.

A Changing Profession

Professional treatment for substance use disorders is a rapidly changing discipline. Research and evaluation studies are identifying new methods and tools for facilitating change and recovery. Payers, clients and their families, and the general public are seeking increased accountability and effectiveness of services. Licensing and credentialing bodies are raising their standards and expecting higher qualifications from applicants for certification or licensure. For example:

- States and the Federal Government are implementing contracts and grants that require treatment organizations to demonstrate specified levels of client outcomes rather than just delivery of services.
- Licensing and funding sources of all types are expecting programs to use evidence-based practices in the delivery of treatment services.

Treatment programs also are seeing clients who have co-occurring disorders and present with complex life situations and issues. More complex treatment issues call for more sophisticated and competent treatment and supervision skills. To meet increasing demands, modern treatment organizations must be able to—

- Monitor, evaluate, and promote clinical competence, directly and objectively;
- Ensure fidelity to evidence-based practices; and
- Increase treatment efficacy and cost-effectiveness.

Historically, professional substance abuse treatment organizations have focused resources on providing direct client care but have not provided sufficient resources for clinical supervision, an activity critical to ensuring service quality and effectiveness. Supervision time is limited in most agencies, and supervisory activities are frequently more administrative than clinical in nature. Supervisors often carry a clinical caseload and have a variety of program management responsibilities. It is no wonder that direct clinical supervision of counselors (including performance observation, feedback, and mentoring) is rarely a part of an agency's staff development plan.

Counselors often are promoted into supervisory positions on the basis of seniority, academic training, or their competence as counselors. Although a high level of counseling proficiency is an important prerequisite, it is not the only qualification of a competent clinical supervisor. Clinical supervision requires a new set of knowledge, skills, and abilities, as well as assumption of a different professional role. Many new supervisors receive little or no training in clinical supervision, leading to enormous inconsistency in the quality of supervision available in the field. As a result, many counselors receive inadequate clinical training and supervision. New counselors working toward certification or licensure frequently have to go outside their agencies, and even outside the field of substance use disorder treatment, to obtain competent supervision.

In addition, as professional performance expectations increase, substance use disorder treatment agencies are experiencing an unprecedented workforce shortage. An aging workforce and the lure of better paying positions in related settings have contributed to the shortage of qualified treatment personnel. Clinical staff members can become overwhelmed or dissatisfied when faced with the high demands of the job and little supervision. Some even choose to leave the profession. At the same time, fewer individuals are entering the field than in the past. Literature suggests that one potential solution is to provide consistent, high-quality clinical supervision in a way that will attract new counselors, enhance career satisfaction, mitigate burnout among veteran providers, and help clinicians become (and feel) more competent and effective.

A Competency-Based Framework for Clinical Supervision

Clinical supervision has become an organizational function with its own conceptual framework and methodology. Key competencies for effective clinical supervision represent an array of knowledge and skills pertinent to the clinical, administrative, and evaluative responsibilities of a clinical supervisor. Before the framework can be described in more detail, definitions of two key terms are needed: *clinical supervision* and *competency.*

A number of definitions for *clinical supervision* have appeared in the published literature. Two of the most popular are the following:

1. Clinical supervision is a disciplined, tutorial process wherein principles are transformed into practical skills, with four overlapping foci: administrative, evaluative, clinical, and supportive (Powell, 2004, p. 11).

2. Supervision is an intervention that is provided by a senior member of a profession to a more 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 the more junior person(s), monitoring the quality of professional services offered to the clients that she, he, or they see, and serving as a gatekeeper of those who are to enter the particular profession (Bernard and Goodyear, 2004, p. 8).

After reviewing the available literature, the Task Force synthesized the following consensus definition of *clinical supervision:*

> A social influence process that occurs over time, in which the supervisor participates with supervisees to ensure quality 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.

Marrelli and colleagues (2004, p. 4) define *competency* as follows:

> [A] measurable human capability that is required for effective performance . . . [composed] of *knowledge*, a single *skill* or *ability*, a *personal characteristic*, or a cluster of two or more of these attributes. Competencies are the building blocks of work performance. The performance of tasks requires the simultaneous or sequenced demonstration of multiple competencies.

A competency-based model, as presented in this document, provides a framework for understanding, learning, and implementing the multiple functions and tasks of clinical supervision. Becoming an effective and fully competent clinical supervisor is a developmental process. As knowledge and skills are accumulated over time, the supervisor's proficiency incrementally increases. This document describes competencies required to reach *mastery* as a clinical supervisor. It establishes a set of expectations for clinical supervision in substance use disorder treatment settings, describes the capabilities of a fully proficient clinical supervisor, and provides a standard toward which organizations and supervisors are encouraged to strive.

The nature of the relationship between supervisor and supervisee is unique. It can be characterized as highly charged and intense. When one person is in a position of power and authority over another, tension, discomfort, and conflict can arise. It is crucial that clinical supervisors understand the nature of this relationship and exercise supervisory responsibilities in a respectful, fair, and objective manner.

It is important, too, for supervisors to understand the developmental process of supervisees (e.g., how they learn, how skills are developed over time) and how to establish a spirit of learning and personal development in an organization. Service improvement occurs most effectively when service providers have the freedom to practice new skills in an environment marked more by support and mentoring than by critical judgment.

The clinical supervision competencies identified in the pages that follow are presented under two major headings: foundation areas and performance domains.

Foundation areas identify the broad knowledge and concepts essential to supervisory proficiency. The competencies representing these foundations of supervision are grouped into five areas:

FA1: Theories, Roles, and Modalities of Clinical Supervision;
FA2: Leadership;
FA3: Supervisory Alliance;
FA4: Critical Thinking; and
FA5: Organizational Management and Administration.

Performance domains identify the specific responsibilities and abilities essential to protecting client welfare, improving clinical services, developing a competent staff, and fulfilling an organization's mission and goals. The competencies relating to these specifics of supervisory practice are grouped into five domains:

PD1: Counselor Development;
PD2: Professional and Ethical Standards;
PD3: Program Development and Quality Assurance;
PD4: Performance Evaluation; and
PD5: Administration.

Clinical supervision is distinguished from administrative supervision in some models of supervisory practice, and many believe that administrative duties take precious time away from the provision of direct supervision to clinical staff. However, in substance use disorder treatment settings, the two kinds of supervision significantly overlap in real-world practice; Powell (2004, p. 11) identified "administrative" as one of four "overlapping foci" of clinical supervision. The Task Force members believe strongly that this document would not be complete if it did not address elements of organizational and administrative functioning. Unlike the other competencies described in this document, the extent to which clinical supervisors are expected (or have the authority) to perform the administrative functions varies greatly from organization to organization. Few supervisors have responsibility for performing *all* of the administrative activities included. However, as supervisors move to other organizations, their administrative activities may well change. It is important that clinical supervisors understand the range of administrative competencies that may be expected of them.

This competencies document is both research and consensus based. A thorough literature search was conducted, and Task Force members developed competencies based on a review of literature available. The specific resources the Task Force used to identify particular competencies are listed in a bibliographic section after each foundation area and performance domain. In addition, Section V provides an integrated bibliography. Additional reading suggestions and resources for further study are in Appendix C.

What This Document Is *Not*

Before discussing ways in which this document can be used, it is important to clarify what this document is *not* intended to be. It is not the following:

- A description of the competencies, models, or techniques of *counseling*. This document presupposes knowledge and mastery of the counseling competencies described in TAP 21, *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice.*
- A clinical supervision certification test preparation manual. Each certifying body can provide guidance about the best preparation material for its test (see Appendix A for a list of national certifying bodies).
- An in-depth description of specific supervision models, approaches, or techniques. The competencies are relevant across treatment settings and models of supervision. The references listed throughout the document and in Appendix C: Suggested Reading and Other Resources are excellent sources of information about models and specific supervision techniques.

Using This Document

Basing clinical supervision practices on the competencies described in this publication may require significant changes in current supervisory practices. State agencies may choose to alter guidelines for clinical supervision in their administrative rules. Community agencies may choose to make changes throughout their organizations in day-to-day clinical supervision practices. Making such changes requires planning and a process designed for gradual incremental change. To assist in the implementation process, Section II contains a discussion of how a set of guidelines could be useful and presents recommendations for facilitating successful implementation at both the State and the community agency levels.

The clinical supervision competencies in the foundation areas (Section III) and performance domains (Section IV) serve as guides to providing consistent and comprehensive supervisory training and development. In general, they promote a common understanding of the clinical supervisor's roles and responsibilities, foster development of standards for the delivery of clinical supervision, encourage the development of clinical supervision credentials, and raise questions for future study. Specifically, the competencies provide a resource for professional development to the following individuals and organizations:

- New and experienced supervisors can assess their proficiency and use their self-assessment to establish personal professional development plans. Aspiring supervisors can develop accurate expectations about the nature of being a supervisor and seek education and training that will prepare them for the role.
- Counselors can become familiar with supervision standards, develop accurate expectations about their role in supervision, and identify how supervision can contribute to their professional development.
- Agency administrators can identify the potential benefits of establishing an effective clinical supervision program, improve their understanding of the clinical supervisor's tasks and responsibilities, and provide clear guidelines for the delivery of clinical supervision in their agencies.
- Professional and advocacy associations can establish practice standards and plan continuing education efforts for clinical supervisors.
- Educators and training professionals can assess and improve existing curricula related to supervision, as well as enhance the quality of supervision in academic practica, field training, and internship experiences.

- Single State Authorities can establish administrative rules related to the availability and delivery of clinical supervision and recommend or provide technical assistance to State-affiliated or contracted agencies that provide treatment services for substance use disorders.
- Certification and licensing bodies can establish or update clinical supervisor credentialing or licensing standards and prepare credentialing examination questions.
- Federal agencies can develop contract and grant guidelines to ensure the quality of services they support and to promote the highest possible standard of care.
- Allied health professionals can establish or improve supervision guidelines in their clinical settings.
- Researchers can develop research agendas.

Directions for Future Research

The Task Force recognizes that more work is needed and hopes that clinical supervision in general and this supervisor competency framework will be the subject of further study. Future research could examine the importance of clinical supervision in implementing empirically supported treatment interventions, the relationship between the quality and quantity of supervision to clinical outcomes, and other important issues related to an improved understanding of the relationship between supervision and effective clinical service delivery.

Research specific to the supervisor competencies in this document could focus on—

- Validating the relationship between these competencies and improved service quality;
- Developing additional tools to assess supervisor proficiency in the competencies;
- Determining how best to train supervisors or teach them the competencies; and
- Determining the best way to prepare aspiring clinical supervisors for their future positions.

The Task Force hopes that this document encourages both continued development of clinical supervision as a discipline and continuous improvement of clinical services for people with substance use disorders.

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Section II:

Implementation Guidelines

Why Have Implementation Guidelines?

Competencies for Substance Abuse Treatment Clinical Supervisors (Supervisor Competencies) succinctly describes the knowledge and skills essential to the competent practice of clinical supervision in treatment settings. Within the performance domains (Section IV), responsibilities are clearly laid out for counselor development, maintaining professional and ethical standards, program development and quality assurance, performance evaluation, and administrative functions. When supervisors have an opportunity to observe and evaluate the work of clinicians, they become aware of both the strengths and the deficits of the services being delivered. They can identify issues that need resolution and services or supervisee skills that need to be enhanced.

Such comprehensive practice, in reality, is relatively rare in clinical settings today. Most treatment agencies have clinical supervisors. However, their work typically is limited to administrative and case management duties such as reviewing case records, facilitating case staffing conferences, and collaborating on difficult cases. Actual observation of clinical services, performance feedback, coaching, teaching, and negotiating professional development plans occur relatively infrequently.

For most agencies, adopting clinical supervision practices consistent with the performance domains identified in this document will require a significant change in operations. In return for their investment in time and resources, agencies will find themselves engaged in an improvement-oriented approach to the monitoring and development of clinical services that likely will lead to improved staff retention, enhanced counselor skills, and better clinical outcomes.

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 development of an implementation plan and to ensure a smooth transition from existing practice to a different way of supervising clinical staff. Some necessary tasks include—

- Defining or clarifying the rationale, purpose, and methods for delivering clinical supervision;
- Ensuring that agency management fully understands and supports the changes that need to be made;
- Providing training and support in supervisory knowledge and skill development; and
- Orienting clinicians to the new supervision rationale and procedures.

These tasks require an implementation *process*. Too often, the assumption is made that systemic changes can be made by administrative order. However, research indicates that successful change requires a comprehensive plan, management support, effective leadership, and a period of effort sufficient for the change to become a normative practice (Bradley et al., 2004). Agencies should introduce and enact changes in supervisory practice over a defined period that allows for procedures to be developed, supervisors to test the new operations, and clinicians to provide feedback and adjust to a more collaborative, observational supervisory process. The broad goal is to create a continuous learning culture in the agency that encourages professional development, service improvement, and a quality of care that maximizes benefits to the agency's clients.

What Needs To Be Implemented?

Agency management needs to study the five performance domains in the *Supervisor Competencies* and compare them with existing agency practice to determine the type and extent of change needed. At a minimum, management needs to examine its current—

- Organizational culture;
- Policies and procedures;
- Position descriptions;
- Direct service expectations; and
- Time allocated to the delivery of clinical supervision.

Time is a significant issue. The type of clinical supervision described in this document takes considerably more time than is typically allotted in community agencies. Nonetheless, that time should be considered an investment that will return benefits of improved service delivery, fewer direct service performance problems, improved risk management, and better treatment outcomes.

If agency management clarifies expectations for both the delivery and the outcome of clinical supervision before its implementation, staff is likely to be more receptive to the time investment necessary to implement an effective clinical supervision model. Supervisors need to be trained in the roles and processes of clinical supervision that are consistent with management expectations. Such training is best delivered over a period that allows supervisors to apply new knowledge and practices during the learning process. Making available a consultant or coach, who can meet regularly with supervisory staff to guide implementation, enhances the likelihood of a smooth and effective transition.

While supervisors are being trained, staff clinicians need to be introduced to the new supervisory paradigm. As clinicians begin to experience being observed, receiving feedback, and negotiating individual development plans, it is important that they discuss their experiences with supervisors and managers. Such discussion likely will yield suggestions for process improvement and provide opportunities to clarify misunderstandings and improve communication.

Most agencies can expect to complete the initial change process within 6 months. However, learning and adjustments to the model will continue as agencies assess the performance and needs of both supervisors and clinical staff. Agencies may need to be encouraged to "hang in there" when faced with implementation difficulties. In addition, when a new practice is introduced and adopted, the ability to monitor, provide feedback, and coach facilitates continuous quality improvement and increases fidelity to a new protocol. Without the opportunity to directly monitor clinical processes, it is unlikely that fidelity to any treatment intervention or protocol will be maintained.

The following guidelines are suggested, for both State- and agency-level implementation efforts, to facilitate successful adoption of enhanced clinical supervision practices in addiction treatment agencies.

Implementation Guidelines: State Level

1. **Appoint a leader for the improvement effort.** Without an accountable leader, change initiatives often move slowly, are plagued with miscommunication, or founder altogether. The leader—

   - Assesses readiness to adopt a new model of clinical supervision;
   - Oversees the change process;
   - Facilitates the achievement of objectives;
   - Monitors data being gathered to measure success;
   - Checks in regularly with key players on the change team; and
   - Troubleshoots when unanticipated problems arise.

   The leader's success often hinges on whether sufficient time has been allocated to the project. When a system change is important, management must ensure that the leader, whether an employee or a contractor, has the time and resources to successfully implement the change plan.

2. **Start with agencies that choose to adopt the change.** Change is often accompanied by resistance. To be successful, statewide initiatives should consider a phase-in process that begins with the agencies most interested in adopting the change. Using this strategy can accomplish two objectives that enhance the possibility of success throughout the system. First, agencies that are most ready are most likely to be successful. Word of their success can be spread throughout the system, thus reducing resistance among a significant number of peer agencies. Second, by starting small, State management and the participating "early adopters" can work out problems and develop a proven set of guidelines for other agencies to use. The selection of agencies for this first phase of the process should be done carefully; only those deemed most ready should be selected to participate.

3. **Establish clear written standards and agreements with participating agencies.** Expectations, timeframes, deliverable products, and progress benchmarks should be clarified in the State's agreement or contract with a participating agency. Before such conditions are established, the State may do several things in preparation. First, it may survey agencies to determine the current state of clinical supervision activities. This survey can provide a baseline for comparison purposes later and can yield information about the types of changes needed to bring agencies in line with the State's goals. Second, the State may consider establishing a set of minimum standards for the delivery of clinical supervision. The minimum amount, type, and frequency of clinical supervision activities (depending on caseload and number of clinicians) could be established, preferably in consultation with selected treatment agency representatives. Third, the State may establish minimum clinical supervisor qualification standards (e.g., for education, clinical licensure, supervisory certification) to provide guidance to agencies in revising their clinical supervision protocols.

4. **Establish criteria for annual performance evaluations of clinical staff.** Evaluations should be based on multiple, periodic direct observations of clinical duties and activities. Performance should be assessed in relation to proficiency in the relevant addiction counseling competencies. The agency should include other criteria that reflect its strategic plan, position descriptions, and individual professional development plans implemented during the year.

5. **Recognize that change is incremental.** Although establishing statewide goals and objectives is important, so is remembering that each agency is different and that success depends on an agency's ability to adapt its clinical services system to the new requirements. Variations in how the new standards are implemented at the agency level are inevitable. It is important to provide clinical supervision in a way that facilitates the continuous improvement of clinical services and improves treatment outcomes. Creative adaptations are to be expected and even encouraged. Agencies, to be successful, need to buy into and own the improvements they make and not simply respond to a mandate from a regulatory authority.

6. **Develop a source of technical assistance and statewide monitoring.** Not all agencies can successfully enhance their supervisory practices without outside assistance. Technical assistance can be provided in a number of ways. For example, the State could develop a manual that includes—

   - Sample supervisory practices;
   - Performance assessment tools;
   - Professional development planning forms;
   - Checklists for required policies and procedures; and
   - A list of resources and external sources of technical assistance.

   Consultants or peer experts could be identified to review a requesting agency's clinical supervision program and resolve specific issues. Agencies also could be required to submit specific prescribed data to allow statewide monitoring of clinical supervision activities, changes, and the effect of supervision activities on other measures of agency performance. Without some objective measures, it is impossible for the State to monitor and assess progress in the delivery of clinical supervision.

7. **Ensure the availability of ongoing training in clinical supervision methods.** Too often the expectation is that new knowledge and skills can be acquired quickly, with brief exposure during a class, workshop, or conference. Complex skills and knowledge, however, are best acquired over time, interspersed with periods of experimentation and practice. Clinical supervision, as described in this volume, is a discipline marked by a large body of foundation knowledge and many performance domains. A working knowledge of the competencies and proficiency in supervisory skills can be acquired only through a learning *process*, not one or even several learning *events*. Clinical supervisors motivated to master their craft need to attend continuing education programs throughout their careers.

8. **Develop a credential that reflects proficiency in the clinical supervision competencies.** Most disciplines with an array of unique competencies establish a way of verifying basic qualifications and practice knowledge. Clinical supervision should not be an exception. A State's existing credentials need to be modified to encompass minimal State qualifications and an assessment of the supervisor's understanding and appreciation of

the competencies described in this volume, or a new credential needs to be established that does so. Only then can employers and State monitors accurately assess an applicant's readiness to fill a supervisory position in a clinical setting.

Implementation Guidelines: Agency Level

1. **Base improvement objectives on needs identified within the agency.** The best way to identify agency needs is to study existing clinical supervision practices, compare them with the competencies in the performance domains, and note important issues to management. Sometimes a consultant trained in facilitating service improvement, who has expertise in clinical supervision, can help management prioritize improvements and recommend implementation processes tailored to agency needs. Often the consultant works with the agency over several months to facilitate the process and provides coaching to agency leadership.

2. **Select only changes that management will fully support.** Some improvements in clinical supervision require significant changes in the amount of time supervisors devote to supervisory activities and the nature of those activities. It is important to choose only objectives that the highest level of management supports. The initiative gains credibility with staff when management announces the importance of the change, identifies how the agency expects to benefit, and clarifies how progress will be measured. Anything less than a serious commitment is likely to limit severely the success of an improvement process.

   When more than one change is identified as a high priority, it is important to limit changes to what can be planned and implemented while attending to other key agency functions. Changing too much at once can be as detrimental as a lack of management support and can overwhelm everyone involved. Overwhelming frequently results in returning to the familiar rather than forging ahead to explore the unknown.

3. **Create a change plan with objectives that are specific, achievable, and measurable.** Management must identify the reasons for change and communicate them clearly to agency staff. The objectives or outcomes sought should be clearly defined and measurable. The change process needs to be initiated by developing, with a small number of key staff members, a detailed plan to achieve management's objectives. Such a plan typically includes a progression of activities that gradually enact the new processes or improvements. As the plan unfolds, revisions can be made to accommodate unanticipated situations or difficulties encountered by participating supervisors.

4. **Identify a leader to facilitate the improvement process.** Regardless of whether the agency secures outside consultation, it should assign a staff member who has the respect of both management and supervisory staff to serve as the internal leader of a change initiative team. This team leader—

   - Collaborates with the consultant and the supervisory team;
   - Helps present the change plan to the staff;
   - Clarifies assignments for implementing the plan;
   - Debriefs and celebrates progress;
   - Prevents discouragement when problems are encountered;
   - Keeps both management and line staff apprised of progress; and
   - Facilitates problem resolution when necessary.

The change leader ensures that data indicating progress are gathered and checks in with those implementing change to ensure fidelity with the plan. In short, the change leader is responsible for moving the project forward, keeping it on track, and identifying both successes and problems along the way.

The supervisory team should also facilitate peer supervision and support as the implementation process progresses. Collaboratively debriefing supervisors about their experiences of directly observing clinicians, providing feedback, and developing learning plans generate momentum and solidify the importance of the improvement initiative. Another value of peer support is that clinical supervisors often are isolated and need as much clinical supervision as the people they supervise.

5. **Make sure that all staff members are prepared to implement the plan.** Supervisors often need training in the new skills and practices they are expected to implement. They typically are promoted based on their performance as clinicians or because they have advanced educational degrees and are considered the best-trained staff in the agency. In either case, supervisors rarely have much training in how to be effective, so most agencies will need to provide supervisory training in both the foundation areas and the performance domains that constitute the *Supervisor Competencies.*

   Just as supervisors need training in the foundation areas and performance domains, clinicians must be oriented to new ways of receiving clinical supervision. Some clinicians are anxious or even resistant to the monitoring, feedback, and coaching that form the essence of the *Supervisor Competencies.* They need reassurance that the goal is to facilitate service improvements, not to criticize individuals. Clinical supervision identifies and acknowledges clinicians' strengths and limitations and provides opportunities for continued learning and improvement of clinical services. The goal of clinical supervision is not to find fault but to identify ways for clinicians to grow professionally.

   When everyone understands the intent and the mechanics of the new procedures, then the agency is ready to begin implementation. Management should arrange for staff members to meet with the change leader and consultant to provide feedback on the new procedures. Modifications can be made to the initial plan as needed.

6. **When success is achieved, implement a sustainability plan.** Once supervisors have integrated the improvement processes and tools into their practice, are experiencing success in their alliance with supervisees, and see improvements in clinical skills and service delivery, it is time to establish an ongoing process to ensure the continued development of supervisory practices. The plan can include periodic (e.g., quarterly) review of quality assurance indicators, the strengths and limitations of current supervisory practices, and adjustments to the agency's expectations of supervisors and clinical staff.

Readers are encouraged to develop a thorough working knowledge of the competencies described in this volume. The Task Force predicts that quality supervision will become a major factor in determining the degree to which evidence-based practices are adopted in community settings; identifying the professional development needs of agencies, clinical supervisors, and clinicians; and improving retention rates for both clients and clinical staff.

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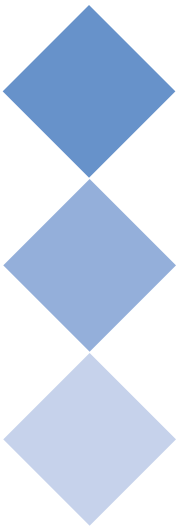
Section III:

Foundation Areas



Effective clinical supervisors are skilled, experienced clinicians. They are knowledgeable about substance use disorders and generally accepted, research-based assessment, intervention, treatment, and recovery strategies. It is important that supervisees believe that their supervisors have substantial knowledge and skill to pass along. However, knowledge and skill as a counselor are not enough to ensure success as a clinical supervisor.

The specific tasks, responsibilities, and roles of supervisors vary depending on agency mission, target population, theoretical model, treatment modality, and general structure. However, some basic competencies are common to a variety of settings and professional disciplines. These basic concepts are reflected in the foundation area competencies in this document. They are common across the variety of disciplines and interest groups that provide care for clients with substance use disorders. The competencies identified as *foundation areas* complement those found in the transdisciplinary foundations section of TAP 21. Clinical supervisors in substance use disorder treatment settings are expected to be familiar with the knowledge described in the transdisciplinary foundations.

The framework used here identifies five foundation areas in clinical supervision:

FA1: Theories, Roles, and Modalities of Clinical Supervision;
FA2: Leadership;
FA3: Supervisory Alliance;
FA4: Critical Thinking; and
FA5: Organizational Management and Administration.

Each contains several competencies that, taken together, define the work of the clinical supervisor.

FA1: Theories, Roles, and Modalities of Clinical Supervision

Introduction

Although some similarities exist between counseling and supervising, there are many important differences. Clinical supervision has its own knowledge base, and supervisors must understand different theoretical perspectives. They also must understand the roles clinical supervisors are expected to fill and the various modalities, or ways of implementing supervision, that are available.

The Competencies

- Understand the role of clinical supervision as the principal method for monitoring and ensuring the quality of clinical services.
- Appreciate the systemic role of the clinical supervisor as a primary link between management and direct services.
- Understand the multiple roles of the clinical supervisor, including consultant, mentor, teacher, team member, evaluator, and administrator.
- Be able to define the purpose of clinical supervision specific to the organization's clinical and administrative contexts, including supervisory goals and methods.
- Be familiar with a variety of theoretical models of clinical supervision, including (but not limited to) psychotherapy-based, developmental, multicultural, integrative, and blended models.
- Be able to articulate one's model of supervision.
- Be familiar with modalities of clinical supervision, including individual, group, direct observation, and consultation.
- Be familiar with the current research literature related to recommended practices in both substance use disorder treatment and clinical supervision.
- Be familiar with the literature regarding multiple learning strategies (e.g., instructions, demonstrations, role plays, critiques).
- Recognize the importance of establishing with the supervisee a productive, healthy learning alliance focused on improving client services and job performance.
- Understand and reinforce the complementary roles of members on a multidisciplinary team.
- Understand the importance of assessing needs and carefully planning and systematically implementing individual and group supervisory activities that promote clinical and program service improvement.

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FA2: Leadership

Introduction

Leadership is an important element of clinical supervision. Leadership may be defined as a bidirectional social influence process in which supervisors seek voluntary participation of supervisees to achieve organizational goals, while providing leadership in the management structure of the agency. Leaders mentor, coach, inspire, and motivate. They build teams, provide structure, create cohesion, and resolve conflict. In addition, leaders build organizational culture, facilitate individual and organizational growth and change, and foster a culturally sensitive service delivery system by consistently advocating, at all levels of the organization, the need for high-quality clinical care for all patients or clients of the agency.

The Competencies

- Use a leadership style that creates and maintains an environment based on mutual respect, trust, and teamwork.
- Be a role model by taking full responsibility for one's decisions, supervisory practices, and personal wellness.
- Seek job performance feedback from supervisees, peers, and managers to improve supervisory practices.
- Create, regularly assess, and revise a personal leadership plan to provide direction for one's continuing professional development.
- Seek out and use leadership mentors to assist with one's personal development, knowledge acquisition, and skill development.
- Understand the historical context of treatment for substance use disorders and use that understanding to participate in developing the agency's guiding vision and its related mission, principles, and sense of purpose.
- Clarify agency vision, mission, and service goals and objectives for the supervisee.
- Interpret agency mission, policies, procedures, and critical events. Effectively communicate those interpretations to supervisees and foster an organizational climate that promotes continuous improvement and excellence in client care.
- Understand, monitor, and ensure compliance with State and Federal regulations and accrediting body (e.g., Commission on Accreditation of Rehabilitation Facilities, Joint Commission on Accreditation of Healthcare Organizations, Council on Accreditation) standards for the delivery of substance use disorder treatment.
- Recognize the safety and security issues facing the organization and participate in enforcing and enhancing organizational policies that ensure the safety and security of clients, personnel, and facilities.
- Understand and acknowledge the power differential inherent in the supervisor–supervisee relationship, using power fairly and purposefully avoiding the abuse of power.
- Proactively structure and schedule clinical supervision activities.
- Teach, mentor, and coach in the context of the organization's core values.
- Provide honest feedback—positive, constructive, and corrective.

- Guide through motivational empowerment rather than control. Facilitate work through team building, training, coaching, and support.
- Plan and organize for orderly workflow, controlling details without being overbearing.
- Empower and delegate key duties to others while maintaining goal clarity and commitment. Delegate mindfully, considering both the supervisee's professional development and the agency's needs.
- Encourage supervisee participation in communicating observations, ideas, and suggestions to agency management.

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FA3: Supervisory Alliance

Introduction

Clinical supervision takes place in the context of the supervisor–supervisee relationship. A positive supervisory alliance includes mutual understanding of the goals and tasks of supervision and a strong professional bond between supervisor and supervisee. To be effective, a supervisor must have a clear understanding of the nature and dynamics of this relationship.

The Competencies

- Be familiar with the literature about supervisory alliance, including key factors that strengthen or compromise the supervisory alliance, supervisory contracting, and relational issues (e.g., transference and countertransference).
- Understand the complex, multilevel, and bidirectional nature of the supervisory triad of client, counselor, and supervisor. Maintain an awareness of potential dual relationships and boundary violations within the triad.
- Recognize that the supervisor–supervisee relationship develops over time and that the stage of relationship development influences the rules, roles, and expectations of the alliance.
- Conceptualize the supervisor–supervisee relationship as a learning alliance that provides for role induction, includes agreement on goals and tasks, and recognizes the bond that develops between the supervisor and the supervisee.
- Understand the value of mentoring as a dynamic way of forming an alliance, teaching counseling skills through encouragement, and giving suggestions for accomplishing goals.
- Create an explicit supervisory contract that clarifies expectations and goals, the relationship's structure and evaluative criteria, and the limits of supervisor–supervisee confidentiality.
- Present as a credible professional who possesses knowledge and expertise relevant to the setting and the population being served.
- Model ethical behavior vis-à-vis the supervisee and reinforce ethical standards in the relationship between the supervisee and the supervisee's clients.
- Be continually alert to the effects of one's interpersonal style on the supervisee.
- Maintain appropriate boundaries in forming and maintaining a safe and trusting professional relationship.
- Attend to cultural, racial, gender, age, and other diversity variables essential to a productive supervisor–supervisee relationship.
- Understand, recognize, and know how to ameliorate the effects of personal countertransference triggered by the supervisee's interpersonal style, the supervisee's developmental issues, or the supervisee's unresolved personal issues.
- Recognize interpersonal conflict and supervisory impasses, accept appropriate responsibility, and actively participate in resolving difficulties.

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FA4: Critical Thinking

Introduction

Critical thinking refers to the cognitive processes of conceptualizing, analyzing, applying information, synthesizing, and evaluating. Supervisors are expected to use critical thinking to make sound decisions and solve problems on a regular basis; they also must help supervisees hone critical thinking skills.

The Competencies

- Understand the various contexts (e.g., organizational, political, societal, cultural) in which supervision is conducted.
- Analyze and evaluate agency issues and policies to better understand, clarify, and participate in the continuous improvement of agency and staff performance and service outcomes.
- Evaluate and select written and oral communication strategies appropriate to the audience and purpose.
- Select, adapt, implement, and evaluate appropriate problemsolving, decisionmaking, and conflict resolution techniques.
- Apply experience, insight, and lessons learned to new situations.
- Apply critical thinking to information gathering by evaluating the content of the information and the credibility of its source.
- Ask supervisees relevant and clarifying questions and listen critically for content and underlying issues in their self-disclosure.
- Help supervisees develop skills in case conceptualization and analysis of client–counselor interactions.
- Negotiate, communicate, and document the resolution of conflicts or disagreements and strategies for resolving performance problems. Document outcomes.
- Develop sound criteria for self-evaluation and clarify personal beliefs, values, and biases.
- Help supervisees develop sound criteria for self-evaluation and clarify their beliefs, values, and biases.

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FA5: Organizational Management and Administration

Introduction

Management can be defined as the process of working with and through others to achieve organizational objectives in an efficient, legal, and ethical manner. Administration, in the context of this document, is the day-to-day implementation of the organization's policies and procedures.

Although clinical supervision is distinguished from administrative supervision in some models of supervisory practice, the two significantly overlap in the real world. Virtually all clinical supervisors have responsibility for some management and administrative activities, but the scope of these activities can vary widely depending on the organization.

The Competencies

- Recognize that organizational and managerial skills and tasks enhance clinical supervision.
- Understand and consistently apply agency policies, procedures, organizational structure, and communication protocols.
- Understand the legal demands and liabilities inherent in supervisory and clinical services, including the vicarious liabilities incurred in supervising interns and students.
- Be familiar with and abide by current principles, laws, ethical guidelines, and agency policies regarding personnel management.
- Learn to implement effective disciplinary and administrative management techniques that enhance clinical supervision and accomplishment of the organization's mission.
- Understand and ensure supervisee compliance with State program licensing requirements and with other State and Federal laws and statutes.
- Understand and ensure supervisee compliance with the substance use disorder treatment standards of the organization's healthcare accrediting body (e.g., Commission on Accreditation of Rehabilitation Facilities, Joint Commission on Accreditation of Healthcare Organizations).
- Monitor and maintain the human and technical resources needed to meet organizational and program objectives.
- Evaluate and contribute to improving the organization's cultural proficiency.
- Possess and continually improve organizational and time management skills.
- Understand and work within the organization's budgetary constraints.
- Effectively apply technology, within agency and regulatory limits, for communication, program monitoring, report writing, problemsolving, recordkeeping, case management, and other activities.
- Ensure the maintenance, storage, and security of employee records and protected health information consistent with the organization's policies and procedures, government regulations, and ethical principles.

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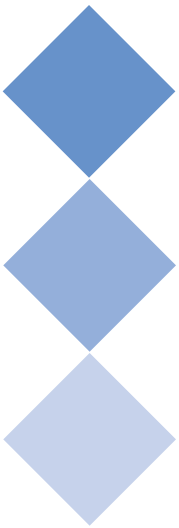
Section IV:

Performance Domains



Performance domains identify specific areas of clinical supervision practice that are essential to protecting client welfare, achieving agency goals, and improving clinical services. To ensure high-quality service delivery, supervisors work to develop and maintain competence among direct service staff while adhering to high professional and ethical standards. Supervisors provide supervisees with appropriate feedback while facilitating knowledge and skill development. To accomplish these tasks, supervisors must gather objective information on which to base an evaluation of their supervisees' performance. Supervisors also perform administrative tasks that preserve and build the organizational culture.

The framework used here identifies five performance domains:

PD1: Counselor Development;
PD2: Professional and Ethical Standards;
PD3: Program Development and Quality Assurance;
PD4: Performance Evaluation; and
PD5: Administration.

The competencies listed within each performance domain identify the specific abilities and responsibilities that clinical supervisors must master to be effective in the essential roles they play in the service delivery system.

Counselor development and performance evaluation are discussed here as two separate performance domains because each requires a distinct set of competencies. It is important to note, however, that each is integral to the other. Performance evaluation without a counselor development process would not necessarily lead to improved counselor proficiency. Similarly, counselor development activities in the absence of performance evaluation would likely be untargeted, general, and of less value to the counselor.

PD1: Counselor Development

Introduction

The continuous development of staff clinical skills is key to the delivery of high-quality client care. Counselor development is a complex process that involves teaching, facilitating, collaborating, and supporting counselor self-efficacy. Supervisors must facilitate this process in the context of a collaborative supervisor–supervisee relationship and within professional, ethical, and legal guidelines. Supervisors also must consistently maintain a multicultural perspective.

The Competencies

- Teach supervisees the purpose of clinical supervision and how to use it effectively.
- Ensure that comprehensive orientation is provided to new employees, including in areas such as the organization's client population, mission, vision, policies, and procedures.
- Build a supportive and individualized supervisory alliance that respects professional boundaries.
- Maintain a constructive supervisory learning environment that fosters awareness of oneself and others, motivation, self-efficacy, enthusiasm, and two-way feedback.
- Conceptualize and plan individual and group supervision activities, incorporating supervisees' preferred learning styles, cultures, genders, ages, and other appropriate variables.
- Encourage supervisees to examine their views regarding culture, race, values, religion, gender, sexual orientation, and potential biases.
- Help supervisees develop skills of empathy and acceptance specific to working with culturally diverse clients.
- Provide timely and specific feedback to supervisees on their conceptualizations of client needs, attitudes toward clients, clinical skills, and overall performance of assigned responsibilities.
- Create a professional development plan with supervisees that includes mutually approved goals and objectives for improving job performance, how goals and objectives will be met (including the respective responsibilities of the supervisor and the supervisee), a timeline for expected accomplishments, and measurements of progress and goal attainment.
- Implement a variety of direct supervisory activities (e.g., role play, live supervision/observation, review of audiotaped and videotaped sessions, presentation/discussion of case studies) to teach and strengthen supervisees' theoretical orientation, professional ethics, clinical skills, and personal wellness.
- Help supervisees recognize, understand, and cope with unique problems of transference and countertransference when working with clients with substance use disorders.
- Acknowledge supervisees' development and celebrate accomplishments through frequent rewards and recognition.
- Encourage and help supervisees develop a personal wellness plan to manage their stress and avoid compassion fatigue and burnout.

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PD2: Professional and Ethical Standards

Introduction

Supervisors work in a complex environment subject to professional, statutory, and regulatory guidelines. This domain identifies competencies related to protecting the public, clients, and staff members. It also describes the development of supervisors' professional identity and integrity in the context of professional supervisory practice.

The Competencies

- Be familiar with relevant professional codes of ethics (see Appendix B), client's rights documents, and laws and regulations that govern both counseling and clinical supervision practices.
- Ensure that supervisees are familiar with generally accepted professional codes of ethics, State and Federal statutes regarding duty to report (e.g., child abuse) and duty to warn (e.g., threat of physical violence against a reasonably identifiable victim or victims), Federal confidentiality (e.g., 42 Code of Federal Regulations, Part 2) and privacy (e.g., Health Insurance Portability and Accountability Act) rules and regulations, and other legal constraints on the counseling relationship.
- Follow due process guidelines when responding to grievances and ensure that supervisees know their rights as employees and understand the organization's employee grievance procedures.
- Ensure that supervisees are familiar with client's rights and understand client grievance procedures.
- Ensure that supervisees inform clients about the limits of confidentiality (e.g., child abuse reporting, specific threats of violence).
- Ensure that supervisees inform clients about supervision practices (e.g., direct observation, session transcripts) and obtain documented informed consent from clients as appropriate (e.g., signed releases for audio or video recording of sessions).
- Learn about supervisees' cultures, lifestyles, beliefs, and other key factors that may influence their job performance.
- Use and teach supervisees an ethical decisionmaking model, such as that described by Corey and colleagues (2002), as a guide for supervisory and clinical practice.
- Understand the risks of dual relationships and potential conflicts of interest in the supervisor–supervisee relationship and maintain appropriate relationships at all times.
- Help supervisees develop awareness of possible dual relationships in the client–counselor relationship.
- Monitor supervisees' clinical practice to enhance their competence and ensure their ethical treatment of clients.
- Provide timely consultation and guidance to supervisees in situations that present moral, legal, and/or ethical dilemmas.
- Ensure that supervisees maintain complete, accurate, and necessary documentation at all times, including detailed descriptions of actions taken in critical situations.

- Intervene immediately and take action as necessary when a supervisee's job performance appears to present problems.
- Report supervisees' ethical violations to the appropriate professional organizations and State bodies as required.
- Maintain familiarity with consensus- and evidence-based best practices in the treatment of substance use disorders.
- Build supervisory competence by actively participating in professional organizations and in a variety of relevant professional and educational activities.
- Seek supervision and consultation to evaluate one's personal needs for training and education, receive and discuss feedback on supervisory job performance, and implement a professional development plan.
- Practice only within one's areas of clinical and supervisory competence.
- Develop and maintain a personal wellness plan for physical and mental health and encourage supervisees to develop and maintain personal wellness plans.

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PD3: Program Development and Quality Assurance

Introduction

Program development is the process of guiding the natural evolution of a service delivery organization to maximize the potential of its staff and resources to meet the needs of the population it serves. Quality assurance (QA) is the process of designing, implementing, monitoring, and improving a program's activities to ensure maximum effectiveness and efficiency of services within the limitations of the agency and its operating environment.

The extent to which clinical supervisors are responsible for program development and QA activities varies, depending on the size, structure, and mission of the organization. However, all clinical supervisors have *some* responsibility for these activities.

The Competencies

- Structure and facilitate staff learning about specific consensus- and evidence-based treatment interventions, program service design, and recovery models relevant to the organization and the population it serves.
- Understand the limitations of addiction treatment in general; its relationship to sustained, long-term recovery; and the specific limitations of the models or design in use by supervisees.
- Understand and be able to apply principles of technology transfer to assist in the adoption and implementation of new clinical practices.
- Identify, develop, and obtain appropriate learning and treatment resource materials that meet the needs of the agency, its clients, and supervisees.
- Plan and facilitate inservice training and other organizational activities that support application of empirically based clinical interventions that are responsive to needs of the agency, clients, and supervisees.
- Understand the balance between fidelity and adaptability when implementing new clinical practices.
- Be familiar with the methods used to analyze the organization's developmental needs and clinical outcomes, including regular needs assessments.
- Advocate within the agency for ongoing quality improvement, including strategies for enhancing client access, engagement, and retention in treatment.
- Understand the organization's QA plan and comply with all monitoring, documenting, and reporting requirements.
- Develop program goals and objectives and counselor development plans that are consistent with the organization's QA plan.
- Solicit, document, and use client feedback to improve service delivery.
- Provide diversity training and other experiences that empower one to become an advocate for the organization's target population and an agent of organizational change.
- Build and maintain relationships with referral sources and other community programs to expand, enhance, and expedite service delivery.
- Develop skills to advocate for clients throughout the entire continuum of care.

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PD4: Performance Evaluation

Introduction

Counselor evaluation is central to the assurance of high-quality client care. It is a professional and ethical responsibility of clinical supervisors to regularly monitor the quality of supervisees' performance, to facilitate improvement in supervisees' clinical competence, and to assess supervisees' readiness to practice with increasing autonomy. As such, this domain is closely related to Counselor Development (PD1). The competencies in each are distinct yet highly complementary and interactive.

The Competencies

- Communicate agency expectations about the job duties and competencies, performance indicators, and criteria used to evaluate job performance.
- Understand the concept of supervision as a two-way evaluative process with each party providing feedback to the other, including constructive sharing and resolution of disagreements. Actively encourage supervisees to provide feedback to the supervisor regarding the supervisor's performance.
- Assess supervisees' professional development, cultural competence, and proficiency in the addiction counseling competencies.
- Differentiate between counselor developmental issues and those requiring corrective action (e.g., ethical violations, incompetence).
- Assess supervisees' preferred learning style, motivation, and suitability for the work setting.
- Use multiple sources of quantitative and qualitative data, direct and indirect observations, and formal and informal methods of assessment to ensure substantiated and accurate evaluation.
- Institute an ongoing formalized, proactive process that identifies supervisees' training needs, actively involves supervisees in conjointly reviewing goals and objectives, and reinforces performance improvement with positive feedback.
- Communicate feedback clearly, including feedback regarding performance deficits, weak competencies, or harmful activities. Provide timely written notification of all performance problems and ensure that supervisees understand the feedback.
- Evaluate the competency, including the fidelity, with which supervisees implement research-based treatment protocols.
- Address and manage relational issues common to evaluation, including anxiety, disagreements, and full discussion of performance problems.
- Guide and evaluate supervisees' ability to use a range of evaluative tools (e.g., process recordings, memory work, audiotapes and videotapes, direct observation) and encourage them to use the most effective techniques available in the setting.
- Skillfully use agency evaluation tools and procedures.
- Self-assess for evaluator bias (e.g., leniency, overemphasis on one area of performance, favoritism, stereotyping) and conflict with other supervisory roles.

- Adhere to professional standards of ongoing supervisory documentation, including written individual development plans, supervision session notes, written documentation of corrective actions, and written recognition of good performance.

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PD5: Administration

Introduction

Clinical supervisors' administrative responsibilities are the executive functions of the position, those duties that help the organization run smoothly and efficiently. Administrative responsibilities include following the organization's policies and procedures (including those related to human resource management), ensuring the maintenance of case records, monitoring case documentation, assisting in financial resource development (e.g., grant proposal writing), and developing relationships with referral sources in the community. Administrative responsibilities also include program development and quality assurance, which are addressed separately in PD3. Although the competencies described below are administrative in nature, many overlap significantly with clinical functions and serve to ensure the quality of services being delivered within the agency. As noted previously, the range of administrative functions clinical supervisors are responsible for will vary from agency to agency.

The Competencies

- Participate in developing, maintaining, applying, and revising the organization's policies, procedures, and forms.
- Monitor, evaluate, and provide feedback regarding supervisees' compliance with administrative policies and procedures.
- Understand and ensure that supervisees understand the organization's chain-of-command and communication protocols.
- Monitor, evaluate, and provide guidance regarding the supervisees' case recordings, including session notes, treatment plans, correspondence, and behavioral contracts.
- Establish and maintain an efficient and comprehensive recordkeeping system that provides clear, chronological documentation of supervisory activities.
- Recommend personnel actions to maintain high standards of clinical care (e.g., hiring, performance recognition, disciplinary action, suspension, termination of clinical staff).
- Maintain and regularly update clinical staff job descriptions according to agency policies and procedures.
- Understand and help supervisees understand and manage the relationships among clinical services, fee assessment and collection, and overall fiscal responsibility.
- Understand and comply with procedures necessary for processing third-party payment claims, if applicable.
- Participate actively in the organization's resource development activities (e.g., grant application or proposal writing).
- Develop and rely on schedules, deadlines, and reminders to meet service needs and ensure completion of assigned projects and tasks.

- Ensure that supervisees have proper training for using information technology systems and have access to technical assistance and other resources.
- Obtain regularly scheduled diversity, crisis management, and safety training for oneself and supervisees.
- Develop and comply with intraorganizational and interorganizational agreements that expand, enhance, and expedite service delivery.
- Maintain security of all supervisory notes, assessments, and other pertinent documents.
- Structure and facilitate effective staff meetings.

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Section VI:

Appendices

- Appendix A: Clinical Supervision Certification—National Resources
- Appendix B: Professional Codes of Ethics Specific to Clinical Supervision
- Appendix C: Suggested Reading and Other Resources
- Appendix D: Field Reviewers

Appendix A: Clinical Supervision Certification—National Resources

Clinical supervisor credentials are available through many State addiction counselor certification boards. Check with the local board for more information about State-level supervisory credentialing.

Approved Clinical Supervisor

National Board for Certified Counselors
Center for Credentialing and Education, Inc.
3 Terrace Way
Greensboro, NC 27403
(336) 482-2856
(336) 482-2852 (fax)
www.cce-global.org/acs.htm

Approved Supervisor Designation

American Association for Marriage and Family Therapy
112 South Alfred Street
Alexandria, VA 22314
(703) 838-9808
(703) 838-9805 (fax)
www.aamft.org/membership/Approved%20Supervisor/AS_Main.asp

Certified Clinical Supervisor

International Consortium of Addiction and Prevention Credentialing Boards
620 Eye Street, N.W., Suite 210
Washington, DC 20006
(202) 785-0683
(202) 785-8949 (fax)
www.icrcaoda.org/credentialing.asp

Certified Pastoral Counselor Supervisor

National Board for Certified Pastoral Counselors
Certification Committee
1331 County Road D
St. Paul, MN 55109
www.nbcpc.org/Webpage.asp?MID=647147

Appendix B: Professional Codes of Ethics Specific to Clinical Supervision

The National Board for Certified Counselors/Center for Credentialing and Education

*The Approved Clinical Supervisor (ACS) Code of Ethics**

Updated September 2005

In addition to following the Code of Ethics of their mental health credentialing body, approved clinical supervisors shall:

1. Ensure that supervisees inform clients of their professional status (e.g., intern) and of all conditions of supervision.

   Supervisors need to ensure that supervisees inform their clients of any status other than being fully qualified for independent practice or licensed. For example, supervisees need to inform their clients if they are a student, intern, trainee or, if licensed with restrictions, the nature of those restrictions (e.g., associate or conditional). In addition, clients must be informed of the requirements of supervision (e.g., the audio taping of all clinical sessions for purposes of supervision).

2. Ensure that clients have been informed of their rights to confidentiality and privileged communication when applicable. Clients also should be informed of the limits of confidentiality and privileged communication.

   The general limits of confidentiality are when harm to self or others is threatened; when the abuse of children, elders or disabled persons is suspected and in cases when the court compels the mental health professional to testify and break confidentiality. These are generally accepted limits to confidentiality and privileged communication, but they may be modified by state or federal statute.

3. Inform supervisees about the process of supervision, including supervision goals, case management procedures, and the supervisor's preferred supervision model(s).

4. Keep and secure supervision records and consider all information gained in supervision as confidential.

5. Avoid all dual relationships with supervisees that may interfere with the supervisor's professional judgment or exploit the supervisee.

   Any sexual, romantic, or intimate relationship is considered to be a violation. Sexual relationship means sexual conduct, sexual harassment, or sexual bias toward a supervisee by a supervisor.

6. Establish procedures with their supervisees for handling crisis situations.

7. Provide supervisees with adequate and timely feedback as part of an established evaluation plan.

8. Render assistance to any supervisee who is unable to provide competent counseling services to clients.

9. Intervene in any situation where the supervisee is impaired and the client is at risk.

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10. Refrain from endorsing an impaired supervisee when such impairment deems it unlikely that the supervisee can provide adequate counseling services.
11. Supervisors offer only supervision for professional services for which they are trained or have supervised experience.

    Supervision should not include assistance in diagnosis, assessment, or treatment without prior training or supervision. Supervisors are responsible for correcting any misrepresentations of the qualifications of others.
12. Ensure that supervisees are aware of the current ethical standards related to their professional practice, as well as legal standards that regulate the practice of counseling.
13. Engage supervisees in an examination of cultural issues that might affect supervision and/or counseling.
14. Ensure that both supervisees and clients are aware of their rights and of due process procedures, and that you as supervisor are ultimately responsible for the client.
15. Refrain from supervising a relative or immediate family member.

Ethical Guidelines for Counseling Supervisors

*Association for Counselor Education and Supervision**

Adopted by ACES Executive Counsel and Delegate Assembly
March 1993

Preamble:

The Association for Counselor Education and Supervision (ACES) is composed of people engaged in the professional preparation of counselors and people responsible for the ongoing supervision of counselors. ACES is a founding division of the American Counseling Association (ACA) and as such adheres to ACA's current ethical standards and to general codes of competence adopted throughout the mental health community.

ACES believes that counselor educators and counseling supervisors in universities and in applied counseling settings, including the range of education and mental health delivery systems, carry responsibilities unique to their job roles. Such responsibilities may include administrative supervision, clinical supervision, or both. Administrative supervision refers to those supervisory activities which increase the efficiency of the delivery of counseling services; whereas, clinical supervision includes the supportive and educative activities of the supervisor designed to improve the application of counseling theory and technique directly to clients.

Counselor educators and counseling supervisors encounter situations which challenge the help given by general ethical standards of the profession at large. These situations require more specific guidelines that provide appropriate guidance in everyday practice.

The Ethical Guidelines for Counseling Supervisors are intended to assist professionals by helping them:

1. Observe ethical and legal protection of clients' and supervisees' rights;

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2. Meet the training and professional development needs of supervisees in ways consistent with clients' welfare and programmatic requirements; and

3. Establish policies, procedures, and standards for implementing programs.

The specification of ethical guidelines enables ACES members to focus on and to clarify the ethical nature of responsibilities held in common. Such guidelines should be reviewed formally every five years, or more often if needed, to meet the needs of ACES members for guidance.

The Ethical Guidelines for Counselor Educators and Counseling Supervisors are meant to help ACES members in conducting supervision. ACES is not currently in a position to hear complaints about alleged non-compliance with these guidelines. Any complaints about the ethical behavior of any ACA member should be measured against the ACA Ethical Standards and a complaint lodged with ACA in accordance with its procedures for doing so.

One overriding assumption underlying this document is that supervision should be ongoing throughout a counselor's career and not stop when a particular level of education, certification, or membership in a professional organization is attained.

DEFINITIONS OF TERMS:

Applied Counseling Settings – Public or private organizations of counselors such as community mental health centers, hospitals, schools, and group or individual private practice settings.

Supervisees – Counselors-in-training in university programs at any level who [are] working with clients in applied settings as part of their university training program, and counselors who have completed their formal education and are employed in an applied counseling setting.

Supervisors – Counselors who have been designated within their university or agency to directly oversee the professional clinical work of counselors. Supervisors also may be persons who offer supervision to counselors seeking state licensure and so provide supervision outside of the administrative aegis of an applied counseling setting.

1. Client Welfare and Rights

1.01 The primary obligation of supervisors is to train counselors so that they respect the integrity and promote the welfare of their clients. Supervisors should have supervisees inform clients that they are being supervised and that observation and/or recordings of the session may be reviewed by the supervisor.

1.02 Supervisors who are licensed counselors and are conducting supervision to aid a supervisee to become licensed should instruct the supervisee not to communicate or in any way convey to the supervisee's clients or to other parties that the supervisee is himself/herself licensed.

1.03 Supervisors should make supervisees aware of clients' rights, including protecting clients' right to privacy and confidentiality in the counseling relationship and the information resulting from it. Clients also should be informed that their right to privacy and confidentiality will not be violated by the supervisory relationship.

1.04 Records of the counseling relationship, including interview notes, test data, correspondence, the electronic storage of these documents, and audio and videotape recordings, are considered to be confidential professional information. Supervisors should see that these materials are used in counseling, research, and training and supervision

of counselors with the full knowledge of the clients and that permission to use these materials is granted by the applied counseling setting offering service to the client. This professional information is to be used for full protection of the client. Written consent from the client (or legal guardian, if a minor) should be secured prior to the use of such information for instructional, supervisory, and/or research purposes. Policies of the applied counseling setting regarding client records also should be followed.

1.05 Supervisors shall adhere to current professional and legal guidelines when conducting research with human participants such as Section D-1 of the ACA Ethical Standards.

1.06 Counseling supervisors are responsible for making every effort to monitor both the professional actions and failures to take action of their supervisees.

2. Supervisory Role

Inherent and integral to the role of supervisor are responsibilities for:

a. Monitoring client welfare;

b. Encouraging compliance with relevant legal, ethical, and professional standards for clinical practice;

c. Monitoring clinical performance and professional development of supervisees; and

d. Evaluating and certifying current performance and potential of supervisees for academic, screening, selection, placement, employment, and credentialing purposes.

2.01 Supervisors should have had training in supervision prior to initiating their role as supervisors.

2.02 Supervisors should pursue professional and personal continuing education activities such as advanced courses, seminars, and professional conferences on a regular and ongoing basis. These activities should include both counseling and supervision topics and skills.

2.03 Supervisors should make their supervisees aware of professional and ethical standards and legal responsibilities of the counseling profession.

2.04 Supervisors of post-degree counselors who are seeking state licensure should encourage these counselors to adhere to the standards for practice established by the state licensure board of the state in which they practice.

2.05 Procedures for contacting the supervisor, or an alternative supervisor, to assist in handling crisis situations should be established and communicated to supervisees.

2.06 Actual work samples via audio and/or video tape or live observation in addition to case notes should be reviewed by the supervisor as a regular part of the ongoing supervisory process.

2.07 Supervisors of counselors should meet regularly in face-to-face sessions with their supervisees.

2.08 Supervisors should provide supervisees with ongoing feedback on their performance. This feedback should take a variety of forms, both formal and informal, and should include verbal and written evaluations. It should be formative during the supervisory experience and summative at the conclusion of the experience.

2.09 Supervisors who have multiple roles (e.g., teacher, clinical supervisor, administrative supervisor) with supervisees should minimize potential conflicts. Where possible, the roles should be divided among several supervisors. Where this is not possible, careful explanation should be conveyed to the supervisee as to the expectations and responsibilities associated with each supervisory role.

2.10 Supervisors should not participate in any form of sexual contact with supervisees. Supervisors should not engage in any form of social contact or interaction which would compromise the supervisor-supervisee relationship. Dual relationships with supervisees that might impair the supervisor's objectivity and professional judgment should be avoided and/or the supervisory relationship terminated.

2.11 Supervisors should not establish a psychotherapeutic relationship as a substitute for supervision. Personal issues should be addressed in supervision only in terms of the impact of these issues on clients and on professional functioning.

2.12 Supervisors, through ongoing supervisee assessment and evaluation, should be aware of any personal or professional limitations of supervisees which are likely to impede future professional performance. Supervisors have the responsibility of recommending remedial assistance to the supervisee and of screening from the training program, applied counseling setting, or state licensure those supervisees who are unable to provide competent professional services. These recommendations should be clearly and professionally explained in writing to the supervisees who are so evaluated.

2.13 Supervisors should not endorse a supervisee for certification, licensure, completion of an academic training program, or continued employment if the supervisor believes the supervisee is impaired in any way that would interfere with the performance of counseling duties. The presence of any such impairment should begin a process of feedback and remediation wherever possible so that the supervisee understands the nature of the impairment and has the opportunity to remedy the problem and continue with his/her professional development.

2.14 Supervisors should incorporate the principles of informed consent and participation; clarity of requirements, expectations, roles and rules; and due process and appeal into the establishment of policies and procedures of their institutions, program, courses, and individual supervisory relationships. Mechanisms for due process appeal of individual supervisory actions should be established and made available to all supervisees.

3. Program Administration Role

3.01 Supervisors should ensure that the programs conducted and experiences provided are in keeping with current guidelines and standards of ACA and its divisions.

3.02 Supervisors should teach courses and/or supervise clinical work only in areas where they are fully competent and experienced.

3.03 To achieve the highest quality of training and supervision, supervisors should be active participants in peer review and peer supervision procedures.

3.04 Supervisors should provide experiences that integrate theoretical knowledge and practical application. Supervisors also should provide opportunities in which supervisees are able to apply the knowledge they have learned and understand the rationale for the skills they have acquired. The knowledge and skills conveyed should reflect current practice, research findings, and available resources.

3.05 Professional competencies, specific courses, and/or required experiences expected of supervisees should be communicated to them in writing prior to admission to the training program or placement/employment by the applied counseling setting, and, in case of continued employment, in a timely manner.

3.06 Supervisors should accept only those persons as supervisees who meet identified entry level requirements for admission to a program of counselor training or for placement in an applied counseling setting. In the case of private supervision in search of state licensure, supervisees should have completed all necessary prerequisites as determined by the state licensure board.

3.07 Supervisors should inform supervisees of the goals, policies, theoretical orientations toward counseling, training, and supervision model or approach on which the supervision is based.

3.08 Supervisees should be encouraged and assisted to define their own theoretical orientation toward counseling, to establish supervision goals for themselves, and to monitor and evaluate their progress toward meeting these goals.

3.09 Supervisors should assess supervisees' skills and experience in order to establish standards for competent professional behavior. Supervisors should restrict supervisees' activities to those that are commensurate with their current level of skills and experiences.

3.10 Supervisors should obtain practicum and fieldwork sites that meet minimum standards for preparing student to become effective counselors. No practicum or fieldwork setting should be approved unless it truly replicates a counseling work setting.

3.11 Practicum and fieldwork classes would be limited in size according to established professional standards to ensure that each student has ample opportunity for individual supervision and feedback. Supervisors in applied counseling settings should have a limited number of supervisees.

3.12 Supervisors in university settings should establish and communicate specific policies and procedures regarding field placement of students. The respective roles of the student counselor, the university supervisor, and the field supervisor should be clearly differentiated in areas such as evaluation, requirements, and confidentiality.

3.13 Supervisors in training programs should communicate regularly with supervisors in agencies used as practicum and/or fieldwork sites regarding current professional practices, expectations of students, and preferred models and modalities of supervision.

3.14 Supervisors at the university should establish clear lines of communication among themselves, the field supervisors, and the students/supervisees.

3.15 Supervisors should establish and communicate to supervisees and to field supervisors specific procedures regarding consultation, performance review, and evaluation of supervisees.

3.16 Evaluations of supervisee performance in universities and in applied counseling settings should be available to supervisees in ways consistent with the Family Rights and Privacy Act and the Buckley Amendment.

3.17 Forms of training that focus primarily on self understanding and problem resolution (e.g., personal growth groups or individual counseling) should be voluntary. Those who conduct these forms of training should not serve simultaneously as supervisors of the supervisees involved in the training.

3.18 A supervisor may recommend participation in activities such as personal growth groups or personal counseling when it has been determined that a supervisee has deficits in the areas of self understanding and problem resolution which impede his/her professional functioning. The supervisors should not be the direct provider of these activities for the supervisee.

3.19 When a training program conducts a personal growth or counseling experience involving relatively intimate self disclosure, care should be taken to eliminate or minimize potential role conflicts for faculty and/or agency supervisors who may conduct these experiences and who also serve as teachers, group leaders, and clinical directors.

3.20 Supervisors should use the following prioritized sequence in resolving conflicts among the needs of the client, the needs of the supervisee, and the needs of the program or agency. Insofar as the client must be protected, it should be understood that client welfare is usually subsumed in federal and state laws such that these statutes should be the first point of reference. Where laws and ethical standards are not present or are unclear, the good judgment of the supervisor should be guided by the following list:

a. Relevant legal and ethical standards (e.g., duty to warn, state child abuse laws);

b. Client welfare;

c. Supervisee welfare;

d. Supervisor welfare; and

e. Program and/or agency service and administrative needs.

Appendix C: Suggested Reading and Other Resources

These books, journals, Web sites, and training resources were recommended by the Clinical Supervision Competencies Task Force or field reviewers.

Books

Addiction Technology Transfer Center Network. *The Change Book: A Blueprint for Technology Transfer* (2d ed.). Kansas City, MO: Addiction Technology Transfer Center Network, 2004.

Addiction Technology Transfer Center Network. *The Change Book Workbook: A Companion to The Change Book.* Kansas City, MO: Addiction Technology Transfer Center Network, 2004.

American Association for Marriage and Family Therapy. *Readings in Family Therapy: Selected Articles from the AAMFT Supervisor Bulletin.* Washington, DC: American Association for Marriage and Family, 2000.

Anderson, B.S., and Hopkins, B.R. *The Counselor and the Law* (4th ed.). Alexandria, VA: American Counseling Association, 1996.

Bernard, J.M., and Goodyear, R.K. *Fundamentals of Clinical Supervision* (3d ed.). Boston: Allyn & Bacon, 2004.

Boylan, J.C., Malley, P.B., and Reilly, E.P. *Practicum and Internship, Textbook and Resource Guide for Counseling and Psychotherapy* (3d ed.). London: Taylor & Francis Group, 2001.

Campbell, J.M. *Becoming an Effective Supervisor: A Workbook for Counselors and Psychotherapists.* Philadelphia: Accelerated Development/Taylor & Francis Group, 2000.

Campbell, J.M. *Essentials of Clinical Supervision.* New York: John Wiley & Sons, 2006.

Holloway, E., and Carroll, M., eds. *Training Counselling Supervisors: Strategies, Methods and Techniques.* London: Sage Publishers, 1999.

Hubble, M.A., Duncan, B.L., and Miller, S.D., eds. *The Heart and Soul of Change: What Works in Therapy.* Washington, DC: American Psychological Association, 2000.

Kinney, J. *Clinical Manual of Substance Abuse.* St. Louis, MO: Mosby, 1996.

Legal Action Center. *Confidentiality and Communication: A Guide to the Federal Alcohol & Drug Confidentiality Law and HIPAA* (revised ed.). New York: Legal Action Center, 2003.

Maxwell, J.C. *Failing Forward: How to Make the Most of Your Mistakes.* Nashville, TN: Nelson Business, 2000.

Maxwell, J.C. *The 360 Degree Leader: Developing Your Influence From Anywhere in the Organization.* Nashville, TN: Nelson Business, 2006.

Maxwell, J.C. *The 360 Degree Leader Workbook: Developing Your Influence From Anywhere in the Organization.* Nashville, TN: Nelson Business, 2006.

Morrissette, P.J. *Self-Supervision: A Primer for Counselors and Helping Professionals.* New York: Brunner-Routledge, 2001.

Powell, D.J., and Brodsky, A. *Clinical Supervision in Alcohol and Drug Abuse Counseling: Principles, Models, Methods* (revised ed.). San Francisco: Jossey-Bass, 2004.

Shulman, L. *Interactional Supervision.* Washington, DC: NASW Press, 1993.

Simon, R.I. *Concise Guide to Psychiatry and Law for Clinicians* (3d ed.). Arlington, VA: American Psychiatric Publishing, Inc., 2001.

Skovholt, T.M., & Rønnestad, M.H. *The Evolving Professional Self: Stages and Themes in Therapist and Counselor Development.* New York: John Wiley & Sons, 1992.

Storm, C.L., and Todd, T.C. *The Reasonably Complete Systemic Supervisor Resource Guide.* New York: Authors Choice Press, 2002.

Walker, M., and Jacobs, M. *Supervision Questions and Answers for Counsellors and Therapists.* London: Whurr Publishers, 2004.

White, W.L. *Slaying the Dragon: The History of Addiction Treatment and Recovery in America.* Bloomington, IL: Lighthouse Institute, 1998.

White, W.L. *The Incestuous Workplace: Stress and Distress in the Organizational Family.* Bloomington, IL: Lighthouse Institute, 1997.

Journals

The Clinical Supervisor: The Journal of Supervision in Psychotherapy and Mental Health. Binghamton, NY: The Haworth Press.

Counselor Education and Supervision. Alexandria, VA: American Counseling Association. Association for Counselor Education and Supervision members receive the journal as a member benefit. For nonmember subscriptions call (800) 633-4931 or write to ACA Subscriptions, P.O. Box 361, Birmingham, AL 35201-0361.

Web Sites

Association for Counselor Education and Supervision
www.acesonline.net

Foundation for Critical Thinking
www.criticalthinking.org

Institute for Professional Development in the Addictions
www.ipdany.org

Legal Action Center
www.lac.org

Training

Clinical Supervision of Alcohol and Drug Counselors: An Independent Study Course.
Thomas Durham, Ph.D., CCS
Distance learning; available through NAADAC, the Association for Addiction Professionals, **www.naadac.org** or (800) 548-0497.

Clinical Supervision: Skills for the Future.
David J. Powell, Ph.D., LADC, CCS, LMFT
Onsite training; available through the International Center for Health Concerns, **www.ichc-us.org/index.htm** or (860) 653-4470.

Clinical Supervision for Substance Abuse Treatment Practitioners Series.
Distance learning; available through the Mid-Atlantic Addiction Technology Transfer Center, **www.mid-attc.org** or (804) 828-9910.

Clinical Supervision in Alcohol and Drug Abuse Counseling: Principles, Models, Methods; Advanced Skills in Clinical Supervision: Updates on the Blended Model of Clinical Supervision; and Expanding the Role of the Clinical Supervisor in Alcohol and Drug Abuse Counseling.
David J. Powell, Ph.D., LADC, CCS, LMFT

Distance learning; available through the Distance Learning Center for Addiction Studies, **www.dlcas.com.**

National Addiction Technology Transfer Centers' Leadership Institute.

Live, intensive training offered at regional Addiction Technology Transfer Centers. For schedules and other information about this training program, go to **www.nattc.org/leaderInst/index.htm** or call the regional center.

Appendix D: Field Reviewers

L. Worth Bolton, M.S.W., LCAS, CCS
Clinical Instructor
University of North Carolina School of Social Work
Chapel Hill, North Carolina

David C. Bowen, LMSW, CASAC
Counselor/International Student Advisor
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Potsdam, New York

Linda J. Bradshaw, M.A., CADC III
Program Manager
ChangePoint, Inc.
Portland, Oregon

Jane M. Campbell, Ph.D., NCC, ACS
Consulting Psychologist
Houston, Texas

Daniel L. Carzoli, M.A., CAP, NCAC II, ICADC, CPC
Corrections Program Director
River Region Matrix House
Jacksonville, Florida

Ann H. Davis, M.Ed., CCS, LCAS
Director of Administrative Services
Walter B. Jones Alcohol and Drug Abuse Treatment Center
Greenville, North Carolina

Michael V. Ellis, Ph.D.
Professor, Division of Counseling Psychology
University at Albany, State University of New York
Albany, New York

Arthur Flescher, LCSW, CASAC
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Suffolk County Division of Community Hygiene
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Sharon R. Foley, M.A., LPC, ACS, CAC
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Maria del Mar Garcia-Rodriguez, M.S.W., M.H.S.
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Caribbean Basin and Hispanic Addiction Technology Transfer Center
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Suzanne Goolden, M.H.A., CTRS, CASAC
Inpatient Services Director
St. Joseph's Rehabilitation Center, Inc.
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Michele A. Packard, Ph.D.
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Program Development Manager
Virginia Department of Juvenile Justice
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Vice President, Director of Clinical Support Services
Odyssey House, Inc.
New York, New York

Donald H. Scherling, Psy.D., ICADC, CCS, LADC, MAC
Program Director
Berkshire Medical Center, McGee Acute Addictions Unit
Pittsfield, Massachusetts

Anne Helene Skinstad, Ph.D.
Director
Prairielands Addiction Technology Transfer Center
University of Iowa
Iowa City, Iowa

Robert M. Vincent, M.S.Ed.(c), NCAC II, CPP
Director
True North Student Assistance and Treatment Services
Olympia, Washington

Michael J. Wagner, LICSW, MAC
Owner MJW Consulting
Seattle, Washington

William L. White, M.S.
Senior Research Consultant
Chestnut Health Systems
Bloomington, Illinois

Other Technical Assistance Publications (TAPs) include:

TAP 1 *Approaches in the Treatment of Adolescents with Emotional and Substance Abuse Problems* **PHD580**
TAP 2 *Medicaid Financing for Mental Health and Substance Abuse Services for Children and Adolescents* **PHD581**
TAP 3 *Need, Demand, and Problem Assessment for Substance Abuse Services* **PHD582**
TAP 4 *Coordination of Alcohol, Drug Abuse, and Mental Health Services* **PHD583**
TAP 5 *Self-Run, Self-Supported Houses for More Effective Recovery from Alcohol and Drug Addiction* **PHD584**
TAP 6 *Empowering Families, Helping Adolescents: Family-Centered Treatment of Adolescents with Alcohol, Drug Abuse, and Mental Health Problems* **BKD81**
TAP 7 *Treatment of Opiate Addiction With Methadone: A Counselor Manual* **BKD151**
TAP 8 *Relapse Prevention and the Substance-Abusing Criminal Offender* **BKD121**
TAP 9 *Funding Resource Guide for Substance Abuse Programs* **BKD152**
TAP 10 *Rural Issues in Alcohol and Other Drug Abuse Treatment* **PHD662**
TAP 11 *Treatment for Alcohol and Other Drug Abuse: Opportunities for Coordination* **PHD663**
TAP 12 *Approval and Monitoring of Narcotic Treatment Programs: A Guide on the Roles of Federal and State Agencies* **PHD666**
TAP 13 *Confidentiality of Patient Records for Alcohol and Other Drug Treatment* **BKD156**
TAP 14 *Siting Drug and Alcohol Treatment Programs: Legal Challenges to the NIMBY Syndrome* **BKD175**
TAP 15 *Forecasting the Cost of Chemical Dependency Treatment Under Managed Care: The Washington State Study* **BKD176**
TAP 16 *Purchasing Managed Care Services for Alcohol and Other Drug Abuse Treatment: Essential Elements and Policy Issues* **BKD167**
TAP 17 *Treating Alcohol and Other Drug Abusers in Rural and Frontier Areas* **BKD174**
TAP 18 *Checklist for Monitoring Alcohol and Other Drug Confidentiality Compliance* **PHD722**
TAP 19 *Counselor's Manual for Relapse Prevention With Chemically Dependent Criminal Offenders* **PHD723**
TAP 20 *Bringing Excellence to Substance Abuse Services in Rural and Frontier America* **BKD220**
TAP 21 *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* **(SMA) 08-4171**
TAP 21A *Competencies for Substance Abuse Treatment Clinical Supervisors* **(SMA) 08-4243**
TAP 22 *Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers* **BKD252**
TAP 23 *Substance Abuse Treatment for Women Offenders: Guide to Promising Practices* **BKD310**
TAP 24 *Welfare Reform and Substance Abuse Treatment Confidentiality: General Guidance for Reconciling Need to Know and Privacy* **BKD336**
TAP 25 *The Impact of Substance Abuse Treatment on Employment Outcomes Among AFDC Clients in Washington State* **BKD367**
TAP 26 *Identifying Substance Abuse Among TANF-Eligible Families* **BKD410**
TAP 27 *Navigating the Pathways: Lessons and Promising Practices in Linking Alcohol and Drug Services with Child Welfare* **BKD436**
TAP 28 *The National Rural Alcohol and Drug Abuse Network Awards for Excellence 2004, Submitted and Award-Winning Papers* **BKD552**
TAP 29 *Integrating State Administrative Records To Manage Substance Abuse Treatment System Performance* **(SMA) 07-4268**

Other TAPs may be ordered by contacting the National Clearinghouse for Alcohol and Drug Information (NCADI), (800) 729-6686 or (240) 221-4017; TDD (for hearing impaired) (800) 487-4889.

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