Clinical Supervision
Jane Dwyer Lee, MSW, LCSW
Associate Teaching Professor
Florida State University College of Social Work

Description
Clinical supervision is “the cornerstone of quality improvement and assurance” in the addiction field, providing, “a bridge between the classroom and clinic” (Substance Abuse and Mental Health Administration 2009). Clinical supervisors are gatekeepers for their profession. Their ability to mentor, educate, and encourage their supervisees is an important determinant of the quality of treatment given to individuals with substance use disorders. Guidance from skilled supervisors helps clinicians achieve more competence, confidence, and knowledge. This webinar will describe how to be an effective clinical supervisor in the substance abuse treatment field. It will include information about: Clinical supervision’s role in substance abuse treatment; ethical and legal considerations of clinical supervision, and supervision issues involved in implementing Recovery Oriented Systems of Care practices. The information will be useful for new as well as experienced clinical supervisors.
Objectives

Participants will learn:

- The role of clinical supervision in substance abuse treatment
- At least two ethical considerations involved in clinical supervision in substance abuse treatment
- At least two legal considerations involved in clinical supervision in substance abuse treatment
- At least two supervisory considerations related to implementing Recovery Oriented Systems of Care (ROSC) practices

Role of Clinical Supervision in Substance Abuse Treatment
Things to Consider

- Clinical supervision plays a significant role in substance use and misuse treatment.

- There are many things to take into consideration in this ever-changing and dynamic realm.

- These include the financial, political, social, and program trends that we need to know.

- We are required to engage in a continuous searching of best practices in order to find our own unique model of supervision that works best for us and for our supervisees.

Things to Consider

- While they do exist, there are very few courses in supervision offered in many of the psychotherapy professions training programs, namely social work, mental health counseling, psychology, or family therapy.

- Just as it is unethical to employ counselors who are not trained in counseling, it is unethical to ask people to supervise without training them in supervision. (Powell 1993 p. xxxi)

- Such factors have given momentum to the professionalizing of clinical supervision.

- A generally accepted time standard for a “reasonable effort to supervise” is 1 hour of supervision for every 20 to 40 hours of clinical services. (SAMHSA, 2014)
Untrained Supervisor Errors

- Confusing clinical supervision with case management, thereby attending inappropriately to the needs of the individuals served rather than the counselor’s needs

- Falling back on what they do know – their counseling skills – so that they become counselors to the counselors, a form of role confusion that may give rise to boundary issues

- Taking a laissez-faire attitude, even to the point of excessive familiarity or other serious boundary violations

- Becoming judgmental, authoritarian, and demanding to the edge of sadism (Powell, p. xxxviii, 2004)

Untrained Supervisor Errors

- Quite often, too, supervisors perpetuate the mistakes of their own supervisors
  (Worthington 1987, p. 206)
Dealing with Counselor Burnout

- According to Edelwich and Brodsky (1980) there are: “cyclic stages of disillusionment leading to professional burnout – enthusiasm, stagnation, frustration, apathy”

- Trained clinical supervisors know how to give emotional support as they intervene to keep counselors from falling into that final stage of apathy

- Supervisors of substance use disorders require a specified knowledge base, core competencies, and training and certification requirements.

Legal Definition of Supervision

- According to the Taft-Hartley Act of 1947, “supervisor” means:

  “any individual having authority, in the interest of the employer, to hire, transfer, suspend, layoff, recall, promote, discharge, assign, reward, or discipline other employees, or responsibly to direct them or to adjust their grievances, or effectively to recommend such action, if in connection with the foregoing the exercise of such authority is not merely of a routine or clerical nature, but requires the use of independent judgement”

  (Biddle and Newstrom 1990, pp. 507-8)
What is the difference between administrative supervision and clinical supervision?

“Administrative supervision is aimed at helping the supervisee as part of an organization, and clinical supervision focuses on the development of the supervisee specifically as an interpersonally effective clinician.”
(Hart, 1982 p. 13)

“Clinical supervision attends to the supervisee’s professional and personal needs as they directly affect the welfare of the” individual served.
(Powell p. 5)

Composite Definition of Supervision

“Supervision should involve facilitating the counselor's personal and professional development as well as promoting counselor competencies for the welfare of the client. Supervisors oversee the counselor’s work through a set of activities that include consultation, counseling, training, instruction, and evaluation.”

(Association for Counselor Education and Supervision (ACES))
Three Main Purposes of Supervision:

- To nurture the counselor’s professional (and as appropriate, personal) development

- To promote the development of specified skills and competencies, so as to bring about measurable outcomes

- To raise the level of accountability in counseling services and programs

(Powell, 2004)

Powell’s Blended Definition of Supervision

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

- **disciplined** – structured, scheduled supervision

- **tutorial** – as in a teacher giving instruction

- **a process** – based on a mutually agreed upon relationship of trust and respect

- **principles** – these are transformed into practice. Learn rationales for what they do instinctively. Step back and ask, “Why did that work? What went right?” or “Why didn’t that work? What went wrong?”

(Powell 2004, pp. 11-14)
More on Supervision

“A working alliance targeted toward goals of mastery of specific skills.”
(Bordin, 1983)

The Four Foci of Supervision

1. **Administrative** – In addition to treatment planning and case management, these administrative functions include:
   - Planning, organizing, coordinating, and delegating tasks
   - Selecting and assisting staff
   - Determining clinical and administrative privileges
Supervision is NOT counseling!

**Personal Counseling**

1. The goal is personal growth and development, self-exploration, becoming a better person.
2. Requires exploration of personal issues.
3. The focus of exploration is on the origins of cognitions, affects and behaviors associated with life issues and how these issues can be resolved.

**Supervision**

1. The goal is to make the counselor a better counselor.
2. Requires monitoring of the care of individuals the counselor serves, and facilitating the counselor’s professional training.
3. The focus is on how issues may affect individuals' care, the conceptualization of individuals' problems and counseling process and accomplishment of individuals' goals.

The Four Foci of Supervision

2. **Evaluative** – A supervisor:
   - Assesses counselors’ skills
   - Clarifies performance standards
   - Negotiates objectives for learning
   - Utilizes appropriate sanctions for job performance impairment and skill deficits

   (Evaluation should create positive motivation for growth!)
3. **Clinical** – The focus is on the supervisee as a counselor and the goal is to instruct. Functions include:
   - Developing counseling knowledge and skills
   - Identifying learning issues and problems
   - Determining counselor strengths and weaknesses
   - Promoting self-awareness and professional and personal growth
   - Transmitting knowledge for practical use

(The best supervisor teaches by example – not just instructing but modeling clinical competencies. Let the student watch you work! A consultative function.)

4. **Supportive**
   - Coaching
   - Cheerleading
   - Morale-building
   - Warding off burnout
   - Encouraging personal growth

(Powell 2004, pp.13 - 19)
Notes About Supervision

- Supervision is not therapy, but the relationship between supervisor and supervisee does have a therapeutic dimension.

- The supervisor sees with the eyes of a therapist – one who is sensitive to feelings, perceptive about intrapsychic issues and interpersonal dynamics, and trained in a particular model of therapy.

- Implications in the field of Substance Use and Misuse: Since many of those working in the field come from a recovery history or are adult children of substance misusing parents, personal growth and recovery are particularly relevant to the work of the substance abuse counselor.

- General Guideline: The clinical supervisor need not and should not provide personal counseling for supervisees. Instead, refer to an employee assistance counselor or an external therapist. Avoid dual relationships that would compromise the supervisory relationship.
  (Powell 2004)

Leadership

“The superior leader gets things done with very little motion. He imparts instruction not through many words but through a few deeds. He keeps informed about everything, but interferes hardly at all. He is a catalyst, and although things would not get done as well if he were not there, when they succeed he takes no credit. Because he takes not credit, credit never leaves him.”
(Lao-Tzu, sixth century)
Leadership Abilities

- To establish trust with co-workers and subordinates
- To serve as a team leader
- To define and set departmental and organizational goals and communicate these goals to the entire team
- To inspire staff by encouragement and motivation
- To communicate enthusiasm and capability
- To keep up staff morale, including one’s own

Leadership Abilities

- To take appropriate risks and be decisive in action
- To possess the ability to change in response to the needs of the organization
- To have vision, drive, clear judgement, initiative, poise, and maturity of character
- To command enthusiasm, loyalty, sincerity, courtesy, and confidence
- To exercise control through inspiration rather than command

(Powell, 2004)
Management Abilities

- To get work done through staff
- To make effective use of departmental resources
- To get results in achieving stated goals and objectives
- To control through command
- To identify, analyze, and solve problems
- To adapt to change and the growing needs of the organization
- To organize work as needed to get the job done
- To intervene to bring about positive results
- To see all aspects of operations

(Powell, 2004)

Supervision Abilities

- To know the responsibilities of staff
- To communicate clearly these responsibilities to staff
- To utilize effectively the performance appraisal system to get maximum productivity of staff
- To write clear job descriptions quarterly and annual goal and work statements for all staff
- To manage time effectively for oneself and staff
- To promote employees’ professional development

(Powell, 2004)
Leadership Qualities/Principles in the New Organizational Context

1. Take full responsibility for the decisions you make. Never blame someone else for something that is your fault.

2. Always put the well-being of the people reporting to you above your personal well-being.

3. Always give subordinates full credit for successes.

4. Do not be afraid to take risks when they are in the best interests of the organization or the client.

5. Protect your supervisees and defend them to senior management when they are unfairly attacked or punished.

6. Take a personal interest in the welfare of your staff.

7. Make decisions promptly. Make the best decisions you can under the circumstances.

8. Be a teacher. Show someone what to do in order to make things turn out right.

9. Do not play favorites.

10. Do not give orders just to prove who is the boss.
    (Powell, 2004)
A Personal Sense of Mission

- A belief in my ability to lead
- A passion for my work
- A devotion to the people and the agency
- A clear vision of the organization’s purpose
- A sense of honesty with myself and others

(Powell, 2004)

The Four A’s of Supervision

1. Available: receptive, trusting, non-threatening
2. Accessible: easy to approach and speak freely with
3. Able: having real knowledge and skills to transmit
4. Affable: pleasant, friendly, reassuring

(Powell, 2004)
Values in Supervision

- Accountability – upholding the promise to deliver quality services.
- Stewardship – mindful use of all available resources.
- Professionalism – consistent and ethical role modeling and application.
- Excellence – the relentless pursuit to provide the best quality care.
- Continuous Learning – steadfast commitment to ongoing development.
- Teamwork – active support of collective wisdom and energy to achieve great results (SAMHSA, 2014)

Supervisor Strengths

The greatest perceived strengths of supervisors were their:

- Knowledge and experience
- Willingness and ability to teach, their communication skills
- Affective qualities (empathy, respect, relational skills)
- Listening skills
- Sense of fairness
- Being well-organized

(Kadushin, 1992)
Learning Objectives for Supervisors

Clinical supervisors in the field of Substance Use Disorders (SUDs) must demonstrate proficiency in the following areas: (Birch and Davis, 1986)

1. Advanced knowledge in SUDs, demonstrated by completion of an advanced degree in the behavioral sciences with a concentration in substance use and misuse
2. Familiarity with a variety of therapeutic modalities
3. Operational experience with a variety of treatment approaches used for SUDs
4. Familiarity with models of clinical supervision
5. Ability to articulate one’s own model of clinical supervision

6. Knowledge and skills in clinical supervision. Skills to be demonstrated include familiarity with various methods of oversight and intervention (such as phone-ins, audio or videotaping, bug-in-the-ear, or one-way mirror)
7. Affective qualities necessary to establish an educational, consultative, supportive, and therapeutic relationship with a supervisee
8. Ability to deal with a supervisee’s psychological and emotional issues, especially with respect to recovery and personal growth processes, as they relate to the supervisee’s work
9. Advanced skills in the evaluation of the supervisee’s skills and in the ability to communicate that evaluation to supervisees. Providing criticism in a constructive, educational, and therapeutic manner is an essential skill in supervision.
Cultural Competence

Culture and other contextual variables influence the supervision process so supervisors need to continually strive for cultural competence. Since supervisors serve as catalysts for change, they need to develop proficiency in addressing the needs of diverse communities and personnel. Cultural competence includes:

- The counselor’s response to individuals served
- The supervisor’s response to counselors
- The program’s response to the cultural needs of the diverse community it serves

(SAMSHA, 2014)

Diversity & Cultural Issues

- Initiate discussions of differences regarding both clinical work with individuals served and supervisory and team relationships.
- Areas of diversity include:
  - Race
  - Ethnicity
  - Gender
  - Religion
  - Socioeconomic status
  - Sexual orientation
  - Disability

(SAMSHA, 2014)
Models of Clinical Supervision

1. Competency-based models
2. Treatment-based models
3. Developmental approaches
4. Integrated models
   (Powell, 2004)

A Blended Model of Clinical Supervision

Philosophical foundations (of the SUD-blended model of supervision):
- People have the ability to bring about change in their lives with the assistance of a guide
- The key to growth is to blend insight and behavioral change in the right amounts at the appropriate time
- Change is constant and inevitable
- In supervision as in therapy, the guide concentrates on what is changeable
- It is not necessary to know a great deal about the cause or function of a manifest problem to change it.
- There are many correct ways to view the world
   (Powell, 2004)
Psychological Foundations

The big four:

1. Extra-therapeutic factors (40%)
   - Individual strengths
   - Supportive elements in the environment
   - Readiness to change
   - Faith and persistence

2. Relationship Factors (30%)
   - The nature of the alliance
   - Affective qualities of the therapist
Psychological Foundations

The big four:

3. Placebo factors (15%)
   - Hope
   - Expectancy

4. Technique (15%)
   - “Learn technique, master technique, then transcend technique” (Powell)
   - Important in terms of history taking, maintaining confidentiality, adhering to ethical and legal standards
   (Duncan, Miller, Wampold, Hubble, 2010)

Spiritual and Contemplative Foundations

A holistic approach to healing the mind, body, spirit.

“To be human is to accept ourselves just as we are, with our history, and to accept others just as they are. To accept history as it is and to work, without fear, to greater openness, understanding, and love of others – searching for truth.” (Vanier 1998, p.15)

Contemplative supervisors should explore their own spiritual journey through stillness, meditation, and reflection.
Twelve Core Functions

Twelve Core Functions of Substance Use and Misuse Counselors:

1. Screening
2. Intake
3. Orientation
4. Assessment
5. Counseling
6. Case management

7. Treatment planning
8. Consultation
9. Crisis intervention
10. Client education
11. Referral
12. Report and record keeping

(Powell, 2004, p.221)
Effective Questions

Twelve Core Functions of Substance Use and Misuse Counselors:

- What have you accomplished so far that you are most pleased with?
- How would you like this case to proceed?
- What kind of support do you need from me to ensure success?
- What were you able to do today that you were not able to do in the past’’?
- What are you doing that is already working well?
- In what way will that allow you to do it even better tomorrow?

(Powell, 2004.)

Supervisory Ethics

In general, supervisors adhere to the same standards and ethics as substance use counselors with regard to dual relationship and other boundary violations.

(Powell, 2004)
Supervisory Ethics

Supervisors will:

- Uphold the highest professional standards of the field
- Seek professional help (outside the work setting) when personal issues interfere with their clinical and/or supervisory functioning
- Conduct themselves in a manner that models and sets an example for agency mission, vision, philosophy, wellness, recovery, and consumer satisfaction
- Reinforce zero tolerance for interactions that are not professional, courteous, and compassionate
- Treat supervisees, colleagues, peers, and individuals served with dignity, respect, and honesty
- Adhere to the standards and regulations of confidentiality as dictated by the field. This applies to the supervisory as well as the counseling relationship (SAMHSA, 2014)

Supervisory Oversight

Supervisors are responsible for exercising reasonable oversight with respect to ethical conduct of those whom they supervise with issues concerning:

- Informed consent
- Confidentiality and its limits
- Duty to warn
- Boundary maintenance
- Dual relationships
- Social and sexual intimacy with clients
- Misrepresentation
- Professional credibility
(Powell p. 274)
Ethical Considerations in SUDs

- According to Walker (2005) many clinicians fail to provide informed consent to persons with SUDs under the belief that their substance use eradicates sufficient free will to make informed decisions.

- Consent should be reviewed at every session at least in a brief way for it engages the autonomy of the person.

- Respect the person’s decision about the treatment experience.

- Respect dropping out of treatment. The freedom of the other person can only be realized through acceptance of the persons‘ right to fail.

Ethical Considerations

- Treat the individual, not the addiction
- Explore how life might have meaning in the absence of drugs or alcohol. This opens the door to a more existential approach to recovery. “What might you see in life if you were drug free? And would it be different?”
- Ask “If you were to get into to recovery, what would that mean for your partner, children, parents, other family members and friends?” This opens the door to an exploration of the ethics and the impact on others.
- Avoid coercive means at all costs!

(Walker, 2005)
Legal Liability for Supervisors

Supervisors are responsible for exercising reasonable oversight with respect to ethical conduct of those whom they supervise with issues concerning:
- Direct liability – a dereliction of supervisory responsibility
- Vicarious liability – a supervisor can be held liable for damages incurred as a result of negligence in the supervision process

(Powell, 2004)

Supervisory Contracting

- Courts have defined a standard of care and practice in supervision to protect from malpractice
- A written supervisory contract signed by the supervisor and supervisee is imperative (Powell, 2004)
- Falvey (2002) provides a workbook of appropriate forms for documenting clinical supervision including logging sheets for supervision
Implementing Recovery Oriented Systems of Care (ROSC)

“A ROSC is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.”

(SAMHSA, 2014)
ROSC

- Relatively new concept in the substance use disorder field
- Acknowledges the biopsychosocial conditions of substance use disorders
- Encompasses the general population, at risk populations, harmful users of alcohol and drugs, those with dependence, and those with chronic dependence

(SAMHSA, 2014)

Guiding Principles

- There are many pathways to recovery.
- Recovery is self-directed and empowering.
- Recovery is holistic.
- Recovery is supported by peers and allies.
- Recovery is (re)joining and (re)building a life in the community.

(SAMHSA, 2014)
Person First Language: A principle of ROSC

The language used is neither stigmatizing nor objectifying. At all times “person first” language is used to acknowledge that the disability is not as important as the person's individuality and humanity, e.g., “a person with schizophrenia” versus “a schizophrenic” or a “person with an addiction” versus “an addict.” This can be a challenge for supervisors and clinicians who have spent years using other terms. Be compassionate and patient!

Mental Health Coordinating Council, 2013

ROSC Functions

Functions to:
- Inform, educate and empower individuals and communities
- Provide prevention, early intervention, treatment and recovery services
- Recommend and implement policy and practice changes
- Mobilize community partnerships
- Evaluate services for ongoing systems improvement

(SAMHSA, 2014)
ROSC Approach

An integrative, person-centered approach:
Along with primary health care, it includes the full continuum of care for the substance use disorder field:
- Prevention
- Early intervention
- Treatment
- Continuing care and recovery

(SAMHSA, 2014)
Ingrained in current health care reform is a public health model that supports ROSC.

Encompasses a menu of individualized, person-centered, and strength-based services within a defined network.

Provides individuals and families with more options.

Services are welcoming, accessible, and easy to navigate.

(SAMHSA, 2014)
Recovery Support Services (RSS)

These are non-clinical services that assist individuals and families working towards recovery from substance use disorders. They incorporate a full range of outside resources that facilitate recovery and wellness.

(SAMHSA, 2014)
Supervisory Considerations

- Implementation – engagement will strengthen efforts to identify and garner resources
  - Participation by counselors, persons in recovery, family members and other allies can best articulate how services should be delivered.

- Evaluation – data collection
  - Promotes sustainability of effective policies, programs, and practices (SAMHSA, 2014)

Q & A
Vignette

Walt has been assigned to redesign the supervision program for a community-based substance abuse treatment program that includes an inpatient program, intensive outpatient program, family therapy, impaired driver treatment, drug court program, halfway house, and educational services. The decision was made to establish an integrated system of supervision. The agency’s staff, with ten full-time-equivalent counseling positions, has a broad range of professional training and experience, from entry-level certified addiction counselors to licensed social workers and licensed professional counselors. All staff, regardless of degrees and training, basically have the same duties.

Until now, staff primarily received administrative supervision with an emphasis on meeting job performance standards. Walt wants to make the supervision more clinical in nature, using direct methods of observation (videotape and live observation). He anticipates program growth in the next five years and wants to mentor key staff who can assume supervisory responsibilities in the future.  

(SAMSHA, 2014)

Discussion

Things to consider:

Using “person first” language
Implementing Diagnostic and Statistics Manual V language
Utilizing Evidence-based Practices
Addressing potential boundary violations
Focusing on job performance
Gaining the support of administrators for clinical supervision
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