THE WISCONSIN CLINICAL SUPERVISOR TRAINING PROJECT

sponsored by

The Foundation for Addictions Research
and Education, Ltd.

The Wisconsin Association of Alcohol and Drug Abuse
Counselors, Inc.

The Wisconsin Certification Board, Inc.

The Bureau of Substance Abuse Services

1998

HISTORY:

During the years 1990 through 1998 the Wisconsin Bureau of Substance Abuse Services has been reviewing and updating the standards for addictions treatment, and prevention providers. A standard change has been proposed that will require treatment providers to formalize the clinical supervision of their staff. It became apparent to those involved that there was a need to expand the availability of supervisors to capacitate this requirement. A group of individuals were brought together to plan an effective response. Their recommendations were to provide a series of intensive training events, around the state, for a reasonable cost.

It was the recommendation of the team that the training be focused to prepare the participants for the IC&RC/AODA national test. The IC&RC/AODA additionally agreed to allow the WCB the exception to offer the test at the end of each training event. The curricula was designed to include the criteria defined in the current role delineation study (RDS) of clinical supervisors prepared by the IC&RC/AODA. These criteria are the basis from which the WCB supervision credential was developed, and the general source for the test questions in the exam.

It was agreed that the actual curricula/educational materials for each day be developed in the practical sense by the faculty person designated to train a particular section. The overall editing of the curricula would be completed by a single member of the team.

TRAINING DEVELOPMENT TEAM & FACULTY

Dave Barrett - Milwaukee**,** WI
Faculty

Jack Culbreth - Penn State University
University Park, PE   Faculty

Gooch Jenkins - Madison, WI

Bill Olcott - Appleton**,** WI **-** Faculty

Jeff Pearcy - Wauwatosa, WI

Ned Rubin - Milwaukee, WI - Faculty

Cheryl Rugg - Pewaukee, WI
Faculty

TRAINING EXPECTATIONS

By the end of the training, participants will be prepared in all of the required education and training of the competency areas for certification as a **Certified Clinical Supervisor**.

Participants will acquire the following knowledge and skills:

• Define supervision and supervisors

• Define four models of supervision

• Define the four domains of clinical supervision

• Identify the tasks performed in each of the four domains

TRAINING NORMS

1. Start and end on time
2. Two breaks - 20 minutes long
3. Respect each other - don t interrupt, or carry on side conversations
4. Ask questions, take risks
5. Participate in discussions-helps everyone make theories practical
6. Respect confidentiality
7. Complete your required homework assignments

FOUR DAY TRAINING AGENDA

DAY ONE

REGISTRATION & PRETEST

WELCOME & GREETINGS

OVERVIEW OF TRAINING EVENT

CLINICAL SUPERVISION DEFINITIONS

THE SUPERVISORY MODELS

THE PERFORMANCE DOMAIN OF COUNSELOR DEVELOPMENT

- developing a supervisory relationship with your staff;

- assisting your staff in their career development;

- developing the ability of your staff to work as a team;

- assessing needs and providing staff with clinical training and education;

- providing direct clinical supervision.

WRITING TEST QUESTIONS

SUMMARY, CLOSURE AND EVALUATION

TEST PREPARATION & QUESTION WRITING TIME

DAY TWO

GREETINGS AND ANNOUNCEMENTS

THE PERFORMANCE DOMAIN OF ASSESSMENT AND EVALUATION

- Assessing your staff s experience and knowledge of the AODA Counseling field, and determining their strengths and weaknesses.

- Assessing your staff s temperament, leadership style/qualities, personal and interpersonal wellness .

- Assessing your staff s performance of the 12 core functions.

- Assessing your staff s level of clinical functioning and their ability to utilize various therapeutic techniques.

- Evaluating their strengths and weaknesses & soliciting feedback from others to identify case load assignments and development needs.

SUMMARY, CLOSURE AND EVALUATION

TEST PREPARATION & QUESTION WRITING TIME

DAY THREE

GREETINGS AND ANNOUNCEMENTS

THE PERFORMANCE DOMAIN OF MANAGEMENT & ADMINISTRATION

develop and implement quality improvement (QI) mechanisms and guidelines

monitor compliance with federal & state regulations, agency policies, and accreditation standards

plan and coordinate the activities of staff and other resources to promote effective management and programing

conduct program assessment / development using QI mechanisms

identify staff or program needs, coordinate consultation services to address needs and issues

supervise the hiring, orientation, evaluation and termination of staff

SUMMARY, CLOSURE AND EVALUATION

TEST PREPARATION & QUESTION WRITING TIME

DAY FOUR

GREETINGS AND ANNOUNCEMENTS

THE PERFORMANCE DOMAIN OF PROFESSIONAL RESPONSIBILITY

- Model and encourage professionalism by active participation in state and national professional associations.

- Adhere to the established code of conduct.

- Pursue and maintain personal and professional development and education.

- Maintain personal, physical, and mental health.

- Take the time to get to know each staff person s unique context as a individual; lifestyle, cultural background, style, etc.

DOMAIN SUMMARY AND CLOSURE

TRAINING SUMMARY AND CLOSURE

POST TEST & FINAL OVERALL EVALUATION

INSTRUCTIONS FOR INTRODUCTION EXERCISE:

Before you start, recall your own experiences of being supervised...

You will be introducing yourself to the other individuals sitting at your table; Share your name, where you are from, and where you work.

Next share your own experiences of being supervised; identify effective /enjoyable /helpful experiences, as well as negative experiences.

Each person will have 5 minutes to introduce themselves to the others, and share their experiences. At the end of the individual sharing your table group will have 10 minutes to discuss your shared experiences.

DAY ONE

INTRODUCTIONS AND GREETINGS

Overview of the workshop, tentative plans, combination of experiential and didactic learning, mention other trainers involved, discuss test question writing exercise, accumulation of certification hours.

_   Administer the three supervision instruments; SSI, SRF, SERF.

GENERAL DEFINITION OF SUPERVISION - Exercise

_   Break up into groups of 6-8 participants to do this activity.

_   Each group member should write down three aspects of a good supervision experience that they have had.

_   Discuss these among group members and then develop a list of common characteristics based on group members input.

_   List these on the board and discuss themes/trends among these characteristics.

_   In looking at supervision, there is not a lot that is unique to supervision that is different from counseling, teaching, and consultation. The roles are slightly different, however the underlying foundations are the same.

_   What skills and competencies do you already have and bring to a supervisor role?

_   What are the roles that you are most likely to associate within your

supervision as a supervisor?

_   What do you focus on within the supervisory relationship?

_   How do you determine answers to these questions?

I.   **GENERAL DEFINITION OF SUPERVISION**

A.   **Considering a definition based on the word   supervision , one could look at the process of   super   vision. Often there is an unusual sense of clarity that goes with supervising that may not have been present had you actually been the one counseling. This may be due to the feeling of being removed from the immediate issues of the counseling situation, the opportunity to be much more objective and less invested in the immediate counseling process.**

         _   **How many of you have had an experience in supervision where your supervisee was dealing with a client situation that was remarkably similar to one in your past, and the path for the counselor was much more clear to you now that it was when you were the counselor?**

B.   **A WORKING DEFINITION OF SUPERVISION: (OVERHEADS)**

     1.   An intervention provided by a more 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 client(s) she, he, or they see(s), and serving as a gatekeeper of those who are to enter the particular profession (Bernard & Goodyear, 1998).

2.   Clinical supervision is a disciplined, tutorial process wherein principles are transformed into practical skills, with four overlapping foci: administrative, evaluative, clinical, and supportive. This definition results in three main purposes: 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, 1993).

C.   **Based on these definitions, it important that we view the role of supervisor as multi-faceted, requiring a broad array of skills, styles, and roles to complete the supervisor package.**

D.   **Clinical supervision should not be taken for granted. It is a distinctly separate process from that of counseling. It has many similarities, but it is different. Therefore, just because a professional is a good counselor does not mean that they are automatically going to be, or are, a good supervisor. Good counseling does not equal good supervision (Hill, Charles, & Reed, 1981).**

E.   **Clinical supervision is also a critical element in the delivery of quality counseling services. It has been associated with maintaining counseling skills after graduation from training programs (Spooner & Stone, 1977) and perceived levels of clinical confidence among graduating trainees (Reising & Daniels, 1983; Wiley & Ray, 1986).**

II.   HISTORY AND GENERAL INTRODUCTION

A   Supervision has been an accepted part of the treatment process for decades. And supervision research and discussion has been present in the literature for about the same amount of time. However, a key shift occurred in the understanding of supervision in the early 1980's. This was the conceptual shift to a counselor developmental model of supervision. That is, viewing supervision as a process that facilitates the development of the counselor (supervisee) both professionally and personally. The developmental model considered counselor development to occur in stages. Prior to the development of these theories, supervision was conducted in either of two fashions.

1.   Within the context of particular counseling theory, such as Rogerian or RET.

2.   As a hodgepodge of discussions without any systematic conceptualization of the supervision process.

B   This paradigm shift was due to the publication of three key articles,

Stoltenberg (1981), Loganbill, Hardy, and Delworth (1982), and Blocher (1983).

C.   Since then, there have been an extremely large number of studies examining many different aspects of clinical supervision. These three articles ushered in a new concept to explore in the consideration of supervision. Each of the models has been researched, along with a multitude of other components and factors that may impact supervision. These areas have included aspects of the supervisory dyad, group supervision, personal factors affecting supervision, supervisory techniques, and supervision for different types of counselor experience level. One distinct area that has been left out is clinical supervision in the chemical dependency counseling field, taking into account issues of recovery status and education level variability.

LEARNING TO THINK LIKE A SUPERVISOR

A.   Cognitive Shift to Supervision - Considering the definitions that were discussed earlier, it is important to begin looking at supervision from a different perspective. A supervisor is more than just a counselor working with another counselor. The supervisor actually has three roles, the counselor, the consultant, and the teacher .

        1.   Counselor - fosters self-examinations constrained by the ethical dilemma of forcing treatment upon the counselor.

        2.   Teacher - tailors education to the individual needs of a specific

counselor.

3.   Consultant - provides an objective viewpoint, however, the parties are not equal.

B.   One of the biggest aspects of this shift from counselor to supervisor is moving from a client focus to a counselor focus. If a supervisor maintains a client focus, then one of two possibilities will result.

1.   Supervision focus will be entirely on the client. Issues occurring with the counselor will be missed, the supervisor will overwhelm the counselor with instructions on how to proceed with the client, the sole purpose of the counselor will be to carry out the supervisor's plan for working with the client. This is called therapy by proxy or counseling in absentia.

2.   Supervision will focus on the counselor as a client. This inappropriately crosses boundaries into the counselor's own issues. An overemphasis on self-awareness moves into an area of unethical supervision. This is a very difficult balancing act, especially in the CD field due to recovery and codependency issues playing a part in a counselor s treatment process.

C.   This is why we must begin to view the supervisor role as a combination of the three roles: counselor, consultant, and teacher. A metaphor for better understanding this blending of roles might be that of a coach. At times, a

coach fits each one of these roles. Yet, a coach does not solely view him/herself as a teacher, or a consultant, or a counselor. A coach is a blending of the three.

D.   Neufeldt, Iversen, and Juntunen (1995) discussed these three roles and the implications for conducting supervision. Based on the work of Stenack and Dye (1982), they developed a training manual for supervisors. Practical strategies are suggested that fit within the scope of the teacher, counselor, and consultant role.

1.   Teacher Role Strategies

a.   Evaluate observed counseling session interactions.

b.   Ask counselor to provide a hypothesis about the client.

c.   Identify appropriate interventions.

d.   Teach, demonstrate, or model intervention techniques.

e.   Explain the rationale behind specific strategies and/or interventions.

f.   Interpret significant events in the counseling session.

2.   Counselor Role Strategies

a.   Explore trainee feelings during the counseling session.

b.   Explore trainee feelings during the supervision session.

c.   Explore trainee feelings concerning specific techniques and/or interventions.

        d.   Facilitate trainee self-exploration of confidence and/or worries in the counseling session.

        e.   Help the trainee define personal competencies and areas for growth.

        f.   Provide opportunities for trainees to process their own affect and/or defenses.

   3.   Consultant Role Strategies

        b.   Provide alternative interventions and/or conceptualizations for trainee use.

        c.   Encourage trainee brainstorming of strategies and/or interventions.

        d.   Encourage trainee discussion of client problems, motivations, etc.

        e.   Solicit and attempt to satisfy trainee needs during the supervision session.

        f.   Allow the trainee to structure the supervision session.

   E.   There are some distinct issues associated with learning to be a supervisor. Also, there are stages to learning this process, much like there are stages in the development as a counselor.

       Powell discusses supervisor development in the chapter on counselor development theories. This part of the chapter is noteworthy and should be reviewed. There has been some research on this topic,

although not very much. Loganbill et al. (1982) spent a significant amount of time discussing this topic in their original work. However, there has not been a lot of research on this topic.

1. **Level one** supervisor characteristics
    a. Displays a mechanistic approach
    b. Plays a strong expert role
    c. Is dependent upon own supervisor
    d. Is highly motivated
    e. Is moderately to highly structured
    f. Is invested in trainee s adopting one s own model
    g. Has trouble with level two counselors

2. **Level two** supervisor characteristics
    a. Displays confusion, conflict issues
    b. Sees supervision/counseling as more complex, multidimensional
    c. Has fluctuating motivation, especially when supervisory functions are not rewarded
    d. Focuses on supervisee
    e. Loses objectivity
    f. Blames supervisee for supervisor s problems
    g. Works best with level one counselors, okay with level two counselors

3.   **Level three** supervisor characteristics

    a.   Functions autonomously

    b.   Displays self and supervisee awareness

    c.   Differentiates boundaries/roles

    d.   Is able to supervise at all times

    e.   Prefers to work with a certain level of counselor

F.   So, when viewed as a whole process, clinical supervision facilitates both counselor development <u>and</u> supervisor development.

IV.   FOCUSING ON THE SUPERVISORY RELATIONSHIP

A.   Research has repeatedly demonstrated that this is the central and most significant component of clinical supervision. This statement is paralleled with the research demonstrating that maintaining a positive counseling relationship is key to successful counseling outcome.

B.   The supervisory relationship begins with the establishment of an open and supportive environment for the supervisee. After that, it takes time to develop and it will have inevitable conflict at some level during the supervisor-supervisee working alliance. This is especially true when you consider the issues associated with counselor development at the second stage requiring some form of conflict or rebellion away from the supervisor.

C. Several variables have been identified that impact the supervisory relationship. One of the primary ones is supervisor style. There have been many different attempts to examine a supervisor s style. One of the predominant studies has been Friedlander and Ward (1984). They define supervisor style as the manner in which a supervisor approaches and responds to supervisees and in the implementation of supervision. They determined that there are primarily three types of supervisor style.

1. Task-oriented, focuses on a structured, goal-oriented, and thorough approach to supervision.

2. Interpersonally-sensitive, focuses on the relationship between the supervisor and supervisee, maintaining the relationship, and addressing the needs of the relationship.

3. Attractive, focuses on reflecting a warm, caring, and friendly demeanor toward supervisees that promotes a sense of trust, support, and openness.

D. In addition to the style of a supervisor, there are four domains that should be addressed in supervision (Lanning & Freeman, 1994). These domains also can impact the supervisory relationship.

1. Counseling performance skills - practical, technique and skills-based focus

2. Client conceptualization skills - considering the bigger picture with the client and/or the counselor, examining various themes

that transcend the in-session issues

3.   Self awareness - counselor personal issues that are a part of and/or affect the treatment process

4.   Professional behaviors - monitoring the legal and ethical aspects of treatment delivery

Now it is time to score the instruments that you took earlier to determine which supervisory style predominantly describes your work and which area of supervision you emphasize.

Use overhead scoring sheets and calculations to help participants

SSI and SRF scoring - Average scores given for each work group according to the SSI score sheet in the appendix.

_   **To obtain a complete score for the AT scale on the SRF, use scores in the SSI for Afriendly@ and Awarm.@ This keeps participants from having to repeat score items that are duplicates between the instruments.**

SERF scoring - Participants write the rank order score they gave for each one of the choices in each set. Make sure that participants understand that the order of A B C D changes for each set. Total each column for the corresponding scale score. Use SERF score sheet provided in appendix.

Once the instruments have been scored, participants may write their scale scores on the assessment results sheet. This sheet provides the scale names and allows participants to view the overall results in their entirety.

SSI/SRF sheet

SSI scale table

SRF scale table

SERF scoring table

Assessment results sheet

Explain the dimensions of each instrument

Supervisory Styles Inventory (Friedlander & Ward, 1984)

Attractiveness (AT) - a style that focuses on being a warm and caring individual, someone that is well liked.

Interpersonally-Sensitive (IS) - a style that focuses on dynamics of the relationship, including relationship process issues, regardless of whether the supervisee likes the supervisor.

Task-Oriented (TO) - a style that focuses on getting the required aspects of the job completed, structured, goal-oriented, and thorough.

_   *One note about the version of the SSI used in this training. This version is not the complete 33 item instrument. Friedlander and Ward (1984) indicated that eight items did not load according to the three dimensions measured, but were kept in the instrument as filler items. These filler items have been removed. For the complete version, refer to the original article or to the appendix in Bernard and Goodyear (1998)*

Supervisor Rating Form (Schiavone & Jessell, 1988)

Expertness (EX) - behaviors that create a perception of competence in the

supervisee of the supervisor.

Attractiveness (AT) - behaviors that make the supervisee cared for and valued.

Trustworthiness (TR) - behaviors that instill a sense of trust in the supervisee.

Supervisor Emphasis Rating Form (Lanning & Freeman, 1994)

Personal Awareness (PS) - counselor personal issues that are a part of and/or affect the treatment process

Professional Behaviors (PB) - monitoring the legal and ethical aspects of treatment delivery

Counseling Skills (SK) - practical, technique and skills-based focus.

Client Conceptualization (CP) - considering the bigger picture with the client and/or the counselor, examining various themes that transcend the in-session issues

_ The domains examined by the SRF are similar to the SSI and are used to provide a comparison, especially given that the instrument is only 12 items long. While there is a high degree of similarity between the SSI and SRF, there are still some elements of the supervisory relationship that are further explored by using this additional instrument. In particular, the concept of expertness.

DISCUSSION - EXERCISE

_   Break up into groups of 6-8 participants and discuss your results.

_   Look for any trends, either, in individual participants or among different participants, based on

other demographic variables.

_ Were there any surprises?

_ Did you find what you expected to find?

_ What do these results mean to you in your role as a supervisor?

_ How do you think that your supervisees might score you on these same domains?

E.   Demographic variables that affect the supervisory relationship.

1.   Gender

a.   Supervisees reported closer relationships with same sex supervisors and they attribute more influence to same sex supervisors than with opposite sex supervisors (Worthington & Stern, 1985).

b.   Male supervisors encourage imitation and are more aware of their impact on supervisees than are female supervisors (Borders & Leddick, 1987).

c.   Female supervisors encourage greater autonomy and are more supportive and non-intrusive with supervisees than are male supervisors (Borders & Leddick, 1987).

2.   Race - There are differences in how supervisors interact with supervisees based on the race of the supervisee (Cook & Helms, 1988).

3.   Recovery Status

a.   Matching of recovery status among recovering and nonrecovering CD counselors has been shown to be a significant factor in the supervisory relationship.

b.   Primarily, the issue is the mismatch of recovery status. Mismatched pairs result in lower ratings of the relationship and satisfaction with supervision. This holds true for both recovering and nonrecovering counselors (Culbreth, in press).

F.   The impact of evaluation on the supervisory relationship

Evaluation automatically creates a hierarchy and power structure that can be detrimental to the relationship. It is important that the supervisor address this issue and not pretend that evaluation and hierarchy are not present. While the supervisor may not want to acknowledge this as a factor, or to pretend it is not an issue, it is an issue for many supervisees.

G.   Three supervisor styles that can hinder the supervisory relationship (Bernard & Goodyear, 1998)

2.   Amorphous - Too little clarity about supervision and supervisory expectations, too little structure and/or guidance. Structure and guidance help relieve anxiety in supervisees, especially those who are new counselors. An amorphous, unstructured supervisor will not help supervisees who need

leadership. Level of structure is dependent on the experience level of the supervisee and will vary accordingly. However, supervisors must acknowledge and act on the need for a leadership position within supervision.

3.   Unsupportive - This type of supervisor is cold, aloof, and sometimes hostile. Support is a critical element in facilitating counselor development and the supervisory relationship. Supervisees who feel unsupported and criticized in the supervisory relationship will begin to monitor what they share in supervision as a protective behavior or engage in various types of resistant behaviors. Then the supervisor attributes problems in supervision to the supervisees resistance, denying any part in the problem at all.

4.   Therapeutic - The supervisor addresses the shortcomings of the counseling as personality problems or deficiencies in the counselor. This is a significant boundary issue, especially given the recovery component of a segment of our professionals. In general, supervisees do not have a problem with being told that they may be doing something incorrectly in a session. What they do not like, however, is having the reason attributed to personal deficits and they do not like having the supervisor attempt to correct it in a pseudo-therapeutic manner in supervision. This problem is the most problematic for supervisees because, (1) they have the fear that on some level the supervisor may be right, (2) the problem is often one that is

difficult to correct, and (3) if they disagree, the supervisor can attribute the disagreement to resistance, denial, or lack of objectivity, which only supports their own assertion, a big double bind for the supervisee.

H.   Supervisee anxiety/resistance

1.   Anxiety stems from a number of different areas within supervision.

   a.   The evaluation component
   b.   Performance anxiety
   c.   Power differential
   d.   Differences in theoretical orientation
   e.   Personal demographic variations

2.   An issue for the supervisor to consider is the degree of anxiety that you promote in the name of the learning process. Some anxiety is positive. However, too much or too little anxiety for the wrong reasons can adversely affect both supervision and the associated counseling.

   a.   Level of resistance is a personality variable.
   b.   Some people are more conducive to change than others.
   c.   Resistance is a normal reaction from people who are being required to change or from people who perceive a

threat within their learning environment.

d.   The supervisor needs to lower the threat level for the supervisee and/or help the supervisee find another coping mechanism for the anxiety.

e.   One possibility to help with resistance is to slow the pace of the supervision.

f.   Resistance can also be a normal reaction to an ineffective supervisor.

g.   It is the responsibility of the supervisor to identify and deal with the resistance in an appropriate manner.

I.   Supervisor Interventions for Resistance

1.   Preventive measures - The purpose is to be proactive, making anxiety a part of the supervision agenda up front.

a.   Establish a working contract for supervision

b.   Anticipate anxiety

c.   Determine learning goals for supervision

d.   Conduct group supervision

2.   Feedback guidelines - The purpose is to avoid making global judgments and labeling, so that the supervisee doesn t hear personal criticism.

a.   Frame feedback in terms of learning goals

      b.   Make specific concrete statements about counselor behavior

      c.   Identify client s response to counselor behavior

      d.   Suggest alternative behaviors

      e.   Help the counselor prepare to change behavior

      f.   State supervision goals positively

      g.   Base goal attainment on attempting new behavior rather than perfecting new behaviors

      h.   Point out small steps toward goals

      i.   Help supervisee identify assets, resources, positive behaviors and attitudes they can use to make changes

      j.   Use supervision interventions that take you out of the expert role

      k.   Use the thinking aloud technique

      l.   Give feedback from the perspective of the client

      m.   Give feedback in the form of a metaphor for client, counselor, and the counseling relationship

3.   Remedial measures - The purpose is to deal more directly with resistance that is resistant to other interventions.

      a.   Ignore

      b.   Identify irrational beliefs or dysfunctional thoughts

      c.   Focus on underlying issues

      d.   Use Columbo technique

      e.   Confront

        f.   Use nondefensive interpretation

        g.   Use nondefensive immediacy statements

        h.   Use metaphor for supervision relationship

        i.   Use paradoxical intervention

        j.   Consider whether the resistance is appropriate

_   **Complete the Counselor Anxiety Worksheet.**

_   **Break up into small groups and discuss responses to each of the questions.**

_   **As you focused on this aspect of supervision, did you experience any surprises?**

_   **Did you hear any similarities among your group members?**

_   **What positive suggestions did you develop or hear?**

_   **How does it feel to examine your part in the resistance from a supervisee?**

      J.   When considering all the issues and factors that can impact the supervisory relationship, supervisor style, emphasis, racial and gender issues, recovery status, ineffective supervision styles, and supervisee anxiety/resistance, it is crucial to note that research has clearly indicated that it is the responsibility of the supervisor to bring up, confront, and address these issues within the supervisory relationship. The supervisee is not the one responsible for taking care of these issues (Borders & Leddick, 1987; Moskowitz & Rupert, 1983).

V.   COUNSELOR DEVELOPMENT THEORIES OF SUPERVISION

      A.   Concerning the developmental model concept

            2.   There is general empirical support for the developmental models of supervision.

3.   The developmental models use stages which are sequential and hierarchical.

4.   A counselor s change in status occurs from adaptations to changes in stimulus facilitated by the supervisor.

5.   A major emphasis in these models is the readiness of the counselor to actually change.

B.   Stoltenberg (1981) **(Overhead)**

1.   The model consists of four levels of counselor development.

a.   Dependent on the supervisor - imitative, lacking self-awareness and other awareness, categorical thinking with knowledge of theories and skills, minimal experience

b.   Dependency/autonomy conflict - increasing self-awareness, fluctuating motivation, striving for independence, becoming more self-assertive and less imitative

c.   Conditional dependency - personal counselor identity is developing with increased insight, more consistent motivation, increased empathy, and more differentiated interpersonal orientation

d.   Master counselor - adequate self- and other awareness, insightful of own strengths and weaknesses, willfully interdependent with others, and has integrated standards of the profession with personal counselor identity

2.   No specific timetable exists for progression through these stages.

3.   Some have suggested that the fourth level is not truly a master counselor, that there is need for a fifth level in this model.

C.   Loganbill, Hardy, & Delworth (1982) **(Overhead)**

1.   This model is very circular and dynamic, probably more realistic, and therefore more difficult to empirically validate.

2.   Consists of three stages and eight supervisory issues.

Stage 1   Unawareness/Stagnation

Stage 2   Confusion

Stage 3   Integration

a.   Competence - ability to use the skills and techniques to carry out the treatment plan.

b.   Emotional Awareness - ability to be aware of and effectively use his or her own emotions in the session.

c.   Autonomy - a true sense of one s own choices and decisions in a situation.

d.   Theoretical Identity - a well integrated theoretical identity is needed.

e.   Respect for Individual Differences - ability to view the

client as a person and to respect differences in backgrounds, values, and appearances.

     f.   Purpose and Direction - intentionality within the session and the overall counseling experience.

     g.   Personal Motivation - what are the reasons for entering this field and how do these reasons affect the counseling arena.

     h.   Professional Ethics - the integration of the code of ethics into day-to-day practices.

    3.   Loganbill et al. Suggested that the first three issues are necessary for the fourth issue to occur, and the last four issues come as a result of the fourth issue.

D.   What are the implications of these two models and their stages on conducting supervision with counselors?

    2.   Early counselor stages require a more teacher/supportive role from the supervisor.

    3.   The middle counselor stages require a counselor focus or orientation from the supervisor.

    4.   The later stages require a consultation focus from the supervisor for the counselor.

POWELL S DISCUSSION OF SUPERVISION MODELS (POWELL, 1993)

A.   The Psychodynamic Model - This models considers supervision as primarily a therapeutic process. The focus is on intra- and interpersonal dynamics of the counselor in relation to the client, colleagues, supervisors, and significant others. The main goal of psychodynamic supervisors is not to teach skills, but rather to refine the supervisee s mode of listening through improvement of the supervisee s dynamic awareness. Changes in a supervisee s intra- and interpersonal dynamics allow the dynamic to become an effective tool in the therapeutic process with clients.

B.   The Skills Model - This model of supervision is a teaching process for the supervisee to learn and refine therapeutic core concepts and competencies for the betterment of the client. Knowledge and skills of the supervisee are assessed by the supervisor to provide a direction for supervision. There are three tenets to skill development supervision.

1.   Counselors must learn appropriate skills and extinguish inappropriate behaviors.
2.   Supervision assists counselors in developing and assimilating specific skills.
3.   Counselor knowledge and skills should be formulated in behavioral terms.

C.   Family Therapy Models - Supervision models in the family therapy context, therefore, tend to be dependent on the therapeutic model being used by the counselor and supervisor. Because of this, a unified family therapy model of

supervision cannot be described. Some supervisors utilize a structural (Minuchin) approach, others use a functional or strategic (Haley) approach, while still others use a systemic (Liddle) or Bowenian approach to supervision.

D. The Developmental Model - Powell has integrated counselor development theories into a working model for the chemical dependency field. This model is based largely on the work of Stoltenberg and Delworth (1987) who modified the earlier developmental theories of Loganbill, Hardy, and Delworth (1982) and Stoltenberg (1981). There are three stages of counselor development with three corresponding areas of supervision issues.

1. Level one counselor characteristics

a. Focused on basic skill development

b. Motivated both by anxiety associated with questions of competence and by high enthusiasm level

c. Strongly emulates a role model, usually that of the supervisor

d. Uses one word descriptions of clients, characterized by categorical thinking

e. Wants to learn the right way to conduct counseling, looks for cookbook answers

f. Is highly dependent with a strong focus on self rather than the client

g. Has difficulty with client conceptualization

       h.   Lacks self-awareness

       i.   Does not know what he or she does not know

       j.   Clings to and overuses a model of counseling, resulting in a theoretical tunnel vision

       k.   Has difficulty with confrontation and appropriate self-disclosure

       l.   Uses anecdotal conceptualization - projecting own experiences onto the client

       m.   Makes categorical, sweeping statements about clients and their issues

       n.   Has a limited idea of treatment planning

              a.   Lacks integrated ethics - does not have a clear understanding of the practical implications of ethical standaards

2.   Level one supervision issues

       a.   Expose supervisees to numerous theoretical orientations

       b.   Be sensitive to trainee anxiety

       c.   Promote autonomy

       d.   Encourage risk-taking

       e.   Promote exposure to counseling models

       f.   Introduce ambiguity

       g.   Balance support with uncertainty

       h.   Use role play, application, and presentations

       i.   Help counselors begin to conceptualize the larger picture

of their clients

    j.   Address their strengths first

    k.   Do not take too much control

    l.   Be aware of trainee learning styles

        i.   Active versus vicarious

        ii.   Locus of control

        iii.   Conceptual levels

        iv.   Oral versus written processors

3.   Level two counselor characteristics

    a.   Focuses more on the client

    b.   Exhibits greater awareness, frustration, and confusion

    c.   May appear to be less advanced than level 1 counselor

    d.   Shows uncertainty and lingering idealism

    e.   Loses motivation after difficult clients

    f.   Has dependency/autonomy conflicts with supervisor

    g.   Is less imitative, more self-assertive

    h.   Is less inclined to ask for recommendations

    i.   Better articulates client classifications

    j.   Evidences greater cultural awareness

    k.   Is more open to alternative theoretical approaches to helping clients

    l.   Attends to the underlying ethical principles in a situation rather than strict adherence to ethical standards

4.   Level two supervision issues

    a.   Understand that the counselor is less technique oriented

    b.   Realize that the counselor is ready for confrontation and needs to learn alternatives to their given approach

    c.   Be prepared for challenges to supervisor competence

    d.   Focus on transference issues

    e.   Develop consultative supervision techniques and approach

    f.   Encourage independence

    g.   Realize the counselor knows something is wrong but lacks the skills to fix it

    h.   Provide a blend of clients to vary counseling experiences

    i.   Recognize the need for a convincing rationale

    j.   Distinguish clearly between supervision and therapy

5.   Level three counselor characteristics

    a.   Has deeper client understanding

    b.   Understands limits and is not disabled by doubt

    c.   Is consistently motivated over time

    d.   Is forging own therapeutic style

    e.   Displays increased autonomy

    f.   Is stable in six key areas

        i.   Intimacy

        ii.   Power

        iii.   Financial concerns

        iv.   Personal growth

        v.   Intellectual abilities

        vi.   Altruism

    g.   Is nondefensive

    h.   Displays appropriate use of self

    i.   Is able to switch tracks

    j.   Is less likely to pigeonhole clients

    k.   Accepts supervisor of a different orientation

    l.   Can move smoothly from assessment to conceptualization to intervention

    m.   Displays broad ethical perspectives

6.   Level three supervision issues

    a.   Requires a level 3 counselor/supervisor

    b.   Use a client-centered approach

    c.   Be a supportive colleague/friend, reality tester, sharer of experiences

    d.   Use wisdom as a guide

    e.   Stimulate and challenge the counselor

    f.   Use catalytic interventions

    g.   Use self-disclosure when helpful

_ **Complete the Counselor Development Worksheet.**

_ **Think of one supervisee that you are working with and answer each of these questions with that supervisee in**

mind.

_   **Use the counselor characteristics and supervision issues listed by Powell to answer these questions.****

_   **Break up into small groups and discuss your answers. Share one example of how you could begin to address this supervision issue with the group.**

_   **Did this model or series of ideas help you formulate a better understanding of the work/issues with your supervisee?**

_   **Does this concept of supervisee development fit for you?**

_   **How can this be used within the context of everyday supervision?**

E.   Powell s Blended Model of AODA Supervision

1.   As we review this theoretical model of supervision, keep in mind a couple of things. First, Powell developed this model after spending many years working for the military as an outside contractor. His counselors and sometimes his supervisors were often military personnel that had either been assigned to work in the military treatment centers or had requested that posting after their own recovery experience. Many of these individuals came to the field without formal academic training. Second, there are several aspects of this theory that reflect many of the already existing roles and emphasis areas of clinical supervision that we either have discussed or will discuss during this week. This is not new information.

2.   This model consists of seven basic assumptions.

a.   People have the ability to bring about change in their lives with the assistance of a guide.

b.   People do not always know what is best for them, for they may be blinded by their resistance to and denial of the issues.

c.   The key to growth is to blend insight and behavioral change in the right amounts at the appropriate time.

d.   Change is constant and inevitable.

e.   In supervision as in therapy, the guide concentrates on what is changeable.

f.   It is not necessary to know a great deal about the cause or function of a manifest problem to resolve it.

g.   There are many correct ways to view the world. Guides do not know all the routes to change and should not impose rigid dogmatisms and hierarchical thinking.   I know the best way.

3.   The model also has nine dimensions - each dimension is represented by a continuum with the perspective of the blended model placed at the appropriate point.

a.   Influence - supervisees are influenced both affectively and behaviorally, often depending on where they are developmentally. Level 1 counselors will focus more on the behavioral end of the continuum while level 3 counselors will work more on the affective end. In between, level 2 counselors tend to go back and forth and deal with theoretical issues.

b.   Symbolic - this continuum examines the range of session content from manifest to latent. The blended model attempts to remain with manifest content in supervision, viewing unconscious material as interesting but nonessential.

c.   Structural - the level of teaching structure within the supervision process, moving from more to less structure as the counselor develops.

d.   Replicative - views the parallel process between supervision and counseling as an area to stay away from, especially given the nature of potential dual relationships and ethical dilemmas based on the recovering counselor population. This issue is considered a discrete entity that falls outside of the supervisory process.

e.   Counselor in treatment - the supervisor deals only with job performance, therefore issues of personal recovery and therapy are not appropriate for the supervisory process and are structurally unrelated to the training and supervision process. These issues should be referred to an outside counselor source for the supervisee.

f.   Information gathering - this refers to the amount of direct observation and information gathering the supervisor is expected to conduct. In the initial stages, supervisors should be more proactive in direct observations of the beginning counselor s work with clients.

g.   Jurisdictional - the ultimate responsibility for the well-

being of the client rests with the supervisor. This is consistent with the overall definition of supervision as providing a gatekeeper and manager of client service delivery for the profession.

h.   Relationship - in general, the Blended Model views the supervisory relationship more from a consultant role rather than as a structured, directive, and hierarchical model. This is dependent on several factors, including type of treatment setting and level of counselor development.

i.   Strategy - the supervisor should focus initial efforts at skill acquisition and the 12 core functions. As the counselor progresses, supervision should move toward helping the counselor begin to formulate a theoretical model for their counseling.

Descriptive Dimensions of Powell s Blended

Model of Clinical Supervision

Level 3	Level 2	Level 1
Affective		Cognitive

Influence

	X	

Latent		Manifest

Symbolic

Level 3	Level 2	Level 1
Reactive		Proactive

Structural

	X	

Parallel		Discrete

Replicative

	X	

Related   Unrelated

Counselor in Treatment

Level 3   Level 2   Level 1

Indirect   Direct

Information Gathering

X

Therapist   Supervisor

Jurisdictional

Level 3   Level 2   Level 1

Facilitative   Hierarchical

Relationship

Level 3   Level 2   Level 1

Theory   Technique

Strategy

SUPERVISION ASSESSMENT INSTRUMENTS

Includes supervision assessment instruments (SSI, SRF, and SERF), scoring sheets, division tables, counselor anxiety worksheet, counselor development worksheet, and references.

Directions: **What are the supervisor characteristics that you feel are important in your supervision? The following words describe styles and traits of supervisors. Please indicate your perception of yourself as a supervisor. Write your response in the box to the right of each word using the scale (1 to 7) provided.**

**Not
Very**   **Very**

1   2   3   4   5   6   7

Supervisor Style	
goal-oriented	
perceptive	
concrete	
explicit	
committed	
practical	
intuitive	
reflective	
structured	
evaluative	
friendly	
flexible	
prescriptive	

Supervisor Style	
didactic	
thorough	
focused	
creative	
supportive	
open	
resourceful	
invested	
therapeutic	
positive	
trusting	
warm	

Supervisor Traits	
experienced	
honest	
likeable	
expert	
reliable	
sociable	
prepared	
sincere	
skillful	
trustworthy	

Directions: A number of competencies that many supervisors consider important for counselors to demonstrate are listed below. Competencies are listed in sets of four. You are requested to rank order the competencies in each set from 1 to 4 in terms of how likely you are to emphasize each in supervision with a supervisee. Within each set, please rank the one you would most likely emphasize as   1" and the one you would least likely emphasize as   4.   Please rank all the competencies within all sets.

Set #

1.   A. The counselor maintains appropriate conduct in personal relationships with clients.
          B. The counselor uses appropriate reflection of feeling with a client.
          C. The counselor maintains a non-judgmental attitude despite value differences with a
             client.
          D. The counselor is able to prioritize client problems.

2.   A. The counselor is knowledgeable about ethical codes of behavior.
          B. The counselor is able to identify client themes.
          C. The counselor recognizes his/her personal limitations.
          D. The counselor demonstrates the use of open-ended questions.

3.   A. The counselor is aware of socioeconomic and/or cultural factors that may influence the
             counseling session.
          B. The counselor uses open-ended questions and allows the client maximum freedom of
             expression.
          C. The counselor is aware of his/her own needs and conflicts.
          D. The counselor keeps appointments with clients.

4.   A. The counselor makes appropriate use of additional information obtained from other
             professional sources.
          B. The counselor is able to risk self in counseling with a client.
          C. The counselor communicates his/her sincerity and genuineness to the client.
          D. The counselor maintains confidentiality of client information.

5.   A. The counselor is aware of the effects of his/her own anxiety in the counseling process.
          B. The counselor engages in appropriate confrontation with the client.
          C. The counselor recognizes when he/she needs consultative help from another
             professional.
          D. The counselor is able to set attainable goals in line with client readiness.

6.   A. The counselor shows a commitment to personal growth.
          B. The counselor prepares clients for termination.
          C. The counselor responds to client non-verbal behavior.
          D. The counselor understands how people are the same even though they may be worked
             with differently.

7.   A. The counselor is able to develop short and long term goals with a client.
          B. The counselor allows him/herself the freedom to be wrong in the counseling session.
          C. The counselor communicates his/her respect and positive regard to the client.
          D. The counselor actively participates in professional organizations.

Set #

8.   A. The counselor formulates specific plans and strategies for client behavior change.
            B. The counselor makes appropriate referrals of clients.
            C. The counselor is able to keep personal problems out of the counseling session.
            D. The counselor accurately reflects the content of a client s speech.

9.   A. The counselor is able to manage a strong expression of client s feelings.
            B. The counselor is on time for client appointments.
            C. The counselor receives feedback in a non-defensive fashion.
            D. The counselor is aware of the client s potential for successful counseling progress.

10.   A. The counselor recognizes when a client needs help in continuing to cope.
            B. The counselor takes advantage of opportunities for additional training.
            C. The counselor is able to identify and manage personal feelings that are generated in counseling.
            D. The counselor maintains a receptive and appropriate posture during the session.

11.   A. The counselor recognizes and admits when he/she enters into a power struggle with the clients.
            B. The counselor appropriately summarizes client statements.
            C. The counselor dresses appropriately.
            D. The counselor conceptualizes a client accurately within a theoretical frame of reference.

12.   A. The counselor identifies the need for and uses immediacy appropriately.
            B. The counselor engages in adequate note-keeping on clients.
            C. The counselor is able to choose and apply techniques appropriately.
            D. The counselor is able to tolerate ambiguity in the counseling sessions.

13.   A. The counselor maintains appropriate relationships with professional colleagues.
            B. The counselor is able to interpret client behaviors within a coherent theoretical framework.
            C. The counselor can effectively manage his/her frustration with lack of progress with clients.
            D. The counselor engages in appropriate non-verbal expressions.

14.   A. The counselor exhibits appropriate eye contact.
            B. The counselor understands which techniques are compatible and consistent with his/her stated theoretical model.
            C. The counselor is aware of his/her personal needs for approval from the client.
            D. The counselor engages in adequate preparation for counseling sessions.

15.   A. The counselor is aware of how his/her attraction to the client is effecting the counseling process.
            B. The counselor maintains his/her office neatly and orderly.
            C. The counselor reinforces appropriate client behavior.
            D. The counselor is able to predict the effects on a client of the techniques applied in counseling.

SSI/SRF Assessment Worksheet

TO
goal-oriented	____
concrete	____
explicit	____
practical	____
structured	____
evaluative	____
prescriptive	____
didactic	____
thorough	____
focused	____

Total ____ **/10=**

IS
perceptive	____
committed	____
intuitive	____
reflective	____
creative	____
resourceful	____
invested	____
therapeutic	____

Total ____ **/8=**

AT
friendly	____
flexible	____
supportive	____
open	____
positive	____
trusting	____
warm	____

Total ____ **/7=**

EX
experienced	____
expert	____
prepared	____
skillful	____

Total ____ **/4=**

TR
honest	____
reliable	____
sincere	____
trustworthy	____

Total ____ **/4=**

AT
likeable	____
sociable	____
friendly	____
warm	____

Total ____ **/4=**

Supervisory Styles Inventory Scale Table

AT scale
divide by 7

IS scale
divide by 8

TO scale
divide by 10

AT scale	IS scale	TO scale	
49 = 7	56 = 7	70 = 7	19 = 1.9
48 = 6.86	55 = 6.87	69 = 6.9	18 = 1.8
47 = 6.71	54 = 6.75	68 = 6.8	17 = 1.7
46 = 6.57	53 = 6.62	67 = 6.7	16 = 1.6
45 = 6.42	52 = 6.5	66 = 6.6	15 = 1.5
44 = 6.28	51 = 6.37	65 = 6.5	14 = 1.4
43 = 6.14	50 = 6.25	64 = 6.4	13 = 1.3
42 = 6	49 = 6.12	63 = 6.3	12 = 1.2
41 = 5.86	48 = 6	62 = 6.2	11 = 1.1
40 = 5.71	47 = 5.87	61 = 6.1	10 = 1
39 = 5.57	46 = 5.75	60 = 6	
38 = 5.42	45 = 5.62	59 = 5.9	
37 = 5.28	44 = 5.5	58 = 5.8	
36 = 5.14	43 = 5.37	57 = 5.7	
35 = 5	42 = 5.25	56 = 5.6	
34 = 4.86	41 = 5.12	55 = 5.5	
33 = 4.71	40 = 5	54 = 5.4	
32 = 4.57	39 = 4.87	53 = 5.3	
31 = 4.42	38 = 4.75	52 = 5.2	
30 = 4.28	37 = 4.62	51 = 5.1	
29 = 4.14	36 = 4.5	50 = 5	
28 = 4	35 = 4.37	49 = 4.9	
27 = 3.86	34 = 4.25	48 = 4.8	
26 = 3.71	33 = 4.12	47 = 4.7	
25 = 3.57	32 = 4	46 = 4.6	
24 = 3.42	31 = 3.87	45 = 4.5	
23 = 3.28	30 = 3.75	44 = 4.4	
22 = 3.14	29 = 3.62	43 = 4.3	
21 = 3	28 = 3.5	42 = 4.2	
20 = 2.86	27 = 3.37	41 = 4.1	
19 = 2.71	26 = 3.25	40 = 4	
18 = 2.57	25 = 3.12	39 = 3.9	
17 = 2.42	24 = 3	38 = 3.8	
16 = 2.28	23 = 2.87	37 = 3.7	
15 = 2.14	22 = 2.75	36 = 3.6	
14 = 2	21 = 2.62	35 = 3.5	
13 = 1.86	20 = 2.5	34 = 3.4	
12 = 1.71	19 = 2.37	33 = 3.3	
11 = 1.57	18 = 2.25	32 = 3.2	
10 = 1.42	17 = 2.12	31 = 3.1	
09 = 1.28	16 = 2	30 = 3	
08 = 1.14	15 = 1.87	29 = 2.9	
07 = 1	14 = 1.75	28 = 2.8	
	13 = 1.62	27 = 2.7	
	12 = 1.5	26 = 2.6	
	11 = 1.37	25 = 2.5	
	10 = 1.25	24 = 2.4	
	09 = 1.12	23 = 2.3	
	08 = 1	22 = 2.2	
		21 = 2.1	
		20 = 2	

Supervisor Rating Form Scale Table

EX scale divide by 4	AT scale divide by 4	TR scale divide by 4
28 = 7	28 = 7	28 = 7
27 = 6.75	27 = 6.75	27 = 6.75
26 = 6.5	26 = 6.5	26 = 6.5
25 = 6.25	25 = 6.25	25 = 6.25
24 = 6	24 = 6	24 = 6
23 = 5.75	23 = 5.75	23 = 5.75
22 = 5.5	22 = 5.5	22 = 5.5
21 = 5.25	21 = 5.25	21 = 5.25
20 = 5	20 = 5	20 = 5
19 = 4.75	19 = 4.75	19 = 4.75
18 = 4.5	18 = 4.5	18 = 4.5
17 = 4.25	17 = 4.25	17 = 4.25
16 = 4	16 = 4	16 = 4
15 = 3.75	15 = 3.75	15 = 3.75
14 = 3.5	14 = 3.5	14 = 3.5
13 = 3.25	13 = 3.25	13 = 3.25
12 = 3	12 = 3	12 = 3
11 = 2.75	11 = 2.75	11 = 2.75
10 = 2.5	10 = 2.5	10 = 2.5
09 = 2.25	09 = 2.25	09 = 2.25
08 = 2	08 = 2	08 = 2
07 = 1.75	07 = 1.75	07 = 1.75
06 = 1.5	06 = 1.5	06 = 1.5
05 = 1.25	05 = 1.25	05 = 1.25
04 = 1	04 = 1	04 = 1

Supervisor Emphasis Rating Form Scoring Table

	PB	SK	PS	CP
Set 1	A ____	B ____	C ____	D ____
Set 2	A ____	D ____	C ____	B ____
Set 3	D ____	B ____	C ____	A ____
Set 4	D ____	C ____	B ____	A ____
Set 5	C ____	B ____	A ____	D ____
Set 6	B ____	C ____	A ____	D ____
Set 7	D ____	C ____	B ____	A ____
Set 8	B ____	D ____	C ____	A ____
Set 9	B ____	A ____	C ____	D ____
Set 10	B ____	D ____	C ____	A ____
Set 11	C ____	B ____	A ____	D ____
Set 12	B ____	A ____	D ____	C ____
Set 13	A ____	D ____	C ____	B ____
Set 14	D ____	A ____	C ____	B ____
Set 15	B ____	C ____	A ____	D ____
TOTAL	____	____	____	____
	PB	SK	PS	CP

Supervision Assessment Results

Supervisory Styles Inventory

AT _____ **(attractive)**

IS _____ **(interpersonally sensitive)**

TO _____ **(task oriented)**

Supervisor Rating Form

EX _____ **(expertness)**

AT _____ **(attractiveness)**

TR _____ **(trustworthiness)**

Supervisor Emphasis Rating Form

PB _____ **(professional behaviors)**

SK _____ **(counseling skills)**

PS _____ **(personal awareness)**

CP _____ **(client conceptualization skills)**

Counselor Anxiety Worksheet

Counselor initials

What indicators of counselor anxiety has this counselor exhibited?

What do you think are potential reasons or sources for this anxiety?

How does this affect the supervisor relationship/process?

What has been or is your typical/regular response to this anxiety?

What are the possible reasons for your response?

How does <u>your response</u> affect the supervisor relationship/process?

What might be a better or more productive supervisory response to the counselor s anxiety based on the information from the workshop material?

How do you think the counselor will respond to this change in your response to his or her anxiety?

What other ideas were developed or suggested from the small group discussion for helping with this counselor anxiety?

Counselor Development Assessment Worksheet

Counselor   **Current Level**

Notable characteristics exhibited by that counselor suggesting the current level:

Next level characteristics:

Current supervision issues:

Supervision issues on the horizon:

Strategies for dealing with/addressing these supervision issues:

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DAY TWO

■   **THE PERFORMANCE DOMAIN OF ASSESSMENT AND EVALUATION**

- Assessing your staff s experience and knowledge of the AODA Counseling field, and determining their strengths and weaknesses.

- Assessing your staff s temperament, leadership style/qualities, personal and interpersonal wellness .

- Assessing your staff s performance of the 12 core functions.

- Assessing your staff s level of clinical functioning and their ability to utilize various therapeutic techniques.

- Evaluating their strengths and weaknesses & soliciting feedback from others to identify case load assignments and development needs.

■   DEVELOPING YOUR PHILOSOPHY OF SUPERVISION

Take a few moments to reflect on your beliefs about AODA supervision. Answer the following questions with brief phrases.

What are some truths you believe about adult learners? *1.* *2.* *3.* *4.*	*What is it you want to accomplish in supervision?* *1.* *2.* *3.* *4.*
What are some truths about substance abuse treatment? *1.* *2.* *3.* *4.*	*What do you believe about how people learn best?* *1.* *2.* *3.* *4.*

Write your philosophy here.
Select from among the most important items in your list above and write your own philosophy of AODA education here.

■   **CAUSAL MODELS OF ALCOHOLISM**

MODEL	*CAUSAL FACTORS*	*EXAMPLES OF INTERVENTIONS*
Moral	Personal responsibility, self-control	Social and legal sanctions
Spiritual	Spiritual deficit	Spiritual growth, prayer, AA
Disease	Irreversible constitutional abnormality of individual	Identification of alcoholics, confrontation, lifelong abstinence
Social Learning	Skill deficits, modeling	Skill training, behavioral modeling
Cognitive	Expectancies and beliefs	Cognitive restructuring
Systems	Family dysfunction, boundaries and rules	Family therapy

Adapted from ***Treatment for Alcohol Problems: Toward an Informed Eclecticism*** in The Handbook of Alcoholism Treatment Approaches, Miller and Hester, 1995.

■   **CHARACTERISTICS OF ADULT LEARNERS**

A good deal of research has been conducted and much has been written on the adult learner. It is important to understand who this adult learner to effectively meet their clinical learning needs.

1. Autonomy (Olcott)
Adults are autonomous in most areas of their life and feel most comfortable when they are able to bring a certain amount of that autonomy to their learning of counseling.

2. Confidence in a small arena will broaden to mastery over a larger context (Wilson)
Supervisees who are exposed to too much, too fast are often overwhelmed and integrate little.

3. Need Physical space (Wilson)
Private space, a desk or cubical, can contribute to the integration of observations and practice.
_   consider a desk in a corner, or a carrel in a student room for students
_   recognize that time to decompress and reflect is critical to students and new employees

4. Learn When There is a Purpose (Wilson)
When adults experience the gap between what is known and what is yet to be learned or mastered they can identify the purpose.

5. Need to experience theories to believe them
Telling the adult learner is not enough. Use real situations with clients to facilitate learning.

6. New skills are learned by doing
Learning theory supports the development of new skills through observation, practice and feedback with the ability to perform the skill again integrating the feedback.

7. Require some unlearning
Certain values and approaches may exist because of past experiences.

8. Learning requires thinking
Learning requires more than simply doing. Learning requires time to think about and analyze what is done.

9. Want to participate in self-evaluation
Learners who regularly participate in self-evaluation are invested in their own learning.

10. Motivation for learning is facilitated by self-efficacy
An important goal of supervision is to increase the supervisee s perception that he can succeed in learning the new skill.

■   **ESSENTIAL TASKS TO THE SUPERVISORY RELATIONSHIP** (Powell)

1. A WORKING RELATIONSHIP: includes laying ground work for trust and respect

2. ASSESSING: determine the counselors clinical knowledge and skills, prior experiences and training needs.

3. CONTRACT: setting the ground rules for supervision and developing agreement

4. PLANNING: setting learning goals for the supervision in the form of a supervision plan.

5. EVALUATING: determine whether progress is made.

■   **GETTING TO KNOW THE SUPERVISEE** (Powell)

Just as good counseling is derived from learning about the client and developing a treatment plan, good supervision is based upon a knowledge of the supervisee. Once the supervisor has a clear understanding of the supervisee, a plan and a supervisory contract can be agreed upon.

Knowledge and Skills
1. How prepared is the counselor to perform certain tasks?
2. Can the counselor articulate a theoretical model?
3. Is the client able to demonstrate basic counseling skills?
4. Does the counselor possess the skills necessary for the specific agency or population?
5. Does the counselor have the necessary qualities and resources to strengthen and develop skills?

Learning Style
1. Does the counselor learning by doing?
2. Does the counselor learn by watching?
3. How does the counselor process; oral or written?
4. Does the person require a great deal of feedback or can they generate solutions?

Conceptual skills
How does the counselor form a hypothesis about a case and develop the treatment plan based upon this hypothesis?

Suitability for Work Setting
Consider whether the individual is a good match for the demands and nature of the work in the agency.

Motivation
Determine the element that keeps the counselor doing this work. What does the counselor get out of the work? What are the counselor s fears regarding this work?

■   **PREFERRED WAYS OF KNOWING   A Self-Assessment**

Directions

Read the four statements below; then respond to the self-assessment questions by circling the answer that most closely represents your view.

A	B
I never take anything for granted. When somebody states an opinion, I like to play the devil s advocate and take the opposite position. Even if I agree with the opinion, I try to find the flaws and weak points in my opponent s logic. I really enjoy a good argument and often learn a lot from responding to the tough criticisms of a worthy opponent. Sometimes I even change my mind as the result of a hard-fought debate.	I don t really enjoy arguments or debates, and I am not too interested in other people s opinions about important topics. Unless they re experts, why bother listening? For example, I d rather listen to a professor lecture than have class discussions. Only people who really know what they re talking about are worth listening to. I respect and accept expert opinion on most things.
C	D
Most of the time, disagreements are just a matter of differences in personal opinions. Sure, it can be interesting to discuss issues with other people, and even to argue about them sometimes; but in the end, it comes down to their opinions against mine. My own experiences change my mind. Other peoples opinions don t.	When I hear somebody state an opinion that is very different from mine, I try to look at it from that person s perspective, to get inside his or her head. I learn a lot from listening to people explain why they think the way they do. They usually have reasons. And sometimes they have better reasons than I do.

1. Which of the four statements most clearly reminds you of yourself?
       A   B   C   D

2. Which of these four approaches do you actually use most when you are communicating with a supervisor?
       A   B   C   D

3. Which of these four approaches do you actually use most in your social/personal life?
       A   B   C   D

4. When other people are communicating with you, which of these four approaches would you prefer them to use?
       A   B   C   D

■   **SELF CONFIDENCE SURVEY**

For this survey, let's define self-confidence as your personal subjective evaluation of your own ability or competence. You make this judgment comparing your performance as you see it with the expectations you believe others have of you. In other words, your self-confidence depends on the distance you perceive between your "actual" ability to perform and the "ideal" performance you imagine.

Although all of us probably have a "global", general level of self-confidence, our feelings of self-worth and self-confidence can certainly vary with situations or settings. This survey focuses on your self-confidence in a particular situation (your counseling), not on your overall feelings.

1. Rate your self-confidence in counseling. How do you feel about it today?

1	2	3	4	5
Extremely Low	Low	Average	High	Extremely High

2. Briefly explain the factors that contribute most to the above rating.

3. Overall, for the past six months, how would your rate your self-confidence?

1	2	3	4	5
Extremely Low	Low	Average	High	Extremely

If you were your own supervisor, what outwardly observable signs would tell you that your self-confidence was low?	What signs would tell you that your self-confidence is high?
Complete the following sentence: A supervisor could raise (or has raised) my confidence by	How, do you specifically raise your own self-confidence? What works?

■ THE INDIVIDUAL DEVELOPMENT PLAN

We have been discussing how supervision parallels the treatment process and relationship in many ways. The individual development plan is similar to a treatment plan for a client. To complete this you need to spend some time thinking about your supervisee after you have gotten to know them.

1. Identification of the counselor s development need

2. Procedures to be used to observe the counselor in practice

3. Procedures to evaluate the counselor

4. Procedures to be used to help the counselor achieve the supervision goals

5. Supervision plan - how often will you meet; what is your schedule

If you maintain a file of each counselor s plans, you have documentation of your involvement for future reference. It can serve the same purpose for you regarding your supervisees that comprehensive treatment records serve for you with your clients.

INDIVIDUAL DEVELOPMENT PLAN   Name:_____   Date Developed_____

Supervision Schedule: Day_____   Time_____   Frequency_____

NEED Define the problem or skill deficit	PLAN Describe the tasks to be done to facilitate the problem resolution	CRITERIA define the criteria against which the counselor is assessed	SUPERVISION METHOD Describe process used to observe and evaluate the counselor	OUTCOME record date and level of accomplishment
1. Lacks information regarding relapse prevention	1. Attend relapse prevention workshop 2. Sit in on relapse prevention program provided on Tuesday nights.	1. Effectively lead the relapse prevention group for one cycle. 2. Incorporate relapse prevention work into individual counseling. 3. Clients are able to develop individualized relapse prevention plans.	1. Supervisor will sit in on relapse prevention group and observe. 2. Counselor will bring relapse prevention plans to the supervision session.	**9/5/98** **Joan has successfully lead the relapse prevention cycle. Client post-group evaluations indicated high satisfaction and direct applicability to their own lives. Relapse plans for clients have been reviewed. They are complete. Joan could improve these by working to individualize strategies more to the specific need of the client**.
2.				
3.				

Counselor Signature_____   Supervisor Signature_____Date_____

INDIVIDUAL DEVELOPMENT PLAN   Name:_____   Date Developed_____

Supervision Schedule: Day_____   Time_____   Frequency_____

NEED **Define the problem or skill deficit**	PLAN **Describe the tasks to be done to facilitate the problem resolution**	CRITERIA **define the criteria against which the counselor is assessed**	SUPERVISION METHOD **Describe process used to observe and evaluate the counselor**	OUTCOME **record date and level of accomplishment**
1.				
2.				
3.				

Counselor Signature_____   Supervisor Signature_____Date_____

GUIDELINES FOR SUPERVISION (Breunlin et al. In Bernard and Goodyear)

1. Focus supervision by setting realistic goals for the supervised therapy session. This serves to reduce the sense of information overload by narrowing down those interventions related to specific goals. Because of this it increases the likelihood that the supervisee will emerge from the session with a sense of satisfaction because realistic goals are indeed attainable.

2. Relate internal process across context. What the therapist experiences in the session is important to discuss in supervision; supervisors should allow the counselor to disclose their perceptions before the supervisor offers their own view. This serves to validate the internal process of the counselor. Beginning with a strategy review can tend to invalidate the internal process of the counselor.

3. Focus on an area that is amenable to change. The focus should be on an area that the counselor is able to change. Selection of areas of increasing intensity can occur when the counselor has become successful in less complex areas of change. Focus on counselor styles or skills that are too complex will be a frustrating and non-productive experience for the counselor.

4. Use supervisor comments to create a moderate evaluation of performance. Breunlin references the work of Fuller and Manning (1993) which found that a moderate discrepancy between performance and the target goal is optimal for learning. In other words, create a little anxiety about performance, but not too much.

5. Refine goals moderately. Supervision of counselor counseling must be seen in the larger context of the supervisee development. What appears easy when viewing a session or discussing it can be far more difficult to pull off in the session. Just as expectations of the client are moderated to fit the current capability of the client, so too are the expectations and goals for the counselor moderated to fit the current ability of the supervisor.

6. **Maintain a moderate level of arousal.** The supervisor must always be conscious of the fact that the supervisee requires sufficient stimulation to grow and develop without becoming overly threatened. The supervisor must be alert to any signs that the counselor is becoming too anxious about the assignments.

■   SUPERVISION FORMATS

INDIVIDUAL SUPERVISION

Many supervisors prefer to conduct individual supervision with their supervisees. This is the preferred method for supervision from an ideal perspective. Benefits include:

1. Supervisee may be more willing to disclose certain difficulties than in a group setting.

2. It is common for group supervision to cover many other administrative areas other than supervisee development.

3. Group supervision often turns out to be case management, where counselors make case specific suggestions rather than look at the work of the counselor.

THE INDIVIDUAL SUPERVISION SESSION

1. Schedule this meeting and make it clear it is not to be changed.

2. Provide feedback from your observations.

3. Use notes or a portion of the tape or something they have written as the reference point.

4. Ask the counselor to describe their own rationale, why they have chosen the strategies they have chosen.

5. Has the counselor considered all treatment strategies and options for this client?

6. Provide your own evaluation of the client s progress.

7. Ask the counselor how they are perceiving their own effectiveness. Are they in touch with their own limitations and strengths? Pay attention to how you are providing the feedback and how they are receiving it.

GROUP SUPERVISION

There seems to be a fair amount of controversy among the supervision experts as to whether individual or group is the preferred method of supervision. These issues aside, there are some compelling reasons to not throw the baby out with the bath water (Bernard and Goodyear):

1. Group supervision is more efficient and cost-effective than individual supervision.
2. Group supervision reduces the dependency.
3. The supervisees   development of skills is enhanced through the verbalization of their process to peers.
4. Those new to counseling may also be able to learn more efficiently from each other than from an expert.
5. Group members who see each others   struggles are less likely to personalize their own frustrations. The group supervision process can function as a support group in this way. Supervisees are able to put their failures or learning needs into perspective.
6. Allows the supervisor to view the supervisee from another perspective. Defenses may prevent an individual from thinking clearly on their own case. This same individual may demonstrate clarity relative to the case of a peer.

■   METHODS FOR ASSESSMENT & EVALUATION

There are a number of methods of monitoring supervisee activity. There are a myriad of assignments the supervisor might attach to these to facilitate and integrate learning. Each supervisor must select a method which works best for the supervisee and is possible within the constraints of the agency.

Self Assessment

Powell suggests that self-assessments are based on the assumption that counselors have insight into their own behavior.   He suggests that level 1 and 2 counselors may have limited self-awareness and this must be taken into consideration and viewed as one piece to the assessment puzzle.

Another benefit to conducting self-assessment with the beginning counselor has to do with setting in motion a lifelong career process. Each counselor must engage in regular and ongoing self-reflection and assessment. Involving even the beginning counselor in this process teaches the importance and hopefully supports it as a normal part of the counseling process.

1.   SELF-ASSESSMENT, FEEDBACK AND IMPROVEMENT
SUPERVISEE PERSPECTIVES

	Level 1	*Level 2, 3*	*Level 4*
Self Assessment	Counselor is able to make judgments on his/her behavior when the supervisor points out concrete evidence.	Counselor senses when her/his performance in a given situation is essentially competent or lacking.	Counselor sees his/her own abilities apart from a given situation and shapes aspirations realistically.
Feedback	Counselor experiences evaluation of his/her	Counselor is able to see the value in separating	Counselor will seek out formative evaluation of

	performance as general affirmation or rejection of himself/herself.	emotional response to feedback from a more objective stance.	his/her work and self-applies formative evaluations to work.
Self Improvement	Counselor is aware of the need for improvement, wants to improve and tries to improve.	Counselor thinks about how to improve, builds on strengths, and is motivated to achieve by explicit criteria.	Counselor takes the initiative to improve his/her work. Counselor finds help and resources to help improve processes.

Adapted from *Self-Assessment: A Vital Component of the Assessment-as -Learning Process,* Stoffels, Julie and Hass, Jackie, Alverno College, 1993.

HOW EFFECTIVE IS COUNSELOR SELF ASSESSMENT?

First read the following scenario regarding an informal counselor self-assessment.

COUNSELOR (Sticking his head in the supervisor s office): Hey Susan, I met with my adolescent group today and the meeting went really well. I am glad we discussed it last week in our session.

SUPERVISOR (looking up from a pile of papers she had been working on): I m glad. Was Roger as hostile as we thought he might be?

COUNSELOR: No. He was very quiet gave me no problems. I really tried to be non-directive this time as you suggested. I think it went really well, lots of stuff came out about why he likes to smoke pot.

SUPERVISOR: Yeah, it makes you feel good when you have a session like that. I m glad the supervision session was productive for you.

COUNSELOR: I am feeling so confident as a counselor. The kids and I are really looking forward to the next session.

SUPERVISOR: I am pleased that you are finding supervision so productive.

Read the following statements about the meeting and put a check in front of those items if you agree
that the supervisor can draw this conclusion from this conversation.

1. ___ The counselor successfully used a non-directive approach in the group session.

2. ___ The counselor feels he did a good job with the group meeting.

3. ___ The client was not hostile during the group meeting.

4. ___ Some significant material was discussed during the group session.

5. ___ The counselor used group work skills which were appropriate for his/her level of development as a counselor.

6. ___ The counselor s group skills are improving as evidenced by his success in conducting this week s meeting.

7. ___ The group members are looking forward to next week s meeting.

8. ___ The counselor was effective in leading the group.

9.___ The counselor s looking forward to the next week s meeting.

10___ This week s meeting was more productive than the meeting with this group last week.

Adapted from: Field Instruction: *Techniques for supervision, Wilson, Susannna, 1981*

2.   Videotaping

_   You **MUST** obtain, from the client, a signed consent to videotape. The consent must indicate the purpose for which the video will be used (education), who will have access to the video (counselor and supervisor) and the period of time it will be active prior to being erased.

_   The client has a right to refuse to be video-taped.

_   Supervisees having little experience with videotaping will be quite uncomfortable and nervous. Be sensitive to this. Acknowledge this ahead of time and discuss your own discomfort. (If you haven=t video taped your own work do it now. Consider taping a session with your supervisee. There is no better opportunity to teach by example).

_   For supervisees with no video experience work up to this. Start by viewing your own taped video session. Then have the supervisee role play a session with a client. If possible act as the client to control the difficulty and increase the potential to develop self -efficacy.

_   Some counselors will be intimidated by the equipment. Be sure that the supervisee is sufficiently oriented to use of the equipment.

_   refer to video tape consent form

3.   Audio-taping
The use of a tape recorder to tape the audio or verbal portion of a session.

4. Self Report
The process of meeting on a one to one basis to discuss cases.

5. Process Notes
Process notes which describe the session according to a set format.

_   refer to process note page

BERNARD AND GOODYEAR PROCESS NOTE OUTLINE

1   What were your goals for this session?

2. Did anything happen during the session that caused you to reconsider your goals?

3. What was the major theme of the session? Was there any important content?

4. Describe the interpersonal dynamics between you and the client during the session.

5. How successful was the session?

6. What did you learn (if anything) about the helping process from this session?

7. What are your plans/goals for the next session?

8. What specific questions do you have for your supervisor regarding this and/or future

    sessions?

6. Live Observation

Involves a method of observing the student without interacting (as differentiated from live supervision).

7. Live Supervision

Live supervision combines direct observation with communication that enables the supervisor to communicate with and influence

the work of the counselor while the session is in progress.

Methods of Live Supervision

1. The Bug in the Ear

A wireless earphone that is worn by the supervisee through which the

supervisor coaches the counselor through the session.

2. Monitoring

The supervisor observes the session and breaks in if the counselor is having

difficulty.

3. In Vivo

Similar to monitoring; rather than taking over, the supervisor consults with the counselor while the family watches.

4. The Walk-in

The supervisor enters the room at some deliberate moment and interacts with the client and the counselor.

5. Phone-ins and Consultation Breaks

6. Sending a Written Message

PROCESS RECORDING

Supervisee Name _____ **Supervisor Name** _____ **Date** _____

Session Objective_____

Theoretical Approach_____

DIALOGUE	COUNSELOR REACTIONS	COUNSELOR ANALYSIS	SUPERVISOR FEEDBACK

SAMPLE PROCESS RECORDING

SESSION DIALOGUE	STAFF ANALYSIS	STAFF FEELINGS & THOUGHTS	FEEDBACK
COUNSELOR: Good morning. Please have a seat here. I believe you wanted to talk about some concerns with your drinking. We have about 45 minutes today, and mainly I want to hear about your situation and concerns. Perhaps you could begin by telling me what concerns you have about your drinking.	*Open ended questions with a focus on the clients concerns.*	I m a little nervous about this interview. My supervisor thinks I know enough to pull this off. I m not sure.	
CLIENT: Well, I m not sure it is a problem at all. My wife seems to think that I drink too much. My doctor did some blood tests, and told me that they showed that I am probably drinking too much. He really caught me by surprise. Ever since I told my wife about that, she has been worried about my drinking. So, I told her I would come here, but I m not really sure I should be here.	*Ambivalence and defensiveness* *Surprise, a sure sign he is a precontemplator*	This guy is really defensive. Too bad he can t see the writing on the wall. But how am I going to get him to see it.	
COUNSELOR: So at least two other people--your wife and your doctor--have been worried that maybe alcohol is harming you. But I wonder what you have noticed yourself? Is there anything you have observed about your drinking over the years that concerns you? Tell me about your drinking.	*Simple reflection.* *Avoid Q&A trap...* Ask open-ended questions		
CLIENT: I guess maybe I drink			

more than I used to. My wife
says I ve been drinking
more over the past few years.

COUNSELOR: So one thing you ve noticed is that you are drinking more now than you used to. What else?	*Reflection*. Open ended questions	
CLIENT: I can t really think of anything else. It doesn t really affect me that much. I don t really get drunk very often.	*Defensive*	What do I do?
COUNSELOR: So although you know that your drinking has gone up over the past few years, it doesn t really seem to affect you more.	*Reflection:* linking pieces of information together	I know I need to roll with the resistance
CLIENT: Right, I can drink all night and it doesn t make me drunk. Other guys have trouble keeping up with me.	*Defensive, Tolerance*	This guy is clueless. I need to reframe his definition of tolerance. Some education to raise doubt.
COUNSELOR: That s interesting. What do you make of that?	*Open question*	I want more information about how he views this.
CLIENT: I think it runs in my family. My dad was like that. He could drink most guys under the table, and it never seemed to bother him.		
COUNSELOR: You and your dad were similar in the way you drink.	*Reflection*	
CLIENT: I am nothing like my dad. He drank our family into debt. We lost our house when I was 10 and he died when I was 12.	*Defensive*. But maybe not an error. I need to find out how he is different from his dad.	I guess I read this one wrong. I m in trouble, need to go back to basics

8.   JOURNALS

Supervisees can be directed to maintain a journal. This journal is designed to create reflection on the counseling experience of the supervisee. Counselors write entries that are no more than one page long.

_   Serves to structure the process of   thinking about cases
_   Provides a means of regular and easy communication.
_   Alerts the supervisor to problems which are ensuing
_   Allows the supervisor to provide direction.

Various formats can be utilized for this:

1. Level 1 Journals
These journals work well if they are topic focused. These journal entries can introduce the new counselor to various orientations and approaches which are common in the agency.

2. Level 2 and 3 Journals
These journals can also be topic focused. Journal entries at this level can assist the counselor in the development of awareness of their own progress and skill development.

3. Level 4 Journals
The level 4 counselor will require less structure in the journals. They can be construed as a means of communication between the counselor and the supervisor. Topics could include difficult case issues, new information the counselor has learned, advanced questions.

JOURNAL FEEDBACK

1. Respond in writing on the journal
2. Normalization.
3. Suggest new learning activities; reading, observation, community resources .
4. Point out the growth and development you have witnessed.
   SAMPLE

■   **JOURNAL ENTRIES - LEVEL I COUNSELORS**

Strengths and Weakness
   Think about your strengths and weaknesses that you bring to the field of AODA counseling. Describe some of these. Describes some weaknesses you have had in the past that you have succeeded in addressing.

Orientation
   Client orientation is an important beginning to treatment for the client. Orientation is equally important for the beginning counselor.
   1.   How were you oriented to the agency

2.   Describe the value of this orientation, either positively or negatively, to your own beginning process.
3.   How has your own experience with orientation influenced how you intend to provide orientation to your clients?

Philosophy

A philosophy is a statement of what the agency believes to be true about substance abuse.

1.   What is the agency s philosophy about substance abuse?
2.   How does this fit with your own philosophy?

Confidentiality

As a counselor you are responsible to protect the rights to the confidential treatment of your clients. Describe what you have seen in the agency regarding confidentiality. What policies have you observed to guarantee an informed consent?

Vision

Describe your vision of yourself as an AODA counselor. When you look in the future, what do you see?

Empathy

Client empathy is experienced when the counselor demonstrates their own understanding of the client s struggle with recovery. Describe two client situations; one in which you were able to demonstrate empathy and one in which you were not.
1.   Describe the client situation.
2.   What about you either contributed to or detracted from your ability to demonstrate empathy?
3.   What interfered with your ability to demonstrate empathy?
4.   Regarding the client to whom you were not able to demonstrate empathy, what is your plan to work on increasing empathy for this type of client in the future?

Beginnings and Endings

Describe the method you use to begin and end sessions.
SAMPLE

■   JOURNAL ENTRIES - LEVEL II AND III COUNSELORS

Transference

Transference is a process whereby the client projects on to the counselor, past feelings or attitudes toward significant people in their lives. This unfinished business produces a distortion in the way the counselor is perceived by the client.

1.   Describe an incident where you experienced client transference.
2.   What was the client transferring on to you?
3.   How did you feel?
4.   How did you integrate this into your counseling?

Countertransference
Countertransference occurs when counselors lose their objectivity and develop a strong emotional reaction to a client.

1.   Describe an incident in which you developed a strong emotional reaction to a client.
2.   What was the original source of this reaction?
3.   How did you feel?
4.   At what point did you identify it as transference?
5.   How did you manage to prevent the transference from interfering in effective counseling?

Values
Values and biases can affect a counselor s work with clients.

1.   Describe an incident in which your values were different from the values of your client.
2.   What attitudes and beliefs did you have about the client?
3.   Were your attitudes and beliefs based upon presumed or actual information about the client?
4.   How did you behave with the client?
5.   What kind of strategies do you use to work with clients whose values differ from yours?

Self-evaluation

The counselor assumes responsibility for their own continuous improvement. Self-evaluation is created by asking for feedback. Counselors can obtain feedback from a variety of sources: peers, clients, and themselves.

1. Describe an instance in which you obtained feedback from one of these sources.
2. What method did you use to process it?
3. What changes in your work resulted from the feedback?

Self acceptance and change

Carl Rogers wrote;   The curious paradox is that when I accept myself just as I am, then I can

change.

1. What does this mean in terms of alcohol and drug counseling?
2. Describe a client and their ability to change or not change based upon what Carol Rogers has to say about change.

9. Process Recording

Process recording requires that the counselor write down, as best as they can remember, everything that took place in an interview, including everything said by both the interviewer and the client. Additionally, counselors go beyond a simple verbatim transcript by discussing what they experienced during the interview.   In this way the process recording fosters self awareness on the part of the counselor. (Level 1 & 2)

- see Process Recording Form and Sample Process Recording, pp. 83-85.

10. Portfolio

A portfolio is a collection of the counselor s work. Portfolios have been used in various areas of the business world. Artists maintain portfolios to demonstrate their skills and accomplishments. Writers maintain similar portfolios. Elementary and secondary education is now using portfolios to assess students   progress in subject areas according to multiple mediums. Counselors who apply to the WCB for certification are essentially submitting a portfolio, the content of which is determined by the WCB. A portfolio creates an opportunity for both counselor self assessment and supervisor assessment. The counselor gathers materials together over time. This collection of materials is reviewed by the counselor and the supervisor.   A portfolio can be developed in a number of formats:

1. **Video Self Evaluation** Counselors make a tape of a session, perhaps as they are just beginning to learn a skill. The tape is filed away for a certain period of time. The counselor then records a second session at a later date. The counselor then is directed to review both tapes and evaluate the changes. (Level 1)

2. **Client Progress Portfolio Evaluation** The counselor tapes various sessions or parts of sessions with the same client. Viewing the tape at a later date can assist in evaluating the change on the part of the client. The counselor can also evaluate the changes in their work. (Level 1,2,3,4)

3. **Clinical Writing Portfolio** Initial copies of samples of written reports are maintained in a portfolio. More recent samples of similar reports are added to the portfolio. Counselors are instructed to complete a directed self-evaluation. The supervisor can do the same. (Level 1,2,3)

4. **Professional Portfolio** The counselor organizes examples of their professional work. The portfolio becomes a representation of the professional counselor and reflects specific

accomplishments, abilities and credentials. (Level 3, 4)

5.   **Sample questions to self evaluate video portfolio**   The assignment of a video portfolio can be developed to serve a number of objectives. As the supervisor, consider what it is that you would like your supervisee to accomplish by preparing a video portfolio and evaluation. The objective, what you would like to accomplish with the counselor, directs and determines the types of questions you use to direct the counselor in their own self-evaluation.

OBJECTIVE	EVALUATIVE QUESTIONS
Increase counselor self-efficacy and esteem	Describe the status of your skills in the initial video. What specific improved skills were obvious in the second video? How did you view your potential at the time you recorded the first video? As you reflect on your potential and skills now, what do you think about your counseling abilities? What strengths have you recognized in your counseling?
Identify and correct errors	Using the initial videotape, identify and describe common errors you made in the counseling session. These would be problems that plagued you consistently. Describe your level of awareness of these errors at the time. View the second videotape and describe your current level of performance regarding these errors. Describe the strategies you used to overcome these.
Assessment and Diagnosis	Refer to the original assessment video and identify the strengths and weakness present. Was it a client-centered interview? Was it a battery of questions with little opportunity for the client to interact? Describe the client s level of motivation and your role in facilitating it. Did questions follow one after another in a pattern? Or were you able to follow the client with pointed questions to direct them to new information? What specific elements of assessment and diagnosis remain for you to master?

■ Characteristics of Helpful Evaluations (Brookfield) (Bernard and Goodyear) (Powell)

1. **Clarity**: Describe the criteria used for evaluation
    _ describe specific favorable and unfavorable approaches
    _ provide a copy of any evaluation criteria at the start of employment

2. **Immediacy:** Provide regular feedback; don t wait for the yearly evaluation
    _ establish a mechanism; a one page monthly feedback form
    _ provide regular feedback prior to the formal evaluation or review; nothing in this should come as a surprise
    _ remember the reason for supervision is to facilitate growth and development on the part of the counselor; research supports the fact that the closer the feedback is to the behavior and the sooner the person is able to re-produce the behavior integrating the feedback, the greater the likelihood for change to occur

3. **Accessibility***:* Counselors can become overwhelmed by feedback; follow-up

4. **Affirming***:* Be supportive of the counselors
    _ acknowledge the counselor efforts
    _ discuss what is done well
    _ focus on actions and not personality
    _ demonstrate regard; let the student know that learning counseling is possible

5. **Justifiable***:* Provide examples as a rationale for your perspective

6. **Educative:** Your job is to teach. A good evaluation is nothing if the counselor has not learned from it. Evaluations should leave the counselor with more than feeling good or bad. Supervision provides guidance.

Guidelines for Useful Feedback (Powell)

7. Timely rather than remote

8. Descriptive rather than judgmental

Feedback Strategies (Powell)

1. **Chunking** broken down into manageable bites
2. **Self-referencing** (sharing one s own experiences in concrete terms)
3. **Sandwiching***:* Positioning unfavorable comments in between favorable comments

GUIDELINES FOR UNSATISFACTORY RATINGS

Unsatisfactory ratings must be factual, accurate, humane, and honest, and written in a manner that substantiates the rating being given. The written evaluation defends itself.

1. Provide more detail than a normal evaluation.
2. Attach a copy of the Individual Development Plan or any written objectives.
3. Describe the counselors skill level at the time the problem is being identified.
4. Describe the efforts to remedy the problem.
5. Describe in detail the counselor s current level of functioning.
6. Describe and substantiate the counselor s response to supervision.
       Was there responsiveness but little follow-through?
       Did the problem area improve for awhile only to reappear?
7. Indicate areas of counselor agreement and disagreement with your evaluation.
8. List sources of information, describe the techniques used to evaluate the counselor s work.
9. Use comments and adjectives that can be substantiated through examples. Provide specific examples to illustrate points made.
10. Avoid the use of diagnostic labels. Describe only behaviors and the effect they have on counseling clients and performing the necessary paperwork.
11. Write a draft and ask another supervisor or your supervisor to review it.

Adapted from: Field Instruction; Techniques from Supervision, Wilson, Suanna, 1981

IMPROVING YOUR EVALUATIONS

1. Experience being evaluated
2. Open your evaluation criteria up to negotiation; have the student recommend criteria
3. Ask the supervisee to evaluate your evaluations and your supervision
4. Promote self evaluation and peer evaluation

ROLE PLAY FEEDBACK FORM

Directions
Divide into groups of three. One person will play a supervisee, one the supervisor and one will be the observer. The supervisor will give the supervisee feedback on a performance issue. Participants might want to chose a supervise who they are supervising and practice providing feedback to this person. The observer in the group will note on the feedback form the specific examples from the feedback of which addresses each of the characteristics.

Clarity; criteria for evaluation provided.	Immediacy; feedback is current.
Changeable; the behavior specified can be changed	Affirming; supports the supervisee
Justifiable; rationale or examples provided.	Educative; provides direction and new information.

DAY THREE

OUTLINE

1. Review the performance domains of MANAGEMENT & ADMINISTRATION

2. The Clinical Supervisor as *manager / administrator*

3. Evolution of   accountability   in healthcare

   - outcomes and outcome evaluation

   - composite outcomes

   - quality assurance (QA)

   - quality improvement (QI)

4. Steps in the process of developing   generic   QI mechanisms

5. The role of the Clinical Supervisor in Quality Improvement

1. MANAGEMENT & ADMINISTRATION

According to Powell (1993), clinical supervision has three main purposes:

1.   to nurture the counselor's professional (and, as appropriate, personal) development

2.   to promote the development of specific skills and competencies, so as to bring about **measurable outcomes.**

3.   to raise the **accountability** in counseling services and programs.

Bernard & Goodyear (1998) describe the CS relationship as having these characteristics:

- It is evaluative (distinguishing it from *consultation*)
- It extends over time (distinguishing it from *training*)

  It simultaneously works to enhance the professional functioning of the supervisee, **monitors** the quality of professional services given clients, and acts as a

  gatekeeper   of those entering the profession

The highlighted areas emphasize the elements of CS that are primarily concerned with MANAGEMENT and ADMINISTRATION.   The CS has the responsibility to monitor specific counselor skills and activities within the context of the performance of the system as a whole. What we will emphasize in today s course material is the knowledge and skills that are required to accomplish that task.

DEFINITIONS

MANAGEMENT: the act, art, or manner of managing, or handling, controlling, directing, etc. (Compton s Dictionary, 1996). In health-care: management activities relate to training, directing, coordinating, supporting, evaluating, and supervising the human resources who interact

with clients throughout the treatment process.

ADMINISTRATION: carrying out a defined set of functions or tasks according to the policies and procedures of the agency which in turn are defined by state and federal laws / regulations, codes of conduct, contracts, practice guidelines, etc. Imbedded in this domain is the ongoing evaluation of benchmarks, guidelines, policies, etc. created to enhance outcomes by standardizing the delivery of services.

PERFORMANCE DOMAIN OF MANAGEMENT AND ADMINISTRATION

The Role Delineation study identified the following TASKS within the domain area:

1-   *Assist in developing quality improvement guidelines*, implementing those procedures and standards with staff involvement in a continuing quality improvement plan, in order to monitor and upgrade clinical performance.

2-   *Monitor compliance with federal and state regulations*, implementing existing QI mechanisms, in order to protect supervisees and client s rights.

3-   *Evaluate and monitor agency policies and procedures* using accreditation standards to ensure compliance.

4-   *Plan and coordinate the activities of supervisees* to promote effective management in order to maintain clinically effective programming, through the review of daily schedules, consultation, knowledge of onsite and community resources, etc.

5-   *Meet with new staff to orient them to all program components and professional expectations* in order to enable new staff to adhere to the program s performance

standards.

6-   *Identify and assess program needs* utilizing available mechanisms in order to formulate a plan for enhancing clinical services and program development.

7-   *Coordinate consultation services with supervisee* utilizing additional resources for the purpose of providing continuity of quality care for clients.

8-   Recommend, in accordance with agency plicy and procedures, the employment and termination of clinical staff by *participating in review, selection, and evaluation processes* in order to retain quality clinical staff.

2. SUPERVISORS AS MANAGERS

Clinical supervisors are often *middle managers,* acting as a link between the important stakeholders involved in treatment services (staff - administration - clients - payors - the public). **As managers**, the CS has to be able to translate UP & DOWN the administrative ladder with tact and discretion; and the CS must be able to communicate to the public with knowledge and confidence.

- **With line staff**: the CS must convey the *goals and intentions* of the corporation, inspiring the staff to embrace and support the goals at the level in which they perform. The CS must also keep line staff apprised of changes in rules, contracts, policies, etc. in order to protect staff and ensure appropriate care.

- **With administrators**: the CS must keep them informed about the impact of policies, procedures, and administrative decisions on staff morale, activities, and

attitudes. It is important that the CS be involved in administrative decision-making because he/she will have to implement decisions, and the CS perspective has the advantage of familiarity with multiple organizational levels.

- **With clients, payors & the public**: the CS is generally the person who fields the difficult questions, investigates complaints, and coordinates the agency s response to adverse events, quality alerts, and other potentially damaging situations. In these situations, the CS must act as an agent attempting to balance the needs of all the parties involved. The CS must reassure the complainant that the concern is being registered and obtain important information for the review of the situation. At the same time, the CS provides direction to staff, and strives to protect the interests of the agency by following policies and procedures and acting with professional responsibility.

In summary, as a manager the CS helps the supervisee function more effectively within the organization, with the overall intent of insuring the smooth and efficient operation of the organization. The CS promotes clinical   team-building   through staff involvement in the important decision-making about program evaluation, development and promotion.

THE CLINICAL SUPERVISOR AS *ADMINISTRATOR*

There is a strong and necessary component of clinical supervision that is administrative in nature.

Administrative supervision involves a number of tasks**:**
- developing and implementing quality improvement guidelines and mechanisms
- hiring, orienting, and training new employees

- conducting performance evaluations and employee termination procedures
- monitoring case records, treatment plans, referral procedures, continuity of care and other accountabilities to ensure that the client is receiving quality care
- monitoring accreditation standards, regulations, and contractual agreements to ensure that agency policies / procedures reflect accepted standards of care

These **administrative** functions have often been down-played in the professional literature on clinical supervision, but in this era of "accountability," it is likely that the administrative role of the CS will increase in importance.

The administration of clinical supervision is complicated by three things:

1.   bias among practitioners that organizational matters are inferior
2.   assumptions that a person cannot be both clinically and administratively competent
3.   the lack of distinction between clinical and administrative supervision

EVOLUTION OF   ACCOUNTABILITY   IN HEALTH-CARE

1980's	1990's	Current
Managed Care	Outcome measurement	Outcome management
Quality Assurance	Health Related Quality of Life measures	Continuous Quality Improvement
Practice guidelines	Outcome monitoring	Computerized assessment,
	Clinical pathways	monitoring and records
		Data warehousing

OUTCOMES EVALUATION

Beginning in the 1990's JCAHO has made outcome measurement a central focus for its agenda for change . Economic forces are compelling the health care industry to develop

models of care that provide acceptable outcomes within limited costs. Beginning in the
1980's with health care reform and the evolution of Managed Care, there were increasing
demands on health care providers to document the effectiveness of services through the
regular evaluation of outcomes. The main impetus for this came from medical studies
that showed dramatic *variation* in the utilization and effectiveness of various medical
treatment for the same diagnosis (Titler & Reiter, 1994). In behavioral health care
(including AODA treatment), concerns centered more on the rapidly increasing utilization
and cost of treatment during the 1980's. In addition, there was resistance in practice to
altering treatment methods despite indications that less intense treatments were effective,
and consistent findings in clinical trials suggesting a range of promising interventions for
diverse client groups (Institute of Medicine report, 1990).

Historically, the clinical supervisor (i.e. program manager) brought together the necessary
resources to produce the expected treatment activity:

Counselors + Clients + Setting + Time = Treatment Services

The clinical supervisor s primary responsibility was to ensure that treatment occurred in a
 predicatable, consistent manner and that accurate clinical records were maintained.

Treatment Services received = Outcomes achieved

Demands from stakeholders rarely went beyond documentation of the above activity.
Programs had fixed goals, methods, tenures, etc. , and data collection was mainly   rule
driven (i.e. focused on compliance with agency rules and procedures). Reports focused
on   encounter data   (i.e. how many clients served; how many days, hours, sessions of
treatment; how much cost for the treatment episode; how many completed treatment, left

AMA, etc.). Study results were generally not used to inform practice and improve how services were delivered, unless there were problems with rule compliance.

The term *quality assurance* was developed to describe the activities that were employed to address issues about treatment quality and effectiveness. QA activities included case review, records review, staffing pattern review, etc. *Practice Guidelines* were employed to describe a best practice models of care. *Assurance* refered to the monitoring of the delivery of services according to the practice guidelines of the agency.

Outcome also referred to the client s status at discharge including staff reports of the client s level of acceptance of treatment services. Clinical outcomes were considered in a dichotomous fashion: ABSTINENT (i.e. success) and NOT ABSTINENT (i.e. fail). This narrow definition of improvement / remission reflects the abstinence-only orientation of the field of practice.

This way of conceptualizing the IMPACT of treatment was limited in a number of ways:

- it did not capture the richness and variability of the way different clients responded to similar treatment
- it underestimated the **positive** impact in a number of life areas such as *well-being, knowledge, role functioning*, and *symptom reduction*
- it did not allow for the natural history of the disorder, and it discounted the importance of time and delayed treatment effects

BROADENING THE DEFINITION OF OUTCOME

Recent developments in AODA treatment outcomes include the refinement of composite or combined outcome measures which allow clients to be categorized into a

range of functional outcome categories based on their level of use, problems reported, and social/occupational/role functioning. (Cisler & Zweben, 1996)

Composite outcome categories

- Abstaining	- Moderate drinking with no recurrent problems	- Heavy drinking with no recurrent - Moderate drinking and recurrent problems	- Heavy drinking and recurrent problems

 (By extension, Composite measures can include Other Drug Use - but this has not been systematically reported in the outcome literature).

Using a continuum of outcome categories and a combination of measures allows for the same measure to be used across a broad range of treatment levels and theoretical orientations. Composite measures are sensitive to subtle changes and can detect improvement in clients who elect to discontinue treatment, or *choose* not to abstain following treatment.

Many of these clients may value highly the services they received, and consider their status   much improved . Composite measures are also sensitive to variations in functional or psychological outcomes (eg. Increased depression with abstinence) which can be useful for identifying client needs that are not adequately addressed by treatments provided.

EXPANDING QUALITY   ASSURANCE

Recognizing that there is a tremendous amount of variability in client s needs and response to treatment, has led to a more inclusive view of quality assurance.   Howard
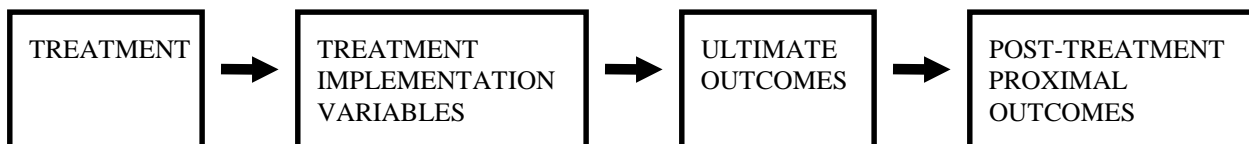
(1986), Finney (1995), and others have described generic treatment   process models that give definitions of outcomes that are more useful for developing evaluation systems that are sensitive to   quality   differences.

Phases in the dosage model of psychotherapy (Howard, etal., 1986)

REMORALIZATION	REMEDIATION	REHABILITATION

Howard and his colleagues describe a   lawful, linear relatonship   between the number of treatment sessions (***dose)*** and measures of patient improvement (***response).*** The DOSAGE model of psychotherapy (below) says that improvement occurs sequentially, and that treatment speeds up the process by which people change. Furthermore, not everyone goes through each stage. Some people who are   remoralized   (i.e. hope is instilled) are able to mobilize their own coping resources and resolve their problems. Others drop out of services when their symptoms (i.e. problem levels) subside. The implication is that attention should be given first to engagement and remoralization, then remediating the client s problems, etc.

Finney s   treatment process model   describes how treatment is supposed to exert its effects on client outcomes. He suggests that outcome measurement and evaluation should emphasize HOW treatment is delivered, and the client s IMMEDIATE response to treatment because these factors are some of the best predictors of the final outcomes of treatment.

TREATMENT	→	TREATMENT IMPLEMENTATION VARIABLES	→	ULTIMATE OUTCOMES	→	POST-TREATMENT PROXIMAL OUTCOMES

Treatment implementation factors: ease of access, level of care, services provided, level

of client participation and satisfaction, agreement on goals, therapist characteristics, etc.

*Proximal (intermediate) outcome variables***:** outcomes that are instrumental in achieving the ultimate outcome (stopping substance use, managing moods, handling social pressure to drink, obtaining a 12-step sponsor, returning to work, ending a destructive relationship, etc.)

Finney also suggests careful measurement of **Client-treatment matching effects** (i.e. factors that effect the strength and direction (+/-) of treatment). Client factors include demographics, alcohol/drug use, AODA treatment history, psychiatric problems, social support factors, motivation, etc. The most useful analysis combines both mediators and moderators diagnostically to determine for which clients there are weak linkages in the treatment process chain, and which linkages are weak.

The implication of research like these is that the most important variables to identify and monitor are variables that the client brings to treatment, and variables that define how treatment unfolds. The client factors can be measured and monitored by aggregating data in order to identify client sub-groups with special treatment needs.
Process implementation variables are often monitored by creating a multi-disciplinary practice guideline called a "clinical / critical pathway" (Wojner, AACN, 1996). Clinical paths are innovations that developed in the medical field to describe "best practice" standards that are integrated with outcome data. This approach to standardized care reflects the view that treatment is "integrative and additive" and that all disciplines contribute to the achievement of desired outcomes. Various disciplines work together to negotiate an integrated standard for how care is to be delivered and then monitor the implementation of care as one of the "outcomes" related to quality.   Clinical paths are program specific reflecting the specific needs of the client population, and are continually

upgraded based on information from the research literature, market surveys, and analysis of information from outcomes monitoring systems.

QUALITY IMPROVEMENT DEFINITIONS

Quality Improvement is defined as "cycles of outcome measurement, outcome management, and program refinement based on identified sources of variability in the processes and outcomes of care" (Berman & Hurt, 1996). It involves team-building with staff to educate, motivate, and empower staff in methods to gather and use clinical data. It requires a "customer" orientation to service delivery because multiple stakeholder values are reflected in the outcomes that are monitored to evaluate the impact and effectiveness of service.

Identifying desired or expected OUTCOMES and the corresponding INDICATORS is the first step in developing a Quality Improvement Mechanism (TASK #1).

EXERCISE -There are many different groups/individuals who have a vested interest in the outcome(s) of treatment. List the outcomes various stakeholders value.

Stakeholder	Valued outcomes
client	
client family	
agency staff	
agency administration	
insurance payor	
community - employer - courts - public	

Outcomes are generally grouped in two categories: *client* and *system*. This means that the source of the information is obtained from observation or self-reports of the individual client, or from monitoring aspects of the   processes   of care delivery.

Below are listed some of the common behavioral health outcomes.

Client outcomes	**System outcomes**
CLINICAL status - drug / alcohol use - mental status FUNCTIONAL status - marital / family - occupational - social / legal PERCEPTUAL / EVALUATIVE - health beliefs - satisfaction	PROCESS - service encounter FINANCIAL - cost and revenue

Treatment outcomes are a function of many factors related to the client and his/her circumstances, and to treatment services that are provided.   Some of these factors **predict** outcome status, and some **facilitate** a desired outcome. These   **indicators**   are important factors to identify and include in your outcome measurement.

Outcome indicators are aspects of outcome domain that can be quantified, given a specific value, and monitored during and/or after treatment. To be useful, an indicator must be valid (it measures what is intended) and reliable (can be measured by two different people and it will give the same reading). Influencing outcome indicators is often a specific objective of treatment services. Below are a list of indicators that are representative of general outcomes identified above.

Client Indicators	**System Indicators**
clinical and functional	**treatment process**
- diagnosis	- client access to service (days to first appointment, distance to clinic)
- level of problems or symptoms related to the diagnosis	- number of treatment units (days, sessions, etc.) and duration of treatment
- client reports of abstinence (or reduced levels) of substance use	- discharge status (normal, maximum benefit, AWOL, etc.)
- biological markers (breathalizer, urine or blood screening tests)	- professional mix of service providers
- client ability to manage daily needs	- degree of adherence to treatment guidelines by staff
- treatment (AODA or mental health)	- staff assessment of client prognosis at discharge
- employment status (unemployed, retired)	**financial**
- number days working (days missed work)	- cost of providing services (unit or entire episode)
- living arrangements (alone, with family, etc)	- revenue generated from services
- days in jail, number of arrests, etc.	
perceptual	
- client health beliefs (i.e. perceptions about the nature of the problem)	
- client well-being	
- client self-efficacy or optimism about resolving problems	
evaluative	
- client investment in treatment	
- client agreement with treatment goals and procedures	
- client satisfaction with services received	

for discussion:

- *Do you effect (change) these indicators through your treatment programs?*

- *Are there other outcome indicators that you specifically target?*

- *How many of these indicators are currently being tracked and are available within your current treatment system?*

- *What changes would you need to make to begin to **measure** and **track** some or all of these indicators?*

THE PROCESS OF DEVELOPING QI MECHANISMS

Outcomes measurement begins with three basic steps:

1   define your treatment methods, objectives and desired outcomes.

2   identify what data is currently collected and what data elements need to be added to adequately measure the primary domains that stakeholders value. It is generally accepted that outcome measurement should include these domains:

- patient **sociodemographic** characteristics

- **clinical** variables (diagnosis, symptoms, associated problems, comorbidity)

- **functional** variables (physical, occupational, social)

- **perceptual** variables (health beliefs, treatment expectations, satisfaction)

- **financial** (and/or encounter) variables

3   design the methodology for collecting data including -

-Decide on assessment instruments and methods (source, style, format, interval, etc)

-Identify QI roles and responsibilities

-Pilot test the QI system focusing on the PROCESS of collecting data, and

the completeness, accuracy and face validity of the results

-Revise the procedures based on results of the pilot

Once you have established a system for collecting data, you can begin to respond

to the research questions that are often asked within such a system of care are:

- **Who are we treating?**
- **What services are we providing?**
- **Are we providing services according to our plan ?**
- **What is the impact on clients and the system?**

CHOOSING A MEASURE AND A METHOD

Measurement plans define which measures will be made, by whom, at which interval,

from what source. Most plans include a general quality of life measure, and problem /

severity measures specific to the treatment population being served. These clinical

measures are combined with client demographic data, and process / systems data for

outcome evaluation.

HEALTH RELATED QUALITY OF LIFE (HRQL):

An important recent development is **HRQL,** an outcome evaluation model that is most

common in physical medicine, but is applicable across health-care settings. HRQL

emphasize self-report measures of clinical symptoms, role functioning, and the client s

  perceptions   about his/her health, impairment, and well being. HRQL utilizes multiple

outcome indicators (including client satisfaction with services received) to assess and

monitor the patient s status. Different measurement methods / instruments have been developed for a variety of medical problems or diagnostic categories. Some may utilize biological or physical markers, but all recognized the importance of clients **perceptions** about health and illness, and the appropriateness of treatment goals and methods.   It should be noted that "satisfaction" with services alone does not ensure "effective" services or a positive outcome. However, client dissatisfaction is almost always reflected in non-compliance with treatment advice, and negative clinical outcomes.

PROBLEMS MEASURES FOR AODA

Many measures from clinical trials have been developed for measuring substance abuse behavioral domains. These include :

- levels of use
- alcohol or drug related negative consequences
- dependence symptoms

A common approach is to combine elements of different domains (ex. MAST). However, a better approach is to use separate measures for each outcome indicator category.

A measure of high utilitarian potential is the DrInC - Short form Index of Problems (Miller, Tonigan, & Longabaugh, 1995).   The SIP has been combined with Quantity / Frequency measures, and psycho-social functioning measures to form a combined, or composite measure described earlier in this section of the CS manual (Cisler & Zweben, 1996).

SHORT INDEX OF PROBLEMS – ALCOHOL AND DRUG

Name:	Today's Date:
Are you completing this questionnaire before or after your first session with your counselor? ( ) Before ( ) After	

Here are a number of events that drinkers or drug users sometime experience. Circle one answer for each item.

During the past 90 days, about how often has this happened to you?	Never	Once or a few times	Once or twice a week	Daily or almost daily
1. I have been unhappy because of my drinking or drug use.	0	1	2	3
2. Because of my drinking or drug use, I have not eaten properly.	0	1	2	3
3. I have failed to do what is expected of me because of my drinking or drug use.	0	1	2	3
4. I have felt guilty or ashamed because of my drinking or drug use.	0	1	2	3
5. I have taken foolish risks when I have been drinking or using drugs.	0	1	2	3
6. When drinking or using drugs, I have done impulsive things that I regretted later.	0	1	2	3
Please indicate whether these things happened to you during the past 90 days.	Not at all	A little	Some-what	Very much
7. My physical health has been harmed by my drinking or drug use.	0	1	2	3
8. I have had money problems because of my drinking or drug use.	0	1	2	3
9. My physical appearance has been harmed by my drinking or drug use.	0	1	2	3
10. My family has been hurt by my drinking or drug use	0	1	2	3
11. A friendship or close relationship has been damaged by my drinking or drug use.	0	1	2	3
12. My drinking or drug use has gotten in the way of my growth as a person.	0	1	2	3
13. My drinking or drug use has damaged my social life, popularity, or reputation.	0	1	2	3
14. I have spent too much or lost a lot of money because of my drinking or drug use.	0	1	2	3
15. I have had an accident while using or under the influence of alcohol or drugs.	0	1	2	3

Total Score _____

Methods generally focus on measurement during treatment (i.e. client variables, and treatment implementation variables) and incorporate post-treatment measures only after the first phase of measurement is running smoothly.

4V   THE ROLE OF THE CS IN A QUALITY IMPROVEMENT (QI) SYSTEM

According to a recent survey of over 100 public & private behavioral health care providers, *there is a high interest in outcome data; however, few of the respondents currently collect such data* (MHCA, 1997). This is likely to change as insurance companies, self-insured corporations, HMO s, and public funding organizations are demanding outcome evaluation as a condition of contracting for service reimbursement. Effective and efficient systems of QI will require time, resources, refocusing of program activities, and the active involvement of staff at all levels.

The clinical supervisor has a key role in the development and implementation of QI activities.   Understanding the concept of quality improvement is a critical knowledge for the CS; Understanding the methods of implementing an outcomes evaluation system is a critical skill for the CS to acquire.

Because QI systems rely on clinical and programmatic data, the CS has a key role in setting up and managing a system of measuring and monitoring outcomes.   The CS is likely to be responsible for spearheading the development of practice guidelines, clinical paths, and an outcome measurement plan.   The CS will also be supervising the collection of data because client measures and treatment implementation data both fall under the

purview of the CS.

These are new terms, but the actual activities of collecting client and programatic data are well within the scope of practice for CS in the field today. What is different is the methodological rigor that will need to be pursued in order to collect data that is valid and reliable.

QI systems are mainly interested in DESCRIPTIVE studies which describe the client population and the process of delivering treatment services and CORRELATIONAL studies which explore variance among clients and processes.

SOME CAUTIONS ABOUT OUTCOME EVALUATION AND QUALITY IMPROVEMENT

It is entirely possible that outcome evaluation will be seen as a solution to all of the problems faced by the treatment field in the 1990's. However, it is unlikely that systems will adapt quickly to become data driven, and outcome data should inform not control treatment practices. Outcomes do not directly assess quality of performance. They only permit an inference about the quality of the process (and structure) of care. The table below lists a number of limitations inherent in outcome evaluation.

Outcomes are *integrative*, they reflect the contributions of everyone (including the patient) who provides care. It is impossible to isolate with certainty the specific contribution of any single component of care.
Because the relationship between process and outcome is a probability, a large number of cases must be evaluated before an inference of quality can be made.
Outcomes can be misrepresented and misunderstood by the public if the problem of multiple

causation is not understood.

Treatment   success   depends on the characteristics of the client, the goals of treatment, and the skill of the therapist to negotiate the terms and conditions of treatment.   Treatment failures can reflect an inappropriate treatment   match   or lack of skill by the therapist.

LIMITATIONS OF CLINICAL SUPERVISORS

CS are likely to resist some of the developments discussed under   quality improvement mechanisms.   Outcome evaluation is time-consuming and at times confusing. The CS responsibility to develop and implement a system is likely to come in addition to his/her other supervisory and client service responsibilities. However, there is no other professional who is likely to have the skills or positional authority to be able to identify strengths and weaknesses that must be addressed in order to effectively organize a system.

Some of the barriers the CS must overcome are structural (i.e. staffing patterns) and some are attitudinal. A recent survey of over 1200 counselors and supervisors regarding entry-level counselor proficiency (INCASE, 1997) gave a   *cautionary alert*   indicating that some of the competencies   undervalued   by both counselors and supervisors include *administrative, evaluative, and case management activities* which are related to success within a managed-care environment.

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42 CFR, part 2, 1987

HFS 94

STAFF SCHEDULE

To illustrate the reality of caseload management, have participants follow the outline on the transparency, and fill out this form in their materials... Process the exercise with the awareness that they will need to be attentive to their staff's schedule to get the service of the organization delivered to the clients, and also to add the needed time for the direct supervision.

HOUR	MONDAY	TUESDAY	WED	THURSDAY	FRIDAY
1					
2					
3					
4					
5					
6					
7					

8					

PERFORMANCE EVALUATION

Use this simple charting format to explain their role as managers in keeping track of the staff person's job performance. Suggest that they review each person's performance at least once a week, and they should record it on a form such as this.

A simple dot in the area that fits the performance that week. The discipline of this should be stressed. It is difficult to remember what staff are doing, much easier and more accurate when recorded like this. As they add weeks they should connect the dots... if all is well with the employee, the graph will reflect that. If a major change in their performance has occured the event should be noted, and a written documentation should also be made.

Downward trends will be evident and should be addressed by the third week; but remind them that they don't want to know what is causing the problem, but rather that they need to return to the expected level of performance...

SUPERIOR								
EXPECTED								
POOR								

May   **June**

ORGANIZATIONAL ANALYSIS WORKSHEET (Olcott, 95)

Have participants complete this form if time allows. It is intended to provide insight into their organization's strengths and limitations. Their answers will help them identify problem areas that need their attention and issues that need to be addressed by administration. Most will be surprised by the information this exercise produces.

1. What is your organization's primary mission?

2. What is your primary task within the organization?

3. Is your organization's physical site appropriate - given the mission?

4. Is your environment appropriate given your primary task?

5. Is there sufficient time allotted in your organization for clinical supervision?

6. What are some of the resources available to you in relation to your administrative tasks?

7. What are some of the resources available to you in relation to your supervision tasks?

8. What is your organization's frame of reference for treatment services?

          A. Treatment Philosophy:

          B. Counseling Theories Used:

9. Are your supervision beliefs compatible with the theories used?

10. How would you describe the nature of communication within your organization?

11. What are the informal traditions, unwritten policies and rules, and how do they impact on the work

of the organization?

12. Describe the staff interaction dynamics.

13. Describe relationships between staff.

14. Draw a simple organizational chart of your organization, including Board members.

15. To whom are you accountable?

16. Who is accountable to you?

17. Who makes decisions in the organization?   How is everyone informed?

18. In what ways do the decision maker(s) support the organization's work.?

19. In what ways do the decision maker(s) obstruct the organization's work?

20. What information and resources do you need to do your job effectively?

21. What information and resources are available to you?

22. How do you determine what goes on in counseling?

23. How do you define client success?

24. How do you measure client success?

25. How do you gather and record treatment feedback information?

26. How do you receive information about your organization's effectiveness?

27. Who manages external boundaries in your organization? Resource acquisition? Public relations?

28. Who manages the internal boundaries? Resource allocation? Resource utilization? Monitoring?

29. How do you receive feedback about your personal effectiveness?

30. How do you get feedback from your supervisees?

31. What are the areas in your organization that need improvement?

32. Do you have any influence in these areas?

COUNSELOR EVALUATION OF SUPERVISORS (Bernard, 1976, 1981)

My Supervisor:	Strongly Agree					Strongly Disagree	
1 Provides me with useful feedback regarding counseling behavior.	1	2	3	4	5	6	7
Makes supervision a constructive learning process.	1	2	3	4	5	6	7
Provides me with specific help in areas I need to work on.	1	2	3	4	5	6	7
Addresses issues relevant to my current concerns as a counselor.	1	2	3	4	5	6	7
Helps me focus on new alternative counseling strategies that I can use with my clients.	1	2	3	4	5	6	7
Helps me focus on how my counseling behavior influences the client.	1	2	3	4	5	6	7
Encourages me to try alternative counseling skills.	1	2	3	4	5	6	7
Structures supervision appropriately.	1	2	3	4	5	6	7
Adequately emphasizes the development of my strengths and capabilities.	1	2	3	4	5	6	7
Enables me to brainstorm solutions, responses, and techniques that would be helpful in future counseling situations.	1	2	3	4	5	6	7
Enables me to become actively involved in the supervision process.	1	2	3	4	5	6	7
Makes me feel accepted and respected as a person.	1	2	3	4	5	6	7
Deals appropriately with the affect in my counseling sessions.	1	2	3	4	5	6	7
Deals appropriately with the content in my counseling sessions.	1	2	3	4	5	6	7
Motivates me to assess my own counseling behavior.	1	2	3	4	5	6	7
Conveys competence.	1	2	3	4	5	6	7
Is helpful in critiquing report writing.	1	2	3	4	5	6	7
Can accept feedback from counselor.	1	2	3	4	5	6	7
Helps me reduce defensiveness in supervision.	1	2	3	4	5	6	7
Prepares me adequately for my next counseling session.	1	2	3	4	5	6	7
Helps me clarify my counseling objectives.	1	2	3	4	5	6	7
Provides me with opportunity to adequately discuss the major difficulties I am facing with my clients.	1	2	3	4	5	6	7
Encourages me to conceptualize in new ways regarding my clients.	1	2	3	4	5	6	7
Motivates me and encourages me.	1	2	3	4	5	6	7
Challenges me to accurately perceive the thoughts, feelings and goals of my client and myself during counseling.	1	2	3	4	5	6	7
Gives me the chance to discuss personal issues related to my counseling.	1	2	3	4	5	6	7
Is flexible enough for me to be spontaneous and creative.	1	2	3	4	5	6	7
Focuses on the implications and consequences of specific behaviors in my counseling approach.	1	2	3	4	5	6	7
Provides suggestions for developing my counseling skills.	1	2	3	4	5	6	7
Encourages me to use new and different techniques when appropriate.	1	2	3	4	5	6	7
Helps me to define and achieve specific concrete goals for myself during the practicum experience.	1	2	3	4	5	6	7
Gives me useful feedback.	1	2	3	4	5	6	7
Helps me organize relevant case date in planning goals and strategies	1	2	3	4	5	6	7

with my client.

Helps me develop increased skill in critiquing and gaining insight from my counseling tapes.	1	2	3	4	5	6	7
Allows and encourages me to evaluate myself.	1	2	3	4	5	6	7
Helps me feel at ease with the supervision process.	1	2	3	4	5	6	7
Appropriately addresses interpersonal dynamics between self and counselor.	1	2	3	4	5	6	7
Enables me to express opinions, questions and concerns about my counseling.	1	2	3	4	5	6	7
Explains the criteria for evaluation clearly and in behavior terms.	1	2	3	4	5	6	7
Applies criteria fairly in evaluating my counseling performance.	1	2	3	4	5	6	7

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THE DOMAIN OF PROFESSIONAL RESPONSIBILITY

- **Model and encourage professionalism by active participation in state and national professional associations.**

- **Adhere to the established code of conduct.**

- **Pursue and maintain personal and professional development and education.**

- **Maintain personal, physical, and mental health.**

- **Take the time to get to know each staff person's unique context as a individual; lifestyle, cultural background, style, etc.**

PROFESSIONAL ORGANIZATIONS

"Being active as an addictions professional and being active in the addictions profession are not the same. To be active in the addictions profession means participating in your professional organization..." (Olcott, 1998)

Have the group offer the names or acronyms for the groups that they are members of and list these on easel pad paper. Review their lists and clarify which are actually organizations that represent the profession and which represent something else... ask the additional questions and discuss their responses. Reinforce the role modeling responsibility that they have and discuss the reasons why they might support their staff joining groups like NAADAC, the ACA, APA, etc..

EXERCISE: What professional groups are you currently a member of? Why did you join? How active are you in that organization? If you have left or quit a professional organization, what was your reason for doing so?

VICARIOUS LIABILITY: As a clinical supervisor, you are legally and ethically responsible for the behavior and services of those persons you supervise. If your staff are implicated in an ethical complaint and ensuing legal action, you will probably be held responsible as well. **Your responsibility is to protect the client - you must "know" your staff "well enough" to prevent harm to the client.**

EXERCISE: Ethics Case Studies; read the studies passed out, and consider the questions at the end of the case. Discuss the case with the others in your group - don't attempt to identify the right answer, but rather discuss the issues brought up in the questions. Listen to each other as you go through this process - and listen to yourself!

YOUR PROFESSIONAL DEVELOPMENT AND CONTINUING EDUCATION

In times of change, the learners will inherit the earth while the learned will find themselves beautifully equipped to deal with a world that no longer exists. (Eric Hoffer)

Until you are willing to be confused about what you already know, what you know will never become wider, bigger or deeper. (Milton Erickson)

When you meet rock, become water. When you meet water, become rock.

WHAT ARE YOU READING?

List the journals they identify they are reading, note again it is their responsibility to be the role model for their staff and that scientific reading is a critical method to keep aware of the changes that will affect how we practice in the future. Support attending research conferences, and making sure their staff have access to journals, research web sites, etc... Discuss the importance of their being current and staying current.

EXERCISE: list the professional journals that you currently read...

PERSONAL SELF-CARE - This ain't Kansas anymore, Dorothy!

When the power of love overcomes the love of power, then we will be at true peace (Sri Chimoy)

When we come to a point of rest in our own being, we encounter a world where all things are at rest, and then a tree becomes a mystery, a cloud becomes a revelation, and each person we meet a cosmos whose riches we can only glimpse. (Dag Hammorskjold)

The significant problems we face cannot be solved at the same level of thinking we were at when we created them. (Albert Einstien)

Personal self-care is again a role modeling task - as supervisors they can facilitate support for their staff, but they need to discipline themselves to take care of themselves. Discuss with the group some of your ideas as well as theirs for taking care of themselves.

APPENDIX A

■   **A MODEL OF DEVELOPING A CURRICULUM;**

• THE NEEDS ASSESSMENT: In their assessments and interviews with their staff, they will discover areas of knowledge and/or skill that their staff are needing additional or further education.

• PLANNING & DESIGN; Once needs are identified, the supervisor should develop a plan for providing the needed training and gather resources and materials. Using a planning outline like the one in their materials, they should then layout the time, method, and content they will provide their staff.

• PRESENT TRAINING; Using adult learning methods, they should present the training to the staff, and

• EVALUATE; Use a standardized evaluation process to access feedback from the your staff, and make corrections...

CHARACTERISTICS OF ADULT LEARNERS

1. Autonomy. Adults become accustomed to making decisions about events that affect them. They want, in training, to take a role in defining what, when and how they learn. They want to be active rather than passive in the process.

You should obtain learner input by asking the learner to articulate their learning expectations, and by being able to articulate your goals and objectives of any training you provide or recommend. Training should have as much participatory activity as possible.

2. Accumulated Experience. We have all accumulated a wide range of experience which can contribute significantly to our learning experience. Adults can and want to help each other to learn from these experiences.

You should facilitate the exchange of learner experience, and assist learners to draw relationships between new learning, prior learning, and past experience. Discussions between staff about topics at inservices can be more useful than bringing in an "expert" sometimes.

3. Readiness to learn. Staff learn most what they believe to be necessary for the performance of their jobs or to solve problems which affect them. Not everyone is ready to learn the same material at the same pace or even at the same time. Motivation can be upward mobility, personal achievement, satisfaction, and personal fulfillment.

SUPERVISION SESSION RECORD

Date:_____ Counselor:_____

DIRECT SERVICE REVIEW: Group session: Sat in   Observed

        Individual session: Sat in   Observed

        Tape Review: Audio   Video

SUPERVISORY FEEDBACK:

Process Observations;_____

_____

_____

Theoretical Issues;_____

_____

_____

Therapeutic Service Evaluation;_____

_____

_____

Counselor Self Awareness/Response to feedback;_____

_____

_____

CASE FILE REVIEW

File number(s)_____

Comments;_____

_____

_____

_____

Recommendations and Corrections;_____

_____

_____

Corrections will be Completed by (date):_____

CASE DISCUSSION   page 2

Case Number: _____   New Case   Active Case   Completed   Reopened

Summary of issues related to case;_____

_____

_____

_____

Counselor's concerns, problems, issues, etc.;_____

_____

_____

_____

Recommendations;_____

_____

_____

SUPERVISORY RECOMMENDATIONS and DEVELOPMENT PLAN:

Clinical: Attitude in general, theory, skill, knowledge, technique, behavior, etc.;_____

_____

_____

_____

Administrative: Compliance with policies and procedures; work habits and performance; ethics and

confidentiality; Relationships with co-workers; etc.._____

Training and personal / professional growth indicated and plan: _____

_____

_____

_____

_____

Supervisor's Signature:_____ Staff Signature _____

APPENDIX B

LEXICON

ADMINISTRATION   The act of administering; planning; deciding on mission, policy and procedure; accessing and managing resources - funding & staff; employment responsibilities - discipline, benefits, etc.; Carrying out a defined set of functions or tasks according to the policies and procedures of the agency which in turn are defined by state and federal laws / regulations, codes of conduct, contracts, policy guidelines, etc. Imbedded in this domain is the ongoing evaluation of benchmarks, guidelines, policies, etc., created to enhance services. Supervisors may also be administrators in some settings, as well as managers. Supervisors should be involved in administrative activities, such as the employment, performance evaluation, discipline, and discharge of staff, planning activities, and policy development.

ATTRIBUTION: Determining the relative importance of each outcome variable (and their interaction effects) through a comprehensive analysis of the data (i.e. how do we explain the change).

BSAS   The Bureau of Substance Abuse Services

CLINICAL SUPERVISORS   A supervisor is an individual:

> who has obtained the skill and knowledge to effectively assess and evaluate the clinical and personal strengths and weaknesses of the counselors they supervise;
>
> who has an understanding of adult teaching and learning methods, and can direct the counselor to, or provide resources that will continue and maintain their competency and growth;
>
> who can identify the boundaries of appropriate client/counselor relationships, and guide their staff when necessary;
>
> and who is competent as a manager.

CULTURAL COMPETENCE   The critical element in cross-cultural competence is not the fullness with which one knows each culture, *but the degree to which the cross-cultural worldview is understood, accurate empathy is established, and adaptation of counseling , communication, and human relations have been mastered.* (Olcott, 95)

DATABASE: The repository of information from the multiple components that define an episode of care. Because of the complexity of issues related to outcomes, the database should take into account the numerous variables that affect health and the results of care. There is general agreement that the database should include at least these categories:

> - patient sociodemographic characteristics
> - clinical variables (diagnosis, symptom levels, comorbidity)
> - functional variables (physical, occupational, social)
> - perceptual variables (health beliefs, treatment expectations, satisfaction)
> - financial (and/or encounter) variables

HEALTH: Health is closely interrelated with every part of human existence and cannot be simplistically achieved through the application of isolated interventions. The treatment of illness and the promotion of health are highly complex issues. Approaches to the assessment of health care outcomes must reflect recognition of that complexity**.   (Hegyvary, JNursQualAssur, 1991, p. 1)**

MANAGEMENT   The act, art, or manner of managing, or handling, controlling, directing, etc. (Compton s Dictionary, 1996) In health care, management activities relate to training, directing, coordinating, supporting and supervising the human resources who interact with the clients throughout the treatment process. Supervisors are

managers - middle managers in most cases, and in doing so they represent both the needs and wishes of administration to the staff, and the needs and wishes of the staff to administration. Managing is bringing together the resources available to produce the expected outcome, i.e., counselors + clients + a setting + time = treatment services

NAADAC   The National Association of Alcoholism and Drug Abuse Counselors

OUTCOMES   the end results of treatments or interventions   (Titler & Reiter, 1994). These include short-term outcomes (eg. client awareness or compliance with elements of treatment, satisfaction with services received, abstinence or reduced levels of use, reductions in symptom levels, and improved functioning in daily activities); and final outcomes (employment, medical health status, social and marital functioning, legal status, mortality, and alcohol/drug problems). Short-term outcomes can be understood as   instrumental   or   facilitative   factors that are often necessary for achieving long-term goals, but are not by themselves sufficient measures of treatment effectiveness (Nelson, J. 1984).

OUTCOME EVALUATION: Applying statistical procedures to outcome data to determine the degree of change, and the power (predictive confidence) of the finding.

OUTCOME INDICATORS: The actual functions measured. These include a number of levels: client, system, financial, etc. The actual outcome indicator will be determined by the client, the type of services provided, and the value attached to certain outcomes by stakeholders.

OUTCOME MANAGEMENT   use of information and knowledge gained from outcome measurement and monitoring to achieve optimal outcomes for individuals in a defined population through improved clinical

decision making and service delivery. (JCAHO, 1994).

OUTCOME MEASUREMENT: Quantifying the domains measured for determining outcomes. Baseline measurement serves to determine treatment needs, assign a diagnosis, and provide a benchmark for determining improvement during and after treatment. Measurement can occur at other times during treatment to determining the impact of services and after services are terminated to determine treatment effectiveness.

PRACTICE GUIDELINES: Recommended therapies or methods for the treatment of specific disorders so as to achieve optimum results as efficiently as possible. Practice guidelines are developed from numerous sources: outcome literature, professional societies, community standards of care, and clinician   best practice   recommendations. These guidelines offer supportive guidance to practitioners and decrease variability of care given by different providers across the system. Practice guidelines do not assure positive outcomes, or the most efficient use of resources, and they should be modified based on quality improvement and other outcome activities.

QUALITY ASSURANCE   A coordinated program of planned or systematic actions through which the level of quality desired throughout the organization is pursued or achieved. (Theis, 1996)

All the measures used to protect, maintain, and improve the quality of care. (Donabedian, 1991)

QUALITY IMPROVEMENT: Cycles of outcome measurement, outcome management and program refinement based on the identified sources of variability in the processes and outcomes of care (Berman, etal., 1996). Team-building to educate and empower staff in methods to gather and use data.   Understanding   customer   expectations with respect to services and outcomes.

SUPERVISION: The activities included in an organization s overall commitment

and active facilitation of *COUNSELOR STAFF DEVELOPMENT*. The supervisor's focus is to facilitate effective *DIRECT CLIENT SERVICES* while maintaining organizational stability.

WCB Definitions taken from the introduction and content of Certification Manual:

> " ...a specific aspect of staff development dealing with the clinical skills and competencies for persons providing counseling."

> " The format for supervision is commonly one on one and or small learning groups on a regular basis."

> " Methods...include auditing of files, case review and discussion, and direct observation of the counselor's clinical work.

> " The primary purpose...is to ensure staff skill development and maintenance of competency evidenced in quality patient/client care."

WAAODA	The Wisconsin Association on Alcohol & Other Drug Abuse
WAADAC	The Wisconsin Association of Alcohol & Drug Abuse Counselors
WADTPA	The Wisconsin Alcohol & Drug Treatment Providers Association
WCB	The Wisconsin Certification Board
WCTC	Waukesha County Technical College

APPENDIX C

TRAINER BIOGRAPHIES

DAVID BARRETT, M.S.: Dave is a Wisconsin Certified Alcohol & Drug Counselor III, and a licensed Professional Counselor. He has been a practicing alcohol and drug counselor since 1981, and has been a clinical supervisor in outpatient clinic, community, and hospital settings.

He has developed and supervised several treatment programs for special populations within a managed-care environment. One of these programs, the Drinking Checkup, was the basis for the awarding of a major research grant sponsored by the National Institute of Alcohol and Alcohol Abuse (NIAAA). Mr. Barrett has considerable experience in quality assurance and clinical case management activities, has been a leader in developing practical outcome assessment tools for use within integrated health-care delivery systems. He has written numerous self-help guides and professional articles on innovative treatment approaches.

He is a research associate at the Center for Addiction and Behavioral Health Research, a public-private consortium located at the University of Wisconsin-Milwaukee.

JACK CULBRETH, Ph.D., LPC, NCC, MAC, ACS: Jack is an assistant professor in the Department of Counselor Education, Counseling Psychology, and Rehabilitation Services at Pennsylvania State University (Penn State). He completed his doctoral work at the University of North Carolina at Greensboro, studying with Dr. L. DiAnne Borders, a nationally recognized researcher and educator in the field of clinical supervision. Jack has been working on studying issues of clinical supervision that are unique to the addictions counseling field. He has conducted several trainings in supervision to a variety of audiences, as well as teaching a course in the chemical dependency counselor master s degree program at Penn State.

Jack s clinical experience includes work in treatment settings as a mental health counselor, substance abuse prevention counselor, addictions treatment counselor, and in the school setting as a student assistance program coordinator and intervention counselor. His current position allows him to train master s level counselors while also conducting research into the dynamics of clinical supervision. Jack holds a license as a professional counselor in North Carolina, is a Nationally Certified Counselor with a

Masters Addiction Counselor Certification, and an Approved Clinical Supervisor specialty certification.

WILLIAM R. OLCOTT: Bill is a Certified Alcohol & Drug Abuse Counselor III, a Certified Clinical Supervisor II, and a Certified Prevention Professional. He has been working in the addictions field for over 25 years as a counselor, supervisor, administrator, prevention professional, educator, and consultant. Bill currently has a consultancy and is a lead faculty member in the Addictions Counselor Degree Program at Fox Valley Technical College in Appleton, WI.

Bill has been training individuals to become clinical supervisors for the past ten years, and has written a book on the topic called   *Maintaining the Profession, A Fieldbook for Clinical Supervisors* . He is an active Board Member of the Wisconsin Certification Board (WCB), currently chairs the education and training committee and participated in the development task force of the clinical supervisor credential.

Active in the addictions profession, Bill is currently the Chairperson of the Board of the Foundation for Addictions Research and Education (FARE), he is Treasurer of the Wisconsin Association of Alcohol & Drug Abuse Counselors (WAADAC), is Regional Vice-President of the National Association of Alcoholism and Drug Abuse Counselors (NAADAC), and is the membership secretary of the International Coalition for Addictions Studies Education (INCASE).

Doing all of the above in his spare time, Bill s primary interest is participating in and enjoying the dynamic life of his five year old grandson, Darius.

EDWARD M. RUBIN, Psy.D.:   Ned holds a Doctor of Psychology degree and an MSW, and is a Licensed Psychologist listed in the National Register of Health Service Providers in Psychology. Since 1977, he has been a Certified Alcohol and Drug Counselor through the Wisconsin Certification Board . He has worked for over 25 years in the field of chemical dependency and dual diagnosis. For 15 of those years, he worked at DePaul Hospital in a variety of positions, ending his tenure there as Clinical Director of Inpatient Treatment Programs and Director of the Impaired Professional Program. He then worked for three years at Jewish Family Services as a clinical psychologist and addiction specialist. Currently, he is at

Sinai Samaritan Medical Center, Aurora Behavioral Health Services, in the Department of Psychiatry as Clinical Coordinator of Dual Diagnosis Services.

Both there and in his private practice with Behavioral Consultants, he provides a wide range of services with adolescents and adults including individual, family, couples and group therapy. In addition, he has been both providing and teaching consultation and supervision to a variety of disciplines throughout his career. This has included not only certified counselors, but psychology doctoral interns and psychiatry residents, and to a variety of community agencies and their staffs.

Along with his clinical and forensic practice, Ned, as he is known, has provided numerous workshops and training experiences as well as published in field of chemical dependency. He has been a consultant in the areas of substance abuse and dual diagnosis for The Counseling Center of Milwaukee, the State of Wisconsin, Milwaukee County, and private industry. He holds an appointment as Clinical Associate Professor at the University of Wisconsin Medical School, in the Department of Psychiatry as well as at the Wisconsin School of Professional Psychology. He has been Certified by the Board of Governors of the American Psychological Association College of Professional Psychology in the Treatment of Alcohol and Other Substance Use Disorders.

CHERYL RUGG: Cheryl is a faculty member in the AODA Counselor Program at Waukesha County Technical College. She is also an adjunct instructor in the School of Social Welfare at the University of Wisconsin-Milwaukee and is in private psychotherapy practice in Milwaukee.

Most recently she has also been working with the Center for Addiction and Behavioral Health Research focusing on screening and brief interventions. Prior to these experiences, she was the Director of Child and Adolescent Services at DePaul Hospital. In this position she supervised approximately 30 staff members including AODA counselors, masters level counselors, child care workers, and graduate students.