Questions Asked During the Live Webinar Broadcast on 6/13/12

Q: I'm in middle management that disempowers us to support our clinical staff by using repetitious data reports. They have embraced a micro-management style that is draining the staff and service quality and can't see it. Any recommendations?
A: Without a clear picture of what is going on at your agency, I am limited as to how I can respond, so I'll need to make some assumptions. First of all, micromanagement is invariably a morale killer. I've experienced it and see it as counter-productive. Assuming you are a clinical supervisor, my advice would be to collect your own "data" – meaning get as much input as you can from the counselors you supervise about their frustrations and needs with regards to their ability to provide effective client care. I realize this is tricky, but by using your diplomatic skills, you may be in a position to convince management that a change in style might positively impact such things as staff morale, client care and, ultimately, the bottom line.

Q: How do you think ethics and boundaries would be different within a tribal program, which is based on linear thinking, rather than hierarchical thinking?
A: I assume you are referring to ethics and boundaries in the clinical relationship (as opposed to the supervisory relationship). First of all, there are certain basic ethical principles that are universal. These include autonomy (fostering freedom to choose), beneficence (holding out hope), non-maleficence (do no harm), and justice (fairness to all). Also, codes of ethics are generally written to be culturally inclusive. However, that being said, there will always be conflicts between values (personal as well as cultural) and ethical principles. One such conflict may involve boundaries. In some cultures the type of helping relationship that is formed may, for instance, become a dual relationship and be totally acceptable. This is often the case in small or rural communities where a counselor may know his or her client because of a prior relationship outside of the clinic (such as a worship community, school or sports activities with children, etc.). In cases like these, the well-being of the client must outweigh everything else and, as a result, a boundary may have to be crossed. So, in some cases, crossing a boundary may be beneficial to the client and, in some cultures, such as those with tribal programs, this may be acceptable *and* therapeutic to the client.

Q: Do you see the role of case manager as someone who offers supervision in some capacity to counselors?
A: The title case manager may mean something different from agency to agency. However, the provision of clinical supervision could be provided by case managers if they have the experience and credentials to provide the type of supervision that would include: an ongoing and empathic relationship with counselors, the development of growth goals, the observation of the counselors' clinical work, and the time and expertise to mentor counselors while forming a partnership in the development of professional growth.

Q: I'm not sure if you plan to address this, or will have time to, but a common dilemma that comes up in addictions counseling is the dilemma of working with a client's goals when

those goals are at odds with the program's goals. Typically, abstinence vs. moderation. As addiction counselors themselves are often not accepting of moderation goals, as a supervisor how do you recommend supervising counselors regarding this issue, particularly as it pertains to the importance of the therapeutic alliance (collaborating on the goals and tasks of counseling, and how that effects the bond)?

A: Unfortunately our field is not exempt from conflict and a typical dilemma occurs when a facility's culture, values or goals, conflict with what a counselor may feel is best for his or her client. You have raised an excellent example with abstinence vs. moderation. We are seeing this conflict be played out more and more in agencies that stick with the old mantra of abstinence for all. My own personal belief is that, in time, our field will evolve to where we truly design treatment around the needs (and levels of motivation) of the client – and this may include moderation for some (I would have been fired from a job back in the '70s for saying that). However, we are not quite there yet. My only advice is for one to diplomatically work within an agency to inspire this evolution. Where that is not possible and conflicts such as this continue, professionals will seek out employment where they have more congruence with regards to agency culture, values, and goals (continuing with the evolutionary metaphor, and referring to treatment programs, I believe that, in time, "survival of the fittest" will prove to be the case).

Q: How do you realign your clinical supervision with a supervisee if you feel that you have self disclosed too much or you want to change the structure of supervision (going from laid back to more goal oriented)? This can be difficult if you have a certain type of supervisory relationship and in an effort to improve, want to realign your boundaries. Thank you for your thoughts.

A: This is a dilemma faced by many of the supervisors I have trained. It is typical that many supervisors upon being promoted to that position for the first time have a hard time with boundaries (especially with those who they had previously worked with as fellow counselors). My advice for the newly promoted supervisor is to clarify, and perhaps, redefine the relationship. The best advice I can give here is virtually the same. If you wish to realign the relationship, it must start with a one-on-one discussion about the current relationship (strengths and weaknesses) as a means to seek realignment. You have ultimate control of redefining it, but you are giving the counselor and opportunity to participate in the redefinition. Start with open-ended questions to the counselor about how the relationship is benefitting them and gradually move into defining the type of relationship that can be most conducive to the counselor's growth and his/her client's well-being. In many ways, this parallels the same process you would use with a client in clarifying or redefining the clinical relationship.

Q: Who can supervise who? Qualifications?

A: As the field raises the bar with regards to credentialing and professionalism, qualifications to become a clinical supervisor will be more and more crucial. There are many in the field today who are excellent supervisors, but may not have the credentials that are increasingly required. They have been in the field a long time and, for many, their experience outweighs their lack of graduate degree and/or credential. That being said, I believe we will be seeing less and less of such a supervisor. I believe experience along with an ability to form a positive working relationship with supervisees should be the top

qualifications. However being credentialed (which of course is a stamp of approval on one's experience) is also a must and in many jurisdictions (e.g. state licensing boards) being credentialed at the level required to supervise also includes the requirement of a master's degree in a related field (social work, counseling, psychology, etc.). But just to reiterate one more time, a degree and credential alone are not what qualifies one to be a supervisor – it takes much more – including experience and an ability to form positive, growth-enhancing relationships with supervisees (difficult to measure, but crucial in successful growth for the counselor).

Q: Readings you might recommend in clinical supervision?

A: My favorite text book is *Fundamentals in Clinical Supervision* by Janine Bernard and Rodney Goodyear (4th edition), published in 2008 by Allyn and Bacon. It is a very broad overview of clinical supervision in the helping professions. Also, you can't go wrong with David Powell's book (co-authored by Archie Brodsky) titled *Clinical Supervision in Alcohol and Drug Abuse Counseling: Principles, Models and Methods* (2nd edition), published in 2004 by Jossey-Bass. Finally I find SAMHSA's TIP 52, titled *Clinical Supervision and Professional Development of the Substance Abuse Counselor*, to be a very helpful publication. It effectively synopsizes clinical supervision, has a section called "A Guide for Administrators," offers a series of vignettes demonstrating interactions between supervisors and supervisees, and includes a number of sample forms supervisors can use with their supervisees.

Q: What are the best practices in supervising counselors with 20 years of experience with no previous supervision and are adamant AA and 12 steppers?

A: I've supervised that person too. It occurred relatively early in my career. I was 30 years old with about 6 years of experience and one year beyond receiving a master's degree. My supervisee was old enough to be my father. The first thing I did was honor his experience and knowledge by simply stating that I expected to learn a lot from him and that my hope was that we would have a mutually beneficial relationship – and we did. He was in recovery, though not what I would call an "adamant AA and 12 stepper," but if he had been, I would have honored that too. Granted, the field has changed (and continues to), but the pioneers of our field are those who, by virtue of their own recovery, have brought so much knowledge and understanding to the work we do. In time, after developing a mutually respectful working relationship (note: "in time" is of significance here), perhaps this person could soften a little by seeing each client as unique, not only with unique needs for treatment, but unique needs for recovery.

Q: What is your opinion of TAP 21?

A: TAP 21 (*Addiction Counseling Competencies*), is a SAMHSA publication (TAP = Technical Assistance Publication). The updated version was published in 2005 and provides an excellent overview of four "transdisciplinary foundations" and eight "practice dimensions." It is not meant to be a "how to" (as typically found in SAMHSA TIPs), but is a thorough outline of addiction counselor competencies as these competencies are listed and defined under each transtheoretical foundation and under each practice dimension. Many state certification boards have incorporated the TAP 21 competencies into their model of credentialing. Note also there is a companion publication, TAP 21A, *Competencies for*

Substance Abuse Treatment Clinical Supervisors, also more of an overview of foundations and competencies and not as specific and thorough as TIP 52 (referenced above).

Q: What is the most important things to document as it pertains to supervision? Do you have any samples of supervision documentation and IDP's?

A: Let's start with the IDP. It is a mutually agreed upon list of target goals, each goal comprised of a list of objectives (I call them steps necessary to reach the goal). Some supervisors will use some of the competencies listed in TAP21. Here is an example, using Competency #86 in TAP21:

Goal – Become proficient in applying crisis prevention and management skills
Objective #1: Read chapter 1 in "Crisis Intervention" by Dr. Green (I'm making this up)
Objective #2: Explain the difference between crisis prevention and crisis intervention
Objective #3: With a client in crisis (or in response to a case study) list steps that would aid him or her in crisis resolution, including the involvement of others (counselor, family, significant other, etc.)
Objective #4: Role-play in supervision a crisis intervention (first with supervisor as the client; then switch roles)
Objective #5: With supervisor observing (as co-therapist) meet with a client who is experiencing a crisis.

Regarding documentation, the counselor's progress (toward a goal) for each of these objectives can be documented in his or her IDP (focusing on both strengths as well as further areas for improvement). In direct answer to the original question, the most important thing to document is what is most relevant to that particular counselor regarding his or her professional development. This could be (as previously stated) the counselor's progress toward an agreed upon goal or it could be an area in need of improvement that has not been previously identified. Note that the latter could be reframed into a growth goal for the IDP.