

# **Clinical Supervision and Professional Development of the Substance Abuse Counselor:** A Review of the Literature—Updates\*

## **A Treatment Improvement Protocol**

# **TIP 52**

\*This document is available online only (<http://store.samhsa.gov>) and supports TIP 52, *Clinical Supervision and Professional Development of the Substance Abuse Counselor*.



**Treatment Improvement Protocol (TIP) 52,**  
***Clinical Supervision and Professional Development***  
***of the Substance Abuse Counselor***

**Updated Findings From the Literature**

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## Introduction

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The following updates were developed to keep current the literature review component of Treatment Improvement Protocol (TIP) 52, *Clinical Supervision and Professional Development of the Substance Abuse Counselor*, published in 2009. The literature review update period for this TIP spanned 3 years post-publication and concluded with the April–September, 2012 update. The same search methodology used in developing the literature review for TIP 52 was used for the updates.

## **June 1, 2007, Through December 31, 2010**

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Most articles found during the above-referenced timeframe met the selection criteria related to the training component of supervision, or the incorporation of didactic learning into practice. Other articles focused on how supervision supports counselors' practice and job satisfaction. In all articles, the authors indicated that supervision of counselors plays a valuable role in the provision of services to clients.

### **Supervision as a Followup to Training**

Two articles presented information on how clinical supervision can reinforce didactic learning after a workshop on a specific topic.

A lack of effective clinical supervision has been one barrier to counselors adopting evidence-based practices. Martino and colleagues (2008) assessed the extent to which counselors in substance use disorder (SUD) treatment programs can implement evidence-based therapies (EBTs) with adequate fidelity so that the therapy could be distinguished from counseling-as-usual (CAU). Thirty-five therapists were recruited to provide either motivational enhancement therapy (MET) or CAU. The 461 clients were divided into two groups. One group received services from counselors who had attended a three-session intensive course in MET, followed by clinical supervision by supervisors who had also attended an intensive workshop; the other, a control group, received CAU. The study attempted to determine whether these expert-led workshops, followed by specialized supervision, enhanced MET's implementation.

The supervisory sessions included using tape recordings of counselor–client sessions to assess the counselors and provide feedback regarding their effectiveness in integrating MET into the sessions. These supervisors also took part in monthly consultative calls with the expert trainers.

Martino and colleagues (2008) concluded that supervision is a major component of implementing EBT, because it provides counselors with feedback when practicing the new skills and reinforcing the EBT training. However, this approach may not be realistic for many agencies for a number of reasons, including the following:

- Some agencies may not be able to free up staff to attend extensive training, because of financial reasons or limited counselor time, especially if several counselors need to be away at the same time.
- Most agencies do not have access to the expert-provided training and ongoing support supervisors received; they need this support to enhance their knowledge of the model and supervisory skills.
- The study focused on incorporation of a single model; however, no one model is likely to be appropriate for all clients.

The authors noted the following limitations to the study:

- Programs participating in the study were part of the National Institute on Drug Abuse's Clinical Trials Network (CTN) and these programs may have been more willing to be involved in the study than programs that were not part of CTN.
- The study did not assess the relationship of counseling techniques conflicting with MET.
- Analysis was done on the 70 percent of clients who completed three sessions and did not include dropouts, which may have affected the outcomes.

Another article discussed the importance of clinical supervision in training counselors in cognitive behavioral therapy (CBT). Friedberg and colleagues (2009) proposed several key components in training counselors and providing effective supervision. These CBT components are conceptualizing cases using critical thinking, attending to immediacy in session, tolerating negative emotional arousal on the part of the client and therapist, fostering emotional and cognitive openness, working toward cultural competence, and enhancing technical proficiency.

As in other articles covered in this Literature Review Update, the authors identified the importance of supervisors in reinforcing didactic training, helping counselors to use new clinical skills, and improving technical proficiency by using techniques, such as role-playing.

## **The Role of Supervision in Training**

Several authors viewed training as being either related to, or part of, the clinical supervision process.

Carroll and colleagues (2010) summarized findings from some of the authors' recent series of multisite randomized clinical trials. Those studies assessed training for SUD counselors, based in the community, to use various EBTs. However, the authors mentioned the importance of supervision.

The authors concluded that an EBT learned through didactic methods is not integrated into practice without ongoing reinforcement, training, and clinical supervision. The clinical supervisor needs to provide individualized training for counselors and consider facts, such as the counselor's level of education. The authors recommended certification for supervisors. However, they recognized that the cost for such certification can be prohibitive.

Amodeo and colleagues (2010) performed a study of a Web-based CBT training program for SUD counselors. The study included 54 supervisors who managed 120 counselors. The authors identified several activities that were helpful in providing effective supervision, such as:

- Mentoring, in which the supervisor encourages and reinforces the counselor to bolster confidence.
- Checking in with the counselor when practice is going well, and not just when a crisis arises.
- Taking part in counselors' training programs so that supervisors can work effectively with counselors as they integrate new knowledge and skills into practice.

The authors commented on the difficulty of locating and recruiting clinical supervisors, because many programs did not employ such personnel. The dearth of clinical supervisors necessitated the expansion of study recruitment from the New England States to programs throughout the United States. The study, which is still in process, currently focuses on supervisors' specific role in supporting counselors.

Rogers, Lautar, and Dunn (2010) studied the instructional skills of clinical supervisors who provided clinical education to interns and students. The study sought to determine whether the supervisors' teaching skills were adequate and whether the supervisors' perceptions of those skills were consistent with their students' perceptions.

The authors administered surveys to 124 interns and students, who assessed supervisors' training competence. (The supervisors had taken a similar survey in another phase of the study.) The students were very confident in the supervisors' ability to teach, but the students identified the following areas as needing improvement:

- Understanding students' different learning styles.
- Preplanning teaching experiences before the students' arrival.
- Giving feedback to the students.
- Assessing student skills based on the identified learning goals.

The students and supervisors felt that the supervisors needed additional professional development in training methodologies. However, both groups saw the supervisors as having effective clinical skills. Students stated that the supervisors needed to be approachable and patient, give students sufficient time to learn, and explain treatment rationales.

Rogers and colleagues (2010) recommended the following approaches to enhancing supervision:

- Conduct workshops for supervisors in education methodology.
- Recognize formally—such as through certification—supervisors who have developed their training skills.
- Create an academic Web site to facilitate training for supervisors who do not have the time or agency resources to attend in-person training.

## **Learning Modalities and Their Applications**

Bennett-Levy and colleagues (2009) not only studied supervision in promoting CBT, but also asked whether different types of training and supervision promote different kinds of learning and clinical-skills development. The authors gave a questionnaire to 120 participants at a workshop. All survey responders were experienced CBT therapists.

The workshop presented the Declarative-Procedural-Reflective model, which identifies three information-processing approaches:

- **Declarative:** Intellectual understanding of the subject matter
- **Procedural:** Ability to apply didactic knowledge to practice

- **Reflective:** Ongoing use of experience to resolve treatment issues with a specific client to enhance overall skills and effectiveness with future clients

The responses to the questionnaire confirmed the authors’ hypothesis that skills in these areas were enhanced by different types of learning experiences, as shown in Exhibit 1.

**Exhibit 1: Most Effective Learning Approaches by Skill Area**

Declarative Knowledge	Procedural System	Reflective System
Modeling	Modeling	Self-experiential work
Reading	Role-plays	Reflective practice
Lectures	Reflective practice	
	Self-experiential work	

Bennett-Levy and colleagues (2009) defined these approaches as follows:

- **Modeling:** The supervisor demonstrating the skill in the session
- **Reading:** Individual reading on the counselor’s own time
- **Lectures:** Formal classroom training
- **Role-plays:** The supervisor, counselor, or other staff member acts the roles of counselor and client
- **Reflective practice:** During a clinical session, learning from an issue and applying it to future work
- **Self-experiential work:** Applying lessons counselors have learned from their own experience

The authors also broke down learning styles into three related skill areas, for which they identified the most effective learning tools:

- **Conceptual knowledge/skills:** Reading, lectures, and modeling
- **Technical knowledge/skills:** Reading, lectures, and modeling
- **Interpersonal skills:** Reflective practice, self-experiential work, and role-playing

The implication is that traditional training approaches—reading and lectures—are best suited for the development of declarative knowledge. Clinical supervision, on the other hand, offers the best opportunity for the development of procedural and reflective knowledge, and related skills that lead directly to improvements in practice. Such supervision is best provided through role-play and reflective practice.

Bennett-Levy and colleagues (2009) noted several limitations to this study, including the following:

- **Subjectivity:** The study relied on self-reporting; therefore, respondents’ saying that they developed knowledge or enhanced their information or skills does not necessarily mean that they did, or that their clinical work improved as a result.

- **Narrow segment of treatment providers:** The respondents were self-selected (attendees of a CBT workshop) and may not be representative of treatment providers as a whole.
- **Biases:** The respondents' view of training and its effectiveness may have been biased by previous reading or other learning.
- **Cursory review:** Because of time limitations, the authors performed an “eyeball analysis,” rather than a formal statistical analysis; the latter might have led to different results.

## Reducing Employee Turnover

Knudsen and colleagues (2008) evaluated whether clinical supervision protects against counselor turnover. The study was performed in SUD treatment programs participating in CTN.

Previous studies have identified counselors' emotional exhaustion as related to turnover. Other factors related to counselor turnover identified in previous studies are the counselors' perceptions of the following:

- **Job autonomy:** Having the ability to make their own decisions
- **Procedural justice:** Being treated fairly by the organization and the supervisor
- **Distributive justice:** Receiving a fair amount of the work

The researchers interviewed 240 administrators of community-based SUD treatment programs to obtain information on the program's organizational structure. These administrators identified front-line counselors the researchers could ask to be in the survey. The researchers mailed questionnaires to these counselors and 1,001 questionnaires were returned. The questionnaires consisted of several items about the counselors' perception of clinical supervision and their job satisfaction.

The findings indicated that quality supervision and the counselors' relationship with the supervisor positively affected the counselors' feelings of well-being, job autonomy, procedural justice, and distributive justice. These factors were related to decreased counselor turnover.

However, the study had the following limitations:

- The data collected were cross-sectional, so causality could not be determined.
- The subjects were not from a national sample, so the results could not be generalized.
- The study did not define quality clinical supervision.
- The analysis used the counselors' subjective perceptions of their supervisor's work; objective measures would have provided more accurate data than did the subjective measures.

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## January 1, 2011, Through September 30, 2011

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### Supervisor Turnover

Knight, Broome, Edwards, and Flynn (2011) used logistic regression analyses to study organizational factors related to clinical supervisor turnover in organizations providing outpatient treatment of substance use disorders. Programs largely were private nonprofit (74 percent), located in urban settings (76 percent), and affiliated with a parent organization (73 percent).

The study used data from the Treatment Costs and Organizational Monitoring (TCOM) project to examine structural elements of programs. It also examined collective appraisals (including job satisfaction) of directors and substance use treatment counselors. The TCOM project collected data from 115 substance abuse treatment programs in 9 States from 2004 to 2006. Measures included clinical supervisor turnover (a dichotomous measure assessed twice during the study), program structure (regular outpatient, intensive outpatient, or mixed), and job attitudes of staff members related to satisfaction, burnout, and director leadership. The researchers used Likert-type scales to study each of these variables.

The study also collected data in the form of an initial organizational structure assessment of several factors, including organizational relationships, services provided, and characteristics of staff members and clients. The investigators also measured recent director turnover and other recent changes within the organization, clinical practices and assessment, and general characteristics of the programs studied. These data were obtained by using a Survey of Structure and Operations (SSO) completed by 467 counselors and 65 supervisors (clinical/program directors). The investigators conducted a followup SSO and a survey of staffing changes 12 months after the beginning of the study.

Supervisory change of 30 percent occurred during the 6 months preceding the start of the study. A change of 33 percent of supervisors occurred during the subsequent 12 months. Factors associated with higher supervisor turnover rates included:

- Affiliation of a program with a parent organization.
- Results of collective supervisor and supervisee satisfaction appraisals.
- Number of hours of counseling provided per client.
- Low collective appraisal of satisfaction following the departure of a previous supervisor.

Results from this study indicate that factors at the organizational level, especially staff satisfaction, can influence supervisory turnover. Efforts to monitor and increase staff satisfaction reduce attrition among substance abuse treatment program personnel. They also reduce the amount of turnover in managerial and supervisory staff.

Limitations of the study included:

- The dichotomous manner (turnover/no turnover) in which the clinical supervisor/program director turnover measure was structured did not make it possible to quantify or characterize overall turnover. The study did not address measures such as the

number of changes that occurred, whether departures were voluntary or involuntary, and the extent to which turnover occurred in middle versus upper management.

- Restricted sample sizes resulting from a low participation rate (78 percent) of TCOM substance abuse treatment programs limited the analysis of prior turnover as an important variable. Larger samples would have increased the robustness of the study. They also would have allowed a more thorough examination of factors influencing supervisor turnover (e.g., possible interactions between individual- and organization-level factors).
- Other factors (e.g., variations in the number of counselors managed by a given supervisor, organizational commitment, director tenure) were not addressed.

## Training of Supervisors

Tebes and colleagues (2011) used a pre/post/followup design to study the feasibility and longitudinal impact of training substance abuse treatment supervisors in three core competency areas of interactional supervision, including (1) managing supervisory relationships, (2) promoting professional development, and (3) managing job performance of supervisees. The researchers conducted 28 hours of training over a 7-month period. The training involved four core functions:

- **Practice.** Observation of supervisee-client interactions.
- **Job management.** Helping supervisees perform their professional functions.
- **Staff development.** Fostering and providing feedback and evaluation concerning supervisee competencies.
- **Professional impact.** Helping supervisees develop skills necessary to contribute to positive organizational change.

The training integrated didactic and experientially based learning and included presentations, analysis of supervision examples, and discussions of case examples generated by the presenter and supervisors.

Training outcomes were assessed using surveys completed by the clinical supervisors who received the training. Competencies were self-assessed before, immediately after, and at 3 months (followup) after the training. Other measures of the study included demographics, satisfaction with work as a supervisor, management of supervisory stress, and satisfaction with the training provided in the study. Statistically significant increases occurred in the supervisors' self-perceived competencies in the three core areas studied, and increases became greater as training progressed. Supervisor satisfaction and the ability to manage stress were associated with increases in supervisor competencies.

The study had the following limitations:

- The lack of a control group consisting of individuals who did not receive the training.
- The use of self-reports by trainees to assess their competencies.
- Poor reliability estimates (perceived versus those observed by the researchers) of two of the competency scales—managing job performance and promoting professional development.

- The fact that the relative importance of each training component could not be determined.
- A high study attrition rate among the participants. Forty-five supervisors (56 percent retention rate) completed pretest and posttest surveys, and 34 supervisors (42 percent retention rate) completed all three administrations of the survey over the 7-month study period.

The study demonstrated the feasibility and potential effectiveness of training of clinical supervisors using interactive supervision. The authors also suggested that the study provided a possible framework for combining supervision with training in the skill-based interventions associated with various evidence-based treatments.

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## October 1, 2011, Through March 31, 2012

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The original review of the literature for this TIP noted the lack of research on clinical supervision in the field of substance abuse, and this update is no exception. Only three articles met the criteria for inclusion for this update. One article examined the issue of counselor turnover and perceptions of organizational functioning, another examined whether there was an association between the rates of staff turnover and client outcomes in organizations that seek to implement evidence-based practices (EBPs), and the third examined the issue of counselor training in EBPs.

### Counselor Turnover

Eby and Rothrauff-Laschober (2012) tracked 598 substance use disorder (SUD) counselors over a 4-year period (Waves 1, 2, 3, and 4) to determine the rate of voluntary counselor turnover. They also examined whether counselor perceptions of the organizational environment and clinical supervisor effectiveness are predictors of voluntary counselor turnover.

Baseline (Wave 1) data were collected from the SUD treatment organizations on counselors who were employed at the time of the initial data collection. In each subsequent year (Waves 2, 3, and 4), the SUD organizations submitted followup data on the employment status of each counselor who was employed in the previous year. The followup (turnover) data included whether the counselor was still an employee of the organization at the time of followup or had left the organization and, if the counselor had left the organization, whether the departure had been voluntary or involuntary. Counselors were only included in the study if they had completed the baseline surveys and either remained employed or had left their respective organizations voluntarily (i.e., those whose terminations were involuntary were omitted from the study). Each participating organization received \$1,000 per year to cover the cost of staff time used for gathering turnover data.

Individual SUD counselors were surveyed at Wave 1 regarding their perceptions of the organizational environment in four areas, with each area assessed by a separate scale that the authors judged to be well-researched and psychometrically sound. Each of these Likert-type scales were constructed with possible responses for each item ranging from 1 (“strongly disagree”) to 5 (“strongly agree”). Exhibit 2 lists the four areas and a sample item from each scale.

### Exhibit 2 Organizational Environment

Area	Sample Item
Procedural justice	“Job decisions are made by center management in an unbiased manner.”
Distributive justice	“I am fairly rewarded considering my responsibilities.”
Perceived organizational support	“My organization cares about my opinions.”
Job satisfaction	“I enjoy nearly all the things I do in my job.”

Counselor surveys in Wave 1 also included their perceptions of their clinical supervisors' leadership effectiveness as defined by four areas:

- Relationship quality
- Extra-role performance directed at individuals
- Extra-role performance directed at the organization
- In-role job performance

The first three areas were each assessed by a separate scale that the authors judged to be well-researched and psychometrically sound. Each Likert-type scale was constructed with possible responses for each item ranging from 1 (“strongly disagree”) to 5 (“strongly agree”). Exhibit 3 lists the first three leadership effectiveness areas and a sample item from each scale.

### Exhibit 3 Leadership Effectiveness

Area	Sample Item
Relationship quality	“The relationship between my clinical supervisor and I is very effective.”
Extra-role performance directed at individuals	“My clinical supervisor helps others who have heavy workloads.”
Extra-role performance directed at the organization	“My clinical supervisor gives advance notice when unable to come to work.”

The fourth area of leadership effectiveness (in-role job performance) was assessed by a scale specifically constructed for the study. This scale included 14 items that covered core tasks for clinical supervisors (e.g., “Provides feedback on my clinical work with individual patients”). Counselors were asked to rate their supervisors on each item from 1 (“very ineffective”) to 4 (“very effective”). (The authors performed a factor analysis on this scale to provide validity evidence, and a brief summary of the results are included in the article.)

Because Wave 1 represented the study baseline, turnover at Wave 1 was 0 percent. When actual turnover data were collected in Wave 2, it was determined that 25 percent of the original sample of counselors had left their organizations voluntarily. The percentage of voluntary turnover increased to 39 percent and 47 percent in Waves 3 and 4 (respectively). The authors found that all of the organizational environment variables predicted turnover. That is, counselors with higher perceived levels of both procedural and distributive justice, higher perceived levels of organizational support, and higher levels of job satisfaction were all less likely to voluntarily leave over the 3-year period than other counselors. However, the authors were surprised to find that none of the leadership effectiveness variables related to clinical supervision were predictors of turnover.

Possible limitations of the study are:

- The researchers used a limited analysis that considered baseline data to predict turnover rates over time. Measuring predictor variables over the course of the study to determine

how counselors' changing perceptions of the organizational environment might have affected the turnover rate.

- Although the predictor variables (organizational environment and clinical supervisor effectiveness) were selected based on previous research, it is possible that other variables (e.g., pay rates, case load) might also predict turnover rates.
- The study focused only on voluntary counselor turnover, so results may not be generalizable to involuntary turnover.

Garner, Hunter, Modisette, Ihnes, and Godley (2012) performed a secondary analysis of data from a large-scale EBP initiative to determine whether there was an association between the rates of staff turnover and client outcomes. Data were collected from 34 organizations, 249 treatment staff, and 3,486 clients across 15 States who participated in an EBP initiative funded by the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment (SAMHSA/CSAT).

The authors computed turnover rates for clinicians and clinical supervisors across the entire SAMHSA/CSAT project so that these could be compared with data from the Bureau of Labor Statistics (BLS) on the national turnover rate in the broader field of health care and social assistance (HCSA). They also computed turnover rates at the organizational level for four categories in order to determine whether there was a relationship between turnover rates and client-level outcomes. The four categories were:

- Agency turnover of clinicians
- Project turnover of clinicians
- Agency turnover of clinical supervisors
- Project turnover of clinical supervisors

Client-level outcomes included four measures related to *treatment implementation* (e.g., treatment initiation and engagement, total number of sessions, an intervention-specific scale) and six primary *treatment outcome* measures (e.g., percentage of days of substance use, indices of social and environmental risks, involvement in illegal activity). The treatment outcome measures were part of the clients' Global Appraisal of Individual Needs (GAIN) assessments at intake and after 6 months of treatment.

Results indicated that the annualized rate of clinician turnover for agencies (31 percent) was not significantly lower than the BLS rate of average annual "total separations" from the broader field of HCSA (30 percent). However, the annualized rate of clinical supervisor turnover for agencies (19 percent) *was* significantly lower than BLS data from HCSA. Consequently, although there may be a perception in the field of SUD treatment that clinician turnover is a problem, the results in this study suggest that the rates of clinician turnover in SUD treatment are not significantly different from the rate of turnover in similar positions nationwide. Contrary to the authors' expectations, the results also did not indicate that a higher level of staff turnover negatively affected client-level outcomes. In fact, for one client outcome variable, the opposite was true. The authors found that higher rates of clinician turnover (both agency and project turnover) were significantly associated with lower levels of illegal activity by clients. Further, agencies with lower rates of clinical supervisor turnover had lower levels of client involvement with illegal activity than did agencies with no clinical supervisor turnover. Although the authors offered

theories regarding these findings, they concluded that additional research would be necessary before their results could be more fully understood.

A possible limitation of the study is that it was conducted using data from the implementation of a well-defined EBP initiative, so it is not known whether the results would be generalizable to other treatment settings. The authors also noted several aspects of the study that may have increased the possibility of error—the number of statistical tests performed, the use of self-report measures for client outcome data (rather than objective data), and the lack of data regarding whether staff turnover was voluntary or involuntary.

## Counselor Training

EBPs were also the focus of a study by Olmstead, Abraham, Martino, and Roman (2012) in which they examined how much on-site, formal training counselors received in four commonly used EBPs:

- Cognitive-behavioral therapy (CBT)
- Motivational interviewing (MI)
- Contingency management (CM)
- Brief strategic family therapy (BSFT)

The data were part of a national longitudinal study (the National Treatment Center Study [NTCS]) and involved face-to-face interviews with the directors of 340 privately funded substance abuse treatment centers. The directors were asked a series of questions specific to the particular type of EBP used in their treatment programs. For example, directors who indicated that their program used CBT with clients were asked how much their program emphasized various CBT components (e.g., the identification of triggers, the development of coping skills, the use of homework for practicing new skills). A similar pattern of EBP-specific questions was used for treatment centers using MI, CM, and BSFT. The interviews also included questions about whether counselors were expected to develop proficiency in the EBPs used with clients and whether the treatment centers provided training for counselors in the EBPs. The results are shown in Exhibit 4.

### Exhibit 4 EBPs and Counselor Training

EBP	Provided Training	Training Included Supervision with Cases	Training Included Supervision with Audio/Video Tape Review
CBT (n=306)	66 percent (203/306)	39 percent (120/306)	7 percent (20/306)
MI (n=188)	80 percent (150/188)	40 percent (76/188)	15 percent (29/188)
CM (n=103)	55 percent (57/103)	NA*	NA*
BSFT (n=46)	28 percent (13/46)	20 percent (9/46)	2 percent (1/46)

\*NTCS data for CM did not include information on supervision.



In spite of the large gaps in training, treatment center directors had high expectations of EBP proficiency from their counselors:

- In centers that used CBT, 72.8 percent of center directors expected all counselors to be proficient in CBT.
- In centers that used MI, 73.3 percent of center directors expected all counselors to be proficient in MI.
- In centers that used BSFT, 46.2 percent of center directors expected all counselors to be proficient in BSFT.

The authors raised understandable concerns about the quality and integrity of EBP implementation in treatment centers when there are such large apparent gaps in training and supervision in the use of EBP interventions.

Limitations include the fact that the study was based on data from a large nationally representative sample of privately funded treatment centers using EBPs so the results may not generalize to other types of treatment centers (e.g., publicly funded treatment centers, treatment centers that do not use EBPs). Second, the data were obtained through face-to-face interviews with treatment center directors and were not corroborated with treatment center counselors; therefore, the directors' self-reports may not accurately reflect the clinical work being done in client sessions (i.e., directors may not know what interventions counselors are actually using with clients). Third, the data did not include evaluation information on the quality of the training counselors received or whether the training improved counselors' level of skill in providing EBP interventions.

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## **April 1, 2012, Through September 30, 2012**

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The original literature review for TIP 52, *Clinical Supervision and Professional Development of the Substance Abuse Counselor* noted the lack of research-based writing on clinical supervision for substance abuse treatment providers. This limitation still stands. Looking more broadly at the behavioral health field, the literature on clinical supervision is more extensive for mental health treatment providers than for substance abuse treatment providers. However, for both fields, literature regarding clinical supervision tends to be descriptive or prescriptive in nature. The literature often describes models of supervision based on clinical activities; the majority of research trends toward small surveys that generally have low response rates. Two of the articles below fall into the categories just described. The third (Smith et al., 2012) presents the findings of a randomized controlled trial.

### **Perspectives on Clinical Supervision**

Pack (2012) investigated the meaning of clinical supervision to both clinical supervisors and supervisees. The author conjectured that for clinical supervision to benefit the supervisee, both the supervisor and supervisee need a similar understanding of the purpose of clinical supervision. The study consisted of 22 participants (10 supervisors and 12 of their supervisees) in various mental health settings (community-based and inpatient settings). The participants were trained as social workers or occupational therapists. The primary question addressed to each participant was: “What does clinical supervision mean to you?”

The clinical supervisors saw their primary goal as ensuring “safe practice” with clients. Other issues mentioned included helping the supervisee provide effective treatment for clients and minimizing legal risk to the organization. Additionally, promoting supervisee awareness and personal growth were seen as important. As a means of achieving these factors, the supervisors emphasized the importance of establishing a collaborative supervisor–supervisee relationship and promoting the use of the supervisee’s whole self in clinical supervision.

The supervisees stated that trusting the supervisor, feeling supported and nurtured, and having a safe place to discuss problems were key elements of effective and helpful clinical supervision. They also valued receiving and giving clear feedback in a consistent manner and on a regularly scheduled basis.

Given that there was divergence as well as convergence between the two groups on the meaning of clinical supervision, the author noted the importance of having clearly articulated roles at the onset of the supervisor–supervisee relationship. The establishment of such creates a resource for each party to reference should difficulties arise during the course of clinical supervision.

### **Supervision and Collaborative Care**

Pratt and Lamson (2012) prescribed a model of clinical supervision that takes into account the behavioral health provider (BHP) who functions as part of an integrated care team. The authors defined behavioral health as an overarching term that encompasses mental health, substance

abuse, and behavioral medicine; therefore, for this article, the authors considered BHPs to come from a variety of disciplines (e.g., marriage and family therapists, psychologists, social workers). In an integrated care setting, patient care can require highly coordinated efforts between BHPs and medical care providers. The authors stated that BHPs are trained to communicate with other professionals about patients, but are rarely trained to provide collaborative care as part of a team. Clinical supervision can be a valuable means of teaching BHPs in training or new to the field how to successfully participate as part of such a team.

The authors mentioned these points regarding integrated care supervision that they felt were important. The supervisor can help the supervisee:

- Learn how the practice operates and develop skills in collaboration, documentation, practice models, brief therapy, and theory.
- Assist in determining the supervisee's role on the team.
- Communicate effectively about psychological, social, and relational information.
- Think about how health conditions affect patients, families, and social systems.

Some behavioral health disciplines require that providers obtain a supervisor (e.g., certain types of counselors, marriage and family therapists, psychologists, some social workers). The authors suggested that selection of an appropriate supervisor is essential to the development of effective BHPs. Further, the authors elaborated on three components that can be incorporated into the supervisory relationship to ensure success in an integrated care environment:

- A contract
- Documentation of practice models
- Levels of clinical supervision

The authors also noted the need for more specificity in regard to conducting electronic communications. They pointed out that this is particularly important in an integrated care setting where multiple codes of ethics must be considered.

## **Supervision by Teleconferencing**

One randomized controlled trial was identified during this update period. Smith et al. (2012) researched training substance abuse treatment clinicians in motivational interviewing (MI). The aim of the study was to test the use of different supervision techniques for improving and sustaining MI skills of counselors after attending an MI workshop. Ninety-seven community-based drug treatment counselors participated in the study. All participants completed a 2-day MI workshop and were randomized according to three supervision conditions that took place following the workshop:

- Live teleconferencing supervision (TCS) (n=32)
- Standard tape-based supervision (tape) (n=32)
- Workshop alone with no followup supervision (workshop) (n=33)

For both the TCS and tape conditions, the supervision phase of the study consisted of five counselor–client sessions conducted over 7 weeks. Actors played clients to provide a similar situation for all counselors in the study. For all three conditions, counselors’ skill levels in MI were assessed four times: prior to the workshop and 1 week, 8 weeks, and 20 weeks after the workshop.

TCS was provided by telephone. Supervisors listened to counselor–client sessions and provided live feedback and coaching to the counselor (who wore an earpiece during the session).

Participants in the standard tape group had their sessions audiotaped. Each session was sent to a supervisor for review, which the supervisor and counselor subsequently discussed. The intent was to model the type of tape supervision found in research and academic settings.

The TCS group scored better than the workshop group for spirit and empathy and in reducing nonadherence to MI principles. TCS was also superior to both workshop and tape in increasing reflection to question ratio, another MI component. However, supervision by tape was superior to TCS in increasing complex reflections by counselors to patients. This may be because supervision via tape may allow more time for the supervisor and counselor to discuss and role-play MI skills outside a client session.

The authors speculated that TCS with its focus on the basic MI skills might have hindered counselors learning some aspects of MI. In particular, the supervisee might have depended too much on the supervisor. For example, instead of identifying important cues from the client, the counselor may have relied on the supervisor to recognize these cues. Given this, the authors stated that live supervision may be better conducted by initially providing immediate feedback but then letting the counselor run the session with a lesser amount of intervention. Additionally, live supervision allows the supervisor to pause the session to ask the counselor what he or she thinks is happening in the session and discuss appropriate strategies to help the client.

The authors stated that further research is needed to improve supervision methods to increase counselors’ skill levels and disseminate evidence-based practices, such as MI. The authors suggested that the findings from this research imply that a longer duration of supervision that uses a combination of TCS and tape could be tested to see if it helps increase counselors’ proficiency in MI.

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