A Hands-On Tool Kit for Clinical Supervisors and Supervisees Serving Women with Substance Use Disorders

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INTRODUCTION

The need for substance use disorder (SUD) treatment personnel to receive regular technical and personal supervision and support as a standard of quality assurance is highlighted in an October 2021 report entitled "Quality assurance in treatment for drug use disorders: key quality standards for service appraisal." The report, authored by a consortium of international organizations, including the United Nations Office on Drugs and Crime (UNODC) and the World Health Organization (WHO), lists supervision as one of the key elements on its "Key Quality Standards Checklist." Fortunately, the SUD treatment field as a whole is increasingly recognizing the value of clinical supervision as a quality standard in the delivery of services. The unfortunate reality however is that clinical supervision is often not included in the budgets of many SUD treatment programs, including programs serving women, a treatment population with special clinical needs that require competent clinical supervision in order to be effectively addressed.

The SUD treatment field as a whole is increasingly recognizing the value of clinical supervision as a quality standard in the delivery of services.

This tool kit is meant for 2 audiences: clinical supervisors and their supervisees who are serving women with SUD in regions around the world. It is not a detailed how-to manual on practicing clinical supervision nor is it a replacement for formal training on clinical supervision in women's treatment settings.

The tool kit's purpose is two-fold; first, to provide an overview of the importance of clinical supervision in serving women with substance use disorders in general, and second, to provide useful hands-on tips on supervision competencies for practical application in the field.

The tool kit's eight TIP SHEETS are intended to support clinical supervisors and their supervisees who serve women with SUDs in a broad range of treatment settings and cultures around the world.

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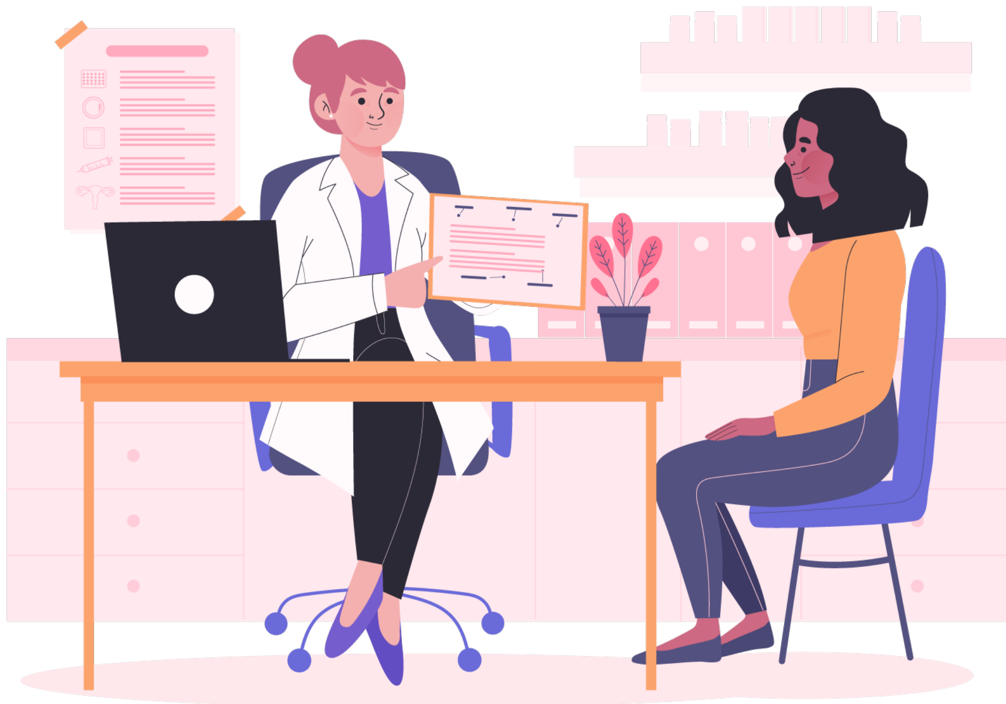
This tool kit can be used as both a stand-alone document or as a supplement to the Colombo Plan's Women's Intervention for Subtance Exposure (WISE) Curriculum. Its content is drawn from peer-reviewed documents and gleaned through extensive consultations with internationally recognized experts on women's SUD treatment and a range of clinical supervisors currently working in women's treatment settings.

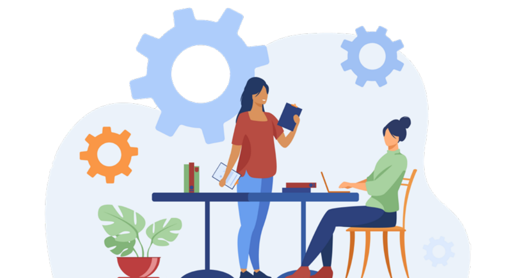
TIP SHEET #1 : What is Clinical Supervision?

Clinical supervision is "an intervention provided by a more senior member of a profession to a more junior colleague; typically, though not always, the supervisor and supervisee are members of the same profession."



A connection of trust and cooperation between a supervisor and supervisee is a bedrock for ensuring that the needs of individual patients are served in accordance with the highest possible standards in the delivery of substance use disorder treatment services.

While many tool kit users may not be familiar with the technical aspects of formal clinical supervision, what lies at the heart of the supervisory experience is rather straightforward: supportive consultation, meaning a connection of trust, understanding, and cooperation between a supervisor and supervisee.



CLINICAL SUPERVISION VERSUS ADMINISTRATIVE SUPERVISION

Clinical supervision and administrative supervision are not the same thing. They differ and here's how:

Clinical supervision is focused on the supervisee's clinical cases, personal well-being, and professional development. Evaluation provided by the clinical supervisor is primarily for the purpose of promoting the supervisee's personal and professional development.

In contrast, administrative supervision requires a focus on issues such as productivity and job performance, typically with an eye on the overall functioning and the financial 'bottom line' of the organization as a whole. An administrative supervisor is not free to

focus on the individual supervisee alone: instead, they must keep the well-being of the larger organization in mind at all times.

When a clinical supervisor also serves as their supervisee's administrative supervisor, this can create confusion about the focus and purpose of the time spent in supervision together.

Supervisees may conclude they must appear highly professional during supervision appointments, for fear of 'losing face' with the person who can grant them a raise and/or a promotion.

Supervisors may feel torn between the desire to support their supervisee's individual goals and their need to tend to the larger organization.

Whenever possible it is recommended that administrative supervisors not serve as clinical supervisors for the people who report to them.

When this dual relationship cannot be avoided, it is strongly recommended that supervisors communicate directly with supervisees about the differences between these two roles, and create a concrete plan for addressing both areas of focus in the supervision appointments.

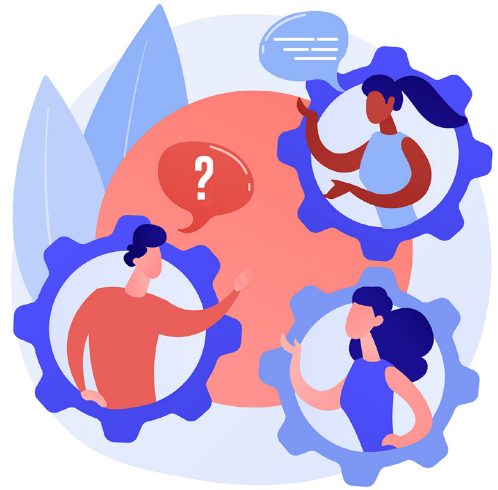
DEFINING ASPECTS OF CLINICAL SUPERVISION:
Evaluative and hierarchical (top-down)
An ongoing relationship which extends over time
Intended to enhance the professional functioning of the junior person
Intended to monitor the quality of professional services
Intended to serve a 'gate keeping' function for the profession
A distinct professional activity

CLINICAL SUPERVISION IS A PROCESS:

Supervision is a collaborative interpersonal process focused on the education and training of the junior colleague.

CLINICAL SUPERVISION IS A ROLE:

- An active role which involves observation, evaluation, feedback, facilitation of supervisee self-assessment, and acquisition of knowledge and skills by instruction, modeling, and mutual problem-solving.
- A supportive role which builds on the strengths and talents of the supervisee, to encourage self-efficacy.



CLINICAL SUPERVISORS HAVE SEVERAL PRIMARY RESPONSIBILITIES:

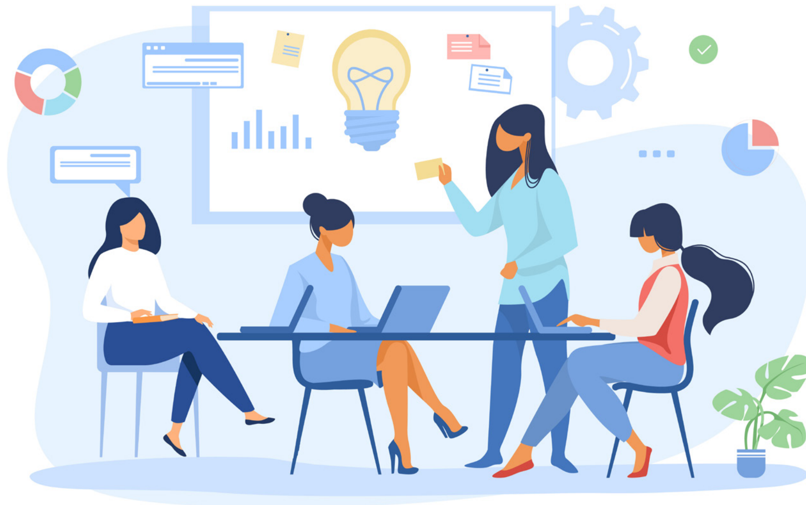
- Training the junior colleague to develop their professional skills.
- Supporting and counseling the junior colleague in order to develop their self-awareness.
- Consulting with the junior colleague to discuss their current concerns and to ensure patient safety.

CLINICAL SKILLS WHICH SUPERVISORS ARE TRYING TO TEACH:

- ✓ Individual and group counseling skills
- ✓ Communication and interpersonal effectiveness skills
- ✓ Case conceptualization skills
- ✓ Diagnostic and assessment skills
- ✓ Counseling/therapeutic methods and techniques
- ✓ Intervention techniques to foster change
- ✓ Written skills
- ✓ Crisis management skills
- ✓ Ethical guidelines and standards
- ✓ Interactions between the individual, their family, their environment, and their presenting problem
- ✓ Multicultural and contextual issues
- ✓ Developmental factors which may impact patient problems

Clinical supervisors are responsible for teaching a broad range of clinical skills to the supervisee

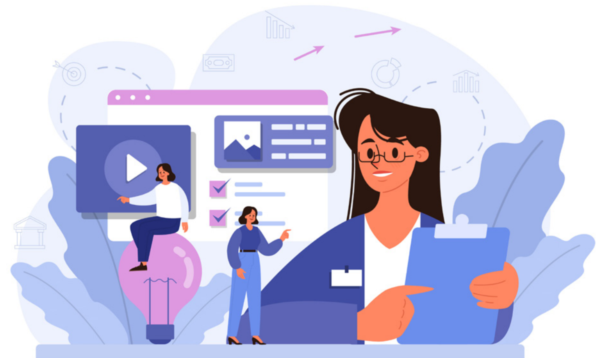
TIP SHEET #2: What is the Role of Clinical Supervision in Women's Substance Use Disorder Treatment?



Clinical supervision is an essential function of any organization that provides treatment services to women with substance use disorders.

COMPETENT, TIMELY CLINICAL SUPERVISION:

- HELPS SUPERVISEES by allowing newer treatment professionals to gain experience and hone their skills under the watchful eye of an experienced practitioner
- PROTECTS CLIENTS by ensuring that each case is carefully reviewed and discussed with the goal of providing the highest quality treatment possible



WOMEN WITH SUDS OFTEN HAVE SPECIAL CLINICAL NEEDS WHICH MUST BE ADDRESSED, INCLUDING:

- ✓ Individual and group counseling skills
- ✓ Communication and interpersonal effectiveness skills
- ✓ Case conceptualization skills
- ✓ Diagnostic and assessment skills
- ✓ Counseling/therapeutic methods and techniques
- ✓ Intervention techniques to foster change
- ✓ Written skills
- ✓ Crisis management skills
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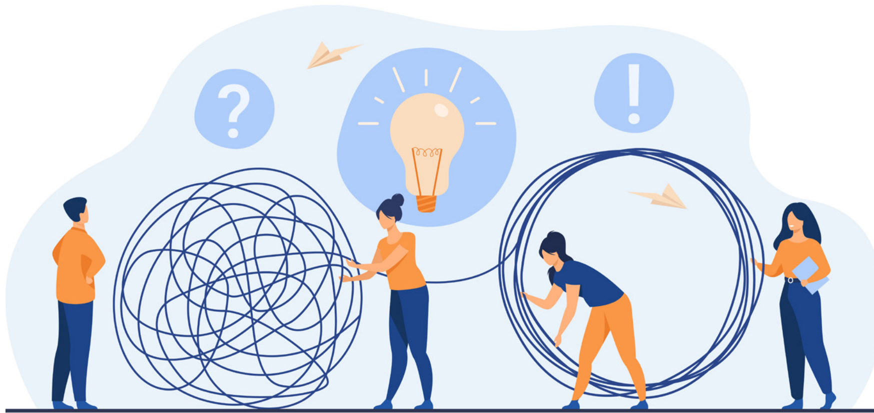
“Women with SUDs often have special clinical needs which must be addressed.”

MANAGING CRISIS SITUATIONS

A competent clinical supervisor will help their supervisee learn how to recognize and address genuine emergencies when they arise.



Supervisors can help supervisees in managing crisis situations, especially when they are faced with them for the first time.

- Suicidal and/or homicidal ideation also represent clinical emergencies which must be addressed immediately.
  - As with post-partum psychosis, emergency commitment procedures should be discussed with supervisees ahead of time, so that if/when a crisis arises, the supervisee is already informed about what steps to take.

- Intimate Partner Violence- A significant percentage of female clients arrive at treatment still involved in one or more relationships with partners who have attempted to kill them, or who have threatened to do so .
  - Safety planning and legal action in the face of ongoing threats of violence are skills which must periodically be urgently addressed in clinical supervision with this treatment population.

- Post-partum psychosis- a rare but extremely serious condition which the clinical supervisor must remain alert to and must educate their supervisee about.
  - Screening and safety planning to address this condition are skills which must be taught to the supervisee prior to the birth of a client's child. Emergency commitment procedures should be reviewed ahead of time, and the supervisor should express their willingness to accompany the supervisee through the process if needed.

- Pre-eclampsia-a dangerous medical condition which can arise suddenly during pregnancy, and must be addressed on an emergency basis. Common symptoms which a SUD counselor could potentially notice could include: high blood pressure, severe headaches, vision problems (blurring, seeing flashing lights), pain just below the ribs, vomiting, and sudden swelling of the feet, ankles, face, and hands.
  - Clinical supervisors of newer clinicians working with this treatment population should review this information with them ahead of time, so the clinician will be prepared to act if they observe these symptoms in their client.

A significant percentage of female clients arrive at treatment still involved in one or more relationships with partners who have attempted to kill them, or who have threatened to do so .

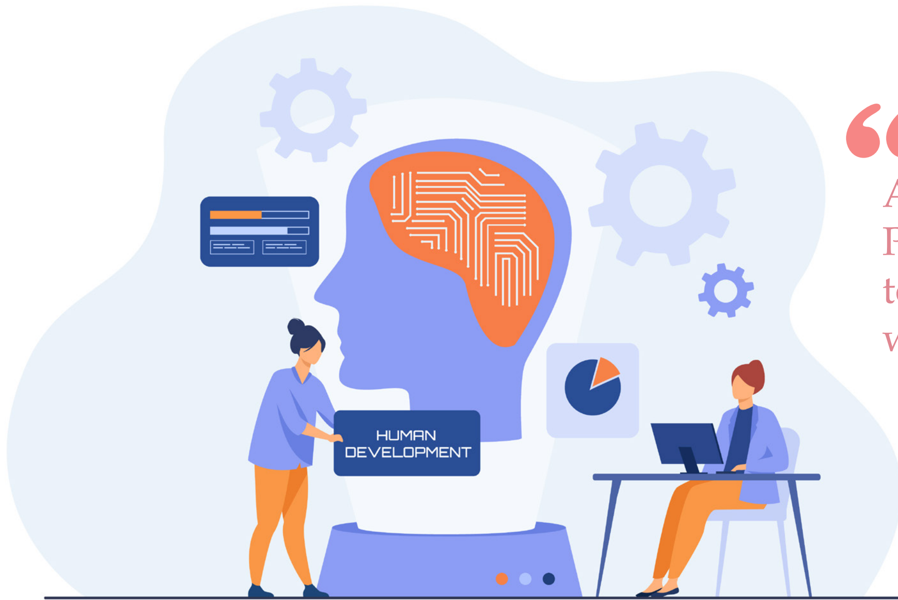
In Addition To Addressing Special Clinical Needs Of Women With Suds, Clinical Supervision Serves To Help Supervisees To Avoid Burn-Out And Develop Professionally:

- Identify and work through countertransference issues
  - 'Countertransference' refers to emotions, beliefs, and ideas that a counselor or case manager 'transfers' onto a client.
  - Countertransference is usually unconscious.
  - Signs of countertransference include: excessive self-disclosure on the part of the counselor; feeling powerful emotions (positive or negative) about the client; and failing to maintain healthy boundaries with the client.
- Reinforce professional standards of self-care and time away from clinical duties, which helps to identify and prevent burnout.
- Develop professional goals and take steps to achieve them.

A competent clinical supervisor will help their supervisee learn how to recognize and address genuine emergencies when they arise.

TIP SHEET #3: Clinical Supervision and Attachment Theory

EFFECTIVE SUPERVISORS TEACH SUPERVISEES ABOUT THEORIES OF HUMAN DEVELOPMENT



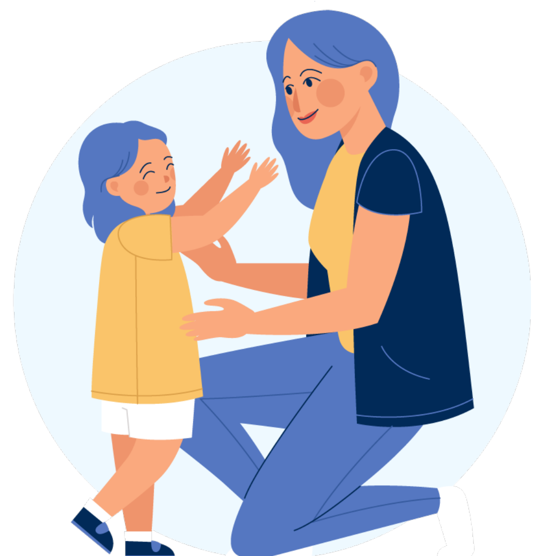
> "Attachment Theory has Practical Applications to Treatment of Women with SUD"

WHAT IS ATTACHMENT THEORY?

- Attachment Theory, originally developed by John Bowlby and further elucidated by Mary Ainsworth, is founded on the idea that "secure attachment" results from the parent or caregiver functioning as a secure base from which the child can explore the world, and to which the child can return for comfort and support.

WHAT ARE THE FOUR ATTACHMENT STYLES BETWEEN MOTHER/CAREGIVER AND CHILD?

- ***Secure:*** caregiver is reliable and will respond when the child needs comfort and reassurance
- ***Anxious:*** caregiver is not reliable, and will not consistently provide reassurance and comfort
- ***Avoidant:*** caregiver is 'reliably unreliable', child avoids contact, shows no separation distress
- ***Disorganized:*** caregiver's behavior is pathologically disorganized and frightening; child is confused, forced to rely on someone they are afraid of, resulting in contradictory behaviors



ATTACHMENT STYLES PERSIST INTO ADULTHOOD AND INFLUENCE RELATIONSHIPS AND LIVES

- ***Secure:*** Adults tend to be direct, self-assured, and responsive to others
- ***Anxious:*** Adults tend to be self-doubting, worried, preoccupied with connections to others
- ***Avoidant:*** Adults tend to be self-reliant and distant
- ***Disorganized:*** Adults tend to be self-sabotaging, isolating, and unpredictable

ATTACHMENT STYLES AND SUBSTANCE USE:

Anxious, avoidant, and disorganized attachment styles correlate with later substance use

REMEMBER:
CLINICAL SUPERVISION IS NOT THERAPY

- Clinical supervision is not--and should never become—therapy, but a supervisor can provide a 'corrective emotional experience' which refers to healing moments in therapy which disprove negative beliefs about oneself formed by traumatic events.
- When a clinical supervisee experiences acceptance, appreciation, reliability, and stability from their supervisor, it may represent one of the first times this has occurred outside of a therapist's office---and can help the supervisee to become a more effective therapist.

WHAT DOES ATTACHMENT THEORY HAVE TO DO WITH CLINICAL SUPERVISION ?

Just as healthy mother-child attachments are grounded in mothers creating a safe and secure base, a healthy relationship between supervisior and supervisee requires the clinical supervisor to create a safe environment on which the supervisee can depend

A "safe environment" for high quality supervision is characterized by:

- ✓ a regular appointment which the supervisee can depend on
- ✓ a suitable, familiar, confidential location in which to meet
- ✓ a nonjudgmental approach on the part of the supervisor
- ✓ a space in which the supervisee can express their thoughts and feelings without condemnation

A supervisee needs to depend on a safe environment in which they feel free to express their thoughts and feelings without judgment.

TIP SHEET #4: Developmental Approach to Clinical Supervision

The Interpersonal Development Model of Clinical Supervision is the understanding that: *Supervisees progress through predictable stages as they learn, have new experiences, and expand their skills.*

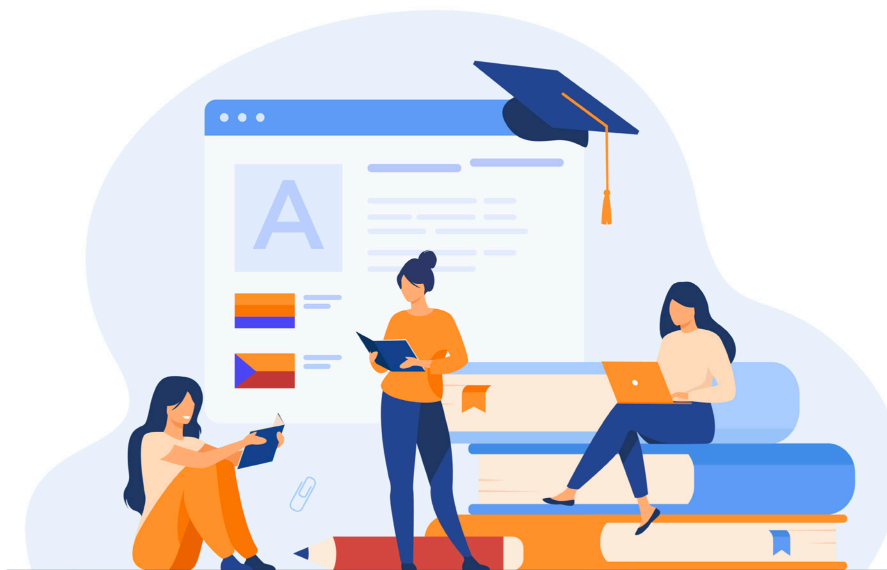
IT IS USEFUL FOR CLINICAL SUPERVISORS:

- ✓ To understand the normal developmental processes most supervisees experience
- ✓ To recognize that supervisees change as they develop knowledge, competence, and skills

SUPERVISEES WILL TYPICALLY PROGRESS THROUGH THE FOLLOWING STAGES:

Level 1: Supervisor is TEACHER; Supervisee is DEPENDENT and in need of structure
Level 2: Supervisor is COACH, Supervisee experiences INTERNAL CONFLICT between their dependency and their desire for autonomy
Level 3: SUPERVISOR is CONSULTANT, Supervisee is more STABLE in their professional development.

Supervisees progress through predictable stages as they learn, have new experiences, and expand their skills



It is useful for clinical supervisors to understand the three normal developmental processes most supervisees experience.

To support supervisees at Level-1, it is recommended that clinical supervisors:

a. Establish (and keep) a regular weekly supervision appointment.

b. Make themselves readily available to their supervisee outside of supervision appointments.

c. Thoroughly review all clinical cases with their supervisee.

d. Carefully discuss the ethics of clinical practice, including concerns such as confidentiality, boundary issues, and the client's right to self-determination. Formally review relevant codes of ethics.

e. Carefully discuss the supervisee's legal responsibilities related to clinical practice. For example, in the United States common legal concerns include the duty to warn standard and involuntary commitment procedures. Provide detailed, practical information about how the supervisee can best ensure they are following all relevant laws.

f. Provide the supervisee with detailed information about local, state, and federal resources relevant to their clinical work. Set an expectation that the supervisee will become familiar with the resources, and with the process of identifying new resources when needed.

g. Engage the supervisee in discussions about their work/life balance with the goal of advising the supervisee about time management and carrying a full but realistic workload.

h. Engage the supervisee in discussions about differential diagnoses and best practices for effective interventions with their clients.

i. Engage the supervisee in discussions about countertransference issues and their potential impact on clinical practice.

j. Encourage the supervisee to pursue continuing education, and make recommendations for appropriate trainings as needed.

At level 1 of the process, clinical supervisors should thoroughly review all clinical cases with their supervisee.

To support supervisees at Level-2, it is recommended that clinical supervisors:

a. Continue to keep a regular weekly supervision appointment.

b. Continue to make themselves available outside of supervision appointments.

c. Continue to review all clinical cases with their supervisee. At this point in the supervisee's development, the supervisor should be asking more questions about what the supervisee thinks regarding their cases. What is their case formulation for each person served? What are their diagnostic impressions? How, specifically, do they feel they can best serve the client?

d. Continue to discuss the ethics of clinical practice. Ask the supervisee questions about ethical dilemmas they may encounter during their practice. Ask them to consult their code of ethics and discuss the best way forward with the supervisee.

e. Continue to discuss legal responsibilities related to clinical practice. Ask questions

to check on supervisee's knowledge and comprehension of laws pertaining to their work. Ensure the supervisee has independent sources of information they can consult to check their understanding. Examples might include the privacy office in a university setting, or the compliance hotline for a given state benefit program.

f. Ask the supervisee questions about resources which may be helpful to their clients. Continue to serve as a source of additional information about relevant resources.

g. Continue to check in with the supervisee about their work/life balance. Ask for their ideas about how best to balance competing demands. Offer suggestions as needed.

h. Ask the supervisee for their thoughts on differential diagnoses for their clients. Ask for their thoughts on best practices to assist their clients. Continue to offer alternative suggestions and perspectives as needed.

i. Ask the supervisee what they are noticing about countertransference reactions they may be experiencing. Establish an expectation that the supervisee will continue to evaluate these issues throughout their clinical career.

j. Continue to encourage continuing education. Ask the supervisee questions about what aspects of clinical practice they are interested in learning more about.

▶ To support supervisees at Level-3, it is recommended that clinical supervisors:

a. Continue to keep a regular weekly supervision appointment. At this stage of the supervisee's development, it is appropriate to offer group clinical supervision if the supervisee is interested in this modality, and if the supervisor has multiple supervisees. Supervision should not occur solely in a group setting. Continue to offer regular individual appointments.

b. Continue to make themselves available outside of regular supervision appointments. At this stage in the supervisee's development, however, the expectation should be that the supervisee now has the skills and knowledge to manage most clinical situations that arise. The supervisor should always be available for consultation, however.

c. Continue to inquire about the supervisee's clinical cases. At this stage of the supervisee's development, it is appropriate to ask questions about which cases the supervisee is having the most difficulty with and would like consultation on.

d. Continue to discuss ethical dilemmas as they arise. The supervisor should now be serving as an experienced person the supervisee can bounce concerns and ideas off of.

e. Continue to discuss legal responsibilities as they arise. Again, the supervisor's role at this point in the supervisee's development is to serve as a resource and a consultant as needed.

f. At this stage of the supervisee's development, they should display a firm grasp of available resources to assist their clients. The supervisor should continue to serve as a consultant as needed.

g. The supervisor should continue to check on their supervisee's state of mind and overall work/life balance. It is common for longer-range career questions to arise during this stage. The supervisor should provide encouragement to the supervisee as they consider their career goals.

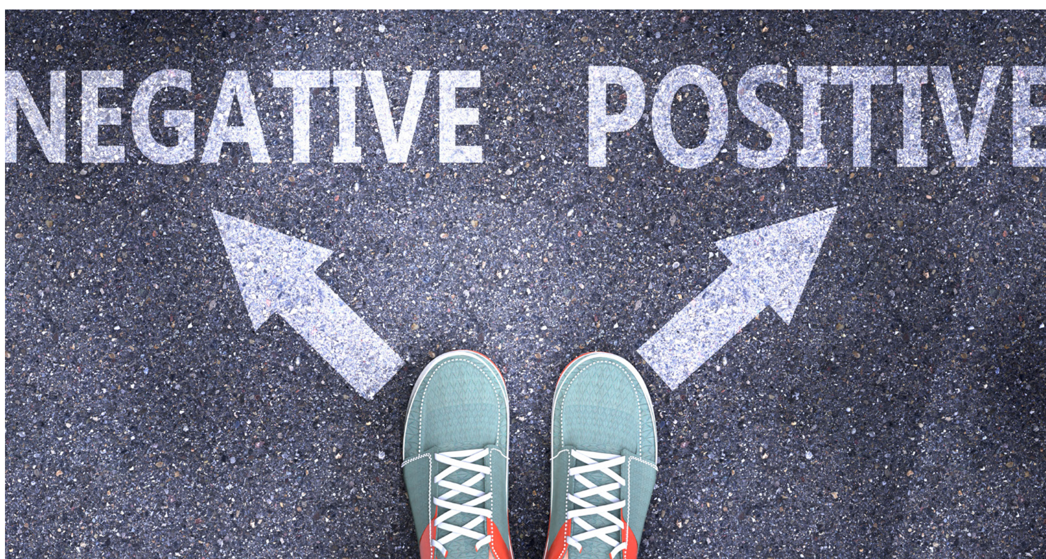
h. At this point in the supervisee's development, they should display a thorough grasp of differential diagnoses

and best practices to assist their clients. The supervisor should continue to play a consultant role.

i. At this stage of the supervisee's development, it is expected that they will bring up countertransference reactions with their supervisor as needed. The supervisor should continue to explore these issues if they notice the supervisee exhibiting strong emotional reactions to clinical situations.

j. Continue to encourage continuing education. At this stage it is appropriate for the clinical supervisor to ask the supervisee what area of clinical practice most appeals to them, and what additional education they may require to pursue it.

TIP SHEET #5: Clinical Supervision and Boundaries



Practicing healthy boundaries begins with being aware of making positive and negative choices.

UNDERSTANDING AND EMPLOYING APPROPRIATE BOUNDARIES ARE KEY PROFESSIONAL SKILLS FOR ALL SUBSTANCE USE DISORDER COUNSELORS.

- Talented clinicians who lack appropriate boundaries are apt to run into significant professional difficulties, and may be at risk for job loss and license suspension.
- Understanding and maintaining appropriate boundaries helps clinicians to reduce job stress, manage countertransference reactions, and better maintain work/life balance.

Understanding and maintaining appropriate boundaries helps clinicians to reduce job stress, manage countertransference reactions, and better maintain work/life balance.

KEY BOUNDARY TOPICS:

a. Clinician's role: Dual relationships, conflicts of interest, and the resulting risks for exploitation, harm, or simply the appearance of any of these should be discussed.

b. Time of day that treatment occurs- The time of day that services are delivered should be reviewed and discussed. Supervisees should be discouraged from devoting excessive amounts of time to some clients over others.

c. Length of time a practitioner spends with any one client- The time of day that services are delivered should be reviewed and discussed. Supervisees should be discouraged from devoting excessive amounts of time to some clients over others.

d. Place/location of treatment - Appropriate and inappropriate locations for the delivery of services should be explicitly discussed.

e. Money/payment for treatment- The way in which clients are expected to pay for services should be carefully reviewed. In the United States, for example, it is not legal to require individuals who receive Medicaid to pay additional fees for services rendered. If a supervisee is billing private insurance or accepting cash/check/credit card payments, the supervisor should review their billing policies and practices to establish a norm of equitable treatment for all clients of the same means. If supervisees wish to provide pro bono services, supervisors can recommend the establishment of fixed pro bono slots in their treatment calendar.

f. Gifts- Supervisors should discuss the giving and receiving of gifts as a boundary concern. It is common for grateful clients to want to give a gift to a counselor. The supervisor should prepare their supervisee for such a situation by discussing it ahead of time and reviewing appropriate ways of responding. Additionally, substance use counselors may feel a strong urge to give a gift to a client from time to time, especially if the client is struggling financially. Again, the supervisor should discuss this possibility ahead of time with the supervisee, and should discuss appropriate ways of securing needed resources.

g. Services- Supervisors should discuss the subject of services as a boundary concern. It is common for grateful clients to offer to perform a service for a counselor. Examples might include offering to work on a counselor's car; offering to clean their house; and offering to prepare meals. Supervisors should discuss appropriate responses to such offers ahead of time, before they take place. If a substance abuse counselor feels a desire to provide a service to a client, this should also be discussed as a boundary concern. New clinicians should be directed to treat all clients in the same manner, and to avoid providing a service to one client they are not willing to provide to all clients. The question of professional role arises again in this situation: supervisees should be encouraged to remain clear about their professional role and its inherent limitations.

h. Clothing- Clothing/attire is an important boundary topic. Supervisors should review their organization's dress code with supervisees, and should encourage professional dress standards at all times during the provision of professional services. An exception might be made for situations in which a supervisee is performing physical labor on behalf of their client (helping them to move, for example). In these cases, the supervisee should ensure their dress is neat, clean, and lacks any statements of personal or political belief.

i. Language- Language should be discussed as a boundary concern.

Supervisors should recommend to their supervisees that profanity, overly familiar greetings, edgy or provocative jokes, and nicknames should be avoided in professional settings.

j. **Self-disclosure-** Self-disclosure can quickly become a boundary concern in clinical practice. Supervisors should encourage supervisees to be wary of any sudden, powerful impulse to share a part of their personal history with their clients. It is likely that these impulses are more about the clinician's emotional needs than the client's needs. Supervisors should encourage supervisees to "sleep on" these impulses and discuss them with their supervisor before proceeding. If a supervisee does decide to share a piece of personal information with a client, the self-disclosure should be brief, related to a subject they have resolved, and should have a specific purpose within the framework of the counseling session. Supervisors should also guide supervisees to exercise caution in online self-disclosure. Supervisors should remind supervisees that their clients and employers are likely to seek information about them on the web, and should ask them to consider what image they wish to present in this medium.

k. **Physical contact-** Physical contact is an essential boundary topic, and must be explicitly discussed with supervisees. Intimate, face-to-face hugs are to be discouraged, as is any excessive use of touch. Supervisors should ask their supervisee to consider: what is the purpose of this physical contact? Am I doing this for my client or for myself? Is there a clear therapeutic purpose for this contact?

BOUNDARY CROSSINGS VERSUS BOUNDARY VIOLATIONS

Supervisors should help supervisees distinguish between boundary crossings and boundary violations.

- **Boundary crossing:** occurs when a clinician takes an action which is "out of the box" for the purpose of fostering the therapeutic alliance with the client. Examples might include handing a crying client a tissue; helping a client who has fallen to stand up; or giving a client a ride to safety during a storm.
- **Boundary violation:** occurs when a clinician intrudes on a client in a seductive, coercive, or destructive way. Examples might include asking a client's relative out on a date; asking a client to keep a secret for you; or crying and confiding in your client about your recent divorce.

Employing appropriate boundaries are bedrock professional skills for all substance use disorder counselors and over time can become good habits.

TIP SHEET #6: Effective Behaviors for Clinical Supervisors

Knowledge Can Only Take a Clinical Supervisor so far. Ultimately it is the behaviors of a clinical supervisor that count.

TWENTY-SIX BEHAVIORS FOR CLINICAL SUPERVISORS TO AIM FOR:

- ✓ Clarifies expectations and style of clinical supervision
- ✓ Maintains consistent and appropriate boundaries
- ✓ Is knowledgeable about relevant theories and current research
- ✓ Teaches practical skills
- ✓ Teaches case conceptualization
- ✓ Provides frequent, scheduled supervision
- ✓ Is accessible and available
- ✓ Encourages the exploration of new ideas and techniques
- ✓ Fosters autonomy
- ✓ Models appropriate ethical behaviors and counseling skills
- ✓ Has a personalized therapeutic style
- ✓ Is personally and professionally mature
- ✓ Perceives growth as an ongoing process
- ✓ Assesses the learning needs of the supervisee
- ✓ Provides constructive criticism and positive reinforcement
- ✓ Invests in the supervisee's development
- ✓ Cares about the well-being of others
- ✓ Has the ability to be present and immediate
- ✓ Has an awareness of personal power
- ✓ Has the courage to expose vulnerabilities, make mistakes, and take risks
- ✓ Is non-authoritarian and non-threatening
- ✓ Accepts and celebrates diversity
- ✓ Has the ability to communicate effectively
- ✓ Is aware of and accepts own limitations and strengths
- ✓ Is willing to negotiate
- ✓ Works collaboratively

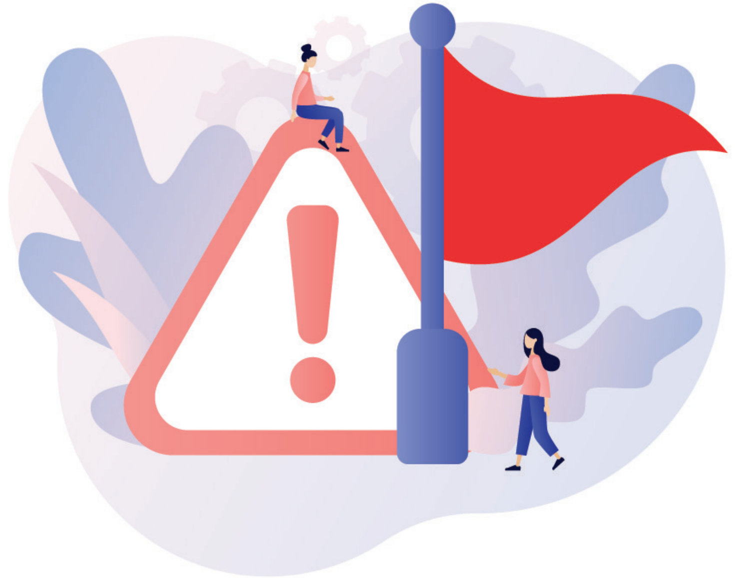
Clinical knowledge is important, but ultimately it is the behaviors of a clinical supervisor that count.

TIP SHEET #7: WHEN IT'S NOT WORKING: Clinical Supervision Red Flags

OCCASIONALLY, CLINICAL SUPERVISION WILL NOT BE SUCCESSFUL.

This can happen when:

- a clinical supervisor is unable to fulfill the basic functions of their role;
- a supervisee is unable to participate usefully in the process of supervision; or
- external circumstances prevent one or both parties from engaging.



There are 'red flags,' some more common than others, which may alert either the supervisor or the supervisee that all is not well with a specific clinical supervision process or relationship.

RED FLAGS FOR SUPERVISEES TO WATCH OUT FOR:

- **Supervisors who fail to keep supervision appointments.**

An occasional missed appointment due to a personal or clinical crisis is understandable and expected, but a chronic pattern of cancellations and/or no-shows for supervision appointments suggests that the supervisor is not prioritizing this responsibility. When a supervisor fails to reliably appear for supervision, it may leave the supervisee feeling lost, vulnerable, and unsure of what steps to take to provide appropriate care to his/her clients. A related concern is when supervisors are chronically unreachable by phone or email.

- **Supervisors who show up for supervision, but who fail to provide concrete, meaningful assistance with the issues and concerns the supervisee raises for discussion.**

For example, a new supervisee raises a concern about a client describing passive suicidal ideation, and the supervisor keeps turning the issue back to the new counselor, asking them: "What do YOU think you should do?" When a supervisor fails to support the supervisee emotionally and practically in difficult situations, it can leave the supervisee feeling scared and vulnerable.

- **Supervisors who use the supervision appointment to talk about themselves.**

While some limited self-disclosure on the part of supervisors can be humanizing and useful for supervisees, excessive discussion of the supervisor's concerns and interests represents a misuse of the supervisee's time and emotional energy. An example of appropriate supervisor self-disclosure might be sharing a short story about their job search after finishing graduate school, if their supervisee is expressing concern about this process for themselves. Examples of inappropriate supervisor self-disclosure include a supervisor who spends 20 minutes or more providing a monologue about his/her most recent professional

achievements; or a supervisor who spends half the supervision appointment discussing his/her recent divorce.

- **Supervisors who complain or gossip about other staff members, supervisees, or clients during the supervision appointment.**

It is one thing to appropriately inform supervisees about relevant issues affecting their work, and it is another to engage in ad hominem attacks, complaints, and slander. This is unprofessional behavior which suggests the supervisor is not ready for the responsibility of their role.

- **Supervisors who micromanage their supervisees.**

All new supervisees require a period of close oversight and monitoring, but as supervisees increase their skills supervisors can best respond by providing the supervisee with opportunities for independent action, with the supervisor always available for consultation as needed. Requiring a supervisee to check in about every detail in every case can become exhausting and demoralizing to the new counselor.

- **A supervisor who asks a supervisee out on a date, makes a 'pass' at them, or otherwise communicates their wish for a private relationship with the supervisee is committing a serious ethical violation.**

This behavior represents a serious ethical violation and a disturbing breach of trust, and should be brought to the attention of the supervisor's employer immediately. The same observation holds true for supervisors who ask members of a supervisee's family out on a date.

- **When a supervisor asks a supervisee for a loan or otherwise attempts to use their position of authority for financial profit or gain.**

This is a serious ethical breach. This behavior must be brought to the attention of the supervisor's employer immediately.

- **Supervisors who appear to be under the influence of drugs or alcohol during the supervision appointment.**

This behavior is highly concerning, and should immediately be brought to the attention of the supervisor's employer.

- **Supervisors who shout, scream, throw objects, or otherwise engage in intimidation tactics are committing a serious ethical violation.**

These behaviors must be brought to the attention of the supervisor's employer immediately.

- **Supervisors who exhibit a condescending, dismissive attitude towards their supervisee may not be behaving in a strictly unethical manner, but they are likely to be hurting their supervisee's feelings and putting that person on the defensive.**

When supervisees become reluctant to share information with their supervisors due to a fear of being judged or criticized, it is difficult for the supervisee to benefit from supervision, and client care may suffer as a result.

- **Supervisors who are experiencing serious physical or mental illness, including acute grief, which prevents them from being able to fulfill their role as a supervisor.**

In these situations, a clinical supervisor should ideally self-identify as being unable to continue, and should direct their supervisee to a well colleague for support and guidance.

FOR SUPERVISEES TO KEEP IN MIND:

- **Supervisors who exhibit a lack of professional competence should not be supervising newer practitioners.**

A lack of professional competence might include: the inability to assist a supervisee to make a differential diagnosis; becoming personally overwhelmed with the emotions of a case to the point where they cannot function; demonstrating an inability to navigate the cultural nuances of a case; struggling to explain fundamental concepts related to addiction counseling; being unable to locate/identify needed resources; failing to discuss countertransference issues; or struggling to provide guidance when the supervisee is managing a clinical case involving lethality. Supervisors are not expected to know all things, but they should have arrived at a stage of fundamental competence in their field prior to being asked to guide others.

- **To address a supervisee's concerns about a supervisor:**

This can be difficult because of the power difference between most supervisors and supervisees. Depending on the nature of the concern, and if the supervisee feels able, they may want to speak with their supervisor directly. If this is not effective, and/or if the issue is too serious for this approach, the supervisee should approach a trusted person in the upper management of the organization where their supervisor works for support and guidance. If the supervisee is a student, they should also approach a trusted staff or faculty member at the school for support and guidance.

RED FLAGS FOR SUPERVISORS TO WATCH OUT FOR:

- **Supervisees who fail to keep supervision appointments, and/or who show up unprepared for the appointments.**

Examples of being unprepared might include: not being able to discuss the relevant details of a clinical case; chronically struggling to focus on work-related content; and otherwise presenting as seriously disorganized.

- **Supervisees who present as chronically hostile and combative.**

While it is natural for supervisees to occasionally challenge supervisors, especially as they learn and develop their skills, it is not appropriate for supervisees to display a perpetually hostile manner in the absence of poor treatment from the supervisor. Continuous hostility is suggestive of unresolved countertransference issues, possible mental illness, or a poor fit between the individual and the counseling field.

- **Supervisees who present as chronically distressed and seriously unhappy.**

While it is natural for supervisees to occasionally cry during clinical supervision, especially as they confront the realities of clinical cases and work through countertransference issues, persistent tearfulness, sadness, and hopelessness is suggestive of a possible mental illness, or a poor fit between the individual and the counseling field. Similarly, supervisees who chronically dissociate during clinical supervision, clinical meetings, and clinical practice may not be emotionally ready to manage the stress of clinical work.

- **Supervisees who speak disparagingly of clients or breach their confidentiality.**

Supervisees who speak unkindly about a client or break their confidentiality may simply need prompt redirection. But supervisees who continue to speak unkindly and condescendingly about their clients, or who continue to break their confidentiality, are displaying a concerning lack of empathy, and may not be a good fit for the field. Supervisees who make bigoted remarks about clients or staff members must be confronted immediately.

- **Supervisees who ignore their supervisor's direction and advice are displaying a concerning lack of respect for their supervisor's judgment and experience.**

It is natural for supervisees to feel frustrated at times as they progress through the process of supervision, but to willfully ignore direct guidance represents risky behavior which may negatively impact the wellbeing of clients.

- **Supervisees who appear to be under the influence of drugs or alcohol during the supervision appointment.**

This behavior is highly concerning, and should immediately be brought to the attention of both parties' employer.

- **Any supervisee who asks a client out on a date, makes a 'pass' at them, or otherwise communicates their wish for a private relationship with the client is committing a serious ethical violation.**

This behavior represents a disturbing breach of trust, and should be brought to the attention of the supervisee's employer immediately. The same observation holds true for supervisees who ask members of a client's family out on a date.

- **Any supervisee who asks a client for a loan or otherwise attempts to use their position of authority for financial profit or gain is committing a serious ethical breach.**

This behavior must be brought to the attention of the supervisee's employer immediately.

- **Supervisees who fail to establish increased independence from their supervisor as formal supervision is nearing its end.**

This may indicate that the supervisee is struggling to assume the professional responsibilities of their role.

- **Supervisees who impose their personal religious and/or political views on clients require immediate redirection and education about the harm which can be caused by these behaviors.**

Supervisees who express their inability to stop speaking to their clients about religious matters may need to be redirected to consider pastoral counseling as a career path.

- **Supervisees who chronically struggle with time management.**

This indicates that the supervisee may need additional support and guidance, especially if their clinical service notes are submitted late.

FOR SUPERVISORS TO KEEP IN MIND:

- **External circumstances which may make clinical supervision difficult include:**

An excessive workload resulting in insufficient time for supervision in the supervisor's or the supervisee's schedule

A lack of a confidential, quiet space in which to hold clinical supervision

Chronic interruptions, such as an expectation that the supervisor or supervisee remain available for crisis intervention during clinical supervision

An organizational culture which does not value clinical supervision. The supervisor or supervisee may receive subtle or overt messages that the activity of clinical supervision is not considered important or worthwhile.

- **To address unfavorable external circumstances:**

The clinical supervisor should take responsibility for discussing the concerns with upper management at their organization. If their supervisee is a student, the supervisor may also want to reach out to the school for help and support in problem-solving.

- **To address a supervisor's concerns about a supervisee:**

the supervisor should first raise the issues directly with the supervisee. If no improvement or insufficient improvement is seen, the supervisor should then speak with a representative of the supervisee's school (if the supervisee is a student). If the supervisee is a fellow staff member, the supervisor should speak with his/her own supervisor for assistance in thinking through how to best support the supervisee, protect clients, and move forward.

TIP SHEET #8: WHEN IT IS WORKING: What Does a Positive Supervisor-Supervisee Relationship Feel and Look Like?

When clinical supervision is working well, you don't have to guess. You can see and feel it!

COMMON OBSERVABLE SIGNS FOR A POSITIVE SUPERVISOR-SUPERVISEE RELATIONSHIP:

1. **Supervision is occurring reliably and regularly.** Both the supervisor and the supervisee keep all supervision appointments unless there is a vacation, illness, or crisis. If supervision must be cancelled, it is quickly rescheduled, ideally for the same week.

2. **Supervisees express a sense of excitement about what they are learning,** and about the new skills they are putting into practice in clinical sessions.

3. **Supervisees express a sense of being challenged but not overwhelmed** by their workload.

4. **Supervisees increase their ability to discuss clinical cases in a meaningful way,** incorporating the new knowledge they are acquiring.

5. **Supervisees demonstrate an increasing ability** to make accurate clinical diagnoses.

6. **Supervisees demonstrate an increasing ability to use relevant professional rating scales,** such as the ASAM scoring tool.

7. **Supervisees begin to raise the subject of their professional future,** and supervisors encourage this exploration and offer support and guidance as needed.

8. **Supervisees begin to prepare for any relevant licensing/credentialing exams** they will take. Supervisors encourage this study and offer support and encouragement as needed.

9. **Supervisees seek out continuing education.** Supervisors support and encourage this activity.

10. **Supervisees begin to discuss countertransference reactions spontaneously** in supervision appointments. Supervisors support the supervisee in this endeavor and provide a safe environment in which this processing can occur.

11. **Supervisees engage in discussions about ethical dilemmas with sensitivity** and awareness of their professional responsibilities.

12. **Supervisees display increasing cultural competence** and actively seek out information to continue expanding their awareness and understanding of different cultural groups.

13. **Supervisees express fundamental enjoyment of their clinical work** and show respect and appreciation for the clients they are serving.

14. **Supervisees express confidence about managing crisis situations,** including those involving lethality.

15. **Supervisees demonstrate an awareness of relevant clinical and practical resources** which can benefit their clients.

16. **Supervisees and supervisors take vacations and shorter breaks** away from clinical responsibilities.

17. **The supervisee feels confident they can reach their clinical supervisor in a crisis.** If the supervisor is away on vacation or out sick, they have designated a back-up.

18. **The supervisee feels an increasing sense of overall confidence in their clinical abilities,** and demonstrates an increasing appetite for independent work.

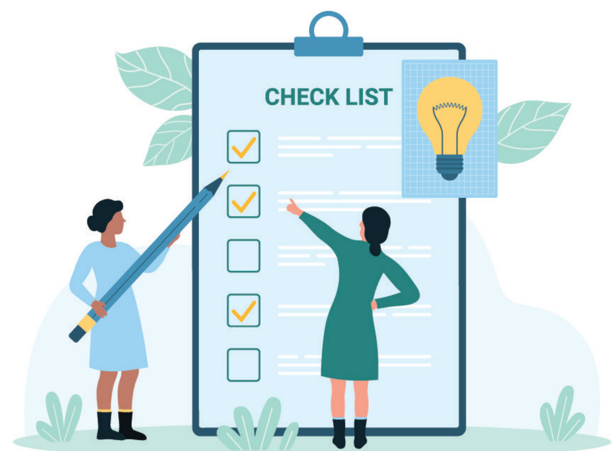
19. **The supervisee feels able to confront their supervisor about any concerns or questions** they have. The supervisor models non-defensiveness in the face of an appropriate confrontation.

20. **The supervisee understands the chain of command at their organization** in the event they ever need to speak to someone in management about their supervisor.

21. **The supervisee feels comfortable and emotionally safe in the presence of their supervisor.** They feel the supervisor will respect their privacy and confidentiality whenever possible.

22. **The supervisee judges their supervisor to be knowledgeable, clinically competent, and capable** of effectively guiding them.

23. **Professional trust develops over time between the supervisor and the supervisee.** The supervisor feels increasingly comfortable allowing the supervisee to engage in more independent activities, and the supervisee feels increasingly assured that the supervisor will be there to actively support them as needed.



When Clinical Supervision is Going Smoothly, Things Fall into Place.

CONCLUSION

This tool kit is meant to support the momentum in the substance use disorder treatment field that is increasingly recognizing the value of clinical supervision as a quality standard in the delivery of services.

Clinical supervisors and their supervisees who are serving women with substance use disorders in regions around the world are in special need of support to achieve and maintain this quality standard.

While clinical supervision is often not included in the budgets of many SUD treatment programs serving women, we hope this evidence-based, hands-on tool kit will be a stride forward in effectively addressing a treatment population with special clinical needs that require competent clinical supervision.

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ACKNOWLEDGEMENTS

- **Senga Carroll, LCSW**
  Senior Clinical and Policy Advisor, UNC Horizons Program
  Clinical Assistant Professor
  Department of Obstetrics and Gynecology
  School of Medicine, The University of North Carolina at Chapel Hill
  Chapel Hill, NC 27516

- **Nancy W. Dudley, M.S.**
  President
  Resilient Soul Services, Inc.
  11 Leland Court
  Chevy Chase, Maryland 20815

- **Hendrée E. Jones, Ph.D.,**
  Executive & Division Director, UNC Horizons
  Professor, Department of Obstetrics and Gynecology
  School of Medicine, The University of North Carolina at Chapel Hill
  Chapel Hill, North Carolina 27516

- **Suresh Perera**
  Graphic Designer - Drug Advisory Programme
  The Colombo Plan Secretariat
  5th Floor, M2M Veranda Office, No. 34, W.A.D. Ramanayake Mawatha,
  Colombo 02, Sri Lanka