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The "How To" Manual For Clinical Supervision in IDAHO

Authorized by the

Division of Behavioral Health Substance Use Disorders Program

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1. REQUIREMENTS FOR CLINICAL SUPERVISION IN THE STATE OF IDAHO

As defined in IDAPA 16.07.20, Clinical Supervision centers on clinician knowledge, skills and attitudes and includes: evaluation of competencies, observation of skills, mentoring, planning and monitoring the work of another clinical staff person by a qualified Clinical Supervisor. (7-1-13)

Clinical supervision, like administrative supervision, implies that the supervisor holds a position of authority over the supervisee. The relationship between clinical supervisor and supervisee is contained in the organizational description of the provider agency, or must be described in writing via a contract or MOU between a provider agency and a DHW approved clinical supervisor. Peer to peer clinical supervision will not be approved. (4-6-11)

Clinical Supervision includes assuring the quality of treatment, creating a positive work environment and developing staff clinical skills.

Each provider of services through contracts with Idaho Department of Health and Welfare, Substance Abuse Program will use the NFATTC model of clinical supervision. The monitoring of clinical supervision is the responsibility under contract with the Management Services Contractor (MSC).

<u>Details of Clinical Supervision:</u>

> Quality of Clinical Supervision and the intensity thereof; is confirmed by the frequency, content and supervisor's time commitment, as based on the counselor's need. Counselor need is determined by the clinical supervisor's review and assessment of counselor's education, experience, licensure/certification, and direct observations of and/or discussions with counselor regarding counselor's clinical skills. Clinical supervision will be 1 hour per month per counselor, unless otherwise specified in Chapter 14. Acceptable activities for clinical supervision include individual tutoring/mentoring, group tutoring/mentoring, individual observation, group observation, professional development plan creation and review. The hour(s) of clinical supervision per month may be broken into shorter time frames during each month, however, may not be comprised solely of one type of activity, rather supervision must be a combination of observation and mentoring/tutoring/professional development plan review.

IDAPA 16.07.20 Section 217 – Effective July 1, 2013
REQUIREMENTS FOR CLINICAL SUPERVISION IN THE STATE OF IDAHO

217. CLINICAL SUPERVISION.

The alcohol and substance use disorders treatment program must provide for supervision of all clinical activities by qualified substance use disorders professionals including: (5-1-10)

01. Inventory of Treatments Written Plan. A written plan for an inventory of treatments providing and defining the procedure for the supervision of all clinical activities by qualified substance use disorders professionals; (5-1-10)

02. Specific Treatment Responsibilities. All members of the treatment team who have been assigned specific treatment responsibilities must be qualified by training or experience and demonstrated competence; (5-1-10)

03. Supervision by a Clinical Supervisor. All members of the treatment team must be supervised by a clinical supervisor as defined in Section 010 of these rules; (5-1-10)

04. Evaluation of Competencies. Clinical supervision must include a documented evaluation of the competencies of the members of the clinical staff, and a plan of activities which bring those competencies to proficiency. The evaluation will be conducted within one (1) month of initial hire and annually thereafter. Documentation of the evaluation and a record of improvement activities must be present in each Clinical Supervision record. The clinical supervision record must contain at a minimum: (5-1-10)

a. Demographic information including name, date of hire, credential, and position; (5-1-10)

b. Professional Development Plan(s) as defined in Section 012 of these rules; (7-1-13)

c. Observation documentation; (5-1-10)

d. Competency rating forms; (5-1-10)

e. Current resume; and (5-1-10)

f. Documentation of clinical supervision activities which include date of clinical supervision, type of clinical supervision activity, and length of time spent performing the clinical supervision activity. (5-1-10)

Counselors tend to respond positively when they receive compliments and positive feedback for their work. When the Clinical Supervisor makes observations or asks questions about specifics, the counselor learns to assess his/her own performance. It is important to reinforce the performance that represents excellence and know the method of presenting areas of concern in a manner in which criticism is minimized. Counselors seem to be self critical and often are aware of areas of challenge in the performance of their work. Allowing them to assess their performance, from a review of their work is valuable. (4-1-11)

2. QUALIFICATIONS FOR CLINICAL SUPERVISORS

In an effort to increase clarity between and among clinical staff qualifications as described in **IDAPA 16.07.20, Sections 216 & 218** are included in the section, in their entirety. Please note that a clinician must first meet the requirements as a Qualified Substance Use Disorders Professional as a prerequisite for qualifying as either a Treatment Supervisor or a Clinical Supervisor.

IDAPA 16.07.20 Section 216 and 218 – Effective July 1, 2013
QUALIFICATIONS FOR CLINICAL STAFF IN THE STATE OF IDAHO

216. SUPERVISORY STAFF QUALIFICATIONS.
Qualifications of the supervisory staff must be verified through written documentation of work experience, education, and classroom instruction. The supervisory staff must meet the requirements in Section 218 of these rules and the following requirements: (5-1-10)

01. Treatment Supervisor. The Treatment Supervisor must meet the requirements in Section 218 of this rule and meet one of the following: (7-1-13)

a. Equivalent of five (5) years full-time paid professional experience providing alcohol and substance use disorders treatment with at least two (2) of the five (5) years providing direct treatment in a state, federal, Joint Commission, or CARF-approved behavioral health services program. State approval includes other states that are approved, licensed, or certified to provide substance use disorders treatment services through their Single State Authority. This experience must be relevant for child and adolescent treatment if supervising treatment in a child and adolescent treatment program; or (7-1-13)

b. Bachelor's Degree in relevant field and four (4) years paid full-time professional experience with two (2) years in direct treatment in a state, federal, Joint Commission, or CARF-approved program. State approval includes other states that are approved, licensed, or certified to provide substance use disorders treatment services through their Single State Authority; or (5-1-10)

c. Master's Degree and three (3) years paid full-time professional experience with two (2) years in direct treatment in a state, federal, Joint

Commission, or CARF-approved program. State approval includes other states that are approved, licensed, or certified to provide substance use disorders treatment services through their Single State Authority. (7-1-13)

02. Clinical Supervisor. The Clinical Supervisor must meet the requirements in Section 218 of this rule and meet the following: (7-1-13)

a. Master's Degree from an accredited, approved, and recognized college or university in health and human services and the equivalent of four (4) years paid full-time professional experience with three (3) years providing direct substance use disorders treatment and one (1) year paid full-time supervision experience in a state, federal, Joint Commission, or CARF-approved behavioral health services program. State approval includes other states that are approved, licensed, or certified to provide substance use disorders treatment services through their Single State Authority or have a Clinical Supervisor designation from the Idaho Board of Occupational Licensure. This experience must be relevant for child and adolescent treatment if supervising treatment in child and adolescent treatment programs; or (7-1-13)

b. IBADCC Certified Clinical Supervisor; (5-1-10)

c. For outpatient programs providing services to children and adolescents, the clinical supervisor must have two (2) years of experience working with families or children in an alcohol and substance use disorders treatment services setting in a state, federal, Joint Commission, or CARF-approved program. State approval includes other states that are approved, licensed, or certified to provide substance use disorders treatment services through their Single State Authority. Working knowledge of child and adolescent growth and development, and the effects of alcohol and drugs on a child's growth and development. (5-1-10)

d. A clinical supervisor must have completed the Clinical Supervision training model as identified by the Department. The Clinical Supervision training must be completed within one hundred eighty (180) days of date of hire or date of designation as clinical supervisor. (5-1-10)

218. QUALIFIED SUBSTANCE USE DISORDERS PROFESSIONAL PERSONNEL REQUIRED. The alcohol and substance use disorders program must employ the number and variety of staff to provide the services and treatments offered by the program as a multidisciplinary team. The program must employ at least one (1) qualified substance use disorders professional for each facility. (5-1-10)

01. Qualified Substance Use Disorders Professional. A qualified substance use disorders professional includes the following: (5-1-10)

a. IBADCC Certified Alcohol/Drug Counselor; (5-1-10)

b. IBADCC Advanced Certified Alcohol/Drug Counselor; (5-1-10)

c. Northwest Indian Alcohol/Drug Specialist Certification - Counselor II or Counselor III; (5-1-10)

d. National Board for Certified Counselors (NBCC) - Master Addictions Counselor (MAC); (5-1-10)

e. "Licensed Clinical Social Worker" (LCSW) or a "Licensed Masters Social Worker" (LMSW) licensed under Title 54, Chapter 32, Idaho Code. (7-1-13)

f. "Marriage and Family Therapist," or "Associate Marriage and Family Therapist" licensed under Title 54, Chapter 34, Idaho Code. (7-1-13)

g. "Nurse Practitioner" licensed under Title 54, Chapter 14, Idaho Code. (7-1-13)

h "Clinical Nurse Specialist" licensed under Title 54, Chapter 14, Idaho Code. (7-1-13)

i "Physician Assistant" licensed under Title 54, Chapter 18, Idaho Code, and IDAPA 22.01.03, "Rules for the Licensure of Physician Assistants". (7-1-13)

j. "Licensed Professional Counselor" (LPC) or a "Licensed Clinical Professional Counselor" (LCPC) licensed under Title 54, Chapter 34, Idaho Code. (7-1-13)

k. "Psychologist," or a "Psychologist Extender" licensed under Title 54, Chapter 23, Idaho Code with a Certificate of Proficiency in the Treatment of Alcohol and Other Psychoactive Substance Use Disorders as issued by the College of Professional Psychology. (7-1-13)

l. "Physician" licensed under Title 54, Chapter 18, Idaho Code. (7-1-13)

m. "Professional Nurse" RN licensed under Title 54, Chapter 14, Idaho Code. (7-1-13)

02. Qualified Substance Use Disorders Professional Status Granted Prior to May 1, 2010. Subsections 218.01 and 218.02 of this section are applicable to all new applications for appointment as a Qualified Substance Use Disorders Professional submitted to the Department after May 1, 2010. If an individual was granted an appointment prior to May 1, 2010, and met the requirements at that time, he may continue to have his appointment recognized. (7-1-13)

3. THE NFATTC MODEL OF CLINICAL SUPERVISION

This model has been adopted State wide in Idaho as the model to be implemented by all provider agencies which provide clinical services on behalf of the State of Idaho through contracts with the Department of Health and Welfare, monitored by Business Psychology Associates (BPA).
Clinical Supervision as defined by this model includes:

1) **Observing counselors in their work**. Observation can be "in person", by video or audio for review by the clinical supervisor. Observations should be recorded on an Observation Sheet or Criteria Sheet.
2) **Creating the Professional Development Plan (PDP):** PDPs are created for each counselor based on needs indicated from the rubrics, rating forms and/or from clinical supervisor observation of the counselor's clinical skills.
3) **Teaching, training and mentoring.** These activities are needed to assist counselors to improve clinical performance. These activities may be 1:1, group supervision or training/mentoring provided by the clinical supervisor. These activities are reported on Clinical Supervision Progress Notes form.
4) **Individual Clinical Supervision Meetings**. Each counselor should have a regularly scheduled time for clinical supervision. While the amount of time needed on a weekly or monthly basis may vary depending on the experience and skill of each counselor, each should have clinical supervision on a scheduled basis. Supervision meetings are documented and a copy of the supervisor's summary of that meeting is provided to the counselor.
5) **Group Supervision/Training.** Group supervision is utilized when there is a common need among counselors which can be addressed in a group meeting. This is a time saving measure and can also be an opportunity for counselors to share information and learning.
6) **Reviewing and updating Professional Development Plans**: PDPs must be reviewed at least every three months at which time the plan will either be updated or continued with appropriate supportive documentation. Updating the plan will include selecting new goals with the counselor and agreeing on activities to achieve those goals.

Each of these activities is to be documented on the Clinical Supervision Progress Notes. PDPs are to be created with the counselor and reviewed/updated at least quarterly; more often as needed

4. IMPLEMENTATION STEPS

HOW TO BEGIN:

1) Distribute copies of the TAP 21 to all counselors.

2) Discuss clinical supervision with each counselor, define what it is and how it will work; provide group supervision.

3) Use the ORAL model of communication and begin relationship development with each counselor. **Appendix A**

4) Schedule individual clinical supervision appointments with each counselor based on need.

5) Complete the rating forms to assess performance and establish a base line to begin performance improvement. **Appendix B**

6) Observe the work of counselors and provide feedback. **Appendix C**

7) Develop a method of feedback that provides positive as well as constructive comments to improve performance.

8) Create a professional development plan. **Appendix D**

9) Teach, train and mentor.

10) Review progress; re-observe counselor performance

11) Update the Professional Development Plan, celebrate successful performance improvement.

5. RATING COUNSELOR PERFORMANCE

In this section reference will be made to:

1. Rating forms
2. Rubrics
3. Tap 21

In order to begin the process of assessing counselor performance it is necessary to establish a starting point or a base line. Rating forms and the rubrics can be used for an assessment of the counselor's skills in each of the competency areas in the TAP 21. To avoid complications with the Human Resources Department in the agency, performance ratings should be completed only in those areas indicated in the counselor's job description. Prior to any ratings, it may be necessary to review the job description to complete any needed updates for consistency. The assessment should focus on those areas indicated in the job description. The clinical supervisor may complete the rating forms if he/she is familiar with the work of the counselor. The counselor may complete a "self assessment". A comparison might occur between the perspective of the counselor and the supervisor as they review each other's rating forms. Any discrepancies within those ratings could indicate a need for observation.

Rating Forms and the Rubrics are specific to the TAP 21 competencies. Although in a different format, each will provide an opportunity for assessing counselor performance. Choose either the rating forms or the rubrics or if there is value in using both, that too may provide more specific information for assessment of counselor performance.

By establishing a “base line” prior to creating a Professional Development Plan (PDP) for the counselor, the supervisor has an opportunity to effectively measure the effects of the PDP.

The Steps in using rating forms:

1) Make copies of the rating forms that are specific to the counselor’s job description. Deliver those to the counselor.
2) Choose only those that are activities your counselor performs in his/her work. Encourage the counselor to "self assess" his/her performance.
3) Discuss the purpose of the rating forms and how these will be used to determine goals for the PDP.
4) Upon completion, discuss those areas in which the counselor feels the need for performance improvement. As the clinical

supervisor, compare your rating to that of the counselor and agree upon areas for improvement.

5) Limit the areas for improvement and remember to keep it simple. Assuming the counselor is committed to his/her work at the agency, prioritize those areas for performance improvement with the counselor and proceed to creating a PDP. It is often a good idea to allow the counselor to prioritize areas for performance improvement; although if the supervisor has concerns about specific performance, that concern should be addressed with the counselor.

6) Agree on areas for improvement and proceed to the creation of a Professional Development Plan (PDP).

6. SCHEDULING CLINICAL SUPERVISION MEETINGS

In this section reference will be made to:

1. Clinical Supervision Agenda
2. The Professional Development Plan (PDP).

Meetings with each counselor should be scheduled by the clinical supervisor. It is important to meet with the counselors on a regularly scheduled basis to discuss performance, observations and concerns that impact the counselor's work. The duration of the meetings as well as the frequency should be determined by the supervisor according to counselor need. Some counselors may need an hour per week while more experienced counselors may need only an hour per month. The most practical method seems to be one in which the meeting is the same time each week or each month so that both counselor and supervisor schedule accordingly.

The focus of the clinical supervision meeting should be the Professional Development Plan (PDP). Following a standardized agenda may create consistency and create an environment of comfort and confidence for the supervisor and the counselor. The supervisory agenda allows counselors to participate in establishing the priorities for each meeting. If the counselor has agenda items, it is important to discuss those items before continuing with the interview.

NOTE: the focus of this meeting is the PDP and the activities designed to improve counselor performance. This is an opportunity for mentoring, teaching and training to assist the counselor to improve performance. **It should be noted in the IDAHO Model, one hour per month of clinical supervision is required. This hour must include observation as well as the other approved clinical supervision activities**.

While the meeting may not require a full hour, the hour should be reserved for clinical supervision activities. Following the suggested agenda will help to keep the meeting focused and extra time can be spent in mentoring, teaching or role playing.

7. OBSERVING COUNSELORS

In this section reference will be made to:

1. Criteria for individual counseling
2. Criteria for group counseling
3. Methods of observation

In order to improve counselor performance it is necessary to observe their work and provide feedback regarding the quality of the counseling activity. While counselors may resist such observation, it is imperative to know what is going on that constitutes “treatment”. The supervisor must establish a relationship of trust with each counselor. Without the collaborative, cooperative relationship, the feedback from the observation will not be effective. It is suggested that the relationship must be established and time devoted to establishing the relationship before the observations begin.

The supervisor should discuss the observation well in advance of the date scheduled for that observation. Allow the counselor to pick the time and activity for the initial observation. This allows the counselor to feel comfortable and perform at their highest level. The idea is to catch the counselor doing their best work; not their areas of weakness. As the counselor develops confidence in the supervisor’s ability to provide feedback, he/she will ask for observation in areas in which they have concerns about their work. When this type relationship is established and the counselor begins to appreciate the feedback and assistance in developing and/or improving skills, the model is working as planned.

Observations may be conducted in-person, via audio/visual internet calls, video taped, audio taped, detailed below: (4-1-11)

Observations may be in person when the supervisor sits in the room as group is being conducted or when the counselor is doing an individual session or an assessment.

Observations may be conducted via audio/visual internet calls. Such calls are in real time and have a similar effect of the supervisor sitting in the room as group is being conducted or when the counselor is doing an individual session or an assessment. (4-1-11)

Observations may be conducted with video tapes and can be very effective when reviewed by the counselor, the supervisor or together.

Observations may be conducted with audio tapes. While this type of observation misses the visual that is often so important, it is a worthwhile method of assessing performance. This likewise offers the opportunity for the supervisor and counselor to review the work independently or together.

Observations should be on-going. At least one observation per month is suggested. In some agencies, the supervisor may reserve the right to "drop in" at any time to observe counselor performance. There is some value in an unannounced observation. It is suggested that this type observation occur only after a period in which the counselor has experienced observation and has an opportunity to prepare. Counselors who feel comfortable in their relationship with their supervisor will not feel threatened by unannounced observations.

The results from completion of the competency rating forms and the observation worksheets form the basis for creating or refining a PDP. The combination of both will provide the greatest opportunity to assess areas of excellence and challenge.

STEPS in the Observation of counselors:

1) Meet with each counselor to discuss the observation, its purpose and how it will occur.
2) If the observation is "in person" and you will be sitting in on the counselor's group, individual session or other counseling work, explain your role in the process. While there may be opportunities for co-therapy, the counselor should be aware if you plan to interact in the group process.
3) While some clinical supervisors prefer to interact in the group process, this should be discussed and determined prior to the observation.
4) If the counselor's work is to be: audio or video taped, or via audio/visual internet call, there is a requirement that the client involved sign release documents. These procedural tasks should be completed well in advance of the observation date. All HIPAA requirements should be discussed and met.
5) The supervisor and counselor should decide what is to be observed. Criteria for observation should be developed so that it is understood what is to be evaluated in the observation.
6) While the supervisor should write comments on everything observed in the session, particular attention should be paid to those areas agreed upon prior to the observation.

7) The counselor and supervisor should agree upon the length of the observation. Often a brief observation is preferable to sitting through the whole group. The supervisor may prefer to see the beginning, the process section or the closing of the group.

8) The role of the supervisor is to take detailed notes.

9) Feedback should include detail and should follow the ORAL method.

10) Feedback should closely follow the observation. If possible, provide brief feedback on the day of the observation and schedule a supervisory interview to provide detailed information from the observation.

11) If audio or video taping occurs, the supervisor may choose to review the tape prior to meeting with the counselor. There is also value in viewing the tape together.

8. PROVIDING FEEDBACK

In this section reference will be made to:

1. The clinical supervision agenda
2. The ORAL model of communications
3. Group criteria for observation
4. Individual criteria for observation

The manner in which feedback is provided to the counselor is very important. Prior to the observation the counselor and supervisor should determine what is to be observed, how it will be recorded and reported to the counselor. An observation sheet can be very helpful. These sample criteria should be a guide for each supervisor in developing a method of recording information in the observation. It is important to be specific and in some instances record exact numbers of incidences to be addressed in the feedback.

As "areas of challenge", are agreed upon by the counselor and supervisor, criteria can be developed which will represent a report on performance improvement or lack thereof. The counselor needs specific information rather than a general report. The responsibility for the supervisor is to record accurately the performance and provide feedback in a respectful manner.

The counselor may be anxious to hear a report from his/her supervisor. It is often important to spend a few minutes giving the counselor a general report and making certain a time if scheduled for the full report in detail. In that meeting the supervisor should have detailed and specific information on improved performance and also address concerns. The supervisor should have detailed notes from the observation recorded on the Group or Individual Criteria for Observation or a similar form.
This meeting should result in an update to the Professional Development Plan (PDP) which could result in successful completion of one of the goals or may require an update to the PDP to address new issues. The focus of the supervisory meeting is always on the PDP.

"Sandwiching" means that the supervisor addresses positive aspects of the observation, then discusses concerns and ends again with positive feedback. It is important to address concerns but not in a condescending or critical manner. This assumes the supervisor knows and uses the ORAL model of communication in providing feedback.

9. USING THE ORAL MODEL FOR FEEDBACK

In this section reference will be made to:

1. The ORAL model
2. Supervisory agenda

The ORAL model of feedback is one way to provide information to the counselor. It is designed to address the OBSERVATION, REPORT to the counselor, state any ASSUMPTIONS and LEVEL so that an agreement can be reached between counselor and supervisor as to the activities needed to improve performance.

The ORAL Model will provide a format for providing feedback. Notice that the model includes asking for permission to provide feedback. In order to maintain a relationship of respect and collaboration, it is important to allow the counselor to determine when it is most appropriate to hear the results of the observation. This will reinforce the cooperative/collaborative nature of the supervisory relationship.

10. CREATING THE PROFESSIONAL DEVELOPMENT PLAN (PDP)

In this section reference will be made to:

1. The PDP
2. Rating forms
3. Rubrics
4. Tap 21

The PDP details the way in which counselor performance may be improved. The sample one-page PDP is in Word format so that it can expand as needed. Remember the mantra "Keep it simple". Work on one area of performance improvement before moving to the next; design the activities so that sufficient time is allowed for successful completion of each KSA.

It is important to create the PDP based on the TAP 21 competencies. The Practice Dimension should be indicated on the PDP and each competency indicated by Knowledge, Skill or Attitude should be detailed. A copy of the page from the TAP 21 should be attached to the PDP and the specific competencies indicated on that copy so there is common understanding regarding expectations.

From the rating form or rubrics, the current level of performance should be indicated as well as the expected level to be achieved. The detailed activities in the learning plan will guide the counselor in their efforts to successfully improve performance.

As the PDP is created or refined between the counselor and supervisor, cooperation and collaboration should be evident in the manner in which activities are developed, timelines are determined and method of evaluating progress are planned. This PDP should be a step by step guide to improve counselor performance.

Determining time lines for completion further reflect the cooperative/collaborative relationship necessary to make this model successful in clinical supervision. The time line should reflect completion of each activity that will lead to improved counselor performance. These activities should be reasonable, achievable and developed in a manner that is consistent with the counselor's learning style. While some activities may take longer than others, it is important to attend to the time lines so that the counselor is always aware of the need to be working on the learning plan activities. If the deadline is three months from the inception, the counselor may "forget" the need to

attend to the activities on a weekly basis. By the same token, it is important to allow sufficient time for completion of the activities agreed upon. The Clinical Supervisor should address the Learning Plan in each scheduled Clinical Supervision Meeting.

The STEPS to create PDP

ESSENTIAL COMPONENTS:

1) Indicate the counselor's name, supervisors name and current date.
2) Indicate the Practice Dimension and the specific area.
3) Indicate the specific Competency(ies) from TAP 21 to be addressed in this PDP.
4) Indicate the counselor's strengths and challenges.
5) Indicate the current level of performance from the rating form(s) or rubrics.
6) Indicate the desired level of performance as a result of the activities in this PDP.
7) Detail the Knowledge, Skills and Attitudes that will be addressed in this PDP.
8) Detail the goal in specific behavioral terms.
9) Indicate specific activities designed to address each of the Knowledge, Skill and Attitudes indicated in this PDP.
10) Indicate the manner in which progress will be measured and the manner in which the counselor will demonstrate the knowledge or skill acquired.
11) Indicate a completion date for each activity. These may vary and all activities may not be completed simultaneously.
12) Be sure the PDP is signed by the clinical supervisor and the counselor and dated.
13) The counselor should have a photocopy of the learning plan as well as photocopies of the specific pages from the TAP 21 which are specific to the Knowledge, Skill and Attitudes being addressed in the Learning Plan.
14) The clinical supervisor should make notations on his/her calendar regarding critical dates for demonstrations of proficiency and remind the counselor to do the same.
15) The current, original PDP should be filed in the counselor's Supervisory File.

Creating the PDP Continued:

Each interaction with the counselor between supervisory meetings should be an opportunity for the supervisor to mention the learning plan and ask if the counselor needs help or assistance in completing the plan.

Updates should be noted on the learning plan as tasks are completed successfully or need more attention. If a task is not completed successfully or the task does not result in a successful completion of a goal, the supervisor and counselor should re-evaluate that portion of the plan to determine if a different activity will help accomplish the goal.
Successfully completed goals should be acknowledged by some sort of celebration, so that these milestones become significant to the counselors as they complete their work. This will reinforce the effort and help the counselor realize the value of the work.

Successful completion opens the way for the next areas of counselor development and that discussion should ensue so that a current PDP is always in place.

11. RE-OBSERVING

In this section reference will be made to:

1. Group criteria for observation
2. Individual criteria for observation
3. Rating Forms Rubrics

In order to assure that counselor performance has improved as a result of the Learning Plan, it is necessary to "re-observe" the counselor after the designated activities have been completed. The counselor and clinical supervisor will determine a date for this re-observation. The clinical supervisor will use the Group or Individual Criteria for Observation that was used initially to re-evaluate the performance of the counselor. The clinical supervisor is looking for improved performance in those areas indicated on the original observation worksheet.

Assuming the activities selected were appropriate for the counselor's learning or skill development, performance should improve. The clinical supervisor will observe and make notes. The feedback should include whether or not the performance has improved and if not, a new plan of activities should be developed. If performance did improve, the counselor should be rewarded for that work.

By comparing the original work of the counselor to the current performance using the Rubrics, the counselor and supervisor can gauge the progress along a continuum.

The improved work can also be recorded on the Rating Form corresponding to the activities developed from the KSA's in TAP 21.

12. UPDATING THE PROFESSIONAL DEVELOPMENT PLAN (PDP)

In this section reference will be made to:

1. The PDP
2. The Rubrics
3. The Rating Forms
4. Observation Worksheets (4-1-11)

Upon successful completion of a Learning objective, it is important to acknowledge the work of the counselor and the improvement in performance. This can be done by a simple "way to go" comment or perhaps something more tangible by taking the counselor for coffee or lunch.

Once the learning objectives are completed, it is time to identify the next goals for the PDP. Often this is simply a revisiting of the Rating Forms completed earlier. This can serve as a guide to future PDP creation or refinement.

Professional Development should be ongoing so that when one set of goals ~~are~~ is completed, another set of goals is developed. By using the electronic version of the one-page PDP the clinical supervisor can continue the form in a Word document so that the historical data of previous PDPs is preserved. Copies should also be made for the Clinical Supervision File and each counselor should have a copy of his/her plan.

STEPS in Updating the PDP:

1) The supervisor and counselor should meet to discuss the performance improvement or lack thereof.
2) If progress has not been achieved, the activities should be reviewed and revised to assure success.
3) If progress has been achieved in the counselor's performance, the supervisor and counselor should agree upon the next goal (s) for the PDP.
4) Reference should be made to the rating forms completed at an earlier stage with the counselor so that new goals can be established for continuing performance improvement.

5) Reference should be made to the rubrics to determine if the counselor can complete tasks in the next level of performance. This evaluation could initiate the next set of learning objectives.

6) Reference should be made to the Observation Worksheet(s) completed at an earlier stage so that progress and challenges may be reflected on the new PDP.

13. DOCUMENTATION OF THE CLINICAL SUPERVISION ACTIVITIES

The approved clinical supervision activities should be recorded so that data can be collected and reported. Each counselor should have a **clinical supervision file that includes:**

1) Demographic Sheet

   Demographic sheets should include counselor's name, date of hire, credentials and title of position.

2) Professional Development Plans (PDPs)

   PDPs should be completed, signed by the counselor and supervisor, dated and include detailed activities for improving performance with deadlines for completion and demonstration of improved performance.

3) Observation Worksheets (4-1-11)

   Observation Worksheets or notes should be dated, signed and indicate details of the observation of counselor performance as well as the time spent. (7-1-13)

4) Rating forms

   Rating forms should be dated. There should be an indication if the form was completed by the supervisor or if the form represents a self evaluation by the counselor.

5) Supervision Notes

   Supervision Notes should reference the regular supervision meetings as well as observations, training, mentoring, group supervision. Notes should always reference the PDP goals and current progress or concerns.

   Notes should be dated and each note should indicate the type of activity, the amount of time spent in the supervisory contact.

6) Intensive Supervision Plan if required

7) Current Resume which must be dated

14. Updates to the How to Manual for Clinical Supervision in Idaho (12-1-11)

These updates will be maintained in Chapter 14 for the foreseeable future.

Program is left without a Clinical Supervisor (CS)

When a CS leaves, or is determined and/or expected to be absent from an agency for more than 30 calendar days, provider shall notify BPA and DHW within 10 business days and provide a 30 calendar day action plan to include:

- Quality assurance considerations;
- Hiring plan and/or projected timeline for when absentee CS is to return to work;
- Recruiting efforts/search, and;
- Alternative options.

BPA has ten business days to review and approve or deny. Once Provider has received an acceptance letter from BPA, the Provider has another 30 calendar days to fill the position.

Any requests for time extension, based extenuating circumstances, will be subject to collaborative review and decision between BPA and DHW

Counselor is absent from Job (Ill, Vacation or left the Job)

A CS may fill in for an absentee counselor when another counselor is unavailable to do so. The CS who is filling in must document below his/her signature that s/he is filling in for the counselor with each entry to the clinical file.

When the absentee counselor, for whom the CS is filling in, is determined and/or expected to be away from the job for 30 or more calendar days, the CS/Provider shall notify the BPA Regional Coordinator (RC) within 10 business days and provide a 30 calendar day action plan to include:

- Quality assurance considerations;
- Arrangements for Clinical Supervisor's direct client SUD treatment services to be clinically supervised by another approved clinical supervisor.
- Hiring plan and/or projected timeline for when absentee counselor is to return to work
- Alternative options.

RC/BPA has ten business days to review and approve or deny. Once CS/Provider receives an acceptance letter from RC/BPA, the CS/Provider

has another 30 calendar days to complete the requirements of the approved plan.

Any requests for time extension, based on extenuating circumstances, will be subject to collaborative review and decision between the CS/Provider and the RC/BPA.

Exceptions to the required one hour of clinical supervision per month requirement

In all cases requiring Clinical Supervision, the CS and/or Provider should consider *Best Practice* in determining the level/frequency of supervision on an individual basis.

One time per quarter Clinical Supervision:

A CS shall provide clinical supervision to clinicians, other than QSUDPTs, no less than one hour per quarter for observation and mentoring, for Clinicians who meet one the following criteria:

- provide only one single SUD treatment function, requiring less than 4 hours of direct client SUD treatment services per week, or;
- conduct GAIN assessments only, providing no other direct client SUD treatment services, with the additional requirement that;
    - CS must conduct monthly quality reviews of random assessments.

The above criteria for one time per quarter Clinical Supervision will apply when the QSUDP

- scores 4 (skilled) or higher on TAP 21 Rating Scale competencies relative to those areas indicated in the counselor's job description
- has access to electronic and/or phone consultation with the CS, and;
- has weekly contact with other agency clinicians. *Note: Discuss these criteria with your BPA RC if you are a staff of one clinician.*

Specifics of above criteria must be documented in the clinician's clinical supervision file and/or Professional Development Plan (PDP).

Two times per year Clinical Supervision:

A CS shall provide face-to-face clinical supervision to another CS who holds a LMSW or a LPC through the Idaho Board of Occupational Licenses no less than two times per year for observation, mentoring, and updating his/her PDP.

This applies to all such clinical supervisors providing direct client SUD Treatment Services including Clinical Supervisors who meet the following criteria:

- clinical skills have been observed and documented by a DHW/SUD approved CS on a one hour per month basis over a 90 day period of employment providing direct client SUD treatment services in a DHW approved SUD treatment facility.
- scores 4 (skilled) or higher on TAP 21 Rating Scale competencies relative to those areas indicated in the counselor's job description
- has access to electronic and/or phone consultation with the CS;
- has weekly contact with other agency clinicians. *Note: Discuss these criteria with your BPA RC if you are a staff of one clinician.*

Specifics of above criteria must be documented in the clinician's clinical supervision file and/or professional development plan.

Wherever possible, the LMSW/LPC professional should be encouraged to work toward Clinical Level of licensure.

<u>One time per Year Clinical Supervision:</u>

A CS shall provide face-to-face clinical supervision to a QSUDP who holds a LCSW, LCPC, LMFT, or PHD License through the Idaho Board of Occupational Licenses, no less than one time per year for observation, mentoring, and updating his/her PDP.

This applies to all such licensed clinicians providing direct client SUD Treatment Services including Clinical Supervisors who meet the following criteria:

- clinical skills have been observed and documented by a DHW/SUD approved CS over a 90 day period of employment providing direct client SUD treatment services in a DHW approved SUD treatment facility.
- scores 4 (skilled) or higher on TAP 21 Rating Scale competencies relative to those areas indicated in the counselor's job description
- has access to electronic and/or phone consultation with the CS;
- has weekly contact with other agency clinicians. *Note: Discuss these criteria with your BPA RC if you are a staff of one clinician.*

Specifics of above criteria must be documented in the clinician's clinical supervision file and/or professional development plan.

Clinical Supervision for Case Managers

A CS who provides clinical supervision to a clinician, who provides both, direct client SUD case management services and direct client SUD treatment services may meet the clinical supervision requirements for both services by including supervision tasks for both services into one hour per month of supervision.

A CS, who provides clinical supervision to a case manager who only provides direct client SUD case management services shall provide clinical supervision to that case manager for one hour per month.

Some case managers may meet one of the exceptions, detailed above, to the one hour per month requirement for clinical supervision, and would therefore be supervised in accordance with the exception.

Wherever possible, the LMSW/LPC professional should be encouraged to work toward Clinical Level of licensure for their field of practice.

Professional Development Plans

Professional Development Plans are now available in forms that are either fillable from the computer or can be copied and filled out with pen. All will be available on the DHW/SUD Qualified Professionals website.

Credentialing for a QSUDPT: change in process:

QSUDPT Initial Professional Development Plan

The CS may now request DHW/SUD approve a clinician as a QSUDPT by submitting the following completed and signed QSUDPT Initial Professional Development Plan along with a copy of the QSUDPT's SUD specific certification or formal documentation of current enrollment in a program pursuant to the qualifications of Section 218 of these rules; to John Kirsch at kirschj@dhw.idaho.gov or fax 208-332-7305.

QSUDPT Professional Development Plan

The CS will have one month from date of QSUDPT initial approval by DHW/SUD to submit a QSUDPT Professional Development Plan based on instructions in the How to Manual for Clinical Supervision in Idaho

Chapter 5/Appendix B and Chapter 7/Appendix C. Professional Development Plans are located in Appendix D.

Posting the QSUDPT credential to the DHW/SUD website will occur upon receipt and approval of the QSUDPT Professional Development Plan.

QSUDPT Initial Professional Development Plan follows:

QSUDPT
INITIAL PROFESSIONAL DEVELOPMENT PLAN (PDP)

This may be submitted to DHW/SUD upon hiring of new clinician. However, it must be followed with a PDP based on TAP 21 review and observations within one month.

(7-1-13)

Date: _____

Clinician Name (print):_____

Clinical Supervisor (CS) Name (Print): _____

I, _____as Clinical Supervisor, agree to complete

a Professional Development Plan developed with _____, QSUDPT, and shall submit it to DHW/SUD for approval no later than one month from date of this initial QSUDPT approval.

*The QSUDPT Professional Development Plan will reflect instructions from the 'How to Manual for Clinical Supervision in Idaho' relative to completion of the following tasks:

- Completion of TAP 21 Rating Scales per Chapter 5 and Appendix B, and;
- Clinical Supervisor Observations of Clinician providing direct client SUD counseling services per Chapter 7 and Appendix C)

Signatures:

Clinical Supervisor: _____Date:_____

Clinician: _____Date_____

**Note: Upon approval of the* QSUDPT Professional Development Plan*, no other Professional Development Plans or updates will be required to be submitted to DHW/SUD. However, Professional Development Plans are subject to audit by both CASAT and BPA during their site visits.*

Submit to John Kirsch at: kirschj@dhw.idaho.gov or fax to 208-332-7305 along with a copy of clinician's SUD specific certification or Professional License as per IDAPA 16.07.20.223 found at:
http://adm.idaho.gov/adminrules/rules/idapa16/0720.pdf
Filable Professional Development Plans can be found at
http://www.healthandwelfare.idaho.gov/Medical/SubstanceUseDisorders/InformationforProviders/QualifiedProfessionals/tabid/1004/Default.aspx

Appendix A

The ORAL Model for Feedback

So, now it sounds like this.....

- Do you have a minute that I can talk with you now or should we plan to talk a little later today?
- I wanted to tell you about.....
- Are you receptive to some feedback?
- I assumed that.....
- My concern is.....and the impact will be.....
- Tell me what it is you have heard me say
- That's right, but you missed the part about.....
- So it is agreed then, that.....

Appendix B

Rating Forms

TAP 21
Rating Forms

Clinician Name (print) _____Date_____

Clinical Supervisor Name (print) _____ Date_____

SECTION I: TRANSDISCIPLINARY FOUNDATIONS

COMPETENCY RATING FORM

1=Understands 2=Developing 3=Competent 4=Skilled 5=Master

TRANSDISCIPLINARY FOUNDATION I **UNDERSTANDING ADDICTION**	**Rating**
1. Understand a variety of models and theories of addiction and other problems related to substance use.	
2. Recognize the social, political, economic, and cultural context within which addiction and substance abuse exist, including risk and resilience factors that characterize individuals and groups and their living environments.	
3. Describe the behavioral, psychological, physical health, and social effects of psychoactive substances on the user and significant others.	
4. Recognize the potential for substance use disorders to mimic a variety of medical and psychological disorders and the potential for medical and psychological disorders to co-exist with addiction and substance abuse.	

TRANSDISCIPLINARY FOUNDATION II **TREATMENT KNOWLEDGE**	**Rating**
5. Describe the philosophies, practices, policies, and outcomes of the most generally accepted and scientifically supported models of treatment, recovery, relapse prevention, and continuing care for addiction and other substance-related problems.	
6. Recognize the importance of family, social networks, and community systems in the treatment and recovery process.	
7. Understand the importance of research and outcome data and their application in clinical practice.	
8. Understand the value of an interdisciplinary approach to addiction treatment.	

Competency Rating Form

1=Understands 2=Developing 3=Competent 4=Skilled 5=Master

TRANSDISCIPLINARY FOUNDATION III **APPLICATION TO PRACTICE: Pages 21 - 26**	**Rating**
9. Understand the established diagnostic criteria for substance use disorders and describe treatment modalities and placement criteria within the continuum of care.	
10. Describe a variety of helping strategies for reducing the negative effects of substance use, abuse, and dependence.	
11. Tailor helping strategies and treatment modalities to the client's stage of dependence, change or recovery.	
12. Provide treatment services appropriate to the personal and cultural identity and language of the client.	
13. Adapt practice to the range of treatment settings and modalities.	
14. Be familiar with medical and pharmacological resources in the treatment of substance use disorders.	
15. Understand the variety of insurance and health maintenance options available and the importance of helping clients access those benefits.	
16. Recognize that crisis may indicate an underlying substance use disorder and may be a window of opportunity for change.	
17. Understand the need for and the use of methods for measuring treatment outcome.	

Competency Rating Form

1=Understands 2=Developing 3=Competent 4=Skilled 5=Master

TRANSDISCIPLINARY FOUNDATION IV **PROFESSIONAL READINESS: Pages 29- 34**	**Rating**
18. Understand diverse cultures and incorporate the relevant needs of culturally diverse groups, as well as people with disabilities, into clinical practice.	
19. Understand the importance of self-awareness in one's personal, professional, and cultural life.	
20. Understand the addiction professional's obligations to adhere to ethical and behavioral standards of conduct in the helping relationship.	
21. Understand the importance of ongoing supervision and continuing education in the delivery of client services.	
22. Understand the obligation of the addiction professional to participate in prevention as well as treatment.	
23. Understand and apply setting-specific policies and procedures for handling crisis or dangerous situations, including safety measures for clients and staff.	

SECTION II: PROFESSIONAL PRACTICE DIMENSIONS

Competency Rating Form

1=Understands 2=Developing 3=Competent 4=Skilled 5=Master

PRACTICE DIMENSION I **CLINICAL EVALUATION - SCREENING** Screening is the process through which a counselor, client and available significant others review the current situation, symptoms, and other available information to determine the most appropriate initial course of action, given the client's needs and characteristics and the available resources within the community.	**Rating**
24. Establish rapport, including management of crisis situation and determination of need for additional professional assistance.	
25. Gather data systematically from the client and other available collateral sources, using screening instruments and other methods that are sensitive to age, developmental level, culture, and gender. At a minimum, data should include current and historical substance use; health, mental health, and substance-related treatment histories; mental and functional statuses; and current social, environmental, and or/economic constraints.	
26. Screen for psychoactive substance toxicity, intoxication, and withdrawal symptoms; aggression or danger to others; potential for self-inflicted harm or suicide; and coexisting mental health problems.	
27. Assist the client in identifying the impact of substance use on his or her current life problems and the effects of continued harmful use or abuse.	
28. Determine the client's readiness for treatment and change as well as the needs of others involved in the current situation.	
29. Review the treatment options that are appropriate for the client needs, characteristics, goals, and financial resources.	
30. Apply accepted criteria for diagnosis of substance use disorders in making treatment recommendations.	
31. Construct with client and appropriate others an initial action plan based on client needs, preferences, and resources available.	
32. Based on initial action plan, take specific steps to initiate an admission or referral and ensure follow-through.	

Competency Rating Form

1=Understands 2=Developing 3=Competent 4=Skilled 5=Master

PRACTICE DIMENSION I **CLINICAL EVALUATION - ASSESSMENT** Assessment is an ongoing process through which the counselor collaborates with the client, and others, to gather and interpret information necessary for planning treatment and evaluating client progress.	**Rating**
33. Select and use a comprehensive assessment process that is sensitive to age, gender, racial and ethnic cultural issues, and disabilities that includes, but is not limited to: - History of alcohol and other drug use; - Physical health, mental health, and addiction treatment histories; - Family issues; - Work history and career issues; - History of criminality; - Current status of physical health, mental health, and substance use; - Spiritual concerns of the client; - Education and basic life skills; - Socioeconomic characteristics, lifestyle and current legal status - Use of community resources: - Treatment readiness; - Level of cognitive and behavioral functioning.	
34. Analyze and interpret the data to determine treatment recommendations.	
35. Seek appropriate supervision and consultation.	
36. Document assessment findings and treatment recommendations.	

Competency Rating Form

1=Understands 2=Developing 3=Competent 4=Skilled 5=Master

PRACTICE DIMENSION II **TREATMENT PLANNING** A collaborative process in which professionals and the client develop a written document that identifies important treatment goals: describes measurable, time-sensitive action steps toward achieving those goals with expected outcomes; and reflects a verbal agreement between counselor and client. At a minimum an individualized treatment plan addresses the identified substance use disorder(s) as well as issues related to treatment progress, including relationships with family and significant others, potential mental conditions, employment, education, spirituality, health concerns, and social and legal needs.	**Rating**
37. Use relevant assessment information to guide the treatment planning process.	
38. Explain assessment findings to the client and significant others.	
39. Provide the client and significant others with clarification and additional information as needed.	
40. Examine treatment options in collaboration with the client and significant others.	
41. Consider the readiness of the client and significant others to participate in treatment.	
42. Prioritize client needs in the order they will be addressed in treatment.	
43. Formulate mutually agreed upon and measurable treatment goals and objectives.	
44. Identify appropriate strategies for each treatment goal.	
45. Coordinate treatment activities and community resources in a manner consistent with the client's diagnosis and existing placement criteria.	
46. Develop with the client a mutually acceptable treatment plan and method for monitoring and evaluating progress.	
47. Inform the client of confidentiality rights, program procedures that safeguard them, and the exceptions imposed by regulations.	
48. Reassess the treatment plan at regular intervals or when indicated by changing circumstances.	

Competency Rating Form

1=Understands 2=Developing 3=Competent 4=Skilled 5=Master

Practice Dimension III: REFERRAL The process of facilitating the client's utilization of available support systems and community resources to meet needs identified in clinical evaluation and/or treatment planning.	**Rating**
49. Establish and maintain relations with civic groups, agencies, other professionals, governmental entities, and the community-at-large to ensure appropriate referrals, identify service gaps, expand community resources, and help to address unmet needs.	
50. Continuously assess and evaluate referral resources to determine their appropriateness.	
51. Differentiate between situations in which it is most appropriate for the client to self-refer to a resource and instances requiring counselor referral.	
52. Arrange referrals to other professionals, agencies, community programs, or other appropriate resources to meet client needs.	
53. Explain in clear and specific language the necessity for and process of referral to increase the likelihood of client understanding and follow through.	
54. Exchange relevant information with the agency or professional to whom the referral is being made in a manner consistent with confidentiality regulations and generally accepted professional standards of care.	
55. Evaluate the outcome of the referral.	

Competency Rating Form

1=Understands 2=Developing 3=Competent 4=Skilled 5=Master

PRACTICE DIMENSION IV: SERVICE COORDINATION IMPLEMENTING THE TREATMENT PLAN The administrative, clinical, and evaluative activities that bring the client, treatment services, community agencies, and other resources together to focus on issues and needs identified in the treatment plan. Service coordination, which includes case management and client advocacy, establishes a frame-work of action for the client to achieve specified goals. It involves collaboration with the client and significant others, coordination of treatment and referral services, liaison activities with community resources and managed care systems, client advocacy, and ongoing evaluation of treatment progress and client needs.	**Rating**
56. Initiate collaboration with referral source.	
57. Obtain, review, and interpret all relevant screening, assessment, and initial treatment-planning information.	
58. Confirm the client's eligibility for admission and continued readiness for treatment and change.	
59. Complete necessary administrative procedures for admission to treatment.	
60. Establish accurate treatment and recovery expectations with the client and involved significant others including, but not limited to: - The nature of services, - Program goals, - Program procedures, - Rules regarding client conduct, - The schedule of treatment activities, - Costs of treatment, - Factors affecting duration of care, - Client's rights and responsibilities, - The effects of treatment and recovery on significant others.	
61. Coordinate all treatment activities with services provided to the client by other resources.	

Competency Rating Form

1=Understands 2=Developing 3=Competent 4=Skilled 5=Master

PRACTICE DIMENSION IV: SERVICE COORDINATION CONSULTING	**Rating**
62. Summarize client's personal and cultural background, treatment plan, recovery progress, and problems inhibiting progress to ensure quality of care, gaining feedback, and planning changes in the course of treatment.	
63. Understand terminology, procedures, and roles of other disciplines related to the treatment of substance use disorders.	
64. Contribute as part of a multidisciplinary treatment team.	
65. Apply confidentiality regulations appropriately.	
66. Demonstrate respect and non-judgmental attitudes toward clients in all contacts with community professionals and agencies.	

PRACTICE DIMENSION IV: SERVICE COORDINATION CONTINUING ASSESSMENT & TREATMENT PLANNING:	**Rating**
67. Maintain ongoing contact with client and involved significant others to ensure adherence to the treatment plan.	
68. Understand and recognize stages of change and other signs of treatment progress	
69. Assess treatment and recovery progress and, in consultation with the client and significant others, make appropriate changes to the treatment plan to ensure progress toward treatment goals.	
70. Describe and document treatment process, progress, and outcome.	
71. Use accepted treatment outcome measures.	
72. Conduct continuing care, relapse prevention, and discharge planning with the client and involved significant others.	
73. Document service coordination activities throughout the continuum of care.	
74. Apply placement, continued stay, and discharge criteria for each modality on the continuum of care.	

Competency Rating Form

1=Understands 2=Developing 3=Competent 4=Skilled 5=Master

PRACTICE DIMENSION V : COUNSELING **INDIVIDUAL COUNSELING** A collaborative process that facilitates the client's progress toward meeting treatment goals and objectives. Counseling includes methods that are sensitive to individual client characteristics and to the influence of significant others, as well as the client's cultural and social context. Competence in counseling is built on an understanding of appreciation of, and ability to appropriately use the contributions of various addiction counseling models as they apply to modalities of care for individuals, groups, couples and significant others.	**Rating**
75. Establish a helping relationship with the client characterized by warmth, respect, genuineness, concreteness, and empathy.	
76. Facilitate the client's engagement in the treatment and recovery process.	
77. Work with the client to establish realistic, achievable goals consistent with achieving and maintaining recovery.	
78. Promote client knowledge, skills, and attitudes that contribute to a positive change in substance use behaviors.	
79. Encourage and reinforce client actions determined to be beneficial in progressing toward treatment goals.	
80. Work appropriately with the client to recognize and discourage all behaviors inconsistent with progress toward treatment goals.	
81. Recognize how, when, and why to involve the client's significant others in enhancing or supporting the treatment plan.	
82. Promote client knowledge, skills, and attitudes consistent with the maintenance of health and prevention of Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), tuberculosis (TB), sexually transmitted diseases (STDs), and other infectious diseases.	
83. Facilitate the development of basic and life skills associated with recovery.	
84. Adapt counseling strategies to the individual characteristics of the client, including but not limited to disability, gender, sexual orientation, developmental level, ethnicity, age, and health status.	
85. Make constructive therapeutic responses when client's behavior is inconsistent with stated recovery goals.	
86. Apply crisis, prevention and management skills.	
87. Facilitate the client's identification, selection, and practice of strategies that help sustain the knowledge, skills, and attitudes needed for maintaining treatment progress and preventing relapse.	

Competency Rating Form

1=Understands 2=Developing 3=Competent 4=Skilled 5=Master

PRACTICE DIMENSION V: COUNSELING **GROUP COUNSELING**	**Rating**
88. Describe, select, and appropriately use strategies from accepted and culturally appropriate models for group counseling with clients with substance use disorders.	
89. Carry out the actions necessary to form a group, including, but not limited to: • determining group type, purpose, size, and leadership; recruiting and selecting • members; establishing group goals and clarifying behavioral ground rules for • participating; identifying outcomes; and determining criteria and methods for • termination or graduation from the group.	
90. Facilitate the entry of new members and the transition of exiting members.	
91. Facilitate group growth within the established ground rules and movement toward group and individual goals by using methods consistent with group type.	
92. Understand the concepts of process and content, and shift the focus of the group when such an intervention will help the group move toward its goals.	
93. Describe and summarize client behavior within the group for the purpose of documenting the client's progress and identifying needs and issues that may require a modification in the treatment plan.	

PRACTICE DIMENSION V: COUNSELING **COUNSELING FOR FAMILIES, COUPLES & SIGNIFICANT OTHERS**	**Rating**
94. Understand the characteristics and dynamics of families, couples, and significant others affected by substance use.	
95. Be familiar with and appropriately use models of diagnosis and intervention for families, couples, and significant others, including extended, kinship, or tribal family structures.	
96. Facilitate the engagement of selected members of the family, couple, or significant others in the treatment and recovery process.	
97. Assist families, couples, and significant others to understand the interaction between the system and substance use behaviors.	
98. Assist families, couples, and significant others to adopt strategies and behaviors that sustain recovery and maintain healthy relationships.	

Competency Rating Form

1=Understands 2=Developing 3=Competent 4=Skilled 5=Master

PRACTICE DIMENSION VI: COUNSELING **CLIENT, FAMILY AND COMMUNITY EDUCATION:** The process of providing clients, families, significant others, and community groups with information on risks related to psychoactive substance use, as well as available prevention, treatment, and recovery resources.	**Rating**
99. Provide culturally relevant formal and informal education programs that raise awareness and support substance abuse prevention and/or the recovery process.	
100. Describe factors that increase the likelihood for an individual, community, or group to be at-risk for, or resilient to, psychoactive substance use disorders.	
101. Sensitize others to issues of cultural identity, ethnic background, age, and gender in prevention, treatment, and recovery.	
102. Describe warning signs, symptoms, and the course of substance use disorders.	
103. Describe how substance use disorders affect families and concerned others.	
104. Describe the continuum of care and resources available to family and concerned others.	
105. Describe principles and philosophy of prevention, treatment, and recovery.	
106. Understand and describe the health and behavior problems related to substance use, including transmission and prevention of HIV/AIDS, tuberculosis, sexually transmitted diseases, hepatitis C and other infectious diseases.	
107. Teach life skills, including but not limited to, stress management, relaxation, communication, assertiveness, and refusal skills.	

Competency Rating Form

1=Understands 2=Developing 3=Competent 4=Skilled 5=Master

Practice Dimension VII: DOCUMENTATION The recording of the screening and intake process, assessment, treatment plan, clinical reports, clinical progress notes, discharge summaries, and other client-related data.	**Rating**
108. Demonstrate knowledge of accepted principles of client record management.	
109. Protect client rights to privacy and confidentiality in the preparation and handling of records, especially in relation to the communication of client information with third parties.	
110. Prepare accurate and concise screening, intake, and assessment reports.	
111. Record treatment and continuing care plans that are consistent with agency standards and comply with applicable administrative rules.	
112. Record progress of client in relation to treatment goals and objectives.	
113. Prepare accurate and concise discharge summaries.	
114. Document treatment outcome, using accepted methods and instruments.	

Competency Rating Form

1=Understands 2=Developing 3=Competent 4=Skilled 5=Master

PRACTICE DIMENSION VIII: PROFESSIONAL AND ETHICAL RESPONSIBILITIES The obligations of an addiction counselor to adhere to accepted ethical and behavioral standards of conduct and continuing professional development.	**Rating**
115. Adhere to established professional codes of ethics that define the professional context within which the counselor works, in order to maintain professional standards and safeguard the client.	
116. Adhere to Federal and State laws and agency regulations regarding the treatment of substance use disorders.	
117. Interpret and apply information from current counseling and psychoactive substance use research literature to improve client care and enhance professional growth.	
118. Recognize the importance of individual differences that influence client behavior and apply this understanding to clinical practice.	
119. Utilize a range of supervisory options to process personal feelings and concerns about clients.	
120. Conduct self-evaluations of professional performance applying ethical, legal, and professional standards to enhance self-awareness and performance.	
121. Obtain appropriate continuing professional education.	
122. Participate in ongoing supervision and consultation.	
123. Develop and utilize strategies to maintain one's own physical and mental health.	

***** Scale developed by Richard Barnhart and reprinted from the following web site: http://www.competinc.com/article2.html

Clinical Supervisor Name (printed) _____

Supervisor Signature_____ Date_____

Counselor Name (printed) _____

Counselor Signature _____ Date_____

Appendix C

Group Counselor Skills Observation Worksheets

GROUP COUNSELOR SKILLS OBSERVATION WORKSHEET

Counselor_____

Observer_____ Observation Time from_____ to_____

Name of the group_____Date_____

SKILLS DEMONSTRATED	*RATING SCALE* 1 2 3 4 5 n/a yes no
Client-Centered Techniques	
Reflective listening – uses feeling statements	
Paraphrasing – restates the clients message	
Rephrasing – restates what the client said	
Empathy – trying to see from the clients perspective	
Acceptance – unconditional regard, respect. Avoids agreement or disagreement	
Transparency – self-awareness, state what you feel	
OTHER:	
Group Structure	
Opening **– strong start. Set tone. Introductory statement of material to be covered during the class.**	
Room preparation **– chairs in a circle or group members seated in a manner that encourages participation, engagement.**	
Curriculum **– approved, evidenced based material presented. Handouts and other materials ready before group starts.**	
OTHER:	
Teaching Methods Used	
Reading	
Group discussion	
Using client case as examples for the group	
Game	
Role playing	
Process	
Using the white board	
OTHER:	
OTHER:	
OTHER:	

Motivational Interviewing Skills	
Ask permission to give feedback	
State what you see in the clients' behavior	
State your concerns about the behavior	
Assume that the client is aware and working on it	
Ask client to clarify what they heard you say	
Clarify misunderstandings and confirm a mutual understanding	

OTHER:	

Comments / Observations / Suggestions: _____

Goal / plan to strengthen skill level: _____-_____

Rating Scale

1 = More training needed to clarify how and when to use this skill. Role-play with colleague or supervisor.

2 = Good efforts to use skill. Observe a colleague's group to see it used within 14 days. _____(Name, date)

3 = Good use of the skill. Growing comfort in using this method. Role-play & observe colleague to strengthen skill level.

4 = Effective use of skill in timing, context. Good understanding this method. Demonstrate, role-play to peers with 1-3 ratings.

5 = Excellent, consistent, effective demonstration of this skill. Mastery of the technique.

n/a = Not applicable to the group context or skill not demonstrated.

_____

Group Facilitator

_____

Clinical Supervisor

INDIVIDUAL SESSION COUNSELOR SKILLS OBSERVATION WORKSHEET

Counselor_____ Date_____

Observer_____ Observation Time: from_____ to_____

Type of interaction: _____
(assessment, treatment planning/review, 1x1 session, conflict resolution, transfer of care planning, other.)

SKILLS DEMONSTRATED	*RATING SCALE*
ENGAGEMENT SKILLS	1 2 3 4 5 n/a
yes no	
Convey warmth, respect and genuineness in a culturally appropriate manner	
Demonstrate active listening, reflective listening, affirming, summarizing	
Counseling style matches the tone of the interaction	
Counseling style matches the client's stage of change	
WORKING THROUGH SKILLS	1 2 3 4 5 n/a
yes no	
Clinical and treatment plan present, reviewed, updated	
Worked collaboratively to identify goals and formulate plans/goals	
Maintained clinical focus regarding progress towards goals	
Recognize and address ambivalence and resistance appropriately	
Ability to re-frame and redirect negative behaviors	
Model and teach effective decision making and problem solving skills	
MOTIVATIONAL INTERVIEWING SKILLS	1 2 3 4 5 n/a
yes no	
Ask permission to give feedback	
State what you see in the clients' behavior	
State your concerns about the behavior	
Assume that the client is aware and working on it	
Ask client to clarify what they heard you say	
Clarify misunderstandings and confirm a mutual understanding	
CLOSING SKILLS	1 2 3 4 5 n/a
yes no	
Ability to summarize and review interaction	
Highlight client strengths	
Progress note completed	

Questions for review of session

What counseling methods did you use and feel most comfortable with?
What was your biggest challenge in this session?

What did you do well?

What did you feel best about?
Any boundary issues arise?
Any questions about any aspect of the session?

Comments / Observations / Suggestions:

_____

Goal / plan to strengthen skill level:

_____

Rating Scale

1 = More training needed to clarify how and when to use this skill. Role-play with colleague or supervisor.

2 = Good efforts to use skill.

3 = Good use of the skill. Growing comfort in using this method. Role-play to strengthen skill level.

4 = Effective use of skill in timing, context. Good understanding this method. Demonstrate, role-play to peers with 1-3 ratings.

5 = Excellent, consistent, effective demonstration of this skill. Mastery of the technique.

n/a = Not applicable to the group context or skill not demonstrated.

Counselor _____

_____

Clinical Supervisor

Appendix D

Professional Development Plans

IDAPA 16.07.20.12.6.

Professional Development Plan. A professional development plan:

a. Is developed cooperatively by the clinical supervisor and the clinician;

b. Is clinician-centered;

c. Is customized to the training needs of the clinician;

d. Details the way in which counselor performance may be improved;

e. Is based on counselor knowledge, skill, and attitude; and

f. At a minimum, is informed by use of Department-approved competency rating scales and observations of counselor's clinical work.

(7-1-13)

Professional Development Plans can be found at :
http://www.healthandwelfare.idaho.gov/Medical/SubstanceUseDisorders/InformationforProviders/QualifiedProfessionals/tabid/1004/Default.aspx