

# SUPERVISION AND AGENCY MANAGEMENT FOR COUNSELORS



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# Supervision and Agency Management for Counselors

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# Supervision and Agency Management for Counselors

*A Practical Approach*

**Elizabeth R. O'Brien PhD, LPC**

**Michael A. Hauser, PhD, LPC, NCC**

*Editors*

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## Contents

<i>Contributors</i>	<i>vii</i>
<i>Preface</i>	<i>ix</i>
<i>Acknowledgments</i>	<i>xi</i>
<b>1. Orientation to Agency Management and Supervision</b>	<b>1</b>
<i>Elizabeth R. O'Brien</i>	
<b>2. Individual and Group Supervision</b>	<b>21</b>
<i>Rebecca M. Goldberg</i>	
<b>3. Ethical Issues in the Supervisory Relationship</b>	<b>49</b>
<i>Richard Deaner</i>	
<b>4. Theories of Supervision</b>	<b>71</b>
<i>Lisa Aasheim</i>	
<b>5. Evaluation</b>	<b>91</b>
<i>Michael A. Hauser</i>	
<b>6. Leadership Principles</b>	<b>115</b>
<i>David W. Rausch and Elizabeth K. Crawford</i>	
<b>7. Budgeting and Fiscal Management for Counselors</b>	<b>127</b>
<i>Dana Lee Baker, Allison Louise Smith, and Deanna L. Sharpe</i>	
<b>8. Clinical Information Management</b>	<b>147</b>
<i>Michael A. Hauser</i>	
<b>9. Marketing for the Professional Counselor</b>	<b>173</b>
<i>Lorrie B. Slater and Amiko W. McPherson</i>	
<b>10. Critical Incidents and Crisis Response</b>	<b>189</b>
<i>Sherry Todd</i>	
<i>Index</i>	<i>213</i>



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## Preface

Becoming a counselor is a lifelong journey, with many learning opportunities along the way. Although many helping professionals will say that their first passion is helping facilitate others' growth, there are opportunities to facilitate that growth that move beyond engaging in counseling and the therapeutic process. If you are in a place along your journey where you have been counseling for a number of years, you feel confident that you have found your strengths, and have made a point to continue to strengthen your weaker areas, you may find that you are wondering where your next challenges may lie.

This book is designed to provide a road map for the next steps along your journey: supervising newer helping professionals, engaging in leadership positions within an agency, or perhaps considering opening your own professional practice. As with any new endeavor, having an idea of the challenges that may await you is one of the best ways to prepare yourself for future success. At this point, much like at the beginning of your counseling career, you may not know what you do not know—this book aims to start you thinking about how you may want to proceed. The next steps of your journey as a professional counselor can be as exciting and invigorating as those first few counseling sessions as a new professional, but now they can be tempered with your experiences, making them richer and something to be shared with your professional community. Let the journey begin!

### ORGANIZATION OF THE BOOK

This book contains 10 chapters and is divided into two sections: supervision and agency management. Chapters 1 to 4 are dedicated to issues related specifically to the supervisory process, such as roles and responsibilities, ethics, and various due-process procedures. Within these chapters, you will find resources that you can adapt to your own practice as a supervisor and additional resources that can help you explore more deeply your journey toward becoming a supervisor.

Chapters 5 to 10 focus on the aspects of agency management (including issues that pertain to private practice) that may be less familiar to counselors, simply because counseling preparation programs typically don't explore these issues in depth. You will find chapters focusing on budgeting, information management, leadership, and marketing. The budgeting chapter not only gives the reader information about how to financially plan, but provides the

information in a very accessible manner. You can also explore how marketing in your community is not only a vital component of your success, but a great way to network with other community agencies and businesses that you may not be as exposed to when you are concentrating on your role as a professional helper.

With all of the information provided herein, you will follow our protagonist, Amy, as she charts a course that is similar to that of many clinicians in transition—making mistakes and learning how she can become a better supervisor to move toward a leadership position within her agency.

## Acknowledgments

To become professional counselors and counselor educators there have been many people Elizabeth and Mike have met along the way who have helped them to become who they are and who will always be integral to their continued development.

Elizabeth would like to thank Mark Young, Joshua Gold, Margaret Burgraff, Beth DuRant, and Beth Hook. All of these individuals have likely shared both the joy and frustration of working with Elizabeth in her development as a beginning counselor and later as a counselor educator. She is particularly grateful to the "Beths," who supervised her throughout some of her most challenging moments as a young professional and were unwavering in their support of her development. Elizabeth would also like to thank her friends Mimi Meriwether, Sarah Protheroe, Crissy Roddy, Amy Gruber, Beth Crawford, and Beka Bohannon.

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Mike would like to thank God, who answered his prayers and provided for his needs. Mike thanks his wife, Brenda, his greatest supporter, who is always there when needed and always provides space and time when needed. Her loving kindness can never be repaid. He would also like to thank the many contributors who signed on to this project. They graciously supported this work with their resources and expertise. Thanks are due to Springer Publishing Company for encouragement and much-needed input. And, of course, Mike is appreciative of his friend and coeditor, Elizabeth. She generated the overall concept of this book and wove the various threads into a meaningful and wonderful fabric. With a mind that never stops, generating ideas wasn't much of a problem for Elizabeth; however, constraining her thoughts was demanding.

Elizabeth and Mike would both like to thank Amiko Warren McPherson for her diligent work in assisting with this project.



O • N • E

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## Orientation to Agency Management and Supervision

*Elizabeth R. O'Brien*

*Amy is a clinical mental health counselor working in a small start-up community mental health agency. The agency is located in a midsized urban area and serves individuals who are dependent on the state for physical and mental health assistance; the agency is funded by local, state, and federal programs as well as community grants. Before this job, Amy worked for 4 years at a psychiatric hospital, during which time she earned her professional counseling license. Prior to earning her master's degree, Amy worked as a case manager at a mental health clinic in a different state for 5 years.*

*During the interview process, Amy's supervisor informed her that she could look forward to assuming some leadership responsibilities in the agency if she was able to demonstrate the requisite competencies for such an appointment. So far, her supervisor has been vague in describing what those competencies might be. Amy is working to ensure her clinical skills are beneficial to the community, but, at the same time, she is trying to acquire the leadership experiences she thinks will help forward her career. She is attending night classes and seeks mentorship and supervision from sources well versed in the challenges she will face.*

*As the agency becomes established within the community and the hurried pace of a start-up begins to die down, Amy's boss begins inviting her to attend management meetings with other staff. As she listens to the discussions, Amy realizes that she will find it challenging to balance the roles and responsibilities of providing clinical supervision to personnel, of helping to manage the agency's nonclinical employees, and learning the business responsibilities of running the agency. After one of these meetings, Amy's boss discusses her first step in leadership: She will begin clinical supervision of three of the new master's-level therapists whom the agency hired.*

## INTRODUCTION

Most beginning counselors graduate from preparation programs with the ability to amalgamate specialized learning to create a framework for counseling practice. For beginning practitioners, the challenge then becomes one of honing and refining their skills so that they become both competent and confident in their clinical ability (Stoltenberg, 1981). As they advance, beginning practitioners will likely have opportunities to experience a wide variety of counseling settings and treatment modalities. Some clinicians may become adept at using brief evidenced-based practices (EBPs) with multidisciplinary treatment teams for efficient and holistic client care, some may choose to engage in a solo or private practice, and others still will oscillate between various settings throughout their careers. Under supervision from senior counselors and other helping professionals, these counselors will obtain licensure and other professional credentials that will mark their passage from beginner to experienced professional.

Amy's story is similar to that of many clinical mental health counselors after they have moved out of their initial phase of development, have graduated, and have gained initial experience in moving toward licensure and beyond. Their peers see these counselors as able to train newer clinicians and as having obtained institutional knowledge (at the agency, community, and state levels) that helps them to create appropriate treatment plans for their clients. When these professionals consistently demonstrate a high level of clinical skill and professional knowledge, their agencies often identify them as emergent leaders. Conversely, some professionals may find that they are comfortable with their knowledge base and are ready to embark on a journey toward establishing their own mental health agency or private practice. The challenge becomes finding a guide to delineate the next steps toward success in either of these endeavors.

To that end, the purpose of this text is twofold: (1) to educate emerging agency leaders on best practices in clinical supervision and (2) to educate established clinicians on basic business practices that are integral in either managing an agency or establishing a private practice. Subsequently, the text is presented in two sections that will address both of these goals. Within this chapter, we discuss broad changes that have taken place in clinical mental health agencies and then lay the groundwork for understanding the supervision process and responsibilities. Subsequent chapters in the first section of the book further elaborate on best practices in clinical supervision. Please note that although this text provides an overview of supervision and business practices, it is not a comprehensive guide. Therefore, suggestions for further research and readings are included at the end of each chapter.

## CLINICAL MENTAL HEALTH AGENCIES IN THE 21ST CENTURY

In the United States, it is estimated that approximately 9.6 million individuals (adults and children) were diagnosed with a serious mental illness (SMI) during the 2012 calendar year (National Institute of Mental Health [NIMH], 2012). Of the adults in this estimate, approximately 58% received mental health services

in the form of inpatient hospitalization, outpatient treatment, and/or prescription medication. Of the 9.6 million aged 18 and under, approximately 50% engaged in the aforementioned services. These numbers indicate that although there is a great need for mental health services, there are still large numbers of adults and children who do not receive the services that they need in order to manage the symptoms of an SMI. Those who do obtain services typically access care through hospital emergency rooms, psychiatric facilities, and community clinical mental health agencies. Our discussion will focus on the latter.

Clinical mental health agencies aim to provide care and services to individuals and the community and seek to enhance individual development and functioning. Often, these agencies offer specific types of mental health service delivery, such as substance abuse treatment, medication management services, psychiatric evaluations, psychological treatment, psycho-educational programs, and case management services, to target interventions for specific populations as needed. The overarching mission of helping individuals to obtain and maintain optimal mental health functioning is a newer concept, as, historically, mental illness has been treated as something shameful and untreatable (Rosenberg, Rosenberg, Huygen, & Klein, 2013). Although the incidence of stigma is somewhat less prevalent than it once was, mental illness and mental health conditions have been stigmatized both publically and personally. Public stigma of individuals can include the prejudice that those with mental illness are dangerous, violent, and unpredictable. Discriminatory practices can result from this type of prejudice, such as friends and family disengaging from relationships with these individuals or difficulty in obtaining housing and/or employment. Personal stigma can result in individuals' feeling shame and experiencing lower levels of self-esteem. Additional consequences can include individuals' adopting self-sabotaging behaviors that fulfill the expectations of public perception (Coorigan & Lee, 2013). However, as mental health and mental illness issues have received greater acknowledgement in the recent past, there has been a societal shift toward treatment and prevention of mental health-related issues.

The 21st century has brought changes in the way clinical mental health agencies function. The adoption of the 10 Essential Public Health Services in 2014 as an addendum to the Affordable Care Act (ACA) extended mental health care benefits to many by requiring that mental and substance use disorder services be included in health plans offered to individuals and group markets. These must be included in health insurance plans and be comparable to other types of medical coverage, such as general medicine and surgical care (Berionio, Po, Skopec, & Glied, 2013). The acknowledgment of mental health care as an essential service is a welcomed feature of the ACA; however, maintaining public acceptance of the necessity of mental health care will depend on outcome data showing that treatments and programs are efficacious—hence the emphasis on evidence-based practices (Berionio, Po, Skopec, & Glied, 2013). Further discussion regarding the financial ramifications of the ACA is found in Chapter 7; now let us briefly explore ideas related to outcome data.

Investigators engage in therapeutic outcome research to determine whether a particular treatment modality is useful for a given disorder. Although this definition is more germane to medical research, the field of



psychology engages in similar research when validating EBPs. EBPs tend to be interventions that are researched in relation to specific client populations, such as trauma-focused cognitive behavioral therapy (TF-CBY) for individuals diagnosed with posttraumatic stress disorder (PTSD). This and other EBPs are sometimes considered “manualized” treatments, meaning specific techniques and approaches of the therapy are taught to clinicians with the intention that they will use this knowledge to treat or counsel clients and their families (Ledley et al., 2009). The strengths of these EBPs are such that they have been shown to be successful for a large number of client issues, such as (a) illness management and recovery, (b) medication management, and (c) family education/involvement (Sands & Gellis, 2001). In addition, they tend to be cost-effective and offer recommendations for specific assessments that one can use in data collection and analysis for agency-level efficacy studies. Agency-level studies generate data that can provide important evidence when these entities are looking for new funding or are attempting to maintain their funding.

Please note that although EBPs are useful for treating clients with particular clusters of symptoms and/or diagnoses, the efficacy of counseling is also deeply affected by common factors inherent in all counseling. These common factors, first articulated by Rosenzweig (1936), are part of the inherent set of circumstances and/or characteristics that exist within therapeutic treatment modalities that lend themselves to the overarching success of counseling. The reality is that all therapeutic interactions contain aspects of these common factors, and that even though specific theories or treatment modalities are ascribed to have more or less of a particular factor, these transtheoretical aspects permeate counseling (Hauser & Hayes, 2010). Although the common factors have been presented in many different permutations, the most succinct come from Bordin (1979) who streamlined them to the following components: (a) an agreement on goals, (b) having tasks or a series of tasks to complete, and (c) the development of bonds and/or the therapeutic relations (p. 253). Although EBPs have benefits, they are not without shortcomings. Individuals who experience mental illness can present with a variety of symptoms and have issues within their lives that can make treatment challenging. Because EBPs are generalizable by design, some argue that they are not designed for “outliers,” or those who may present with more severe symptomology. One other problem with EBPs is that it is virtually impossible to research the efficacy of all treatment modalities against all forms of mental illness, particularly with the recognition that clients rarely present with a singular mental illness. Most clients tend to have co-occurring disorders, which severely complicates the principles involved in efficacy research. In addition, one must consider the aforementioned common factors, and the degree to which they are present or absent within treatment, as this can have a deep impact on the overall success of treatment, yet be unmeasurable by an EBP's assessment. Although counselors can augment their practices and treatment modalities to tailor interventions for clients, this may threaten the validity of a particular EBP. Finally, those responsible for evaluating the usefulness of an EBP within a particular agency should be aware of research design and basic statistics so they can determine whether an approach has been well validated and is appropriate for the population that the agency serves.

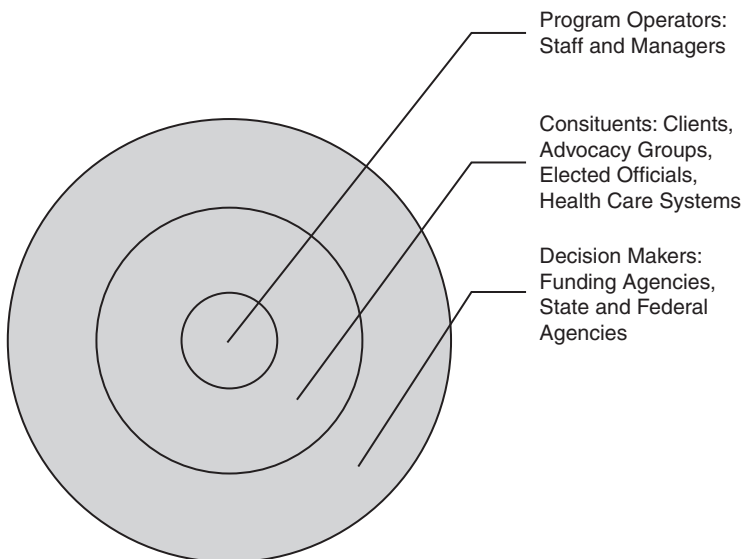
## COMMUNITY STAKEHOLDERS

Community partners or “stakeholders” are those individuals, groups, or organizations that have a “stake” in how the organization runs and the services it provides to the community. In particular, certain community partners can have specific expectations regarding services the agency provides and the manner in which the agency provides these services. By adapting the Centers for Disease Control and Prevention’s (CDC’s) model of stakeholders (Figure 1.1), one can categorize these groups in the following ways:

1. Program operators, such as managers, staff, and funding agencies
2. Constituents, those served by the program, such as clients, advocacy groups, and elected officials
3. Decision makers, those who have a vested interest in the success of a program, such as the general public, funding agencies, and partners (CDC, 2015)

Public health issues are very complex and include a range of stakeholders, all of whom have an important role to play. It must also be said that although all partners have a vested interest in how agencies are run and how they serve their community constituents, these partners’ interests do not always align with the mission of the agency. In examining the previous list, one can see that a power hierarchy may exist among stakeholders, with some having more formalized and institutional power and influence than others. More institutionally powerful stakeholders, such as local and state government agencies, are imperative for funding and licensure. However, one should acknowledge that although clients and community groups may have less formalized power, they

FIGURE 1.1 • Program evaluation.



Source: Adapted from Centers for Disease Control and Prevention (2015).

are the rationale for the existence of these agencies and should be respected members of the stakeholder community. In other words, they need to be heard.

Ideally, stakeholders should use a utilitarian approach when defining the purpose of a mental health agency: to do the greatest good for the greatest number of people within the community. However, issues typically arise when the priorities of one group do not align with the priorities of a second group. For example, imagine a local advocacy group is looking at mental health services provided in a city and sees that the only agency is located in an area that is inaccessible to individuals living in a high-poverty area with limited transportation options. The advocacy group decides to conduct a cost-effectiveness analysis on establishing a small mental health clinic in the impoverished area. A cost-effectiveness analysis compares the relative costs of a service compared to the effectiveness of the benefits that the service will provide. Although this may sound similar to a cost-benefit analysis, *effectiveness* is a term that is used when evaluating the usefulness of health services because health is a difficult quotient to quantify. In this case, the cost-effectiveness analysis would examine the cost of opening and operating a small clinic in a high-need area compared to the overall health benefits to individuals and the community. Suppose the advocacy group found that the health benefits of opening the clinic (e.g., lower rates of hospitalization and police interventions in domestic disputes) would indeed offset the overall cost of the clinic—it would seem this would be a no-brainer, right?

But then we must consider this example from the perspective of the government—the state mental health office—and its budgeting issues. Funding for the upcoming fiscal year has been cut, and there is less money allocated in the budget to fund mental health agencies. Because of this cut, the local mental health agency will have to downsize its staff to two thirds of the previous workforce. This downsizing will diminish the services that the clinic can provide to the whole community. Now the idea of trying to take the resources that remain and create a small clinic would be extremely difficult, and, in the eyes of the state mental health office, could further diminish the health benefits to the overall community.

So, how can stakeholders reconcile this idea of doing the greatest good for the greatest number when each group can present a rationale for how its ideas are beneficial to the community? This type of misalignment can cause a great deal of strife among stakeholders, which often plays out in public forums, such as the media. Too often, these types of struggles disempower those stuck in the middle, who are unable to voice their opinions. Ultimately, these decisions are often based on funding, and, in our example, although the state office wishes to help all community members, the decision at this point is to fund only one clinic and put off discussions of a second clinic until more funding can be secured.

## Stakeholders and Program Evaluation

One of the most important roles that stakeholders play in the life of a mental health agency is helping in the evaluation process. Agencies as a whole must engage in continuous evaluation so they can gather evidence regarding their

impact on the community they serve, which is somewhat similar to the discussion of EBPs in the previous section. Program evaluation is an intensive process that helps agencies determine the efficacy and efficiency of their current practices and can yield important information regarding areas for improvement. Chapter 5 features a more in-depth discussion of program evaluation; what follows here is a concise description of how stakeholders can be a part of this process.

As mentioned previously, one can sort stakeholders into specific categories that make them easier to identify. After identifying these categories, contact stakeholders to ascertain whether they are interested in providing input to the agency regarding its benefits to the community. Often, interested parties will convene in focus groups, open community meetings, and have meetings with officials. These forums allow stakeholders to discuss the components of mental health intervention and/or agency outcomes that matter to them. Identifying outcomes, or what stakeholders want the mental health agency to “do,” is integral when creating an evaluation plan. Questions that are important for stakeholders to answer can include:

- Whom do you represent and what is your interest in this agency?
- What would you like this agency to accomplish?
- How would you measure progress toward accomplishing these goals?
- How much progress would you expect this agency to have made at this time?
- What do you see as a critical evaluation question at this time?

After answering these questions, it is important to find common themes that are included in stakeholders' answers. This is important for two reasons: (1) it will help evaluators understand the salient issues that are shared between groups and (2) it will help unite stakeholders in a shared vision for the agency.

After identifying these themes, presented as desired agency outcomes, stakeholders should begin examining ways that the agency can collect data to evaluate the degree to which the outcomes are being met. Representatives from different stakeholder groups can meet on a regular basis in the form of an advisory board to discuss the relevance of the outcomes, data that are being collected to determine whether outcomes are being met, and augmentation to practices that may be needed in the face of evaluation results.

Dissemination of evaluation results and reports to stakeholders and others on a regular basis is a part of agency transparency within the community and beyond. As previously stated, the ACA and other funding entities are deeply interested in the impact that agencies have on their clients and the cost-benefit scenarios of agencies in terms of their results. Evaluation reports allow for stakeholders, funding entities, and agency critics to make data-informed decisions regarding the overall efficacy of an agency with its treatment populations.

## DEMOGRAPHICS

Demographic changes in the United States have also made it imperative that clinical mental health agencies are able to provide culturally appropriate interventions to an increasingly multicultural society. U.S. Census data from 2000 to 2010 show an increase in the number of Hispanic or Latino individuals,

as well as those identifying as two or more races (U.S. Census Bureau, 2012). Census updates from years subsequent to 2010 show that this trend is continuing. Data on poverty show that the number of adult individuals sharing a household (beyond the primary adult) increased for all age levels, and that the rate of children living in poverty was 21.6% in 2010—at that time, the highest rate ever recorded.

Racial minorities and individuals living in poverty often do not have adequate access to mental health resources and/or have access to mental health providers who are inadequately equipped to help with the specific needs of these populations (Sands & Gellis, 2001). The additional mental stress that can be present for minorities and those living in poverty can often compound and exacerbate symptoms. Counselors must be aware of these issues so that they are able to engage in therapeutic interventions that are respectful of the potential challenges that these populations face.

The consequences of interventions that are culturally inappropriate can include client attrition, prolonged symptomology, and client estrangement from therapeutic interventions. Professional organizations, such as the American Counseling Association, the official professional organization for counselors, have attempted to respond to this disparity by delineating multicultural competencies within ethical codes. In counselor preparation programs, such as those accredited by the Council for the Accreditation of Counseling and Related Educational Programs (CACREP), programmatic requirements delineate multicultural competencies that students are required to learn (CACREP, 2009).

However, individually, counselors must make the commitment to engage in continuous education (see Chapter 2) and immersion experiences so that they are able to acknowledge the differences that exist within communities that are culturally and ethnically diverse and to provide culturally responsive care to their clients. Supervisors of clinical counselors must also stay abreast of multicultural issues that can affect the counselor–client relationship and the supervisor–supervisee relationship. In its *Best Practices in Clinical Supervision*, the Association for Counselor Education and Supervision (ACES) states, “The supervisor recognizes that all supervision is multicultural supervision and infuses multicultural considerations into his/her approach to supervision” (Borders et al., 2011, p. 8). These stances reflect the need for mental health services to be available to fulfill a wide range of diversity needs in society and that continuous training must be in place to help counselors meet these needs.

## HISTORICAL FACTORS

Whereas multiculturally responsive counseling typically encompasses issues related to racial identity, socioeconomic status, and gender issues, there are other diversity and historical factors that influence service delivery. Examples include the following:

1. The acceptance of same-sex relationships and national legalization of same-sex marriages in the Supreme Court decision on the case of *Obergefell v. Hodges* on June 26, 2015

2. The advent of terms, such as “technology addiction,” and treatment modalities for individuals who engage in compulsive Internet and technology usage
3. Increased mental health services and support for veterans and their families experiencing trauma from deployment and family reintegration issues

These specialized issues, and recognition of how they contribute to mental health, are becoming more prevalent in society and deeply affect the overall development of individuals throughout the life span. For example, recent research has shown that children and nondeployed parents tend to have higher levels of psychological, behavioral, and academic/work distress during military deployment, and families experience these same symptoms during reintegration of the deployed spouse (Chandra et al., 2010; Siegel & Davis, 2013).

## MULTIDISCIPLINARY TEAMS

To this point, the discussion of mental health agencies has focused on forces that exist largely outside of the agency. However, this final section focuses on an important component of agencies that resides within: multidisciplinary teams (MDTs). MDTs are a vital part of comprehensive treatment and are defined as “individuals from various disciplines who are involved in a project but work independently” (Ciofi, Wilkes, Cummings, Warne, & Harrison, 2010, p. 62). Agency teams often comprise counselors, nurses, social workers, case managers, psychiatrists, and general physicians. Research shows that MDTs are advantageous when working with clients who present with complex issues, such as co-occurring disorders or SMIs (Belanger & Rodriguez, 2008). Team members tend to possess different talents, knowledge, and experiences, all of which can help the group to create interventions tailored to the specific needs of individual clients. The outcomes of these interventions can increase clients’ access to quality care, reduce individual and familial stress, reduce hospitalization rates, and improve overall client outcomes (Ciofi et al., 2010).

When they are working well, MDTs can be extremely beneficial to clients and help to create a collegial working environment. However, issues can arise within teams that can hinder productivity. Team structure and functioning can be derailed if members feel threatened or unsure of their roles within the group. For example, if a power hierarchy exists within the group (such as physicians as the head members of the treatment team), it could make other members wary of sharing their opinions if they are contradictory to those of the more powerful members. Defining the roles and responsibilities of each team member could help in mitigating some of these issues. It is also recommended that communication training and/or team building should be included in the ongoing education of MDTs. This becomes particularly important when professionals from diverse disciplines are engaged in treatment planning and have differing points of view.

## OVERVIEW OF SUPERVISION

Supervision is an important process that protects clients and helps all clinicians maintain ethical behavior and engage in best practices. With that being

said, it was once described to me in terms of the Dr. Seuss book *Did I Ever Tell You How Lucky You Are?*: "his job is to watch. Is to keep both his eyes on the lazy town bee, a bee that is watched will work harder you see" (1973, p. 26). Later in the story, it is determined that the watcher needs his own watcher, who then needs his own watcher, until finally a long string of watchers is engaged to watch what the original bee is doing. Supervision is similar in its layers of people who are "watching"; new counselors are supervised by individuals who themselves are accountable to their own organizational and/or clinical supervisors, consultation partners, and regulatory agencies such as state licensure boards.

Gaining the responsibility of supervision can come in two ways: formally and informally. Formal supervision responsibility is obtained by gaining a specialized license through one's state credentialing board or being promoted within an agency to supervise other clinicians. More informal mechanisms include allowing interns/new clinicians to observe one's practice when conducting psycho educational groups, group counseling, or individual therapy. Other modes of informal supervision include answering questions regarding institutional processes, treatment planning and aftercare services, and community resources. Consider Amy's journey toward becoming a clinical supervisor:

*Amy's first responsibility as an emerging leader is to begin supervising three newly hired master's-level clinicians. With guidance from her agency supervisor and her clinical supervisor, she contacts the state licensure board to find out what requirements she must meet in order to supervise new clinicians toward their own licensure. Amy lives in a state that requires that supervisors have 2 years of clinical experience beyond their initial licensure and complete three continuing education credits (CEs) per licensure renewal on supervision practices.*

*Amy completes the supervisor application and the board approves her as a licensed professional counselor supervisor (LPC-supervisor). This responsibility means that she can supervise newer clinicians on their cases, is well versed in local and state laws that affect practices, and can recommend clinicians for licensure when they have completed the clinical requirements.*

*Although Amy has completed her three CEs in supervision, she now knows that balancing the roles and responsibilities of being a clinical supervisor will be challenging. She considers her supervisees, who until this point have been casual friends of hers at work. She decides that in her first supervision session, she wants to begin with a conversation about the role she now plays as their clinical supervisor and their perceptions of what this means for their working relationships in the agency and in supervision.*

In the next pages, we will explore the process of supervision, the roles and responsibilities of supervisors, and the various entities and agencies that influence supervision practices.

## DEFINING SUPERVISION IN A CLINICAL SETTING

Merriam-Webster (n.d.) defines *supervision* as “the action or process of watching and directing what someone does or how something is done.” The responsibilities of mental health supervision can be grouped into two distinct categories: organizational supervision and clinical supervision. Organizational supervision in agencies typically pertains to “directing,” particularly as it relates to having clinical and other employees follow established agency policies and procedures. The organization creates these policies and procedures based on standards of care established by agency accrediting bodies, and state and federal laws drive them. Examples can include documentation of client interventions, time frames for linking clients to services outside of the agency, or assessment procedures used in determining interventions that will best suit clients’ needs and yield outcome data for the agency regarding efficacy.

Clinical supervision is a more specialized process and involves “watching”—for example, ensuring that clinical employees are engaging in theoretically and ethically sound treatment practices that they are fully qualified to use. Ultimately, a clinical supervisor’s first responsibility is to ensure the safety and welfare of the client, and this is done by engaging new clinicians in the supervision process. Bernard and Goodyear’s (2009) definition of *clinical supervision* states that it “is an intervention provided by a more senior member of a profession to a more junior member or members of that profession” (p. 7). The authors also articulate that the relationship is hierarchical in nature, that supervision is an ongoing process, and that the supervisory process is imperative as a *gatekeeping* measure to ensure clients’ welfare. The gatekeeping role is particularly important in training and maintaining clinical professionals who are competent and ethical practitioners who abide by their state laws, licensure codes, and professional ethics codes.

Gatekeeping is, in this author’s opinion, one of the greatest responsibilities that a supervisor has in the supervision process. Essentially, the supervisor ensures that an individual is competent to ensure clients’ welfare, is able to engage in appropriate clinical interventions, is ethical, and is able to practice within the standards set forth by the state and other credentialing agencies. However, this role is not simply a confirmatory process; the gatekeeper also maintains the burden of preventing incompetent clinicians from entering into the field or continuing practice for reasons of unethical behavior and/or impairment. Although this may seem to be a didactic process, it in fact rests on a continuum, with supervisors also helping supervisees to ameliorate inappropriate practices so that they can be successful clinicians. Supervisors who provide ongoing evaluation (as discussed in the next section) are transparent in the gatekeeping process so that supervisees are able to make a successful transition from apprentice to independent clinician.

The irony is that most professionals who engage in supervision and the gatekeeper role are experienced clinicians who have had either limited or no formalized training in supervision processes. Typically, professional credentialing groups and accrediting bodies set eligibility and qualifications criteria



necessary to engage in supervision, but the entities that have the most impact on supervisors are standards set by individual state regulatory boards. These standards vary from state to state; for example, several states require that supervisors be approved by their state licensure board (e.g., Arkansas), whereas other states delineate that supervision with any licensed mental health professional is approved (e.g., District of Columbia). However, a few states clearly articulate that supervisors must have obtained training in supervision before they are approved to supervise (e.g., Oklahoma; American Counseling Association, 2010). Because Amy is from a state with guidelines similar to those of Oklahoma, she completed some education in supervision before she was board approved to supervise; however, even this requirement gives a limited scope to the responsibilities of clinical supervision.

Professional credentialing groups, such as the National Board for Certified Counselors (NBCC), also engage in credentialing both professional counselors and supervisors. Specifically, the American Association for Marriage and Family Therapy (AAMFT) offers credentials for individuals who can demonstrate a level of competence that is more advanced compared to that of their professional peers. The AAMFT also has a specific set of criteria for credentialing clinical supervisors. Finally, accrediting bodies, such as the CACREP, have specific standards that educational programs must follow in order to prepare all counselors and counselor educators.

The number of CACREP education standards regarding teaching supervision to master's-level clinicians is relatively small, only two, when compared with the requirements for those completing doctoral work in counselor education and supervision—a discrete section that includes six outcomes that articulate the knowledge, skills, and practices doctoral candidates must learn (CACREP, 2009). Understandably, individuals preparing to train counselors in an educational setting must have extensive knowledge of clinical supervision practices. However, given that master's-level clinicians supervise most beginning counselors in the field, it stands to reason that some attention should be given to these processes within counselor preparation programs.

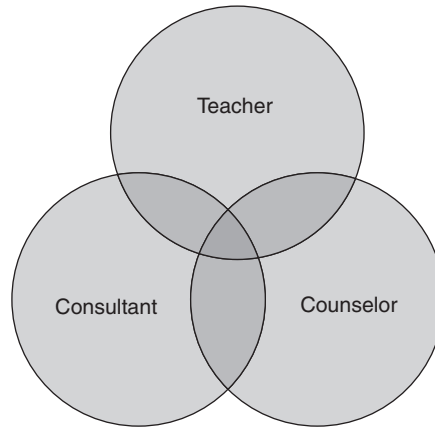
## **SUPERVISION PROCESS AND ROLES**

Supervision is a didactic process, meaning that supervisors and supervisees should engage in a dynamic learning environment that focuses on constructing knowledge and skills. This description may imply that supervision follows a specific set of steps or pedagogy; rather, it can be an ambiguous process that requires a great deal of flexibility on the part of the supervisor in order to meet the needs of supervisees and their clients.

Supervision has many parallels to teaching, counseling/psychotherapy, and consultation (see Figure 1.2); each of these will be discussed further. However, it is important to be mindful that although supervision is a combination of the aforementioned, it is a separate construct with specific ethical guidelines and processes.

As stated previously, supervision does have some parallels to teaching. A more advanced practitioner is actively engaged in teaching and modeling behaviors that the less experienced counselor is expected to learn and/or

FIGURE 1.2 • Supervision Venn diagram.



emulate in his or her own style. As professional gatekeepers, supervisors are responsible for the evaluation of supervisees' performance and giving appropriate feedback regarding their performance. Because the relationship is hierarchical, supervisors have both power and responsibilities. In mental health agencies, clinical supervisors are typically responsible for completing or contributing to employee performance reports, reporting supervision hours completed toward licensure requirements, and making recommendations to licensure boards regarding the ethical practice of supervisees.

Ideally, supervision happens in a dynamic learning environment, but there is not a specific teaching formula that supervisors follow in order to inculcate their supervisees with knowledge. The term *dynamic* is used because there are so many working parts to a given supervision session, and there can be many opportunities for learning experiences beyond discussing cases. Although this may sound similar to a counseling session, sometimes the ambiguity of supervisees' needs can be frustrating for those who are beginning supervisors. It is at this point that the supervisory relationship becomes especially important—just as counselors ascribe to the idea that the therapeutic relationship is the impetus for change, so too is the supervisory relationship the impetus for counselor growth. Through supervisee self-report, therapy recordings, and case records, supervisors can learn the specific needs of the supervisee and tailor their interventions in order to promote optimal professional growth.

In addition to teaching, supervision also has some parallels to the counseling process. In Chapter 4, you will see that supervision theories have some similarities with counseling theories—particularly important is that supervision theories are very interested in a supervisee's worldview. Worldview is determined by an individual's attitudes, values, and opinions, which in turn can affect how the individual thinks and behaves, and influence decision making (Sue & Sue, 2013). Within supervision, worldview is a crucial aspect of how the supervisee conceptualizes the client and can be the root of problematic thoughts, feelings, and behaviors that hinder the success of the therapeutic relationship. Supervisors must be able to use their counseling

skills in order to probe supervisees regarding how these issues are influencing their interactions with clients. At the point of insight, supervisors then move supervisees toward reflective practice that focuses on minimizing the negative impact of the client–counselor working relationship. Supervisors must be vigilant when working with supervisees in this type of modality for many reasons. Supervision is a hierarchical relationship in terms of power, and the evaluative aspect that exists therein should not be influenced unduly by the intimacy that is inherent in a counseling relationship. In effect, supervisors should know that supervisees are not impaired and are professionally competent, but more knowledge could impair supervisors' ability to evaluate supervisees in a fair manner. If a supervisor suspects a supervisee is experiencing a significant impairment, he or she should refer the supervisee for personal counseling and work with the individual to determine whether he or she is able to remain in the counselor role. Although these conversations can be intimidating, they are an inherent part of ensuring client welfare, as well as helping supervisees with issues that can lead to attrition in the profession.

Finally, the supervisor fulfills the role of consultant when working with supervisees. The consultant role is well conceptualized by Hart and Nance's (2003) two-by-two model, which delineates a supervision style that is lower in support and directionality than its teacher/counselor counterparts. When consulting, the supervisor and supervisee engage in more egalitarian and peer-like conversation that can range from discussing client cases to how to use therapeutic interventions with client populations with which the supervisee is less familiar.

It is recommended that certain competencies be met before consultation is used as a supervision modality. First, supervisors must ascertain that supervisees are capable of performing their duties and are not in need of the "hand-holding" that supervisees may need when they are newer in the field or new at a particular agency. Note that supervision roles shift throughout relationships, and new experiences can require more direction; however, when supervisees are becoming more autonomous in their practice, consultation can fulfill the important role of helping supervisees reframe their experiences from that of novice to colleague.

## **ROLES AND RESPONSIBILITIES**

As mentioned previously, supervisors have very specific functions in terms of training both pregraduate and prelicensure counselors in an agency setting. In this section, we explore the supervisor's role as an evaluator and recorder. It should be noted that there is some discussion of how supervisors' roles can vary depending on whether they are engaged in organizational supervision, clinical supervision, or both types at the same time. This is an important distinction to make because not all clinical supervisors have influence over supervisees' work environments, but they are still considered responsible for client welfare, whereas organizational supervisors are likely to be responsible for client welfare regardless of their involvement in their supervisees' clinical supervision and development.

A supervisor is responsible for assessing and evaluating the performance of a supervisee, regardless of whether the position is that of clinical or organizational supervisor. Part of this evaluation entails informed consent of the supervisee; this means supervisors must inform supervisees in their purview of the policies and procedures that they must adhere to as well as due-process procedures for appealing supervisory actions. Although this is discussed more fully in Chapter 3, it bears mentioning here that all of those who engage in supervision should take the time to reflect on their expectations for both their supervisees and themselves within the supervisory relationship. One could assume that supervision is simply two people in a room discussing cases and that is all, but, in fact, supervision is much more successful when there are clearly delineated expectations, procedures, and evaluations in place.

Examples of record keeping include supervision notes, supervisory evaluations of new clinicians' performance, and evaluations, as well as agency-generated evaluations such as annual reviews. Anyone who has worked in an agency or business setting has likely experienced the process of an annual review. For those who may not have, an annual review usually occurs once per year and entails a supervisor assigning performance ratings for particular tasks that the supervisor expects employees to complete as a course of their duties. A great example of record keeping is keeping client records or charts up to date. Because medical records and documentation are tied to how agencies are reimbursed for services, peer audits are often performed monthly or bimonthly to ensure that employees are documenting services in a timely and approved format. Audits are typically performed by having clinicians randomly select their clinical peers' client records and review them with a checklist; the clinicians then submit the checklist to a supervisor. Checklists often include items such as treatment plans, physician orders, completed intake assessments, and similar items. This type of intervention is designed to ensure that employees are reminded to keep records up to date as well as compliant with agency and governmental requirements for documentation.

Peer audits also help supervisors to determine how well employees are performing on this particular task. Most of the time employees are documenting in a timely manner; however, if there is a clinician who is not, supervisors must work with the clinician to ensure that this does not happen, given that the results of nondocumentation can result in loss of revenue, paybacks to insurance companies, and fines levied on the agency. Typically, noncompliant employees are given a warning; however, if they persist in noncompliance they may risk being written up. In egregious cases, employers can fire employees for failure to document appropriately.

Supervisors are responsible for reviewing several aspects of employee performance, such as in the record-keeping example, as well as other aspects of professionalism such as ethical practice, comportment, and adherence to company policies. They are also responsible for communicating to supervisees when they have violated professionalism or policies and the due process for appealing decisions regarding poor performance reviews, professional censures, and termination of employment. The adage that "with power comes responsibility" is very true, and potential supervisors must consider whether they can fulfill this important role and whether they are able to handle taking

on the difficult tasks of supervision, such as employee termination, along with the more enjoyable tasks, such as signing final paperwork before a supervisee submits an application for licensure.

Additionally, reflective supervisors consider and acknowledge the impact that their role can have in working relationships and their personal lives. Supervisors must be able to cope with the isolation that can sometimes accompany the supervisory role. Questions that anyone interested in taking on supervisory responsibilities should ask himself or herself include:

1. Do I want to take responsibility for the actions of others?
2. Do I want to be the individual who will be "on-call" when others are ill or unable to perform their duties?
3. Do I want to be responsible for negotiating the needs of the agency with the workload of my workforce, particularly in difficult times?
4. Do I want to be part of a vision team that devotes time to the development of the agency rather than engaging in helping?
5. Am I comfortable with participating in the social and networking events that will become part of my job description?
6. Am I (and my family) comfortable with losing some aspects of privacy due to work impacts?
7. Am I ready to be the person who will have to reprimand and/or terminate another clinician?

Although this is not an exhaustive list, it is a good start for those who are evaluating their readiness to supervise. Another aspect that supervisors and potential supervisors should consider is how they model professionalism and comportment to their peers and supervisees, as discussed next.

### **Commitment to Continuous Professional Engagement and Training**

Perhaps one of the most important ways that a supervisor can model professionalism is by continuously engaging in professional service and training. Examples of professional service/engagement include membership and/or leadership in one's local, state, or national-level counseling organizations; presenting at a local, state, or national conference; and serving as a board member for a nonprofit organization. Professional training is just as it sounds: attending conferences and/or education sessions to procure knowledge in areas that one is interested in (such as supervision training, play therapy training, etc.), as well as training that reinforces best practices in the field (e.g., continuing education in ethics and multicultural competencies).

Another responsibility of professional engagement is staying up to date on one's state licensure laws and regulation board requirements. Licensure laws vary from state to state, and supervisors should be knowledgeable of the rules that govern licensed professional counselors (LPCs) and LPC interns in their area. Supervisors who live near state borders should also be aware of the licensure laws of those states as well. Additionally, supervisors should be aware of the written laws that govern their practice—that is, the legislation that is part of the legal code, such as the age of consent. Again, those living near state borders should be aware of laws pertaining to their clients in the

states in which they reside. Typically, one can download licensure laws for reference as well as call licensure boards to resolve questions that may arise in the course of professional practice and/or supervision.

It can be easy to regard these types of endeavors with a bit of a sigh; most people are busy, and these activities can seem like one more item to be checked off of one's never-ending "to do" list. However, there are inherent benefits to these activities that professionals often forget, such as being presented with the opportunity to engage with peers who understand your professional joys and difficulties, learning new techniques that can be adapted to your clients and/or supervisees that will invigorate your practice, and being reminded of those best practices that you may have "drifted away" from because you are busy minding other responsibilities. It is also easy to forget that newer clinicians, peer clinicians, and your supervisors are watching you to see how you conduct yourself and how you represent the profession. This is not to assign an additional burden, but rather is meant as a gentle reminder of the responsibilities that are inherent in the role of supervisor. For this author, the opportunity to be a teacher and supervisor has been a great gift; if most supervisors are being honest, they will say that they learn more from those they supervise than by any other means. It is the gift of the role: Supervisors encounter so many different worldviews and ways to counsel that they are given the opportunity to see helping with fresh eyes.

## SUMMARY

Individuals who wish to move into positions with greater responsibilities within an agency must consider both the current trends within agency management and efficacy as well as what it means to become a supervisor. Balancing the requirements of both managing an agency and ensuring the ethical conduct and continued development of counselors and staff can be a large task that may seem overwhelming. However, interested individuals can take steps to learn more about these aspects of supervision so that the task seems less intimidating.

In the 21st century, there has been an increase in the acceptance of mental health issues and an acknowledgment that individuals diagnosed with mental health disorders should be given access to treatment and care. The Affordable Care Act, and its inclusion of mental health care as part of provided services, is evidence that the government recognizes that individuals should have access to treatment. However, with this type of endorsement comes the requirement to provide data-driven evidence that treatments are successful for a wide variety of clients. Although some mental health issues no longer generate stigma, multicultural and historical factors continue to affect individuals' abilities to access care and receive appropriate services. Additional issues that can influence agency services and delivery include relationships with community stakeholders and within multidisciplinary teams.

Supervision within an agency can be conceptualized as organizational or clinical supervision. Organizational supervision is the act of directing others, such as being a manager. Clinical supervision includes aspects of teaching, counseling, and consultation, such as working with peer clinicians to supervise

their clinical practice and development. However, supervisors of either type must be prepared to document and evaluate those they are supervising, and this inherent power comes with responsibility. One of the most important of these responsibilities is continuously modeling appropriate ethical behavior and comportment through continuing education, knowledge of one's agency and area, and service to the profession.

## REFLECTION QUESTIONS

1. Who are your stakeholders?
2. How do you see mental health and mental health agencies evolving in the next 10 years?
3. How do you think your historical era has changed the mental health services that are currently delivered and should be delivered in the future?
4. What are your thoughts regarding the current push for the use of evidence-based practices in mental health settings?
5. Consider the roles of both an agency supervisor and clinical supervisor; which role appeals to you more? What steps do you think you would need to take to prepare for your desired role?

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