

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

Update

*Reviews Literature From October 1, 2011  
Through March 31, 2012*

*Treatment Improvement Protocol (TIP) Series*

## 52

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



# UPDATED FINDINGS FROM THE LITERATURE, APRIL 2012

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## Updated Findings From the Literature, April 2012

This Treatment Improvement Protocol (TIP) Literature Review Update includes findings published between October 1, 2011, and March 31, 2012.

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

### Counselor Turnover

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

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

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

#### Exhibit 1 Organizational Environment

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

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

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

The first three areas were each assessed by a separate scale that the authors judged to be well-researched and psychometrically sound. Each Likert-type scale was constructed with possible responses for each item ranging from 1 (“strongly disagree”) to 5 (“strongly agree”). Exhibit 2 lists the first three leadership effectiveness areas and a sample item from each scale.

**Exhibit 2 Leadership Effectiveness**

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

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

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

Possible limitations of the study are:

- The researchers used a limited analysis that considered baseline data to predict turnover rates over time. Measuring predictor variables over the course of the study to determine how counselors' changing perceptions of the organizational environment might have affected the turnover rate.

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

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

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

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

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

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

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

## Counselor Training

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

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

The data were part of a national longitudinal study (the National Treatment Center Study [NTCS]) and involved face-to-face interviews with the directors of 340 privately funded substance abuse treatment centers. The directors were asked a series of questions specific to the particular type of EBP used in their treatment programs. For example, directors who indicated that their program used CBT with clients were asked how much their program emphasized various CBT components (e.g., the identification of triggers, the development of coping skills, the use of homework for practicing new skills). A similar pattern of EBP-specific questions was used for treatment centers using MI, CM, and BSFT. The interviews also included questions about whether counselors were expected to develop proficiency in the EBPs used with clients and whether the treatment centers provided training for counselors in the EBPs. The results are shown in Exhibit 3.

### Exhibit 3 EBPs and Counselor Training

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

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

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

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

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

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

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

## **Methodology**

The methodology used in the development of TIP 52 was used in the preparation of this update.

## **References**

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