

WEST VIRGINIA CERTIFICATION BOARD FOR  
ADDICTION AND PREVENTION PROFESSIONALS

1400A Ohio Avenue  
Dunbar, WV 25064  
(304) 768-2942  
(304) 768-1562 FAX

APPLICATION FOR CLINICAL SUPERVISOR CERTIFICATION

THE ENTIRE APPLICATION MUST BE TYPED

Guidelines and Procedures for Completing the Certification Process

Please read the enclosed materials carefully BEFORE you complete any portion of the application.

It is the responsibility of the applicant to meet all deadlines and be aware of all test dates, etc. If a deadline for submission of documentation is missed, a late fee will be assessed. If documentation is submitted so late that the Board does not have time to consider the material, testing may be deferred to the next testing cycle, generally one year later in the case of the written test. Therefore, **TIMELY SUBMISSION OF ALL FEES AND MATERIALS** is of utmost importance.

Payment of fees is best made by Postal Money Order or Cashier Check, since personal checks that are returned for insufficient funds will cause you to be assessed a penalty fee of \$20.00 beyond the bank charge for such, and can cause your application to be too late to process.

THIS APPLICATION PACKET CONTAINS:

1. WVCBAPP Clinical Supervisor Certification Manual
2. Clinical Supervisor Performance Domains
3. NAADAC Code of Ethics (WVCBAPP's adopted Code of Ethics)
4. Application
5. Demographic Data Form

## CERTIFICATION PROCEDURES AND GUIDELINES

1. **Application/portfolio** must be received 60 days prior to the International Certification Reciprocity Consortium/Alcohol and Other Drugs of Abuse (IC&RC/AODA) scheduled test date. These dates are in March, June, September and December. If the WVCBAPP does not have at least seven applicants to test in the month that IC&RC scheduled tests, there will be no test administered. Applications will be held until the following test date.

2. **Notification of the Results** of the Application/Portfolio Review - Applicants will be notified by the WVCBAPP regarding the status of the application, missing or deficient items, and approval to sit for the test, etc. The application packet and documentation of qualification must be substantially complete in order for the applicant to be eligible to take the written test.

3. **Written Test** – Approximately the 2<sup>nd</sup> Saturday in March, June, September and December dependent upon IC&RC schedule.

4. **Completing the Process**-Once an applicant has taken the written test and passed it, he/she has two years to complete the certification process. Individuals who fail to do so within two years of the date of their written test will have to re-take the written test. Additionally, portions of the application may have to be updated and resubmitted, at the discretion of the Certification Board.

5. **Allowances for Missing Items**-The Certification Board may allow individuals whose application packets are incomplete to take the written exam. This is left to the discretion of the Board. In order to obtain a credential all requirements must be completed and documented. Applicants are notified by mail of the status of their application packets (i.e. complete or deficient).

APPLICATION FOR CLINICAL SUPERVISOR CERTIFICATION

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**A. FEES**

I understand that the application process requires pre-payment of the NON-REFUNDABLE application fee. I also understand that a written test fee (\$100) will be due later in the process for CCS applicants. I have enclosed a check, postal money order or cashier's check. I wish to be considered as an applicant for certification as:

( ) Certified Clinical Supervisor (CCS) \$75.00

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SIGNATURE	DATE	SOCIAL SECURITY NUMBER
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PRINT YOUR NAME HERE



# APPLICATION FOR CLINICAL SUPERVISOR CERTIFICATION

## C. QUALIFYING EXPERIENCE

List your most recent employment first. Select **ONLY** those work experiences which fit the description of qualifying work experience as described in the Certification Manual. "Full-time Equivalent Work" means that you spent at least 35 hours per week in work-related activities. One **MAY NOT** earn more than one year's experience in one year.

**1. WORK EXPERIENCE SPECIFIC TO ADDICTION COUNSELING:** If addiction counseling experience represents only a portion or percentage of a full-time job, report **ONLY** the addiction counseling work in this category. Example: You have a full-time job that is 20% administrative, 20% addiction counseling, and 60% counseling other populations. Only the addiction counseling should be reported here.

EMPLOYER/AGENCY: \_\_\_\_\_

YOUR JOB TITLE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

SUPERVISOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

( ) Paid Position ( ) Volunteer Position

BRIEFLY DESCRIBE JOB DUTIES:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DATES: Beginning \_\_\_/\_\_\_/\_\_\_ Ending \_\_\_/\_\_\_/\_\_\_

(a) Total Number of Months: \_\_\_\_\_

What percentage of full time equivalent was this job? (b) \_\_\_\_\_%

Multiply the total number of months (a) by that percentage (b) = © \_\_\_\_\_ actual months worked

What percentage of your work time was dedicated to addiction counseling? (d) \_\_\_\_\_ %

Multiply actual number of months worked © by the percentage of work time dedicated to addiction counseling (d).  
For example: a half time job that lasted six months and was spent on addiction counseling specific work 25% of the time: 6 months (a) X 50% (b) = 3 months © X 25% (d) = .75 month.

Enter that number: \_\_\_\_\_ months of addiction counseling specific work.

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EMPLOYER/AGENCY: \_\_\_\_\_

YOUR JOB TITLE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

SUPERVISOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

( ) Paid Position ( ) Volunteer Position

BRIEFLY DESCRIBE JOB DUTIES:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DATES: Beginning \_\_\_/\_\_\_/\_\_\_ Ending \_\_\_/\_\_\_/\_\_\_

(a) Total Number of Months: \_\_\_\_\_

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Enter that number: \_\_\_\_\_ months of addiction counseling specific work.-----

EMPLOYER/AGENCY: \_\_\_\_\_

YOUR JOB TITLE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

SUPERVISOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

( ) Paid Position ( ) Volunteer Position

**BRIEFLY DESCRIBE JOB DUTIES:**

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**DATES:** Beginning \_\_\_/\_\_\_/\_\_\_ Ending \_\_\_/\_\_\_/\_\_\_

(a) Total Number of Months: \_\_\_\_\_

What percentage of full time equivalent was this job? (b) \_\_\_\_\_%

Multiply the total number of months (a) by that percentage (b) = © \_\_\_\_\_ actual months worked

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Enter that number: \_\_\_\_\_ months of addiction counseling specific work.

**FOR BOARD USE ONLY:**

**WORK EXPERIENCE SPECIFIC TO ADDICTION COUNSELING:**

\_\_\_\_\_ MONTHS TOTAL

**2. WORK EXPERIENCE SPECIFIC TO ADDICTION CLINICAL**

**SUPERVISION:** If clinical supervision experience represents only a portion or percentage of a full-time job, report **ONLY** the clinical supervision work in this category. Example: You have a full-time job that is 20% addiction counseling, 20% counseling other populations and 60% clinical supervision. Only the addiction clinical supervision should be reported here.

EMPLOYER/AGENCY: \_\_\_\_\_

YOUR JOB TITLE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_  
SUPERVISOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

( ) Paid Position ( ) Volunteer Position

BRIEFLY DESCRIBE JOB DUTIES:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DATES: Beginning \_\_\_/\_\_\_/\_\_\_ Ending \_\_\_/\_\_\_/\_\_\_  
(a) Total Number of Months: \_\_\_\_\_

What percentage of full time equivalent was this job? (b) \_\_\_\_\_%

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Enter that number: \_\_\_\_\_ months of addiction counseling specific work.  
\*\*\*\*\*

EMPLOYER/AGENCY: \_\_\_\_\_

YOUR JOB TITLE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

SUPERVISOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

( ) Paid Position ( ) Volunteer Position

BRIEFLY DESCRIBE JOB DUTIES:

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DATES: Beginning \_\_\_/\_\_\_/\_\_\_ Ending \_\_\_/\_\_\_/\_\_\_

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Enter that number: \_\_\_\_\_ months of addiction counseling specific work.

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EMPLOYER/AGENCY: \_\_\_\_\_

YOUR JOB TITLE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

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SUPERVISOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

( ) Paid Position ( ) Volunteer Position

BRIEFLY DESCRIBE JOB DUTIES:

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DATES: Beginning \_\_\_/\_\_\_/\_\_\_ Ending \_\_\_/\_\_\_/\_\_\_

(a) Total Number of Months: \_\_\_\_\_

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\*\*\*\*\*

EMPLOYER/AGENCY: \_\_\_\_\_

YOUR JOB TITLE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

SUPERVISOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

( ) Paid Position ( ) Volunteer Position

BRIEFLY DESCRIBE JOB DUTIES:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DATES: Beginning \_\_\_/\_\_\_/\_\_\_ Ending \_\_\_/\_\_\_/\_\_\_

(a) Total Number of Months: \_\_\_\_\_

What percentage of full time equivalent was this job? (b) \_\_\_\_\_%

Multiply the total number of months (a) by that percentage (b) = © \_\_\_\_\_ actual months worked

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Enter that number: \_\_\_\_\_ months of addiction counseling specific work.

FOR BOARD USE ONLY:

WORK EXPERIENCE SPECIFIC TO ADDICTION CLINICAL SUPERVISION:

\_\_\_\_\_ MONTHS TOTAL

**D. SUPERVISION**

TO SUPERVISOR: Please complete this form indicating this applicant's on the job supervision in providing clinical supervision. This form is not intended to document applicant's total number of hours worked but rather the hours of face to face supervision this applicant has provided to counselors.

Applicant's Name: \_\_\_\_\_

I hereby attest that minimum of 200 clock hours of face to face supervision in the following performance domains have been provided to counselors by the above named applicant as outlined below.

**PERFORMANCE DOMAINS # HOURS PROVIDED IN EACH**

- 1. Assessment/Evaluation \_\_\_\_\_
- 2. Counselor Development \_\_\_\_\_
- 3. Professional Responsibility \_\_\_\_\_
- 4. Management/Administration \_\_\_\_\_

**TOTAL MUST BE AT LEAST 200 HOURS** \_\_\_\_\_

\_\_\_\_\_  
SUPERVISOR SIGNATURE

\_\_\_\_\_  
DATE

**E. EDUCATION/TRAINING IN CLINICAL SUPERVISION**

YOU MUST ATTACH DOCUMENTATION IN THE FORM OF TRANSCRIPTS OR CERTIFICATES OF ATTENDANCE, FOR ALL HOURS LISTED. THIRTY (30) HOURS OF DIDACTIC EDUCATION/TRAINING IN CLINICAL SUPERVISION IS REQUIRED. THIS MUST INCLUDE EDUCATION/TRAINING IN EACH OF THE FOLLOWING FOUR DOMAINS: ASSESSMENT/EVALUATION; COUNSELOR DEVELOPMENT; MANAGEMENT/ADMINISTRATION; AND PROFESSIONAL RESPONSIBILITIES (must be a minimum of six (6) hours in each domain). For distance learning please see subsequent pages.

COURSE TITLE                      SPONSOR                      DATE                      # CONTACT HOURS

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BRIEFLY DESCRIBE CONTENT OF EDUCATION:

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RELEVANT TO THE FOLLOWING PERFORMANCE DOMAIN:

ASSESSMENT/EVALUATION ( )                      COUNSELOR DEVELOPMENT ( )

PROFESSIONAL RESPONSIBILITY ( )                      MANAGEMENT/ADMINISTRATION ( )

\*\*\*\*\*

COURSE TITLE                      SPONSOR                      DATE                      # CONTACT HOURS

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BRIEFLY DESCRIBE CONTENT OF EDUCATION:

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RELEVANT TO THE FOLLOWING PERFORMANCE DOMAIN:

ASSESSMENT/EVALUATION ( )                      COUNSELOR DEVELOPMENT ( )

PROFESSIONAL RESPONSIBILITY ( )                      MANAGEMENT/ADMINISTRATION ( )

\*\*\*\*\*

COURSE TITLE                      SPONSOR                      DATE                      # CONTACT HOURS

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BRIEFLY DESCRIBE CONTENT OF EDUCATION:

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RELEVANT TO THE FOLLOWING PERFORMANCE DOMAIN:

ASSESSMENT/EVALUATION ( )                      COUNSELOR DEVELOPMENT ( )

PROFESSIONAL RESPONSIBILITY ( )                      MANAGEMENT/ADMINISTRATION ( )

\*\*\*\*\*

COURSE TITLE                      SPONSOR                      DATE                      # CONTACT HOURS

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BRIEFLY DESCRIBE CONTENT OF EDUCATION:

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RELEVANT TO THE FOLLOWING PERFORMANCE DOMAIN:

ASSESSMENT/EVALUATION ( )                      COUNSELOR DEVELOPMENT ( )

PROFESSIONAL RESPONSIBILITY ( )                      MANAGEMENT/ADMINISTRATION ( )

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See next 4 pages to document distance learning.

DISTANCE LEARNING

Application Form  
Distance Learning Approval  
For Use By Individuals Applying for Initial Certification

Part I

DATE OF APPLICATION \_\_\_\_\_

APPLICANT'S NAME \_\_\_\_\_

APPLICANT'S ADDRESS \_\_\_\_\_

APPLICANT'S PHONE NUMBER \_\_\_\_\_

COURSE/TRAINING/WORKSHOP TITLE \_\_\_\_\_

INSTITUTION SPONSORED BY: \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_

Part II

EDUCATION TRAINING DESCRIPTION

Please read the enclosed "Counselor Core Functions" and "Skill and Knowledge" forms and check mark the items which will be emphasized in the training event. If you are applying for approval for an event which has several different sessions and presenters, please make multiple copies of the attached form. Complete one form per session.

When you receive the letter of approval for this training, keep it along with other documentation related to your application for initial certification. This form is not to be used for re-certification.

I hereby attest that all information provided in this application is true and valid to the best of my knowledge.

\_\_\_\_\_  
Authorizing Signature

\_\_\_\_\_  
Name Printed

\_\_\_\_\_  
Date

**A COPY OF A BROCHURE, SCHOOL BULLETIN OR  
COURSE DESCRIPTION MUST ACCOMPANY THIS**

DISTANCE LEARNING

EDUCATION TRAINING DESCRIPTION

NAME OF SESSION \_\_\_\_\_

DATE(S) OF SESSION \_\_\_\_\_

OBJECTIVES FOR SESSION \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

INSTRUCTORS CREDENTIALS including licenses, certifications and academic degrees  
(please attach resume) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

OTHER INFORMATION USEFUL IN EVALUATING TRAINING FOR THE PURPOSE OF  
WVCBAPP CERTIFICATION BOARD ENDORSEMENT: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

NUMBER OF CONTACT HOURS FOR THIS SESSION \_\_\_\_\_

\* ONE CONTACT HOUR EQUALS 50 MINUTES OF CONTINUED STRUCTURED  
LEARNING  
EXPERIENCE.

**ATTACH WORKSHOP OR CONFERENCE BROCHURE TO THIS APPLICATION**

## DISTANCE LEARNING

### Please check mark all which will be addressed by the training **12 CORE FUNCTIONS OF ADDICTION COUNSELING**

- ( ) **SCREENING:** The process by which a client is determined appropriate and eligible for admission to a particular program.
- ( ) **INTAKE:** The administrative and initial assessment procedures for admission to a program.
- ( ) **ORIENTATION:** Describing to the client the following: general nature and goals of the program; rules governing client conduct and infractions that can lead to disciplinary action or discharge from the program; in a non-residential program, the hours during which services are available; treatment costs to be borne by the client, if any; and client's rights.
- ( ) **ASSESSMENT:** Those procedures by which a counselor/program identifies and evaluates an individual's strengths, weaknesses, problems and needs for the development of a treatment plan.
- ( ) **TREATMENT PLANNING:** Process by which the counselor and the client identify and rank problems needing resolution; establish agreed upon immediate and long-term goals; and decide upon a treatment process and the resources to be utilized.
- ( ) **COUNSELING (Individual, Group and Significant Others):** The utilization of special skills to assist individuals, families or groups in achieving objectives through exploration of a problem and its ramifications; examination of attitudes and feelings; consideration of alternative solutions; and decision-making.
- ( ) **CASE MANAGEMENT:** Activities which bring services, agencies, resources or people together within a planned framework of action toward the achievement of established goals. It may involve liaison activities and collateral contacts.
- ( ) **CRISIS INTERVENTION:** Those services which respond to an alcohol and/or other drug abuser's needs during acute emotional and/or physical distress.
- ( ) **CLIENT EDUCATION:** Provision of information to individuals and groups concerning alcohol and other drugs abuse and the available services and resources.
- ( ) **REFERRAL:** Identifying the needs of a client that cannot be met by the counselor or agency and assisting the client to utilize the support systems and community resources available.
- ( ) **REPORTS AND RECORD KEEPING:** Charting the results of the assessment and treatment plan, writing reports, progress notes, discharge summaries and other client-related data.
- ( ) **CONSULTATION WITH OTHER PROFESSIONALS IN REGARD TO CLIENT TREATMENT/SERVICES:** Relating with in-house staff or outside professionals to assure comprehensive, quality care for the client.

DISTANCE LEARNING

Please check mark all which will be addressed by the training  
**SKILLS AND KNOWLEDGE AREAS OF ADDICTION COUNSELING**

(Please see the Counselor Certification Manual for a Complete List)

- Human Behavior
- Signs and Symptoms of Alcohol and Other Drug Abuse (including pharmacological factors)
- Behavioral Addictions (including gambling, eating disorders, sexual addiction)
- Counseling Approaches, Modalities, Philosophies, Techniques, Methods and Objectives
- Working Therapeutically With Individuals, Groups and Families
- Communication Skills
- Establishing Rapport
- Continuum of Care (including Case Management)
- DUI Safety and Treatment
- Federal, State and Local Statutes, Administrative Rules and Regulations
- Ethics
- Chemical Dependency Resources at the Federal, State and Local Level  
(including agencies, organizations, facilities)
- How to Refer to and utilize 12 Step and Other Support Groups (Attendance at 12 Step meetings is not included)
- Clinical Supervision
- Other (please describe and be specific) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FOR BOARD USE ONLY: TOTAL HOURS EDUCATION/TRAINING \_\_\_\_\_

**F. RESUME - Please attach a complete, typewritten resume.**

**G. CERTIFICATION OF TRUTH**

**1. APPLICANT**

MUST BE NOTARIZED

I hereby certify that the statements contained in this application and supporting documents, given for consideration of my application for certification as a Clinical Supervisor are, to the best of my knowledge, true and correct.

I further certify that I have read and subscribe to and abide by the WVCBAPP Code of Ethics. I authorize the Board to conduct inquiries or interviews as they deem necessary.

\_\_\_\_\_  
Signature of Applicant

STATE OF WEST VIRGINIA,

COUNTY OF \_\_\_\_\_, TO-WIT:

Subscribed and signed this \_\_\_\_\_ day of \_\_\_\_\_.

My commission expires: \_\_\_\_\_  
Notary Public

**2. Supervisor**

MUST BE NOTARIZED

I hereby certify that the statements contained in this application and supporting documents, given for consideration of my supervisee’s application for certification as a Clinical Supervisor are, to the best of my knowledge, true and correct.

\_\_\_\_\_  
Signature of Supervisor

STATE OF WEST VIRGINIA,

COUNTY OF \_\_\_\_\_, TO-WIT:

Subscribed and signed this \_\_\_\_\_ day of \_\_\_\_\_.

My commission expires: \_\_\_\_\_  
Notary Public

## **ETHICAL CODE OF CONDUCT**

It is the policy of the West Virginia Certification Board for Addiction and Prevention Professionals to promote and safeguard the quality, effectiveness and competence of professional addiction counselors through the insistence of adherence to its Code of Ethics by all WVCBAPP certified clinical supervisors.

The ethics committee recommends an ethical code of conduct for adoption by the Board of Directors. Currently, the Board has adopted the code of conduct adhered to by the International Certification & Reciprocity Consortium/Alcohol and Other Drug Abuse (IC&RC/AODA). The ethics committee has jurisdiction over all matters of violation and misconduct by certified clinical supervisors in the state of West Virginia. It immediately and thoroughly investigates such charges and makes recommendation to the Board of Directors for appropriate action.

### **ETHICAL CODE OF CONDUCT FOR CLINICAL SUPERVISORS**

#### **I. Code of Ethics**

This code of ethics applies to Alcohol, Tobacco and Other Drugs (ATOD) Substance Abuse Professionals who are credentialed as Certified Clinical Supervisors (ATOD/CCS) and applies to their conduct during the performance of their clinical duties as supervisors.

#### **II. Supervision**

Supervision is a disciplined and defined clinical activity. It has a parallel, but linked relationship to teaching, consulting, administering and researching. It is a necessary, significant and meaningful aspect of the delivery of competent, humane, ethical and appropriate services to clients/consumers.

#### **III. Rules of Conduct**

These ethics constitute the standards an ATOD/CCS should maintain. These ethics shall be used as an aid in resolving any ambiguity, which may arise in the application and interpretation of these rules.

#### **IV. Competence**

An ATOD/CCS shall limit practice to areas of competence in which proficiency has been gained through education or documentable experience or through the awarding of a reciprocal professional certification or licensure. An ATOD/CCS shall accurately represent areas of competence, education, training, experience and professional affiliations, in response to responsible inquiries, including those from appropriate boards, the public, supervisees and colleagues. An ATOD/CCS shall aggressively seek out consultation with other professionals when called upon to supervise counseling situations outside their realm of competence. An ATOD/CCS shall refer supervisees to other competent professionals, when they are unable to provide adequate supervisory guidance to the supervisee.

## V. Client Welfare and Rights

The primary obligation of an ATOD/CCS is to train substance abuse counselors to respect the integrity and promote the welfare of their clients. ATOD/CCS should have supervisees inform clients that they are supervised and that details of their treatment can and will be discussed or reviewed with a supervisor. Any audio or video taping of a client/consumer's treatment must be authorized in writing. An ATOD/CCS should make supervisees aware of clients' rights, including protecting clients' rights to privacy and confidentiality in the counseling relationship and the information resulting from it. Clients should also be informed that their right to privacy and confidentiality will not be violated by the supervisory relationship. Records of the supervisory relationship, including interview notes, test data, correspondence, the electronic storage of these documents, and audio and video recordings are to be treated as confidential materials. Written permission for use of these materials outside of the supervisory session must be granted by the client. An ATOD/CCS is responsible for monitoring the professional actions of their supervisees. An ATOD/CCS is responsible for the presentation of adequate training for all supervisees in the area of transference, dual relationships, cultural sensitivity and professional deportment.

## VI. Professional Behavior

Due to the unique scope of practice substance abuse counselors provide, ATOD/CCS must monitor the following behaviors of their staff and themselves.

- A. Conviction for the possession or use of any illegal drug, narcotic or mood altering substance.
- B. The use of intoxicants and/or non-physician prescribed and monitored mood altering substances when engaged in professional pursuits.
- C. The conducting of intimate, personal and/or business relationships of any kind with any patient or their families. This applies to all clients. A supervisee should have all relationships of this kind reviewed. An ATOD/CCS should consult with an objective peer when this issue is raised.
- D. ATOD/CCS, who are members of Alcoholics Anonymous, Cocaine Anonymous, Narcotics Anonymous, Al Anon, etc., shall not become a sponsor to any active, discharged patient or family member.
- E. ATOD/CCS are in violation of this code and are subject to revocation or other appropriate action if after certification they:
  - 1. Are convicted of any felony
  - 2. Are convicted of a misdemeanor related to their qualifications or functions
  - 3. Engage in conduct which could lead to conviction of a felony or misdemeanor related to their qualifications or functions
  - 4. Are expelled from or disciplined by other professional organizations

5. Have their certification suspended, revoked, or otherwise disciplined by regulatory bodies
  6. Shall refuse to seek treatment for alcohol/drug abuse, mental/emotional problems, or physical health problems that interfere with professional functioning
  7. Fail to cooperate at any point of an ethical complaint investigation.
- F. ATOD/CCS respect the dignity and protect the welfare of participants in research and are aware of regulations and professional standards governing the conduct of research including informed consent.
- G. ATOD/CCS make financial arrangements with clients, third party payers and supervisees that are understandable and conform to accepted professional practices. Supervisors do not allow their supervisees to offer or accept payment for referrals. Clinical supervisors will disclose any fees to clients and supervisees at the beginning of services and represent facts truthfully to clients, third party payers and supervisees regarding services rendered.
- H. ATOD/CCS accurately represent their competence, education, training and experience relevant to their practice as ATOD/CCS and clinical experience. ATOD/CCS assure that advertisements and publications in any media (such as directories, announcements, business cards, newspapers, radio, television and facsimiles) convey information that is necessary for the public to make an appropriate selection of professional services.

## VII. Supervisory Role

Inherent and integral to the role of supervisor are responsibilities for monitoring of client welfare, insuring compliance with relevant legal and professional standards of service delivery, monitoring clinical performance and professional development of supervisees and evaluating and certifying current performance and potential of supervisees for academic, screening, selection, placement, employment and credentialing purposes.

- A. An ATOD/CCS must maintain professional decorum and standards. Unprofessional behaviors as outlined in item VI above will not be tolerated.
- B. An ATOD/CCS should obtain ongoing training in supervision.
- C. An ATOD/CCS should pursue professional and personal continuing education activities to maintain their ATOD/CCS credential and improve their supervisory skills. Competency in the Four Performance Domains of ATOD Clinical Supervision must be maintained.
- D. An ATOD/CCS should make their supervisees aware of professional and ethical standards and legal responsibilities of the counseling profession. In the absence of agency policy, industry standards of ethical behavior should be explained to the supervisee.

- E. An ATOD/CCS should not exploit, but should strive to enable supervisees to be competent, autonomous, professional, judicious, aware of limitations, and to become future supervisors if that is an appropriate career goal.
- F. Procedures for contacting the supervisor, or an alternative supervisor, to assist in handling crisis situations should be established and communicated to supervisees.
- G. Supervision is maintained through regular face to face meetings with supervisee in group or individual sessions.
- H. Actual work samples via audio, counselor report, video or observation should be part of the regularly scheduled supervision process.
- I. An ATOD/CCS should provide supervisees with ongoing feedback on their performance.
- J. An ATOD/CCS who has multiple roles (e.g. teacher, clinical supervisor, administrator, etc.) with supervisees should avoid any conflict of interest caused by these disparate roles. The supervisees should know the limitations placed on the ATOD/CCS and the supervisor should share supervision when appropriate.
- K. An ATOD/CCS should not sexually harass, make sexual advances or participate in any form of sexual contact with supervisees. Supervisors should not engage in any form of social contact or interaction, which would compromise the supervisor-supervisee relationship. Dual relationships (including outside consults, partnerships, nepotism, etc.) With supervisees that might impair the supervisor's objectivity and professional judgment should be avoided and/or the supervisory relationship terminated.
- L. ATOD/CCS should not use the supervision process to further personal, religious, political or business interests.
- M. ATOD/CCS should not endorse any treatment that would harm a client either physically or psychologically and should ensure the professional quality of the programs on which their supervisees participate.
- N. An ATOD/CCS should not establish a psychotherapeutic relationship as a substitute for supervision. Personal issues should be addressed in supervision only in terms of the impact of these issues on clients and on professional functioning.
- O. An ATOD/CCS should never supervise past or current clients who are staff or their families.
- P. An ATOD/CCS should model appropriate use of supervision themselves for problem solving and practice reviewing.
- Q. An ATOD/CCS must be straight forward with supervisees about observed professional and clinical limitations of the supervisee. These concerns must be clearly documented and shared with the supervisee.
- R. An ATOD/CCS should not endorse a supervisee for certification or credentialing if the supervisor has documentable proof of impairment or professional limitations that would interfere with the performance of counseling duties in a competent and ethical manner. The presence of any impairment should begin with a process of feedback and remediation so that the supervisee understands the nature of the impairment and has the opportunity to remedy the problem and continue with his/her professional development.

- S. An ATOD/CCS should incorporate the principles of informed consent and participation; clarity of requirements, expectations; roles and rules; and due process and appeal, into the establishment of policies related to progressive discipline.
- T. An ATOD/CCS must be able to integrate the Core Functions of Substance Abuse Clinical Competency into their theoretical and supervisory approach. A clear understanding of the Global Criteria is essential.
- U. An ATOD/CCS should be an active participant in quality assurance and peer review.
- V. The supervision provided by an ATOD/CCS must be provided in a professional and consistent manner to all supervisees regardless of age, race, national origin, religion, physical disability, sexual orientation, political affiliation, marital or social or economic status. When a supervisor is unable to provide non-judgmental supervision a referral to an appropriate supervisor with a complete explanation of the supervisee must be made.