IDENTIFYING COMPETENCIES OF AODA CLINICAL SUPERVISORS FOR INTEGRATION INTO REHABILITATION COUNSELOR TRAINING CURRICULUM: A DELPHI STUDY

by

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A Dissertation Proposal
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DISSERTATION APPROVAL

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AN ABSTRACT OF THE DISSERTATION OF

MARISSA FAY MCKEE, for the Doctor of Philosophy degree in Rehabilitation, presented on October 21, 2011 at Southern Illinois University Carbondale.

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This study preliminarily identified clinical supervision competencies needed for alcohol and other drug abuse (AODA) clinical supervisors for integration into rehabilitation counselor training (RCT) curriculum. The Delphi method via LimeSurvey® was utilized to identify competencies specific to AODA clinical supervision. A panel of six experts in RCT and AODA clinical supervision completed five rounds of data collection beginning with an open-ended question. Consensus and stability of responses were calculated following Rounds 2-5 of data collection. Panelist fatigue resulted in data collection being discontinued after Round 5, prior to a consensus or stability of responses being reached.

A total of 115 competencies and 51 competency sub-items were administered in Round 5. Results suggested that a consensus was not reached on items as one panelist represented a minority view on many items during multiple rounds of data collection. This panelist discontinued responding during the fifth round of data collection. Rank analysis of items based upon mean response was inconclusive due to limited sample size and response options. Sub-item analysis revealed mixed results regarding original competencies versus sub-items. At times a competency was rated higher, at times a sub-item was rated higher, and in other examples a second sub-item was rated higher. A clear pattern of responses for sub-items was not evident upon visual inspection of mean responses. Content analysis with two reliability raters in addition to the primary investigator suggested competencies fell into seven content areas: Legal and

Ethical Concerns; Organizational Management, Administration, and Program Development; Personal Characteristics and Skills of Leadership; Supervisee Performance Evaluation and Feedback; Supervisory Relationship; Theory, Roles, and Interventions of Clinical Supervision; and Treatment Related Knowledge and Skills. Implications for the field, supervisors, supervisees, and rehabilitation educators; limitations including panel and data collection, technology, and reliability and validity; and future research were discussed.

DEDICATION

This dissertation is dedicated to all individuals whose lives have been impacted by alcohol and other drug abuse disorders.

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CHAPTER ONE

INTRODUCTION

The field of alcohol and other drug abuse (AODA) counseling is part of the social science field. AODA treatment has often been a subject of debate as to if it is a standalone profession or belongs as a sub-profession to professions such as mental health or social work. In a survey of members of the Council for Accreditation of Counseling and Related Educational Programs (CACREP), Salyers, Ritchie, Luellen, and Roseman (2005) found that 73.6% of respondents viewed AODA counseling as a specialty within mental health counseling and only 2.3% viewed the field of AODA as a separate standalone profession. Kerwin, Walker-Smith, and Kirby (2006) reported that, in comparison to mental health training programs, mental health counselors were often required to have higher-level degrees and complete more practicum hours, whereas AODA counselors were required to complete more post-degree work experience hours for credentialing purposes. However, only half of the states included in Kerwin's study required a credential to practice as an AODA professional as opposed to 86% requiring a credential to be a mental health counselor. As of 2003, only 14 of the 32 state AODA certifying boards analyzed included any of the CACREP core knowledge areas (Mustaine, West, & Wyrick, 2003).

Mustaine et al. (2003) questioned how AODA counselors, as a specialty of general counseling, were not required to obtain basic counselor competencies before ensuing their AODA credential. In addition, AODA clinical supervisors have often been promoted to their positions from counselor rank due to tenure at the agency, counseling capabilities, or formal academic training which may or may not have included training in clinical supervision (Center for Substance Abuse Treatment (CSAT, 2007). CSAT stated, "It is typically the clinical supervisor's responsibility to mentor counselor development and facilitate the building of new

knowledge and skills, not only during counselors' early years but throughout their careers" (p. 1). Thus, it is logical to assert that before counselor competencies may be overseen by supervisors, the supervisors themselves should be trained in currently identified clinical supervision competencies. The purpose of this study was to identify AODA clinical supervision competencies for integration into rehabilitation counselor training (RCT) curriculum.

Statement and Significance of the Problem

Clinical supervision has been defined in numerous ways throughout the literature (Bernard & Goodyear, 2004; Haynes, Corey, & Moulton, 2003; Milne, 2007; Powell & Brodsky, 2004). The definitions overlap and include components of a more experienced member of the field overseeing a less experienced member of the field over time through teaching, evaluation, encouragement, administration, and clinical skill development. It is difficult to identify competencies for a profession that does not have a consensual definition of the field itself.

Worldwide, the field of AODA counseling has sought to examine the importance of clinical supervision within its field. Roche, Todd, and O'Connor (2007) indicated that as the field of AODA in Australia became more reliant on evidence-based practices, the need for clinical supervision increased. McMahon and Simons (2004) summarized a history of literature indicating the need for clinical supervision training during initial counselor training; in reality, most individuals did not receive any training until they had received a promotion. McMahon and Simons found both counselors that were also supervisors and counselors that were only supervisees benefited from clinical supervision training in areas of confidence/self awareness, theoretical/conceptual knowledge, and skill and techniques for supervision. As there is evidence that training improves outcomes related to clinical supervision confidence, knowledge, and skills

(McMahon & Simons, 2004), it is imperative to identify the important competencies that should be focused on in AODA clinical supervision training.

In addition, CSAT (2007) indicated that the profession of AODA counseling is changing as pay sources are now focusing on client outcomes for performance based contracting. Thus, it was suggested that treatment providers must focus on providing efficacious treatment while minding cost effectiveness. Evidence-based practices, which are new and ever evolving, will need to be integrated into current treatment agencies. Clinical staff cannot be expected to be competent in integrating and utilizing evidence-based practices if clinical supervisors are not competent in the same.

AODA counseling has been housed under the umbrella of rehabilitation counseling; however, the availability of role and function research pertaining specifically to AODA counseling and supervision is much less than the broader field of rehabilitation counseling. Thus, a need exists to further examine the field of AODA counseling and specifically, AODA supervision as a distinct type of supervision from general rehabilitation counseling and supervision. A challenge specific to AODA agencies includes the cultural issue of recovery status of both supervisor and supervisee, which could affect ethical issues of role boundaries and multiple relationships potentially resulting in favoritism issues between clinical staff (McKee, Boston, & Dallas, 2009). In addition, AODA clinical staff may take on characteristics of an addictive family system including roles of the enabler, hero, scapegoat, lost child, and mascot (Sayre, 1992; Tepper & Woods, 1999). If AODA staff identify themselves as being in recovery, it is possible that a return to old behaviors and family roles could easily occur if clinical supervisors do not assist staff in being proactive to prevent such roles from being filled in an unhealthy manner.

The Annapolis Conference on Behavioral Health Workforce Education and Training occurred in September 2001 to focus on the growing concerns of provider competencies in healthcare. McLellan, Carise, and Kleber (2003) found a 53% turnover rate among directors of substance abuse treatment providers in the previous year. The Executive Report published in 2007 stated seven goals for the field including "Goal 5: Actively foster leadership development among all segments of the workforce" (Hoge, Morris, et al., 2007, p. 14). It is possible that if proper training and development of clinical supervisors occurs, the turnover rate of administration/supervisors would decline creating a more stable treatment system. Less staff turnover allows agencies to retain expertise developed overtime resulting in cost efficiency due to not having to train as many new staff members.

The most current competency research was published by CSAT and the International Certification and Reciprocity Commission (2007; International Certification and Reciprocity Commission (IC&RC), 2008b). CSAT published competencies based upon previous research and a consensus of the task force. Some of the cited research was not specific to the field of AODA and thus it is unknown as to the validity of said competencies. Research is needed which focuses specifically on the AODA field. The 2008 Job Analysis Report (IC&RC, 2008b) presents a summary of the 2008 survey methodology and demographic results. The study appears to have weak methodology due to the subject matter experts overriding their predetermined decision criteria and using their experiences to write the summary of competencies that will be discussed further in Chapter Two. A methodologically sound study is needed to explore competencies for AODA clinical supervisors to integrate into the academic curriculum.

Purpose of the Study

This Delphi study preliminarily identified AODA clinical supervision competencies for integration into RCT curriculum. A Delphi technique was used to reach consensus of a panel of experts to determine competencies differentiated from general counseling supervision that should be addressed during RCT.

The specific research question was

"What are the competencies specific to alcohol and other drug abuse clinical supervisors that should be included in rehabilitation counselor training programs?"

Significance of the Study

This study was significant in that it focused on AODA clinical supervision competencies as identified by experts with educational or research backgrounds while extending the role and function research history of the rehabilitation counseling field. Traditionally the AODA field has trained supervisors through on the job experiences; as social services moves toward evidence-based practices, it is imperative that supervisors have the proper educational training along with experience. As AODA counseling is a field that expands over several fields, the implications for education, training, and credentialing could be far reaching. Behavioral health professionals have an ethical responsibility to remain current in the field. Current knowledge cannot be achieved without further research in the field, which is improved on from past research.

Definition of Terms

Within the field of social sciences, numerous definitions exist for common terms found through the literature. It is essential for any discussion that key terms be defined clearly. Key terms in this study include ability, clinical supervision, clinical supervisor, counselor,

competency, consensus, expert, knowledge, and skill. For the purpose of this manuscript, these terms were defined as follows.

Ability

"A demonstrated cognitive or physical capability to successfully perform a task with a wide range of possible outcomes" (Marrelli, Tondora, & Hoge, 2005, p. 537).

Clinical Supervision

An on-going process in which typically a more tenured member of the field with knowledge and skills specific to the supervisee's profession helps the supervisee develop knowledge, skills, and abilities to effectively practice in the field. Clinical supervision includes various roles such as administrative and clinical (Bernard & Goodyear, 2004; Haynes et al., 2003; Milne, 2007; Powell & Brodsky, 2004).

Clinical Supervisor

Individual who provides clinical supervision to a supervisee.

Counselor

Individual who provides counseling to a client. Also referred to as a supervisee or trainee.

Competency

"A competency is a measurable human capability that is required for effective performance. A competency may be comprised of knowledge, a single skill or ability, a personal characteristic, or a cluster of two or more of these attributes. Competencies are the building blocks of work performance" (Marrelli et al., 2005, p. 534).

Consensus

As the Delphi model does not operationally define consensus, consensus will be considered met if convergence has been achieved. Convergence will be met if >74% agreement is present for each item (e.g., 75% of panelists rate an item as important).

Expert

An expert "is someone who possesses the knowledge and experience necessary to participate in a Delphi" (Clayton, 1997, para. 26). For this study, an expert must have earned a doctoral degree in rehabilitation counseling or a related field. In addition, he or she must have met at least two of the five criteria since 2005 (unless otherwise noted) in order to qualify as a panelist.

1. Taught a course focused on alcohol or drug abuse treatment at the undergraduate or graduate school level
2. Published peer reviewed work on the topic of AODA clinical supervision
3. Presented at a national refereed conference on AODA clinical supervision
4. Supervised a minimum of five counselors in training and/or supervisors in training in the AODA field at the graduate school level or in the clinical field
5. Served on an editorial board of a journal and personally reviewed at least two articles pertaining to AODA clinical supervision

Knowledge

Concrete or abstract information, understanding, concepts, rules, guidelines, or awareness acquired through experiences and learning needed to complete tasks (Marrelli et al., 2005).

Skill

Capacity to perform a certain task with a specific outcome as the goal (Marrelli et al., 2005).

Limitations and Delimitations

A limitation of the study was that it was unknown as to how many rounds of the Delphi would be required to reach consensus. With each round of the Delphi, there was a greater risk of attrition. In addition, attrition could have affected the panel's ability to reach consensus. Not all experts in the field of AODA clinical supervision were included as panelists in the study. The Delphi technique relies on self-report and therefore participants were assumed to have answered the study unassisted by others.

A delimitation of the study was that initial panel members were selected based upon suggestions from the research committee advisor. In addition, Round 2 of the Delphi was created based on how the primary investigator organized and combined responses submitted by panelists in Round 1. The definition of expert, consensus, stability, and significant attrition were set a priori.

Summary

Although the field of AODA appears to only be recognized as a separate profession by some, it often is included within the rehabilitation counseling field and requires separate and specific research to further define the field. For the AODA field to have effective counselors, effective clinical supervisors first need to be trained in essential knowledge and skill competencies so that they may then provide the needed supervision to counselors. However, supervisors cannot be trained if competencies have not first been identified. It is essential to

further the field of clinical supervisor research to determine from expert points of view the competencies needed for inclusion in RCT curriculum.

This dissertation manuscript is organized into five chapters to identify the competencies needed for inclusion in RCT curriculum. Chapter One provided a background and statement of the problem, purpose of the study, research question, significance of the study, operationalized definitions, limitations and delimitations, and a framework for subsequent chapters. Chapter Two contains a review of literature associated with a history of role and function studies in the rehabilitation field to provide groundwork for competency research for AODA clinical supervisors and related fields. The chapter discusses an overview of rehabilitation role and function studies; competency overview and model development; competencies in rehabilitation; overview of clinical supervision; clinical supervision competencies in psychology and mental health, rehabilitation, and AODA; and the Delphi technique. Chapter Three discusses the study design including the Delphi technique, sampling, and current study design including criteria for consensus and content analysis. Chapter Four will summarize research results. Chapter Five will present a summarization of the research results, implications of the research, limitations of the study, and a discussion of applications for future research.

CHAPTER TWO

LITERATURE REVIEW

The central focus of the present research was to identify AODA clinical supervision competencies for integration into RCT curriculum. Limited research exists that has defined knowledge and skill competencies (previously roles and functions) of AODA counselors and supervisors. The following literature review was gathered from books, scholarly journal articles, and professional websites.

This chapter provides a chronological history of rehabilitation counseling role and function studies focusing on the studies' methods and analyses. Next, an overview of competencies and competency model development were presented in addition to an overview of clinical supervision definitions. Five studies were reviewed from the field of rehabilitation focused on competencies for the field. As little research has been published emphasizing competencies for AODA clinical supervisors, related fields were reviewed. Three articles from the fields of psychology/mental health and two studies from rehabilitation were reviewed to provide a foundation for a brief discussion of AODA clinical supervision development. Most recently, CSAT and IC&RC have disseminated publications focused on AODA clinical supervisor competencies, which were assessed as a basis for the current study.

Rehabilitation Role and Function Studies

The field of rehabilitation counseling has an extensive research history focused on defining roles and functions for the field. In 1969, Muthard and Salomone published a study that is often identified as the beginning of rehabilitation role and function research serving to define "program curriculum and Commission on Rehabilitation Counselor Certification examination content" (Rubin, Matkin, et al., 1984, p. 200). The general process utilized in Muthard and

Solomone's study has been extended to numerous role and function studies in rehabilitation literature; thus, it will be detailed here. Muthard and Salomone created the Rehabilitation Counselor Task Inventory as a part of their study. The Task Inventory technique developed by the United States Air Force Personnel Research Laboratory was adapted to help create the main measure used in the Muthard and Salomone study. First, job descriptions were obtained from over 250 agencies in the United States. In addition, the principle investigator solicited detailed current job tasks and duties from former students, which when combined with the other job descriptions, resulted in 400 items. Rewritten and condensed, 250 items were used in stage two of the tool development. Field-testing comprised the second stage of the tool development in which 25 counselors were administered the items through a structured interview format to encourage comments regarding the tool. Following five revisions, the tool reached its final form.

Prior to the last revision, reliability was tested and, due to analysis, the final tool had 119 task statements (111 utilized in the final analysis). For each item on the tool, six different scales were to be used to rate the item: (a) To what extent is the task a part of your job? (b) To what extent should the task be a part of your job? (c) How satisfying do you find the task? (d) With what proportion of your clients did you perform the task? (e) What education and training is necessary for the satisfactory performance of this task? and (f) Who should carry out the task? Other scales were developed specifically for rehabilitation counselor educators and rehabilitation administrators to utilize. Muthard and Salomone also examined social desirability and validity when constructing The Rehabilitation Counselor Task Inventory (TI). A factor analysis of the 111 items revealed eight duty factors in which 43 items were retained. The eight duty factors included placement, affective counseling, group procedures, vocational counseling, medical referral, eligibility case finding, test administration and test interpretation.

As the TI is rather long, 40 items were extracted to comprise the Abbreviated Task Inventory (ATI). Analyses indicated that basic factors emerged from both analyses. The ATI was often utilized in future studies. Muthard and Salomone (1969) went on to administer other scales to participants and test several hypotheses related to satisfaction, preparation and training, demographics, and so on in comparison to answers received from the TI. The factors extracted from both the TI and the ATI are significant to the present study as it was imperative in this study to identify not only the specific competencies, but organize them into factors for easier integration into RCT curriculum.

Numerous other role and function studies flourished in the field of rehabilitation following Muthard and Salomone (1969). Fraser and Clowers (1978) examined perceptions of time spent in various vocational rehabilitation functions previously identified in Fraser's 1976 dissertation that utilized counselor educators and agency counselors as the participants. The original tasks used in the dissertation were identified over a three-year period by the Wisconsin State Department of Vocational Rehabilitation and by the University of Wisconsin Rehabilitation Research Institute. Fraser and Clowers asked Region X vocational rehabilitation counselors to review the functions, estimating the amount of time they spent in each of the 15 functions along with a rating of complexity. Results indicated a slight trend toward less time spent in counselor-client interaction and reduced time spent in professional growth and development as well as research activities. A later study (Emener & Rubin, 1980) suggested less time in counselor-client interactions could be a factor in burnout which is likely pertinent when identifying clinical supervisor role and functions as well and should be kept in mind when drawing implications in the present study of AODA clinical supervisor competencies.

Berven (1979) reanalyzed data from Muthard and Salomone (1969) using a cluster analysis technique subsequent to the factor analysis previously performed. Berven reported eight duty factors slightly altered from Muthard and Salomone's original findings. Berven reported the eight factors were placement, affective counseling, group counseling, professional development and supervision, vocational counseling, case management, test administration and test interpretation. Berven asserted his further analysis of the data led to stronger duty factors than Muthard and Salomone reported. A larger scale study should be conducted once competencies are identified in the present study in order to clearly statistically delineate factors present from the identified competencies.

Emener and Rubin (1980) utilized Muthard and Salomone's (1969) 40 item ATI, sending it to a random sample of 1,000 participants comprised of members of the National Rehabilitation Counseling Association of which 266 usable responses were received. Prior to administration, the authors organized the 40 items into 11 categories utilizing a combination of factor analysis and rational sorting process. The 11 categories identified were placement, affective counseling, group procedures, vocational counseling, medical referral, eligibility-case finding, test administration, test interpretation, case services coordination, intervention with client's family, and miscellaneous. It was suggested by the authors that role functions for rehabilitation counselors had changed since Muthard and Salomone's study, which could be expected due to changes in federal legislation during that time. However, results also indicated that rehabilitation counselors reported not enough time in their jobs to spend on client-focused activities which was suggested could be a precursor to burnout in the field. Of importance to the present study, it is likely that too many administrative responsibilities could also hinder AODA supervisors and lead to burnout as well. In addition, legislation and clinical practices are evolving in the AODA

counseling field. An up-to-date role and function study of clinical supervision that can be easily updated in the future as legislation continues to evolve is needed.

A large-scale survey to assess rehabilitation counselor role and functions was published by Rubin, Matkin, et al. (1984) as work duties of Certified Rehabilitation Counselors (CRC) utilizing the 130 item CRC Job Task Inventory (JTI) were explored. The JTI is comprised of 55 items from Muthard and Salomone's 119 item Rehabilitation Counselor Task Inventory, 67 items from Matkin's Rehabilitation Specialty Task Inventory, and eight new items developed from current literature and agreed upon via Delphi techniques. The surveys were sent to CRCs as part of the annual Commission of Rehabilitation Counselor Certification (CRCC) newsletter. It was estimated that of the 7,039 individuals comprising the population, approximately 6,400 received the survey and 1,135 usable responses were received in return for three hours of continuing education credits. Due to the large number of surveys returned, only the 715 surveys from rehabilitation counselors were used (versus rehabilitation managers or educators). A series of factor analyses were conducted on the data, which indicated five job task categories existed for rehabilitation counselors: job placement and development, case management, professional/policy/test development, vocational counseling and assessment, and affective counseling. Eight items were excluded due to failure to meet the .35 loading criterion. Each of the five factors had a Cronbach alpha value of .87 or greater indicating high reliability. It is evident that work duties in the field of rehabilitation are important as the survey was sent to all CRCs. As AODA is now evolving within the field of rehabilitation, the same emphasis should be given to this subset of the field beginning with the identification of competencies for AODA clinical supervision.

Beardsley and Matkin (1984) utilized the Rubin, Matkin, et al. (1984) data from the 715 rehabilitation counselor responses. Beardsley and Matkin extracted the 40 items, which comprised the ATI, and conducted a principal axes factor analysis with a Varimax rotation. The ATI analysis produced six factors, four of which were comparable to the factors derived in the 1984 Rubin, Matkin, et al. study. The six factors identified were vocational counseling and assessment, affective counseling, job development and placement, case management, test administration and interpretation, and case collaboration and reporting. Discussion focused on the need for a content validated, brief, job task analysis instrument for rehabilitation counseling.

In 1984, Rubin and Puckett utilized existing data from studies that previously utilized the ATI developed by Muthard and Salomone (Emener & Rubin, 1980; Muthard & Salomone, 1969; Rubin, Matkin, et al., 1984). Independent samples t-tests were used to compare the Muthard and Salomone (1969) data to the Emener and Rubin (1980) data and then compare the Emener and Rubin data to the Rubin, Matkin, et al. (1984) data. The study used the Bonferroni procedure to control for an inflated alpha on the 40 t-tests. Results indicated that changes in role functions did change over time, but not to a significant enough degree to warrant major changes in the job role. It is probable that as the field of AODA counseling evolves (e.g., performance-based contracting, evidence-based practices), job functions will evolve as well. Thus, the present study will be an attempt to capture current roles of a subset of rehabilitation counseling.

Beardsley and Rubin (1988) extended the research on job tasks and role function in addition to knowledge areas and domains for varied groups of rehabilitation service providers. The sample was composed of (a) 470 applications for the October 1984 CRC examination, (b) 1,282 applicants for the October 1984 Certified Insurance Rehabilitation Specialist (CIRS) examination, (c) 845 randomly drawn current CRCs, (d) 451 randomly drawn certified

vocational evaluators who were not CRCs, (e) all 309 currently certified work adjustment specialists who were not CRCs, (f) 436 randomly drawn members of the Job Placement Division of the National Rehabilitation Association members, and (g) 750 independent living service staff persons. Participants were divided into two groups with group one being administered the job task inventory and the second group being administered the knowledge inventory.

In 1988, the instruments for Beardsley and Rubin's study were created in a series of steps. The Rehabilitation Profession Job Task Inventory (RPJTI) began with a list of 85 job tasks derived from literature. Second, the 85 items were reviewed by the 19 members of the Board for Rehabilitation Certification and two invited guests resulting in a list of 103 job tasks. The revised RPJTI was then sent back to the 21 individuals asking them to focus on clarity of items and add any additional items. The final RPJTI consisted of 107 items. The rating scale used was adopted from Matkin's 1983 study in which a six-point scale was used to assess how often the job task was performed. The Rehabilitation Profession Knowledge Competency Inventory (RPKCI) was developed by first identifying 200 knowledge areas from a literature review. The list was eventually reduced to 75 items in a method similar to the RPJTI. A six-point scale was adopted to assess how often the knowledge area was utilized in each participant's job.

In 1988, three mailings were utilized in Beardsley and Rubin's study: initial mailing including cover letter and survey, reminder card two weeks later to non-responders, and then two weeks later a new complete mailing. The authors considered a knowledge area of job task to be considered generic to all groups if it received a mean rating of three or greater (utilized at least once a month) by each group. Principle axis factor analysis was conducted on generic tasks and generic knowledge areas separately. A scree test was used and then factors were rotated

orthogonally to the Varimax criterion. A minimum factor loading of .35 was adopted to locate tasks or knowledge areas on each factor. Results indicated that 29 job tasks loaded into four factors of service planning and evaluation activities, therapeutic service activities, client staffing activities, and professional study activities with two items excluded due to not reaching minimum factor loading criteria (Beardsley & Rubin). Twenty-eight knowledge areas loaded into four factors of medical and psychosocial aspects of disability, legal and sociological influences in rehabilitation, rehabilitation and human services, and principles of human behavior with two items excluded due to not reaching minimum factor loading criteria.

Many studies exist which identify roles and function of rehabilitation counselors; thus, it is imperative to continue identification of roles and functions as job roles evolve. AODA clinical supervisors must be at the forefront of these changes. As researchers and educators are familiar with tracking the evolution of the profession, it is imperative that they are involved in the identification of the current competencies.

Competency Overview and Model Development

A long history of role and function studies exists within the field of rehabilitation. However, few studies have been published recently utilizing the key terms "role and function." It appears that more studies are using the terms competency or essential knowledge or skill domains (Lombardo, 2007; Thielsen & Leahy, 2001). It is possible that the change in vernacular is due to researcher preference. However, it could also be due to the moratorium on rehabilitation role and function studies called for by Thomas (1990). Marrelli et al. (2005) defined competency as

> a measurable human capability that is required for effective performance. A competency may be comprised of knowledge, a single skill or ability, a personal characteristic, or a

> cluster of two or more of these attributes. Competencies are the building blocks of work performance. (p. 534)

Using this definition and looking back to Muthard and Salomone's (1969) seminal study, examples of job tasks are worded similarly to what are now identified as competencies. For example, Muthard and Salomone stated job task item "100. Writes case notes and summaries (including analysis, reasoning, and comments) so that others can understand the client's progress." CSAT (2007) stated a clinical supervision competency as "Adhere to professional standards of ongoing supervisory documentation, including written individual development plans, supervision session notes, written documentation of corrective actions, and written recognition of good performance." Despite the slight differences in counseling versus supervision focus, the items are comparable. In addition, per Marrelli's definition, Muthard and Salomone's job tasks fall into the category of skills or abilities. Thus, job tasks that were once the focus of role and function studies are now identified using the updated language of competencies.

Competencies can be comprised of knowledge, skills, abilities, or personal characteristics (Hoge, Tondora, & Marrelli, 2005). Knowledge is typically focused on within educational settings such as school or trainings. However, Hoge, Tondora, et al. (2005) asserted that this knowledge needs to be linked to work-related outcomes as well. Skills tend to be the easiest elements of competency to develop through training such as completing a form. Abilities are more difficult to obtain than skills, as there is an element of innate capability involved such as analytical thinking. Personal characteristics include "values, attitudes, traits and the behaviors that are manifestations of these human characteristics" (Hoge, Tondora, et al., 2005, p. 518).

Personal characteristics are different from skills and abilities, as there is a more affective quality to them versus a cognitive quality in skills and abilities.

Hoge, Tondora, et al. (2005) explained that competencies can be turned into competency models at three levels: core, job family, and level. Core competencies apply to everyone in an organization. Job family competencies apply to employees performing similar jobs such as billing or counseling. Level competencies apply to varied job levels within a job family such as unlicensed staff, licensed staff, and supervisors. Marrelli et al. (2005) presented a process encouraging healthcare based fields to create a competency-based model for their respective role, functions, or position. They define a competency model as

> an organizing framework that lists the competencies required for effective performance in a specific, job family (e.g., group of related jobs), organization, function or process. Individual competencies are organized into competency models to enable people in an organization or profession to understand, discuss, and apply the competencies to workforce performance. (p. 537)

Step 1 is to define the objectives (Marrelli et al., 2005). The authors suggest that the questions of (a) Why is there a need to develop a competency model? (b) What is the unit of analysis (c) What is the relevant time frame? and (d) How will the competency model be applied? should be answered to define the objectives. Step 2 is to obtain the support of a sponsor. The authors suggest that the sponsor will help all parties be involved such as employees, administration, or other participants. Marrelli et al. (2005) suggested that an oral and written agreement be present. Step 3 is to develop and implement a communication and education plan. Stakeholders should be identified and then placed into committed, compliant, or resistant to change groups. A schedule should be developed for communicating with each group

including frequency, type of information to be covered, and what medium of communication will best work. Step 4 will be to plan the methodology including sample selection and data collection. Data collection should include at least two methods such as literature review, focus groups, structure interviews, behavioral event interviews, surveys, observations, work logs, or competency menus and databases. Step 5 is to identify the competencies and create the competency model. Within step five, the operational definition of the job should first be delineated. Next, competencies should be identified to address each area of the work identified in step four. The competency model should next be created to identify the most critical aspects for the certain position. The number of competencies should typically be no greater than 20. Subject matter experts should then review the competencies resulting in a revision of the initial list. Finally, within Step 5, behavioral examples should be developed to identify how the competencies are actually used in a position. The authors suggested creating behavioral examples at different proficiency levels and recommends the behavioral examples be reviewed by subject matter experts if possible. Step 6 is to apply the competency model to areas such as strategic workforce planning, selection, training and development, performance management, succession planning, rewards and recognition, and compensation. Finally, Step 7 is to evaluate and update the competency model. The authors suggested that standard program evaluation techniques may be utilized.

The present study was an attempt to identify competencies and potential domain areas that could later be used in a competency model for AODA clinical supervisors. However, as the present study was an attempt to differentiate AODA clinical supervision competencies from general counseling or supervision competencies, there is a need to further review competency research previously published as an extension of the role and function research introduced above.

Rehabilitation Counselor Competencies

Linkowski et al. (1993) developed a 58-item survey used to assess importance and preparedness of rehabilitation knowledge areas. The survey development began with compiling the Council on Rehabilitation Education (CORE) curriculum standards, CRCC content areas, and three test items selected by the authors. Four revisions of the measure were completed with the assistance of rehabilitation educators, students, and CORE and CRCC members. Next, an expert panel of CORE and CRCC commissioners was utilized to establish content validity with CORE and CRCC standards. Finally, the survey was tested on CRCC recertification applicants in 1991 (n = 1,025). Analyses consisted of principal component analysis of intercorrelations of importance ratings of the 58 items which resulted in 10 factors: vocational and employer consultation services; medical and psychological aspects of disability; individual and group counseling; program evaluation and research; case management and service coordination; family, gender, and multicultural; foundations of rehabilitation counseling; workers' compensation; environmental and attitudinal barriers; and assessment. The authors utilized more than two forms of data collection, literature review and survey, in line with suggestions for competency model development offered by Marrelli et al. (2005). In similar fashion, the present study focused on literature review and survey data collection.

Leahy, Szymanski, and Linkowski (1993) utilized the survey developed by Linkowski et al. (1993) to investigate and validate the knowledge content areas for rehabilitation counselors. Participants were 1,535 CRCs applying for recertification. In addition to rating importance and preparedness of the 58 knowledge items, participants were asked to suggest any other knowledge areas that were not already captured in the instrument. A principal component factor analysis with Varimax rotation was conducted on the importance ratings of the 58 items. The resulting

10 factors were comparable to those of Linkowski et al., suggesting validity of the knowledge items. It should be noted that the Linkowski et al. sample (n = 1,025) was included in the Leahy, Szymanski, et al. sample. Although a previous study had been conducted, this study provided evidence that it was worthwhile to continue to improve on the methodology to strengthen results.

Scully, Habeck, and Leahy (1999) examined disability management (DM) practice, knowledge, and skill areas for rehabilitation counselors. Participants include mostly convenience sub-samples of individuals attending national DM conferences, subscribers to a DM newsletter, and CRCs that worked in the private sector in three states. The 101 item Disability Management Skills Inventory (DMSI) was created for the study. Items were compiled from a pilot study inventory entitled The Role of the Rehabilitation Counselor in Disability Management and the Rehabilitation Skills Inventory. The pilot study inventory was developed through conduction of a literature review and then a structured and unstructured pilot administration to counselors at a national conference. The authors kept 31 of the items for inclusion of the DMSI. The RSI items were reviewed seemingly by the authors based on the merit of their relation to disability management. After expert review of the retained items, two more items were added to equal 101 items. Participants rated each item based on their perceived importance and their individual preparedness in each area. Analyses included a common factor analysis used to compress knowledge and skill areas. An orthogonal rotational method was used in addition to a Varimax rotation. Similar to Scully et al., after the identified experts in the current study reached consensus of competencies for AODA clinical supervisors, a validation step will be needed to test the competencies on a larger sample of individuals.

Leahy, Chan, and Saunders (2003) identified seven job functions and six knowledge domains utilized by currently practicing CRCs. The study was sponsored by CRCC to assist in

certification exam development. Two samples comprising 10% each of the CRC database were chosen at random. One sample was provided with a research packet including the Knowledge Validation Inventory-Revised (KVI-R) and the other sample a research packet containing the Rehabilitation Skills Inventory-Revised (RSI-R). Both instruments were revised prior to being sent to the sample. The revision process included utilizing a Delphi method with 47 content experts to identify new areas in the field that should be included as well as validate prior items. Thirty-eight items were added to the KVI-R for a total of 96 items. There were 18 items added and 12 items deleted to make a total of 120 items on the RSI-R. The KVI-R measured importance and perceived preparedness of various rehabilitation knowledge areas. The RSI-R assesses the frequency and importance of rehabilitation job tasks. After collecting data, a principal axis factor analysis was performed on the RSI-R resulting in seven job task factors: vocational counseling and consultation, counseling intervention, community-based rehabilitation services, case management, applied research, assessment, and professional advocacy. A principal axis factor analysis was also conducted on the KVI-R that resulted in six factors: career counseling, assessment and consultation services; counseling theories, techniques, and applications; rehabilitation services and resources; case and caseload management; health care and disability systems; and medical, functional, and environmental implications of disability.

Leahy, Muenzen, Saunders, and Strauser (2009) published an updated study focused on major knowledge domains across all rehabilitation settings. Participants were a sample of CRCs selected randomly from those that had email addresses on file in the CRCC database. The method included first utilizing a Job Analysis Task Force (JATF) of subject-matter experts to update the KVI-R. Next, researchers from the Professional Examination Service conducted telephone interviews with members of CRCC's Examination and Research Committee to mine

information regarding overlap of knowledge domains and other comments. Next, a 10-member JATF met several times to review and revise the knowledge domains and subdomains while utilizing the results of the telephone interviews. Twenty-five external reviewers evaluated the revised knowledge domains and subdomains. The final version of the KVI-R consisted of 81 subdomains within 12 domains. This final version was sent to the CRCs asking them to rate each item for its importance, frequency of use in the past year, and when this knowledge should be obtained during professional development. Two versions of the survey were created; one version sought importance and frequency ratings and the other sought importance and acquisition ratings. The intent of creating two versions was to reduce completion time of the instrument in hopes to increase response rates. In the discussion, the authors assert that replicated studies demonstrating similar results are of importance to the field as there is a current push for evidence-based practices. Following the guidelines set forth by the Marrelli et al. (2005) study, the authors utilized more than one method in data collection including survey, structured interview, and utilizing a preexisting database which in this case was the pre-existing measures. In addition, the final version consisted of 12 domains, well under the 20 competency limit that Marrelli et al. suggested. The authors also clearly stated the need for the study on knowledge domains citing a behavioral health push for evidence-based practices. The present study offers one method of collecting competency data for the AODA clinical supervisor population.

A history of rehabilitation counseling role and function (now competency) research has been presented ranging from Muthard and Salomone (1969) to Leahy, Muenzen, Saunders, and Strauser (2009). The extensive literature review of this research is needed in order to provide a basis for clinical supervision competency research and differentiate AODA clinical supervision competencies from general rehabilitation competencies previously identified.

Overview of Clinical Supervision

Within the counseling field, no clear and concrete definition of supervision exists and thus definitions may be interpreted in several ways (Tromski-Klingshirn, 2006). Bernard and Goodyear (2004) stated that clinical supervision should occur when a senior member supervises a junior member of the profession, the relationship is evaluative, occurs over time, provides opportunities for the supervisee to develop skills under their supervisor's monitoring, and acts as a gate-keeping function for the profession. Clinical supervision has also been defined as

> a process whereby consistent observation and evaluation of the counseling process is provided by a trained and experienced professional who recognizes and is competent in the unique body of knowledge and skill required for professional development. . . there are two general categories of supervision: clinical and administrative. (Haynes et al., 2003, p. 3)

Milne (2007) created an integrative definition of clinical supervision to test against existing literature in the field based upon their logical deductions. Bernard and Goodyear's (2004) definition did not meet the four necessary conditions of precision, specification, operationalization and corroboration needed to be an empirical definition. Milne's working definition of clinical supervision stated "the formal provision by senior/qualified health practitioners of an intensive relationship-based education and training that is case-focused and which supports, directs and guides the work of colleagues (supervisees)" (p. 440). The functions of supervision include quality control, maintaining and facilitating the supervisees' competence and capability, and helping supervisees to work effectively. Milne concluded that Bernard and Goodyear's definition could be improved, but was accepted as proposed with the caution that more research should be conducted.

Powell and Brodsky (2004) extended the idea of AODA counselor supervision stating supervision "is a disciplined, tutorial process wherein principles are transformed into practical skills, with four overlapping foci: administrative, evaluative, clinical and supportive" (p. 11). Powell and Brodsky argued that many definitions of clinical supervision fail to include the area of administrative as many definitions are directed to counselors in training in formal academic settings. However, clinical supervision in the professional field can often include tasks such as arranging, developing, and assigning roles and tasks within an agency. The evaluative area of clinical supervision for AODA supervisors includes goal setting and feedback. Evaluation may include performance standards, formal performance reviews, and sanctions for impairments and deficits. The clinical focus area concentrates on the supervisee's development of skills, knowledge, ethics, and conceptualization of the counseling process. The focal area of support in AODA clinical supervision pertains to encouraging the supervisee and helping him or her prevent burnout and have someone to talk to about personal challenges (within ethical boundaries) to the supervision process. Each of the four foci acts separately as well as interacts with one another.

Surprisingly, IC&RC as the credentialing body of AODA clinical supervisors does not provide a current definition of clinical supervision on their website. However, according to the Arkansas Substance Abuse Certification Board (ASACB)

> The IC&RC defines clinical supervision as a specific aspect of staff development dealing with developing clinical skills and competencies for persons providing counseling. A primary purpose of clinical supervision is to ensure skill development as evidenced in quality patient/client care. (n.d., para. 1)

Bernard and Goodyear (2004) stated that due to supervision being such an integral part of counseling, many mental health professionals at some point would provide supervision. It is unclear as to whether AODA counseling is included in Bernard and Goodyear's statement. Regardless, as the field of AODA advances, it is logical to consider that many AODA professionals will provide supervision during some portion of their professional life due to tenure and therefore appropriate competencies and training should be identified and used.

Clinical Supervision Competencies

Research related to current competencies for clinical supervisors in the field of AODA counseling are scarce. As the field of AODA is often thought of as a branch of other counseling fields, the related fields were included in a literature review of clinical supervision competencies. A review of these other fields is needed in order to compare and contrast any competencies identified in the present study to ensure their exclusivity to AODA clinical supervision.

Psychology and Mental Health

In 1989, the Association for Counselor Education and Supervision (ACES) Supervision Interest Network engaged a subcommittee to develop a set of training guidelines for clinical supervisors (Borders et al., 1991). The curriculum guide was based upon empirical research current to the field. The core content areas included models of supervision; counselor development; supervision methods and techniques; the supervisory relationship; ethical, legal, and professional regulatory issues; evaluation; and executive (administrative) skills. Each of the core content areas included learning objectives in the areas of self-awareness, theoretical and conceptual knowledge, and skills and techniques as well as a list of the major topics within each core content area. The authors acknowledged that the guide was developed based upon limited

research in the field and included the work group's professional experiences as clinical supervisors.

Green and Dye (2002) conducted a Delphi survey in the United Kingdom to help identify suitable components of a supervisor training program. A panel of 50 participants was recruited. The authors created the original 45 item questionnaire consisting of components identified via existing academic literature, professionals in related fields, existing guidelines, and existing curricula. Panelists were asked in round one to rate each of the 45 items on a scale of 1 (irrelevant) to 7 (essential) as well as an opportunity to provide qualitative comments. Panelists were also encouraged to provide up to three other recommendations for additional components not included on the questionnaire. These suggestions resulted in five more items being added to the questionnaire. Round two provided panelists with the mean, range, standard deviation, and up to three comments for each of the 50 items. Results indicated that the four most important components were (a) considering when and how to fail a placement (b) legal responsibilities of supervisors (c) the need to ensure that the supervisee's client receives appropriate care and (d) how to negotiate placement contract. The four least important components were (a) requires that supervisor provide audio or video records of actual supervision sessions (b) the use of non-traditional formats such as group, peer, team (c) provide formal supervision for the trainee supervisors and (d) providing specific instructions for trainees. The researchers concluded that a reasonable consensus existed between UK clinical psychologists regarding components of clinical supervision training.

Falender et al. (2004) reported on a work group that had the tasks of identifying competency components in supervision, educational and training experience needs, and ways to assess competence in the decided areas. The group then helped identify action steps to move

supervision forward as a profession. The work group identified knowledge, skills, and values needed for an entry-level psychologist supervisor. Overarching themes of diversity, ethical and legal issues, developmental process, knowledge of the system and expectations of which the supervision is conducted, awareness of sociopolitical contexts, and creation of a safe environment for feedback permeate all other areas of knowledge, skills, and values. Training and assessment both focused on the supervisor-in-training having had received supervision in the past and having completed a course on supervision. The Falender et al. study was the first to identify supervisor competencies in psychology supervision. The work group only included individuals who had provided some type of supervision in the past. As AODA counseling is often viewed as a subset of mental health counseling, it is logical to extend the discussion of supervision competencies to AODA clinical supervisors.

Rehabilitation

Thielsen and Leahy (2001) conducted a study to identify the essential knowledge and skills needed for rehabilitation counseling clinical supervision. Using a Delphi technique, a panel of participants provided three rounds of feedback to identify 95 items. Round one used an open-ended question to elicit the essential knowledge and skill domains for rehabilitation counselor supervision. The researchers then conducted a content analysis and added four items identified in the literature to equal 114 items. Panelists rated the importance of each item and had the opportunity to clarify the statements, which resulted in four new items being identified. In round three, panelists were provided with their previous response and the group mean and standard deviation for each of the original 114 items. They had the opportunity to either retain or revise their original rating. The new mean, review of literature, and comments and recommendations of panelists were considered when identifying the most essential skills and

knowledge resulting in 95 items. The extent of the knowledge and skills identified indicated CRCs perceive many items as important for effective supervision in the field. The measure developed from the 95 identified items was then used for further research. The authors administered a survey to 774 CRCs and used principal component analysis to identify six domains of competencies: ethical and legal issues, theories and models, intervention techniques and methods, evaluation and assessment, rehabilitation counselor knowledge, and supervisory relationship. It should be noted that the domains noted in the results of the Thielsen and Leahy study include, but are not limited to, domains found in competency domain studies for rehabilitation counselors alone. Experts were used to construct the measure, but then counselors rated item importance to be used in the principal component analysis. The present study will differ in that researcher/educators will be identified as the experts in order to assist in identification of competencies for RCT curriculum integration.

Moorhouse (2008) conducted a Delphi study to identify competencies of rehabilitation counseling supervision in order to create a clinical supervision instrument. Potential panelists were contacted via the National Council of Rehabilitation Education listserv. The survey itself was administered via SurveyMonkey®. The survey was pilot tested with five educators prior to actual administration. Round 1 included demographics to ensure panelists met the expert criteria set by Moorhouse. In addition, an open-ended question was presented soliciting skills, abilities, and attributes that would be useful in evaluating rehabilitation counselor trainees. Of the 410 items submitted in Round 1, 183 items were found to meet consensus in Round 3, which were subsequently sorted into 10 domains. Future research was suggested to analyze the items utilizing Item Response Theory methods. The methodology in the current study will be very similar to the methodology utilized by Moorhouse, but focused on AODA clinical supervision.

AODA

Although little research exists on AODA clinical supervision competencies, a brief history of AODA competencies can still be reviewed. Hoge, Paris, et al., (2005) provided a summary of competency development with the AODA counseling field. This brief history provides a background for current AODA clinical supervision competency literature. Hoge, Paris, et al. indicated that credentialing initiated in the late 1970s with the first publicized report becoming available from Birch and Davis Associates, Inc. (1984) spurring the development of the twelve core functions which have been used as a basis for certification standards. By the late 1980s, most states had voluntary certification boards including 43 states as members of the National Certification and Reciprocity Consortium. The National Association of Alcoholism and Drug Abuse Counselors (NAADAC) developed a national certification process in 1990 that was comprised of education, state certification, and exam competency. The Addiction Technology Transfer Center (ATTC) Network was established in 1993 by the CSAT, a part of the Substance Abuse and Mental Health Services Administration (SAMHSA). An ATTC committee compiled a list of competencies that were then validated by Adams and Gallon in the year 1997 (Hoge, Paris, et al., 2005).

The mid-1990s brought committees together delineating knowledge, skills, and attitudes of professionals in the field as well as the role-delineation study supported by the IC&RC. The information gathered from these sources was compiled in a Technical Assistance Publication (TAP) by SAMHSA, which identified eight dimensions essential for the practice of addiction counseling. At the time of press (Hoge, Paris, et al., 2005), the counseling competencies were in revision and clinical supervision competencies were in development. It is interesting, and disconcerting, that the field failed to identify clinical supervision competencies for the first 30

years that competencies were available for counseling. Presently CSAT and IC&RC have taken more of an interest in identifying the needed clinical supervision competencies for the field of AODA.

CSAT (2007) reported that it convened the Clinical Supervision Competencies Task Force in the fall of 2005. The task force had the challenge of identifying competencies needed to reach mastery as a clinical supervisor in the AODA field. The TAP manual reports that competencies are research and consensus based, but does not provide further detail as to what extent of the competencies are research based and which are consensus based. The Task Force identified two headings of competencies: foundation areas and performance domains. The five foundation areas are theories, roles, and modalities of clinical supervision; leadership; supervisory alliance; critical thinking and organizational management; and administration. The performance domains include counselor development, professional and ethical standards, program development and quality assurance, performance evaluation, and administration. Numerous competencies are identified under each foundation area and performance domain.

IC&RC currently bases their certification examination for clinical supervisors from the 2008 Job Task Analysis Assessment Study (2008a). The September 2008 revision of the certified clinical supervisor examination content was the first revision since 2002 when the examination guide was based on the 2000 Role Delineation Study (IC&RC, 2002). Unfortunately, the 2000 Role Delineation Study is no longer available from IC&RC for reference to that study's methods (T. Bransford, personal communication, January 25, 2010). The 2008 examination guide (IC&RC, 2008b) presented six performance domains included in the examination content including counselor development, professional and ethical standards, program development and quality assurance, performance evaluation, administration, and

treatment knowledge. Numerous tasks fall under each of the identified performance domains. The method of the study included a committee of 10 subject-matter experts being appointed to oversee the development of a survey comprised of tasks based upon previous job analysis surveys and approved textbooks. Email invitations were sent to 3,364 professionals in the certified clinical supervisor field of which 317 (9.42%) surveys were completed. The survey asked participants to complete a section of demographics and then rate tasks in each of the six domains answering the question "How important is being competent in this task when considering the safe and effective performance of a Clinical Supervisor?" Finally, participants were asked to provide weight of importance of each of the six domains.

A committee consisting of four experts from the first committee convened to determine which tasks were deemed essential. The inclusion/exclusion criteria were initially statistically based; however, at the end the committee could overturn a statistical exclusion rule they developed by simply determining to keep the item in the list of essential tasks. The committee then assigned a percentage of importance to each domain, which affects the percentage of questions from each domain that appears on IC&RC's clinical supervision exam. The executive summary asserts, "the approved tasks, knowledge, and skills establish the link between the competencies necessary to perform a Certified Clinical Supervisor's job and evaluation of competency" (IC&RC, 2008b, p. 1). It is of concern that a panel of only four subject-matter experts chose which competencies from the original survey were essential to remain a part of the international credentialing exam. All of the subject-matter experts appeared to work in a clinical setting; however, specific demographic information was not published due to confidentiality. The emphasis on supervisor ratings of importance has its place in research. However, it is possible in some instances that an individual entered the field with no educational background

(IC&RC). Thus, educators knowledgeable about current research and issues in the field are valuable to competency identification.

CSAT and IC&RC are quite possibly two of the most renown and influential organizational bodies influencing credentialing of AODA clinical supervisors. It is alarming that both appear to utilize many of the same competencies in their most recent publications and neither utilized sound methodology in obtaining their lists of competencies and subsequent domain areas. A methodologically sound study is needed in order to identify the competencies exclusive to AODA clinical supervision, which was attempted in the present study.

Previous Delphi Studies

The Delphi technique will be used in this study (see Chapter Three for a more extensive discussion). The Delphi technique has been utilized in several social service type studies. Three studies, Green and Dye (2002), Thielsen and Leahy (2001), and Moorhouse (2008) were previously mentioned in this review. Green and Dye identified components of a supervisor training program using a panel of 50 participants. The authors created the original survey based on previous research and existing documents. The researchers concluded that a reasonable consensus existed between UK clinical psychologists regarding components of clinical supervision training. Thielsen and Leahy conducted their study to identify essential knowledge and skills needed for rehabilitation counseling clinical supervision using CRCs as panelists. Panelists defined the first sets of items via open-ended questions and then conducted a content analysis to create the first survey. After importance ratings were received in subsequent rounds, principal component analysis was conducted to identify competency domains for future research. Moorhouse solicited items defining rehabilitation counseling clinical supervisor competencies in order to build a reliable evaluation tool.

Recently, Delphi methods have become more popular in the rehabilitation field. Vazquez-Ramos, Leahy, and Hernandez (2007) provided an overview of the Delphi model for the field of rehabilitation and summarized four recent studies utilizing the method within the field. In one such study, Rubin, McMahon, Chan, and Kamnetz (1998) examined the research directions within the field of rehabilitation using a panel of 23 experts representing the Commission on Rehabilitation Counselor Certification, Certification of Disability Management Specialists Commission, or the Commission for Case Manager Certification. In another study, Currier, Chan, Berven, Habech, and Taylor (2001) used a Delphi panel to identify functions and knowledge domains for disability management practice. A panel of 44 experts in disability management participated in round one of the Delphi method and only 23 in the second round; further rounds were suspended due to attrition. A third study was conducted by Hakim and Weinblatt (1993) with a panel of experts comprised of federal legislators, federal and state policymakers, individuals in academia, rehabilitation center administrators, and direct service staff. Results indicated that legislators and federal executives were not aware of the a priori goals and objectives for funds intended for rehabilitation services. The fourth article mentioned by Vazquez-Ramos et al. was Thielsen and Leahy (2001), previously discussed.

Delphi techniques have been used in other counseling fields to help identify competencies. Israel, Ketz, Detrie, Burke, and Shulman (2003) sought to examine competencies required for working with lesbian, gay, and bisexual (LGB) clients. The first round panel to identify competencies to be considered consisted of 22 experts identified as either a professional expert or a LGB expert. In the second round 33 participants responded, some of which participated in round one. A major limitation of this study was requiring LGB professionals to identify as LGB on the survey to verify expert status. Thus, few panelists participated.

Another study examined multicultural supervisory behaviors (Dressel, Consoli, Kim, & Atchison, 2007). Multicultural supervision was defined as when individuals in a supervisory dyad had different ethnicities. The panel consisted of university counseling center supervisors with experience in multicultural supervision. Attrition was also a factor in this study whereas 21 participants responded in round one, but only 13 responded by round 3. As attrition is a common occurrence in Delphi studies, the initial panel of experts in this study should be large enough to allow for some level of attrition.

Two studies were identified in the literature that addressed curriculum for training AODA counselors. Klutschkowski and Troth (1995) sought nominations of panelists from member board presidents of the National Certification Reciprocity Consortium/Alcohol and Other Drugs (now IC&RC). Results indicated that the panel could not agree that the written standards should be part of the ideal AODA training curriculum. It was suggested that using university counselor educators as experts would have likely affected their results. This argument should be extended to research on AODA clinical supervisors. Whittinghill (2006) used a 28 member panel to examine knowledge and skills needed for effective clinical practice of master level AODA counselors. In Whittinghill's study, each subsequent round of the survey included fewer items based on the previous responses, which is in contrast to what is suggested by Hasson, Keeney, and McKenna (2000). The present study will retain all items between rounds to support the spirit of the Delphi (Hasson et al.).

Summary

Numerous definitions of clinical supervision exist and one definition is directed towards the AODA field. However, the lack of consensus of a definition makes identifying competencies for a field even more difficult. Many of the definitions overlap and should be taken into account.

A few studies have examined competencies of clinical supervisors in various counseling fields utilizing literature, survey research, and personal experience to identify competencies for clinical supervisors. However, no study specific to AODA clinical supervisors was methodologically without flaw from an academic/research perspective. Thus, a study is needed to focus specifically on competencies of clinical supervisors in the AODA field for integration into RCT curriculum. Chapter Three will detail the participants, methodology, and data analysis. Chapter Four details the results. Chapter Five discusses implications, limitations, and future research.

CHAPTER THREE

METHODOLOGY

The purpose of this study was to identify AODA clinical supervision competencies for integration into RCT curriculum. The previous chapters outlined an introduction and literature review of clinical supervision as it applies to AODA and similar fields. This chapter details the study design including participants and analyses. This study utilized a Delphi technique followed by content analysis in order to solicit competencies necessary for AODA clinical supervisors that are in addition to general clinical supervision competencies.

Delphi Technique

Development

The Delphi technique's name is derived from the ancient Greek myth of the Delphi oracle. A specific individual was believed to be able to read the Delphi oracle and predict the future. The Delphi technique was developed by the Air Force sponsored by the RAND Corporation during experimental research seeking expert opinions in the early 1950s (Linstone & Turoff, 1975). It was not until 1964 that the Delphi technique became more noticed as a study by Gordon and Olaf led to civilian use of the Delphi technique. From the mid 1960s to the mid 1970s, the use of the Delphi technique spread to Europe and Asia and was found in settings such as government, education, and industry (Linstone & Turoff, 1975).

Key Characteristics

Several characteristics comprise the Delphi technique. First, three types of Delphi studies exist:,conventional, real-time, and policy (Clayton, 1997). The present study utilized the conventional technique in which the moderator sent the survey to a larger expert group and then revised the questionnaire based on previous responses leading to readministration of the

questionnaire (Linstone & Turoff, 1975). The Delphi technique utilizes a panel of experts as the respondents in the study. An expert "is someone who possesses the knowledge and experience necessary to participate in a Delphi" (Clayton, 1997, para. 27). Clayton suggested that a sample size of 15-30 would be appropriate for a homogeneous population with homogeneous being defined as experts coming from the same discipline.

After the panelists are identified, a survey is then administered to the panel soliciting both quantitative and qualitative responses (Green & Dye, 2002). The researcher, moderator, or moderating team then summarizes the survey results and returns the survey to panelists including feedback, both quantitative and qualitative. Panelists then have the opportunity to revise their answers a minimum of one time. The process may be repeated to attempt a more cohesive consensus, but often results in higher attrition rates (Green & Dye, 2002).

Application

According to Linstone and Turoff (1975), the Delphi technique has been used in a number of application areas including

- Gathering current and historical data not accurately known or available
- Examining the significance of historical events
- Evaluating possible budget allocations
- Exploring urban and regional planning options
- Planning university campus and curriculum development
- Putting together the structure of a model
- Delineating the pros and cons associated with potential policy options
- Developing casual relationships in complex economic or social phenomena
- Distinguishing and clarifying real and perceived human motivations

- Exposing priorities of personal values, social goals. (p. 4)

The current study proposed to examine the competencies of AODA clinical supervisors that extend beyond general counseling clinical supervision competencies in order to better prepare RCT educators for working with future AODA clinical supervisors.

The Delphi technique is typically utilized when the subject matter being studied does not fit well with other investigative techniques, participants have very broad backgrounds with no prior communication, or the sample size needed is larger than can be accommodated in person. For example, the Delphi technique is more economically beneficial than holding a face-to-face meeting requiring travel expenses for various individuals across a large geographic area. Furthermore, the Delphi technique works well if disagreements are present between participants that are so disruptive a moderator is needed. In addition, if strong personalities are present in the sample, they are evened out when using the Delphi technique as the dominant personality cannot take over a group discussion that is moderated on paper. Thus, higher validity of results is expected (Linstone & Turoff, 1975).

Sampling

The steps, phases, and activities suggested by Vazquez-Ramos et al. (2007) to conduct a study utilizing the Delphi technique in the field of rehabilitation were followed for this study. Step 1 was listed as selection, including the activities of identifying potential experts, inviting them to participate, recruitment of panelists, and finally the constitution of the panel of experts. As the Delphi technique does not concretely identify how to define who constitutes an expert in order to be included as a panelist, the following criteria were defined in order to define a rehabilitation counselor educator expert in AODA clinical supervision for the purposes of this study. To be eligible for the present study each individual must have earned a doctoral degree in

rehabilitation counseling or a related field. In addition, he or she must have met at least two of the five criteria since 2005 (unless otherwise noted) in order to qualify as a panelist.

1. Taught a course focused on alcohol or drug abuse treatment at the undergraduate or graduate school level
2. Published peer reviewed work on the topic of AODA clinical supervision
3. Presented at a national refereed conference on AODA clinical supervision
4. Supervised a minimum of five counselors in training and/or supervisors in training in the AODA field at the graduate school level or in the clinical field
5. Served on an editorial board of a journal and personally reviewed at least two articles pertaining to AODA clinical supervision

Delphi study panel sizes ranging from 10 to over 1600 have been reported in the literature (Powell, 2003). Skulmoski, Hartman, and Krahn (2007) suggested 10-15 panelists are appropriate for a homogeneous population whereas several hundred may be needed for a heterogeneous population. The Delphi technique does not require a representative sample (Powell, 2003). Due to the challenge of attrition in Delphi studies and the mostly homogeneous population (regarding expert criteria), 30 panelists were initially sought for the first round of this study in order to allow room for attrition.

Once approval was granted from the Southern Illinois University Human Subjects Committee, my dissertation chair identified approximately 10 potential experts known to the field of RCT and AODA. Contact information for the potential panelists was gathered from their respective university websites. The experts were initially contacted via email because most universities were on holiday break at the time panelist recruitment began. The email explained the purpose of the study and provided them with the expert criteria set (Appendix A). It was

believed that contacting experts via email versus voicemail would yield more response over the break. Each expert was asked to respond via email if he or she was willing to participate as a panelist in the study. If so, each individual was asked to provide their vita as confirmation of meeting panelist criteria. Vitas were kept to verify experts' experiences, describe the expert panel, and were destroyed at the conclusion of the study. All expert panelists were provided a summary report at the conclusion of the study as an incentive for completing the study. In addition, each panelist who completed the study was given the option of having their name included in the acknowledgements of the study.

A snowball sampling method was partially employed in order to recruit panelists for the study. A snowball sample "is like a two-stage convenience or purposive sample" (Huck, 2008, 113). All experts initially contacted were asked to supply names of other experts in the field who may have met the expert criteria. Of the initial 10 potential expert contacts, one replied that they were unavailable due to other commitments, one declined due to not meeting criteria, five agreed to participate and three provided no response. Of all responses received, if names of other potential experts were not suggested, a follow-up email request was sent to encourage suggestions. A total of two new unduplicated names were provided by the initial seven responses. Approximately two weeks after the first 10 potential experts were contacted, an initial email was sent to the two newly suggested experts (Appendix B). No new responses were received and thus 10 days later a follow-up email was sent to the initial three non-responses in addition to the two suggested non-responses. Of these five contacts, two agreed to participate, one declined due to other commitments, and two never responded.

Due to minimal suggestions of experts from the snowball technique, CORE accredited program websites were reviewed to identify potential panelists through published research

interests, courses taught, and so forth. In addition, directors of programs known to provide substance abuse concentrations were contacted via email requesting the name(s) of who taught or oversaw the substance abuse program. Review of program websites and contacting program directors yielded a potential of 14 more experts that might have met criteria. These 14 potential expert panelists were contacted via email. Of these 14, one met criteria, seven responded they did not meet criteria, and six never responded. Due to a pre-existing relationship with potential panelists, the research advisor for this study initiated personal telephone contacts with the non-responses. The telephone contacts yielded one more panelist. As it appeared all means of recruiting panelists had been exhausted, the study began with nine panelists. A total of 26 potential expert panelists were contacted in attempts to create the panel. Recruitment of panelists took a total of 53 days.

Present Study Design and Analysis

An invitation to complete Round 1 of the survey was sent to each panelist's email address via LimeSurvey®. LimeSurvey® is a free open source survey software program. Engard (2009) highly recommended LimeSurvey® for librarians as it provides numerous opportunities to collect unlimited responses, manage users, import and export questions, and create a print version of the survey, which can be integral to have comparable versions of the online and paper questionnaire. LimeSurvey® was chosen as the survey software for the present study due to cost, availability, export capabilities, and user management capabilities via the program's tokens (unique identifier) feature. Tokens were utilized in order to match participant responses between rounds.

Round 1

Per Vazquez-Ramos et al. (2007), Step 2 of the Delphi process included exploration. Exploration activities included distribution of the Round 1 questionnaire, follow-up, collection, collation and categorization, and construction of Round 2 questionnaire. An email was sent via LimeSurvey® to the identified expert panel inviting them to participate in the Round 1 questionnaire (Appendix C). Prior to commencing the Round 1 survey, potential panelists were informed of the purpose, procedure, criteria for inclusion, voluntary nature of the study, confidentiality of records, and contact information of the researcher. Each panelist was required to agree to the informed consent statement prior to LimeSurvey® allowing him or her to continue the survey.

The Round 1 survey consisted of the instruction:

> "Please develop and write below a list below of competencies specific to alcohol and other drug abuse clinical supervisors that should be included in rehabilitation counselor training programs. Please include knowledge, skills, abilities or personal characteristics. Please do not include competencies that could be generalized to other types of clinical supervision (e.g., social work, psychology, rehabilitation counseling, and mental health counseling). You may provide any comments or explanation that you wish with the knowledge that your comments may be included in future rounds of the survey to clarify or assist others. Your individual responses will not be publically attributed to you in subsequent rounds or in the published results."

In order to better describe the panelists, a brief demographic section was also included (Appendix D). Two weeks after the Round 1 survey became available, a follow-up email

(Appendix E) was sent to all panelists who had not yet completed the survey reminding them to respond.

Corbin and Strauss (1990) stated that when conducting qualitative research, as soon as an incident is noted it should be compared to other incidents. Thus, for the purposes of this study, upon receipt of five responses, collation and categorization of responses began. As additional responses were received, the process continued. An additional benefit to beginning analysis prior to receipt of all responses is reduction of time needed between rounds in order to reduce and prevent panelist attrition. I combined duplicate responses or responses deemed to mean the same. Moorhouse (2008) provided specifics of how items could be combined. For example, similar items such as ""paraphrasing," "know how to paraphrase," and "ability to paraphrase" were condensed into the item "paraphrase client statements"" (p. 68). The process for the combination of items was recorded in order to remain accountable to the prevention of research bias in the form of a memo writing (Appendix F). Memo writing "captures the … choices the researcher makes as a study is implemented and as a theory is developed, providing a means for making transparent the interpretive, constructive processes of the researcher" (Fassinger, 2005, p. 163). Wordings provided by panelists were utilized as much as possible with minor editing to stay true to the Delphi technique and reduce bias (Hasson et al., 2000).

At the end of the three week period (15 weekdays, 21 days total), five complete responses were received by panelists. Two panelists had not logged in to start the survey and two others completed the demographic information, but not the main content question. An additional reminder email was needed in order to prompt a higher response rate. Approval was sought and granted from the Southern Illinois University Human Subjects Committee to modify the study protocol in order to send an additional email reminder to non and partial responses reactivating

the Round 1 survey for a period of three business days. This additional activation period yielded one more response. Collation and categorization of responses was completed. All items were utilized to construct the Round 2 questionnaire. Items with similar content were grouped together in the overall order.

Round 2

Vazquez-Ramos et al. (2007) indicated that Step 3 of the Delphi technique is evaluation. Evaluation activities include distribution of the Round 2 questionnaire, follow-up, collection, collation and categorization, and construction of the Round 3 questionnaire. Following the extension of data collection, two days separated the completion of Round 1 and the beginning of Round 2. Panelists who responded to Round 1 received an email invitation to access the Round 2 questionnaire via LimeSurvey® (Appendix G). Panelists were asked to rate their level of agreement on a five point Likert scale (Clayton, 1997; Dillman, 2007) as to whether the item listed was a competency specific to AODA clinical supervisors (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree). Each item included ample space for comments regarding the rating given and comments or wording changes to the item itself. Panelists were each provided the opportunity to suggest up to five items not included on the questionnaire at the time of completion (Appendix H). Follow-up emails were sent to prompt participation one week and two weeks after the questionnaire became available and the day prior to the questionnaire closing (Appendix I). Round 2 was available for 16 weekdays (including Good Friday) and 22 days total. Upon collection of the responses, items were collated and categorized.

SPSS 16.0 and Microsoft Office Excel 2007 were used to analyze item ratings, calculating measures of central tendency and levels of dispersion. Means, standard deviations,

medians, Tukey's hinges, and frequency tables were calculated and created. Standard deviation was calculated using the formula $SD = \sqrt{(\sum(X\text{-}M)^2/(N\text{-}1))}$ as it was believed that the six panelists represented only a sample of the available expert population opinions in the field as opposed to dividing only by N (Howell, 2007). Numerous methods of calculating quartiles are available (Frigge, Hoaglin, & Iglewicz, 1989). Tukey's hinges were used to represent the interquartile range in this study, as they are recognized as one of the most common definitions (Schwertman, Owens, & Adnan, 2004). Tukey's hinges are calculated by rank ordering the responses and then dividing the responses into two halves. If the number of responses is odd, the median will be used in both halves. The median of each half then represents the hinges used to calculate what is referred to as the H-spread (Tukey, 1977) often interchanged with the term interquartile range (Glass & Hopkins, 1996). As interquartile range appears to be more prevalent, it was the term utilized in this analysis to label the H-spread and for instrument construction. Of note, in smaller samples, the interquartile range based upon percentiles and Tukey's hinges may differ; however, in larger samples the two methods typically achieve equivalent results (School of Chemical and Mathematical Sciences, 2010).

As the Delphi model does not operationally define consensus, consensus was considered met in this study if convergence was achieved as described below. Carnes, Mullinger, and Underwood (2010) reported reviewing several studies and determined that convergence should be considered met if >74% agreement is present for each item (e.g., 75% of panelists rate an item as 4 = agree versus the other four rating options). Thus, the same criterion was utilized in the present study. As consensus was not reached in Round 2, data collection continued in Round 3.

Rounds 3-5

Vazquez-Ramos et al. (2007) stated Step 4 of the Delphi technique as reevaluation. Reevaluation includes activities of distribution of the previous round questionnaire, follow-up, collection, re-collation and categorization, and calculation of summary statistics. Two days separated the completion of Round 2 and the initiation of Round 3 in order to prevent attrition. Panelists who responded to the Round 2 questionnaire received an email via LimeSurvey® inviting them to participate in the next round of the study (Appendix J). All items from the Round 2 questionnaire were included on the Round 3 questionnaire as readministration of the entire survey is more desirable than only readministering certain items so to not introduce bias (Hasson et al., 2000). Items from the Round 2 questionnaire were presented with their median and interquartile range, as these items are more robust than mean or standard deviation (Murphy et al., 1998). In addition, frequency distributions, means, and standard deviations were provided in order to provide panelists with as much information as possible in order to evaluate their rating in comparison with the group rating. To potentially assist others in their ratings, comments regarding the items were included in the Round 3 questionnaire. Finally, the rating that the panelist gave in the prior round was provided. New items suggested in Round 2 were added to the end of the Round 3 survey, but did not include prior ratings or summary statistics, as these items had not yet been rated by the panel (Appendix K).

Panelists were asked to examine their previous rating for each item and either retain or modify their rating taking into account the statistics presented of the panel's opinion as well as comments provided. Panelists whose responses fell outside of the interquartile range were asked to provide rationalization for their rating. Reminder emails were sent, as well as reminder phone calls placed to nonresponsive panelists as needed, to encourage participation (Appendix L).

Round 3 was available for 16 weekdays (22 days total). One participant requested an extension due to a technology error causing some responses to not save. Thus, the survey was available for one additional day for this panelist. Summary statistics were calculated utilizing SPSS 16.0 and Microsoft Office Excel 2007.

According to Scheibe, Skutsch, and Schofer (1975), the evaluation of stability takes into account change in the group opinion versus individuals' ratings. The absolute difference of the difference in frequency of participant responses between rounds was calculated to determine stability. Table 1 helps demonstrate the method of calculation for stability.

Table 1

Method of Stability Calculations

	Response Option				
Numerical Value	1	2	3	4	5
Round 2 Frequency	A	C	E	G	I
Round 3 Frequency	B	D	F	H	J
Absolute Difference	|A-B|	|C-D|	|E-F|	|G-H|	|I-J|

Next, the total units of change were summed (|A-B| + |C-D| …+|I-J|), divided by two then divided by the number of participants to produce the percent change level. A change level of 15% or less was considered stable and did not require a further round of the survey. If the change level was 15% or more, the entire survey was sent out as another round (Schiebe et al., 1975). A change level for the items added in the construction of the current round was not calculated as only the present round ratings existed. However, if another round of the questionnaire was needed, the change level was calculated in subsequent rounds. If neither stability nor convergence was met after Round 3 as suggested by Vazquez-Ramos et al. (2007),

Steps 4 and 5 of the Delphi process were repeated until consensus was reached. A third way the data collection rounds could have ended was dependent on response rates. If the rate of attrition from Round 1 to Round 3 or later was greater than or equal to 30% of the panelists, the data collection was discontinued as attrition rates ranging from 16.4% to 78.8% have been reported in literature (Dressel et al., 2007; Moorhouse, 2008; Vernon, 2004; Williams & Webb, 1994). However, Sumsion (1998) suggested the need for a 70% response rate. Neither consensus nor stability of responses was achieved in Round 3, thus another round of data collection was required. The above-mentioned steps in this section were repeated for Rounds 4-5 (Appendices M-R) due to lack of consensus, stability, or attrition.

Sixteen days separated the completion of the Round 3 extension and the initiation of Round 4 as extra time between rounds was used to create sub-items based upon panelist comments. Round 4 was available for 15 weekdays (19 days total). However, a two-day extension was granted per a panelist's request in order to complete the round. Nineteen days separated the completion of Round 4 and the initiation of Round 5 due to software updates slowing the Round 5 questionnaire development. Round 5 was available for 16 weekdays (22 days total) in addition to a one day extension requested by a panelist.

Data collection was discontinued after Round 5 due to panelist fatigue. See Chapter Four for more details. An email was sent to all panelists informing them the study had concluded (Appendix S).

Final Consensus

Vazquez-Ramos et al. (2007) indicated that Step 5 of the Delphi process is final consensus. Activities that are to be included in this step were identification of items on which consensus was obtained, summary of final results, and development of instrument prototype. In

this study, five rounds of data collection were conducted. Data were analyzed in regards to rankings per round based upon mean ratings as well as an examination of competencies in which sub-items added throughout the rounds of data collection. Sub-items were analyzed to examine if themes were present between initial items and sub-items added later in the data collection process. In addition, as neither complete consensus nor stability were achieved due to panelist fatigue, it was determined a content analysis could be helpful in a final description and analysis of the data collected in order to assist with summary of final results and potentially the development of instrument prototype and curriculum suggestions.

Content Analysis

Content analysis has been defined as a method of analysis in which “meanings, themes, and patterns that may be manifest or latent in a particular text” (Zhang & Wildemuth, 2009, p.1) may be examined to help increase meaning of a social reality. Busch et al. (2005) stated that two types of content analysis exist: conceptual and relational. For the purposes of this study, focus was on conceptual analysis of the competencies rated in Round 5 of the study. As both the original competencies and sub-items were presented in Round 5, both the original competencies as well as the sub-items were included in the initial content analysis as it is possible the variations of sub-items could have indicated a variance in conceptual ideas.

Several methods of conducting content analysis are readily available in the literature (Carley, as cited in Busch et al., 2005; Rabiee, 2004; Zhang & Wildemuth, 2009). Content analysis in the current study was conducted as follows. Each competency was coded as a whole idea as opposed to looking at individual words within each item. Existing literature was used to determine the initial categories (Zhang & Wildemuth, 2009). CSAT’s TAP manual 21A (2007) foundation areas and performance domains were used. Themes from this CSAT research and

IC&RC (2008b) comprise the research most closely related with the current study; however, CSAT produced more categories of interest than IC&RC and thus it was chosen to provide initial concepts. The initial categories were Theories, Roles, and Modalities of Clinical Supervision; Leadership; Supervisory Alliance; Critical Thinking; Organizational Management and Administration; Counselor Development; Professional and Ethical Standards; Program Development and Quality Assurance; Performance Evaluation; and Administration. Immediately prior to sorting of competencies the domain of Organizational Management and Administration and the domain of Administration were combined into one category for the purposes of this study.

Competencies were individually sorted into categories by the primary researcher. However, not all items fit cleanly into these categories as labeled. Thus, category names were edited during the sorting process. All competency items were utilized within the edited concept categories. The edited categories were Treatment Related Knowledge and Skills; Organizational Management, Administration, and Program Development; Theory, Roles, and Interventions of Clinical Supervision; Personal Characteristics and Skills of Leadership; Supervisee Performance Evaluation and Feedback; Supervisory Relationship; and Legal and Ethical Concerns.

The complete list of unsorted competencies and the list of seven edited categories were sent to two independent raters familiar with the topic of AODA clinical supervision and rehabilitation counseling, but unfamiliar with the current study's results. The raters were unaware of the identity of the other rater until after their response had been received to best control for independent ratings. A request was sent via email for the individuals to sort the competencies into the categories provided, suggesting feedback if they observed a category not mentioned or if category titles needed clarification. A reminder was provided that these were

competencies of supervisors and not supervisees. A priori, it was decided that if two of the three raters assigned an item to a specific category as independent ratings, it was considered agreed upon for the purposes of this study (Marques & McCall, 2005; Stebnicki & Cubero, 2008). Upon receipt of the reliability rater's responses, a comparison of coding was conducted.

Various statistical methods of inter-rater reliability such as percent agreement, Holsti's method, Scott's pi, Bennett's S, Cohen's kappa, Fleiss's kappa, and Krippendorff's alpha are available dependent upon factors such as number of raters, measurement scale used (nominal, ordinal, interval), independent versus dependent ratings, and so forth. (Cohen, 1960; Fleiss, 1971; Hayes & Krippendorff, 2007; Lombard, Snyder-Duch, & Bracken, 2002; Perreault, Jr. & Leigh, 1989). However, due to the number of raters used (n = 3), nominal data measurement scale, independent ratings, and all items rated by all raters, none of the above-mentioned methods appear appropriate for this data. Thus, percent agreement between raters per competency was solely calculated for the purposes of content analysis.

Studies varied as to how items that did not fit well into categories were handled. Past content analysis studies have chosen to discard any items not meeting the preset level of agreement (Wallace & Chen, 2010). In addition, scale development studies often conduct factor analysis if sample size is large enough, which it is not in the current study. Hatcher (1994) reported that in factor analyses, items are dropped from analysis if they load on more than one factor. The present sample of six panelists was too small to conduct a factor analysis. It should be noted that in the present study competency items utilized in the content analysis came from the list of items rated in Round 5 by the panel. It is assumed that Round 5 best represents the ratings and competencies from the panel's point of view. However, data collection was discontinued due to panelist fatigue prior to consensus or stability being achieved. Thus, in this

study instead of discarding the items that did reach categorical agreement, a discussion was conducted regarding the categorization of the competency between all raters to best determine category placement (Blancher, Buboltz, & Soper, 2010). After two rounds of discussion, all items were agreed upon by at least two of the raters.

Summary

This study utilized the Delphi technique in order to seek consensus from a panel of experts on AODA clinical supervision and rehabilitation counseling. The purpose of this research was to identify competencies of AODA clinical supervisors for integration into RCT. Five rounds of the Delphi were conducted with rounds discontinued due to panelist fatigue evidenced by lack of qualitative responses. Content analysis was conducted to preliminarily identify themes of competencies to assist in future research. Chapter Four will discuss results and Chapter Five will discuss implications, limitations, and future research.

CHAPTER FOUR

RESULTS

The present study was an attempt to utilize the Delphi technique in order to identify clinical supervision competencies specific to AODA clinical supervisors for inclusion in RCT programs. Previous chapters detailed the introduction, literature review, and methodology. This chapter presents results including a description of the panelists, results from Rounds 1-5, rankings, sub-items, content analysis, and summary.

Panelists

Of the six panelists that completed Round 1 of the study, 83.3% (n = 5) were male and 16.7% (n = 1) was female. Panelists reported 83.3% (n = 5) White and 16.7% (n = 1) Black or African American. The average age of the panelists was 41.5 years. Panelists self-reported expert status based upon provided criteria. In addition, a review of submitted curriculum vita information was completed. Each panelist appeared to have met a minimum of two criteria for inclusion as panelist in the study. Each panelist indicated that he or she met criteria by submitting their vita. Due to the vagueness of some vitas, the following information is an estimate of criteria met: 66.7% (n = 4) taught a course focused on AODA treatment, 66.7% (n = 4) published on AODA clinical supervision, 16.7% (n = 1) presented at a conference on the topic of AODA clinical supervision, 83.3% (n = 5) appeared to have supervised a minimum of five individuals in the AODA field (typically indicated by teaching practicum/internship), 100% (n = 6) indicated serving on an editorial board that often publishes in the field of AODA (it is unknown for certain if they personally reviewed two articles on AODA clinical supervision). CORE Regions III, IV, V, and VI are represented by the panelists.

It should be noted that one of the panelists was also a dissertation committee member for this study. Subsequent to replying via email indicating willingness to participate as a panelist, that panelist was no longer consulted as a committee member until after data collection was completed to minimize potential bias of the data or data collection process. At the end of data collection, the individual resumed the role of a committee member.

Round 1

An open-ended question was utilized in Round 1 to solicit responses from panelists regarding competencies specific to AODA clinical supervisors that should be included in RCT programs. A response rate of 66.7% was achieved at the end of Round 1. After consolidation and interpretation of responses received, 109 competencies were identified. The 109 competencies were utilized to construct the Round 2 questionnaire.

Round 2

Round 2 achieved a response rate of 100%. Numbers of comments per panelist ranged from 0 to 25 with 40 comments received between three panelists. Panelists also provided suggestions for a total of six additional competencies for inclusion in the Round 3 survey. Table 2 details results for Round 2 including mean, standard deviation, median, interquartile range, and convergence for each competency. Means for items in Round 2 ranged from 3.50 to 4.83. The top three rated competencies were items “43. Skill in supervising AODA interventions,” “66. Ability to establish rapport with supervisees,” and “67. Ability to maintain rapport with supervisees.” Each competency received a mean rating of 4.82 (SD = 0.408) and median of 5.00 (IQR = 5.00-5.00). Competencies rated with the lowest level of agreement of importance were “32. Understand the function of a behavior (e.g., attention, sensory/automatic reinforcement, avoidance conditioning, gain something tangible. Understand how function is then linked to

treatment intervention. A review of Iwata's functional analysis principles will be helpful)" and "47. Ability to conceptualize AODA cases." Each of these competencies earned a mean rating of 3.00. Competency 32 had a standard deviation of 1.378 and a median of 3.5 (IQR = 2.00-5.00). Competency 47 had a standard deviation of 1.225 and median of 4.0 (IQR = 2.00-5.00).

Upon inspection of the 40 comments received, three types of comments emerged. First, one panelist stated for the first seven competencies "Counselors as well as supervisors, and other AODA need to know this information" and then did not provide any other comments. Of note, this panelist rated a majority of items lower than the other panelists did. One panelist provided 23 comments regarding clarification of meaning and grammar of competency items. A total of 10 comments, between two panelists, focused on why the panelist felt an item was important. Many of the comments received in this round (n = 35, 85%) were on items in the first half of the questionnaire. It is possible that panelist fatigue prevented more comments on latter items.

Convergence was calculated in order to determine if consensus had been met. Thirteen items (11.9%) reached the level of convergence predefined to represent consensus (>74% agreement). However, 96 items did not meet the predefined level of convergence and thus another round of the survey was conducted.

Round 3

Round 3 achieved a response rate of 100%. Number of comments per panelist ranged from 0 to 26 with a total of 37 comments received between three panelists. Table 3 details results for Round 3 including mean, standard deviation, median, interquartile range, consensus, and stability for each competency. Means ranged from 3.50 to 4.83. Seven items (12, 43, 65, 66, 67, 91, and 104) had the highest level of agreement with mean ratings of 4.83. Items 46 and 47 had the lowest level of agreement with means of 3.50. Comments received demonstrated two

main themes. First, 27 of the 37 comments focused on rewording or clarification of content of the competency (e.g., two ideas were presented in one competency and the suggestion was to split the two ideas). For example, "17. Content knowledge and skills in individual counseling." Ten comments focused on reasons for the level of importance of the competency. Four of these 10 comments challenged content of the items such as "I feel that focusing on two models is not best-practice. Especially since disease & moral have been replaced by more sophisticated paradigms." The other six comments were in support of the competency listed such as "For sure this is important information because there tends to be coexisting disabilites [sic] manifesting themselves in a number of clients." Items were presented in the same order as in the previous round. As in the last round, a majority of comments were received on items presented earlier in the questionnaire. In this round, 81% of the comments were received on items in the first half of the questionnaire.

Stability of responses was calculated between Rounds 2 and 3 on the 109 items administered in both rounds. Nineteen of the 109 items (17.43%) met the predefined criteria of <15% change between rounds. Twenty-two of the 115 items (19.13%) comprising Round 3 met the predefined level (>74%) of convergence to represent consensus. Seven items met convergence in both Rounds 2 and 3. However, as not all items met the predefined levels of convergence or stability, and there was no attrition, all items were readministered in Round 4.

Round 4

The Round 4 survey consisted of the original 115 items administered in Round 3 in addition to 50 new competency variations based upon comment suggestions in Round 3 tracked in the memo (Appendix F). All new items were considered sub-questions of a previous competency with minor wording changes for clarification of content. The Round 4 survey

achieved a response rate of 100%. Number of comments per panelist ranged from zero to three with a total of seven comments received between four panelists. Table 4 details results for Round 4 including mean, standard deviation, median, interquartile range, consensus, and stability for each competency and sub-items as data was available. Means ranged from 3.33 to 4.83. Seven items (35, 43, 53, 65, 66, 91 and 104) were rated highest with mean ratings of 4.83. Item 46 was the lowest rated item with a mean of 3.33 (SD = 1.211).

Of the seven comments received, three themes emerged. Three of the comments focused on the importance or non-importance of the items presented. One comment focused on clarification of wording. One comment was provided for the first three items stating "I am confused by the question because such knowledge is not specific to AODA clinical supervisors; other clinicians need such knowledge. Thus I put 3 = neither agree/disagree for these items." This panelist also provided the comments in Round 2 stating "Counselors as well as supervisors, and other AODA need to know this information." Items with comments received were again near the beginning of the questionnaire as 85.7% of the comments (n = 6) were on the first half of the items presented. Panelist fatigue with latter items is evident. An integral part of the Delphi technique is qualitative comments explaining ratings, making suggestions, and so forth. As comment numbers decreased, the likelihood of reaching consensus in future rounds decreased as well.

Stability and convergence were examined. Stability of responses was calculated between Rounds 3 and 4 on the 115 items administered in both rounds. Sixty-two of the 115 items included in both Rounds 3 and 4 (53.91%) met the predefined criteria of <15% change between rounds. Twenty-six of the 165 items (15.76%), including sub-items, comprising Round 3 met the predefined level (>74%) of convergence to represent consensus. Fifteen items met criteria

for convergence in both Rounds 3 and 4. Of these, six met criteria in Rounds 2, 3, and 4. However, as not all items met the predefined levels of convergence or stability and no attrition existed, all items were readministered in Round 5.

Round 5

Round 5 consisted of the 165 items administered in Round 4 in addition to one new competency variation based upon a comment received in the previous round. Changes were tracked in the memo (Appendix F). Round 5 achieved a response rate of 83.3% (n = 5). The sixth panelist completed the first nine items and then discontinued the questionnaire. Only one comment was received from one panelist. Table 5 details results for Round 5 including mean, standard deviation, median, interquartile range, consensus, and stability for each competency. Means ranged from 3.40 to 5.00. Thirty-five items were rated with the highest mean rating of 5.00. Item 46 was the lowest rated item with a mean of 3.40 (*SD* = 1.342).

The single comment received this round was “My comments are the same as last round.” This comment was received by the panelist who in the previous round stated “I am confused by the question because such knowledge is not specific to AODA clinical supervisors; other clinicians need such knowledge. Thus I put 3 = neither agree/disagree for these items.” In the current round, this panelist discontinued responding after item 9. An email was received from this panelist at the point of discontinuation, including the following comment:

> I am concerned that I am not being helpful to your study. I continue to rate many of the items as neither agree/disagree because I don’t think the content is idiosyncratic to AODA supervisors. I think you need to either re-word the fundamental question (‘…specific to AODA clinical supervisors…”) and/or change all of the general items to

> include adjectives such as "advanced" or context modifiers such as "more than the AODA counselor."

The receipt of this comment suggests that this panelist, who often provided response ratings lower than the other panelists, represented a minority view of the competency ratings. It is unknown if this panelist and the other panelists understood the core question of the study in a different manner, or if the understanding was the same and the remaining panelists chose to rate items higher due to encouragement of reaching consensus via the Delphi technique.

Stability and convergence were examined for Round 5. Stability of responses was calculated from responses submitted between Rounds 4 and 5 with different number of participants per item based upon the number of responses received for each item (e.g., items 1-9, n = 6; item 10, n = 4; and items 11-115, n = 5). Eighty-eight of the 165 items (53.3%) met the predefined level of stability (<15% change) between rounds 4 and 5 using the number of panelists per item as previously identified. This stability calculation indicates a higher number of stable responses than if the sixth panelist had completed Round 5 with the same responses as he or she had provided in Round 4. Having only changed ratings of two items between Rounds 3 and 4 it is likely this panelist's responses would have been the same, or very close to the same, in Round 5. If the panelist's responses had remained the same as the previous round, the number of stable responses would have been only 79 versus 88. This result is due to many responses having a 16.67% change rate if all six responses had been received in this round. Ninety-five of the 166 items (57.23%) comprising Round 5 met the predefined level (>74%) of convergence to represent consensus based upon responses received. Twenty-six total items met convergence in both Rounds 4 and 5 including six items that met convergence in all rounds. Of the 95 items that met convergence criteria in Round 5, 36.84% (n = 35) met convergence criteria in at least one

previous round. Of note, had the panelist with the incomplete responses provided the same responses from Round 4 for items 10-115, only 40 of the 166 (24.01%) items would have met the pre-defined level of convergence instead of 95. Table 6 displays a summary of results across the five rounds of data collection for comparison purposes.

Rankings

The rankings of items based upon their means in each round were explored. Table 7 reports the means and ranks of competencies across Rounds 2-5. However, interpreting results for these rankings proved difficult, as there are only six panelists in the present study with five response options for each competency item. The number of panelists and numbers of responses available significantly limited the variability of means across items. Duplicate means resulted in there only being nine unique means being reported in both Rounds 2 and 3 (e.g., all items in Round 2 had means of either 4.83, 4.67, 4.50, 4.33, 4.17, 4.00, 3.83, 3.67 or 3.50). As there were 109 items in Round 2 and 115 items in Round 3, it was difficult to make sense of specific rank ordering for interpretation purposes. Round 4 had eight unique means and Round 5 produced 12 unique means. The increase in means in Round 5 was likely due to receiving one incomplete response; thus, altering the number of responses per item, which affected the number of means available. A larger sample would likely provide rankings that are more meaningful.

Sub-Items

Of particular interest were the items that had sub-item variations added throughout the data collection rounds. Table 8 focuses on sub-item means and rankings in comparison with the original competency items. Twenty-six competencies had sub-items added with the intent of clarifying wording or meaning based upon panelist comments received. Items with sub-items were examined following Round 5 results with an assumption that consensus or lack thereof was

most stable at this point. Twenty-two of the 26 items (84.6%) had either the main competency or at least one sub-item meet the predefined level of stability after Round 5. At the end of Round 5, 15 items (57.7%) had at least one sub-item with a mean rating higher than the original competency indicating a greater level of agreement that the item was a competency specific to AODA clinical supervisors. Ten of the 26 items (38.5%) resulted in an equal rating of agreement between the original competency and a sub-item. Only one original competency had a higher mean than its sub-item(s) (3.8%).

Several of the original competency items focused on content knowledge and skills in various core skills and modalities of care common in AODA services. It is interesting that when the "content knowledge and skills" items were split into two separate sub-items, responses were not consistent. For some competencies, the content knowledge was more important than the skills. For other competencies, a skill was more important than content knowledge. For example, "13b. Content knowledge in AODA assessment" had a mean rating of 5.00 in Round 5 whereas "13c. Skills in AODA assessment" had a mean rating of 4.80. Item "14b. Content knowledge in AODA diagnosis" had a mean rating of 4.80 whereas "14c. Skills in AODA diagnosis" had a mean rating of 5.00. While these means in and of themselves are not necessarily meaningful, a point can be made regarding a potential trend to be examined in future research. An argument could be made that diagnosis and assessment are overlapping skills and knowledge. Thus, it is curious that they appear to have conflicting ratings of importance when comparing skills and knowledge. It is possible that some other factor such as participant fatigue could have affected results.

Content Analysis

Of the 166 competencies present in the Round 5 data collection, I and the two reliability raters had 100% agreement on 65.7% (n = 109) of the items. Two out of three of the raters agreed on category assignments on 50 items (30.1%). Thus, based on the a priori criteria of two out of three raters categorizing a competency in the same category, 95.8% (n = 159) of all items reached agreement upon initial category assignment. Seven items had no matching categorizations following initial ratings. Following initial discussion between raters, five more items reached categorical agreement (n = 2, 100% agreement; n = 3, 66.7% agreement). Discussion continued resulting in the remaining two items being agreed upon by two out of the three reliability raters. Table 9 displays the seven categories with the competencies assigned to each with the percentage of raters in agreement. Number of items per category was as follows: Legal and Ethical Concerns (18 items); Organizational Management, Administration, and Program Development (20 items); Personal Characteristics and Skills of Leadership (15 items); Supervisee Performance Evaluation and Feedback (7 items); Supervisory Relationship (10 items); Theory, Roles, and Interventions of Clinical Supervision (20 items); and Treatment Related Knowledge and Skills (76 items).

An exploratory analysis was conducted calculating the means of items assigned within each category to find a category mean. The categories in descending order were Legal and Ethical Concerns (M = 4.81); Theory, Roles, and Interventions of Clinical Supervision (M = 4.77); Supervisory Relationship (M = 4.65); Personal Characteristics and Skills of Leadership (M = 4.63); Treatment Related Knowledge and Skills (M = 4.63); Organizational Management, Administration, and Program Development (M = 4.56); and Supervisee Performance Evaluation and Feedback (M = 4.37).

Summary

Six panelists reporting they met criteria as an expert in AODA clinical supervision and rehabilitation counseling participated in the study. Five rounds of data collection utilizing the Delphi technique were implemented. Initially, 109 items were identified by panelists as competencies of AODA clinical supervisors that should be included in RCT programs. At the end of Round 5 166 items, including sub-items, were presented to panelists seeking levels of agreement as to whether the items listed were specific to AODA clinical supervisors. Comments were sought in each round with numbers of comments per round diminishing with each round to the point of panelist fatigue in Round 5 resulting in discontinuation of data collection.

Data collected in Rounds 2-5 were examined for convergence of responses representing consensus of the panel. Rounds 3-5 of the data were examined for the rate of change indicative of stability of responses between rounds. Neither consensus nor stability of responses was achieved for all items in the present study, likely attributable to panelist fatigue. Items were additionally analyzed in regards to their rank based upon mean rating per round and an examination of items in comparison to any sub-items added during the data collection rounds. Content analysis was conducted in order to examine the potential categorization of responses using two inter-raters in addition to the primary researcher. Chapter Five will discuss implications, limitations, and future research.

CHAPTER FIVE

DISCUSSION

Previous chapters have discussed the introduction, literature review, methodology, and results of the study. AODA counseling's professional identity lacks clarity as several fields such as psychology, mental health, social work, and rehabilitation counseling all provide AODA clinical services. The field of rehabilitation counseling has an extensive history of role and function, now called competency, studies to assist in developing the professional identity of the field. No known research exists in the RCT field focused specifically on AODA counseling competencies or supervision competencies. Thus, the purpose of this study was to identify AODA clinical supervision competencies for integration into RCT curriculum. The Delphi technique was used to work toward consensus of a panel of experts to determine the competencies differentiated from general counseling supervision that should be addressed during RCT. The specific research question was

> "What are the competencies specific to alcohol and other drug abuse clinical supervisors that should be included in rehabilitation counselor training programs?"

Five rounds of data collection via the Delphi technique created 166 competencies including sub-item options. Data collection was discontinued prior to consensus or stability being reached due to panelist fatigue. Content analysis identified seven categories of competencies that were similar to CSAT's (2007) competency domains. The current chapter will discuss implications, limitations, future research, and summary of the study.

Implications

The results of this study suggest a potential division even within the field of RCT/AODA experts as to what constitutes AODA clinical supervision competencies needed for integration

into RCT curriculum. In addition, the results mimic other publications (CSAT, 2007; IC&RC, 2008b) in that methodological challenges exist in defining AODA clinical supervision competencies. For instance in this study, termination of data collection occurred due to panelist fatigue prior to consensus or stability of the responses. The present study revealed both a majority and a minority view of the competencies. The majority view was held on most competencies by five of the panelists and the minority view by the panelist with a dissenting view. It is unknown if this minority view truly was a minority view, or if the other panelists simply interpreted the research question in a different manner. If there was truly a division of opinions, the implications are significant for the field.

Clinical supervisors cannot be expected to function at satisfactory levels if their roles and functions are not clearly defined. With a current emphasis on evidence-based practices and performance contracting (CSAT, 2007; Roche et al., 2007), treatment programs literally cannot afford to have incompetent supervisors in positions of authority. Second, undefined competencies could result in supervisor burnout. For example, if administrative or clinical expectations change often in the workplace, the supervisor may experience feelings of being overwhelmed, overworked, and always playing catch-up in their position. If not handled and addressed in an appropriate manner, the supervisor could experience burnout leading to further expense for the treatment program and personal and professional implications for the supervisor (McLellan et al., 2003). Third, research has demonstrated that supervisor performance improves with training (McMahon & Simons, 2004). If AODA clinical supervision competencies are not clearly defined, training cannot address the topic. An ethical dilemma may arise as it could be questioned as to the ethical implications of having an untrained supervisor overseeing supervisees. In the litigious world that now exists, the supervisee, supervisor, treatment

program, and potentially higher entities such as a facility or healthcare conglomerate could be at risk simply through respondeat superior if the supervisor's role was not clearly defined and supervisee misconduct occurred. Thus, an employer is responsible for actions of employees regardless of how the employee was acting.

Supervisee development is a central focus of most clinical supervision definitions (IC&RC as cited in ASACB, n.d.; Milne, 2007; & Powell & Brodsky, 2004). Supervisee development will likely be sluggish or deficient if supervisors are not adequately trained and possess the skills to train the supervisees. In addition, supervisees may receive negative performance evaluations due to lack of skill that could be attributed to supervisor performance in either the evaluation or training of the supervisee. If a supervisee desires to work on promotion toward being a supervisor themselves within the field, it would be difficult to study and train for promotion when clinical supervision competencies are not clearly defined. Thus, professional mobility is stunted by both negative evaluations that might not be their sole responsibility in addition to lack of vision of what they could try to attain in the future.

Lack of consensus on AODA clinical supervision competencies for integration into RCT curriculum also creates implications for RCT educators. As no clear and respected list of competencies exist specifically for integration into RCT curriculum, educators could ignore the topic all together. Alternatively, the educators may present as fact what they personally believe to be competencies of AODA clinical supervisors. It is daunting to think how vastly different these competencies could be across the field that are presented to students. Professional identity of the field is dependent upon uniformity of competencies.

Limitations

Panel and Data Collection

Limitations in this study include the panel size and timing of the study. While the original intent was to recruit 30 panelists, only six completed the data collection rounds. More than one potential panelist reported they were not eligible to participate based upon the predefined criteria of an expert for the present study. Some of the panelists reporting they were not eligible are known in the field to be knowledgeable in the areas of RCT and AODA clinical supervision. Thus, it is possible that the definition of an expert was too restrictive which may have prevented some "experts" from participating in the study.

Of the six panelists, only one was female, only one was Black or African-American, and only four CORE regions were represented. The panelists self-reported their qualifications as an expert for the study supplemented by submitted vitas. The results cannot be generalized to all RCT faculty and programs as only six participants self-reported as experts in RCT and AODA clinical supervision participated in the study. In addition, it is unknown if these panelists' views are representative of views of other individuals impacted by this study including AODA clinical supervisors in varied field settings and AODA student and new professionals who have completed RCT training and are involved in the AODA field.

From a qualitative standpoint, the number of panelists does not matter; however, panel size can have a major impact when mixing qualitative and quantitative methods. As the number of panelists was low, there was difficulty in reaching the levels of consensus and stability. For example, in order for the level of convergence to indicate consensus had been met, five of the six panelists had to rate an item as the same. Thus, for every item, five of the six panelists had to agree on the response in order to have a convergence percentage of greater than 74%. If there

had been 30 panelists, 23 of the 30 panelists would have had to rate an item the same to meet the convergence criteria. A larger panel would have allowed a few panelists to report a minority view without preventing stability or consensus from being reached.

In addition, as the panelists in this study were faculty members, the timing of the study could have been a potential limitation. For example, each round of the survey was available for three weeks. However, the timing of many of the rounds fell in conflict with academic schedules including spring break, end of spring semester, holidays, intercession, summer session, summer travel, and national conferences. Although all six panelists completed at least part of each round, the amount of time and effort put into the questionnaire rounds is unknown. On multiple occasions, panelists waited until the last day the survey was available, or requested an extension, in order to complete the round of data collection. It is possible the panelists were rushed and thus did not provide as much thought and feedback as they could have if they had allowed more time for the questionnaire completion. In addition, the overall number of comments throughout the rounds was minimal considering the number of competencies and sub-items presented each round. It is unknown if panelists simply did not have a comment to add or if the survey construction and presentation did not emphasize the need for comments in a sufficient manner.

Reliability and Validity

Reliability is questioned in this study due to the lack of consistency observed between rounds. As noted in the discussion of competencies and their sub-items, there did not appear to be a clear pattern of response when examining similar items. In addition, the means between rounds of the same item varied such as increasing, decreasing then increasing back to the original mean without additional information such as explanation of ratings. In a study utilizing the Delphi technique, there is an expectation that ratings will likely change between rounds.

However, there is also an expectation of qualitative comments to assist in understanding the reasons for the rating movement. The possibility exists that some panelists may have not given full effort into their responses by thoughtfully comparing information from previous rounds as they waited until the last day or requested an extension to complete the round. It is possible that answers were chosen somewhat randomly and thus prevented stability or consensus from being reached. If reliability cannot be observed between rounds in this study, it is unlikely to occur if the same set of competencies were provided to a different panel for examination in the future without a larger sample size.

Development of competencies with content validity for AODA clinical supervision was a goal in the present study. Due to premature data collection termination, the full extent of content validity is unknown as neither consensus nor stability was reached.

Technology

Numerous errors and challenges due to LimeSurvey® were encountered and reported throughout this study. The true impact of these errors on the results of the study is unknown. However, panelist and researcher frustration, delay in questionnaire round creation, and delay in questionnaire completion all likely impacted panelist fatigue which resulted in termination of data collection prior to complete consensus or stability being reached.

Technology errors in Round 1 of the survey included a panelist, having received a reminder email, trying to access the survey, and being informed the token for that person had already been used. Upon review of the survey records, it was indicated that this panelist had not completed this round of the survey. After trying the token again, access to the questionnaire was granted as it was designed to do. As this was the first round of the study, it is unknown if some of the other non-response panelists received the message and believed that they had already

completed the questionnaire. This error with LimeSurvey® may have contributed to the response rate received despite the extended time for response offered to the potential panelists.

A technology challenge was discovered in creating the Round 3 questionnaire. LimeSurvey® has a function of being able to input previous responses into current questions using attributes. In the planning stages for this study, the attribute feature was tested and worked well in that responses from a previous round could be imported and then inserted into the new round questionnaire. However, upon creation of Round 3, it was discovered that LimeSurvey® limited the number of attributes to 84. Numerous sources were consulted to try to find a workaround for this challenge including the LimeSurvey® help forums, chat, and user's manual. No optional strategy was identified that successfully achieved the needs of this study; a separate survey was created in LimeSurvey® for each panelist with previous responses 85-109 entered manually. This challenge occurred in each of the remaining rounds. Thus, each panelist had their own survey created for Rounds 3-5. The limitation is that despite numerous checks for accuracy, the chance of their previous round response being entered incorrectly increased with the manual entering of previous round responses and extended time between rounds for questionnaire development.

A panelist reported that after completing the Round 3 questionnaire a confirmation email was not received. Upon review of the completed responses by the primary researcher, it was determined that LimeSurvey® had not saved the end of the questionnaire responses. The survey was reset so that the panelist could log back in and resume the survey resulting in an extension time for data collection for that round.

The technological error reported in Round 4 of the survey administration included one panelist receiving an error message that the panelist's token was invalid or had already been

used. The panelist had not yet accessed this round and the token was valid. Upon a subsequent attempt to access the survey, the token worked.

In addition, during the analysis of Round 4 data in order to create the Round 5 questionnaire, the university server hosting LimeSurvey® was updated to a newer version of the program. While the updated version did correct some of the previous reported malfunctions of the software, it created numerous new difficulties in creating the Round 5 questionnaire including limited permissions to alter survey templates, altered import and export capabilities, and so forth. The Round 5 questionnaires were eventually created to appear and function in the same fashion as the previous rounds. However, there was a delay in time between Rounds 4 and 5 because of the delay in questionnaire development that likely affected panelist fatigue.

The technological error reported in Round 5 of the survey was reported by a panelist having received an error message about not having completed all required items in the first set of questions displayed. Administrative review of the incident revealed all required items had been completed by the panelist. The panelist resumed the questionnaire; however, no response for item 10 was recorded by LimeSurvey®.

Future Research

The current study provides many implications for future research. First, the Delphi technique should be utilized to replicate this study with a different homogeneous panel. As noted above, the definition of expert may have been too narrow to effectively capture experts in the fields of RCT and AODA. Second, a validation study is needed with a larger heterogeneous population of panelists. As the Delphi technique has been used for heterogeneous populations, this body of research would benefit by being replicated using a panel including RCT educators, AODA clinical supervisors in the field as well as AODA/RCT students or new professionals.

Increasing the panel size could allow for more quantitative analysis, such as a principal component analysis, to statistically organize the information into components for organization of the competencies. It is necessary to eventually use quantitative methods to study the competencies identified in order to generalize findings to the larger population of AODA clinical supervisors with a background in RCT. In this line of future research, a method may need to be devised to more specifically examine if there is a difference between competencies of AODA clinical supervisors and competencies that need to be taught in RCT programs. It is possible that although there are specific AODA clinical supervisor competencies, they will be more beneficially learned by the supervisee in a clinical setting rather than an academic setting.

In addition, due to numerous challenges presented with LimeSurvey® in this study it could benefit this line of research to find a more reliable program to utilize electronic data collection. Preventing software errors would likely reduce panelist frustration, reduce the amount of time to create questionnaire rounds, and reduce the amount of time to complete each round of the questionnaire thus reducing panelist fatigue, which may have caused incomplete data collection in this study.

Summary

Results from this study lacked consensus or stability regarding the level of agreement in including AODA clinical supervision competencies defined in this study in RCT training programs. Lack of consensus, likely caused by panelist fatigue, has implications for supervisors, supervisees, and educators. Incompetent supervisors could cost treatment programs money due to unknown roles and functions, which could result in mismanagement of programs resulting in noncompliance with evidence-based practices, contracts not being renewed, supervisor burnout, or litigation. Supervisee development will likely be underdeveloped with lack of supervision

competencies. Supervisees cannot train and strive for upward mobility in the field if competencies of the next level are undefined. In addition, supervisees may be limited by poor performance evaluations, which they are not solely responsible for. A list of competencies to integrate into curriculum is not readily available to educators. Thus, if the topic is addressed at all, the final list of competencies included would be based upon the educator's personal preference likely resulting in wide variance across the field.

Limitations in the study included a small panel with data collection occurring at times that conflicted with busy academic schedules. In addition, numerous technology challenges were reported potentially causing frustration as well as extending time between data collection rounds. Future research could focus on a replication study with a less restrictive definition of expert. A validation study is needed to compare supervisors, supervisees, educators, and non-substance abuse related professionals to determine the content validity of the competencies identified. It is also recommended more reliable technology be used for data collection in the future.

This study made progress toward identification of AODA clinical supervision competencies for integration into RCT curriculum. Six experts in AODA and RCT were identified to serve as panelists for the study. The Delphi technique was used to conduct five rounds of data collection that was prematurely discontinued due to panelist fatigue based upon number of responses received. Content analysis revealed seven categories or domains of competencies existed agreed upon by at least two out of three raters. Domains were similar to those published by CSAT (2007). Due to premature termination of data collection, implications are tentative at best. However, the significance of the implications cannot be ignored due to the critical importance of defining competencies for the field of AODA clinical supervisors for integration into RCT curriculum.

Table 2

Round 2 Results: Descriptive Statistics and Convergence

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)
1. Knowledge of the different drug types (e.g., Cocaine, Oxycontin, Crystal Meth, etc.)	4.33	1.211	5.0	4.00-5.00	66.67 (5)
2. Knowledge of the major functions of drugs	4.33	1.211	5.0	4.00-5.00	66.67 (5)
3. Knowledge of the drug's impact on the user (e.g., psychological, physical, psychosocial)	4.17	1.169	4.5	4.00-5.00	50.00 (5)
4. Knowledge of the drug's impact on persons in the consumer's circle (e.g., family members, peers, employers, etc.)	4.33	1.211	5.0	4.00-5.00	66.67 (5)
5. Knowledge of why individuals avoid using drugs	4.17	1.329	5.0	3.00-5.00	66.67 (5)
6. Understand the power of relapse	4.00	1.265	4.5	3.00-5.00	50.00 (5)
7. Understand the disease model of addiction	4.17	1.169	4.5	4.00-5.00	50.00 (5)
8. Understand the moral model of addiction	4.33	1.211	5.0	4.00-5.00	66.67 (5)
9. Knowledge of AODA specific legal/ethical issues	4.33	1.211	5.0	4.00-5.00	66.67 (5)
10. Knowledge of ACOA, etc.	4.17	0.983	4.5	3.00-5.00	50.00 (5)
11. Knowledge of follow up	4.33	1.211	5.0	4.00-5.00	66.67 (5)
12. Advanced skills in AODA counseling, assessment, diagnosis, etc.	4.67	0.516	5.0	4.00-5.00	66.67 (5)
13. Content knowledge and skills in assessment	4.33	1.211	5.0	4.00-5.00	66.67 (5)
14. Content knowledge and skills in diagnosis	4.33	1.211	5.0	4.00-5.00	66.67 (5)
15. Content knowledge and skills in treatment	4.33	1.211	5.0	4.00-5.00	66.67 (5)
16. Content knowledge and skills in detox	4.17	1.169	4.5	4.00-5.00	50.00 (5)
17. Content knowledge and skills in individual counseling	4.33	1.211	5.0	4.00-5.00	66.67 (5)
18. Content knowledge and skills in group work	4.50	1.225	5.0	5.00-5.00	83.33 (5)
19. Content knowledge and skills in family work	4.17	1.329	5.0	3.00-5.00	66.67 (5)
20. Knowledge of 12 core functions or KSAs	4.17	1.329	5.0	3.00-5.00	66.67 (5)
21. Knowledge of counseling and behavioral techniques used in treatment of AODA	4.50	1.225	5.0	5.00-5.00	83.33 (5)

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale.

Table 2 (continued)

Round 2 Results: Descriptive Statistics and Convergence

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)
22. Knowledge of using evidence-based practices specific to the treatment of AODA	4.50	1.225	5.0	5.00-5.00	83.33 (5)
23. Experience in using evidence-based practices specific to the treatment of AODA	4.67	0.516	5.0	4.00-5.00	66.67 (5)
24. Knowledge to determine the appropriate treatment modality	4.50	1.225	5.0	5.00-5.00	83.33 (5)
25. Knowledge of treatment modalities	4.50	1.225	5.0	5.00-5.00	83.33 (5)
26. Content knowledge and skills in outpatient	4.33	1.211	5.0	4.00-5.00	66.67 (5)
27. Content knowledge and skills in inpatient hospital	4.00	1.095	4.0	4.00-5.00	50.00 (5)
28. Content knowledge and skills in inpatient non-hospital	4.17	1.169	4.5	4.00-5.00	50.00 (5)
29. Content knowledge and skills in medication	4.17	1.169	4.5	4.00-5.00	50.00 (5)
30. Advocate for utilization of evidence-based practices in their specific practice	4.17	1.329	5.0	3.00-5.00	66.67 (5)
31. Ability to locate treatment facilities (e.g. SAMHSA's treatment locator)	4.17	1.329	5.0	3.00-5.00	66.67 (5)
32. Understand the function of a behavior (e.g., attention, sensory/automatic reinforcement, avoidance conditioning, gain something tangible. Understand how function is then linked to treatment intervention. A review of Iwata's functional analysis principles will be helpful)	3.50	1.378	3.5	2.00-5.00	33.33 (2, 5)
33. Recipient of training in how to train others to use evidence-based approaches specific to AODA	4.67	0.516	5.0	4.00-5.00	66.67 (5)
34. Knowledge of the supervision process in general (e.g., Bernard and Goodyear book, etc.)	4.67	0.516	5.0	4.00-5.00	66.67 (5)
35. Knowledge of the supervision process more specifically for supervisors working in the AODA arena	4.50	0.548	4.5	4.00-5.00	50.00 (4, 5)
36. Knowledge of Powell's integrated model of clinical supervision	3.83	0.983	4.0	4.00-5.00	66.67 (4)
37. Ability to apply Powell's integrated model of clinical supervision	4.00	1.095	4.0	4.00-5.00	50.00 (4)

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale.

Table 2 (continued)

Round 2 Results: Descriptive Statistics and Convergence

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)
38. Awareness of variables including cultural beliefs that can impact the supervision process (e.g., supervisor's attitudes toward AODA)	4.50	0.548	4.5	4.00-5.00	50.00 (4, 5)
39. Understand factors that enhance or inhibit the relationship between supervisor and supervisee	4.50	0.548	4.5	4.00-5.00	50.00 (4, 5)
40. Competency in the area of crisis management	4.33	1.211	5.0	4.00-5.00	66.67 (5)
41. Competency in the area of conflict resolution	4.17	1.169	4.5	4.00-5.00	50.00 (5)
42. Skill in teaching AODA interventions	4.67	0.516	5.0	4.00-5.00	66.67 (5)
43. Skill in supervising AODA interventions	4.83	0.408	5.0	5.00-5.00	83.33 (5)
44. Skill in harnessing the power of the clinical team to meet organization goals	4.50	0.837	5.0	4.00-5.00	66. 67 (5)
45. Skill in collaborating with other providers	4.00	1.095	4.0	4.00-5.00	50.00 (4)
46. Ability to delegate duties ensuring accountability and that plans are empowering and not too burdensome	3.83	1.169	4.0	3.00-5.00	33.33 (4, 5)
47. Ability to conceptualize AODA cases	3.50	1.225	4.0	2.00-5.00	50.00 (4)
48. Ability to facilitate supervisees' ability to conceptualize AODA cases	4.00	1.095	4.0	4.00-5.00	50.00 (4)
49. Ability to facilitate AODA case presentations	3.83	1.472	4.5	2.00-5.00	50.00 (5)
50. Skill in using strategies to help supervisees avoid burn-out	4.67	0.516	5.0	4.00-5.00	66.67 (5)
51. Knowledge of processes for licensure and/or certification specific for AODA supervisees	4.50	0.548	4.5	4.00-5.00	50.00 (4, 5)
52. Knowledge of different models, techniques, and practical applications of clinical supervision fundamentals	4.67	0.516	5.0	4.00-5.00	66.67 (5)
53. Understand one's supervisory role in developing novice supervisees	4.67	0.516	5.0	4.00-5.00	66.67 (5)
54. Understand one's supervisory role of helping seasoned supervisees to evolve	4.50	0.548	4.5	4.00-5.00	50.00 (4, 5)

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale.

Table 2 (continued)

Round 2 Results: Descriptive Statistics and Convergence

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)
55. Understand the collaborative nature of the supervisory alliance	4.33	0.516	4.0	4.00-5.00	66.67 (4)
56. Attend to the collaborative nature of the supervisory alliance	4.50	0.548	4.5	4.00-5.00	50.00 (4, 5)
57. Facilitate regular structured supervisory sessions	4.33	0.516	4.0	4.00-5.00	66.67 (4)
58. Understand different learning styles	4.17	1.169	4.5	4.00-5.00	50.00 (5)
59. Respond to different learning styles with different forms of teaching/modeling	4.00	1.095	4.0	4.00-5.00	50.00 (4)
60. Understanding of quantitative and qualitative appraisal techniques for supervisee progress	4.50	0.837	5.0	4.00-5.00	66.67 (5)
61. Utilization of a mixed methods approach to gain a thorough understanding of the supervisee's progress	4.00	0.632	4.0	4.00-4.00	66.67 (4)
62. Awareness of models for communicating counselor progress appraisal results	4.00	1.095	4.0	4.00-5.00	50.00 (4)
63. Understand models for communicating counselor progress appraisal results	4.00	1.095	4.0	4.00-5.00	50.00 (4)
64. Ability to present critical appraisal and evaluation of supervisees in a practical, non-inflammatory way	4.50	0.548	4.5	4.00-5.00	50.00 (4, 5)
65. Ability to build rapport with supervisees	4.67	0.516	5.0	4.00-5.00	66.67 (5)
66. Ability to establish rapport with supervisees	4.83	0.408	5.0	5.00-5.00	83.33 (5)
67. Ability to maintain rapport with supervisees	4.83	0.408	5.0	5.00-5.00	83.33 (5)
68. Ability to model desired behaviors (including ethical behaviors)	4.50	1.225	5.0	5.00-5.00	83.33 (5)
69. Possesses the personal characteristic of being empathetic	4.17	1.169	4.5	4.00-5.00	50.00 (5)
70. Possesses the personal characteristic of being supportive	4.17	1.169	4.5	4.00-5.00	50.00 (5)
71. Possesses the personal characteristic of being respectful	4.17	1.169	4.5	4.00-5.00	50.00 (5)
72. Possesses the personal characteristic of being tolerant	4.00	1.095	4.0	4.00-5.00	50.00 (4)
73. Possesses the personal characteristic of valuing diversity	4.33	1.211	5.0	4.00-5.00	66.67 (5)
74. Possesses the personal characteristic of being hopeful	4.33	1.211	5.0	4.00-5.00	66.67 (5)

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale.

Table 2 (continued)

Round 2 Results: Descriptive Statistics and Convergence

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)
75. Possesses the personal characteristic of being energetic	4.00	1.265	4.5	3.00-5.00	50.00 (5)
76. Possesses the personal characteristic of being hard working	3.67	1.033	4.0	3.00-4.00	50.00 (4)
77. Possesses the personal characteristic of good team working skills	4.00	1.265	4.5	3.00-5.00	50.00 (5)
78. Understand the agency mission	4.17	1.169	4.5	4.00-5.00	50.00 (5)
79. Support the agency mission	4.17	1.169	4.5	4.00-5.00	50.00 (5)
80. Make progress toward the agency mission	4.17	1.169	4.5	4.00-5.00	50.00 (5)
81. Adherence to goals	3.83	1.169	4.0	3.00-5.00	33.33 (4, 5)
82. Recognition that organizational or business oriented skills are pivotal for supervisors to possess	4.33	0.816	4.5	4.00-5.00	50.00 (5)
83. Awareness of organizational techniques such as budgeting, record keeping, case retention, human resources management, understanding the use and limits of technology in substance abuse counseling settings, and personnel development procedures	4.00	1.095	4.0	4.00-5.00	50.00 (4)
84. Knowledge of organizational techniques such as budgeting, record keeping, case retention, human resources management, understanding the use and limits of technology in substance abuse counseling settings, and personnel development procedures	4.50	0.837	5.0	4.00-5.00	66.67 (5)
85. Skill in organizational techniques such as budgeting, record keeping, case retention, human resources management, understanding the use and limits of technology in substance abuse counseling settings, and personnel development procedures	4.17	0.753	4.0	4.00-5.00	50.00 (4)

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale.

Table 2 (continued)

Round 2 Results: Descriptive Statistics and Convergence

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)
86. Ensure quality services are provided extending to areas of counseling services, cultural competence, updates with technology, utilization of evidence based practices, in-service training, and program evaluation activities	4.17	0.408	4.0	4.00-4.00	83.33 (4)
87. Knowledge of coexisting disabilities	4.33	1.211	5.0	4.00-5.00	66.67 (5)
88. Knowledge of special populations within the AODA arena	4.33	1.211	5.0	4.00-5.00	66.67 (5)
89. Knowledge of the vast array of resources that can assist both the supervisor and supervisee (e.g. SAMHSA website, NIDA website, NAMI website, etc.)	4.00	1.095	4.0	4.00-5.00	50.00 (4)
90. Ability to teach AODA specific documentation	4.33	0.816	4.5	4.00-5.00	50.00 (5)
91. Ability to supervise AODA specific documentation	4.33	0.816	4.5	4.00-5.00	50.00 (5)
92. Understanding of payment mechanisms in the AODA arena	4.00	1.265	4.5	3.00-5.00	50.00 (5)
93. Awareness of societal views of drug abuse	3.83	1.169	4.0	3.00-5.00	33.33 (4, 5)
94. Knowledge of ethical issues common to treatment of AODA	4.50	1.225	5.0	5.00-5.00	83.33 (5)
95. Demonstrate knowledge of ethical practices in treatment of AODA	4.33	1.211	5.0	4.00-5.00	67.77 (5)
96. Skill in navigating AODA specific legal/ethical issues	4.50	1.225	5.0	5.00-5.00	83.33 (5)
97. Knowledge of state and federal laws related to the treatment of substance abuse clients. Including protection of clients with HIV/AIDS, medical coverage (Medicaid laws, insurance...), mandated reporting...etc.	4.50	1.225	5.0	5.00-5.00	83.33 (5)
98. Understanding of local, state and federal laws as they relate to the everyday business of the agency	4.17	1.169	4.5	4.00-5.00	50.00 (5)
99. Understanding of local, state and federal laws as they relate to the work of the supervisee	4.67	0.516	5.0	4.00-5.00	66.7 (5)
100. Knowledge of confidentiality as it applies to treatment of AODA	4.33	1.211	5.0	4.00-5.00	66.7 (5)
101. Ethical practice which incorporates specific language utilized in treatment	3.67	1.506	4.0	2.00-5.00	50.00 (5)

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale.

Table 2 (continued)

Round 2 Results: Descriptive Statistics and Convergence

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)
102. Understanding of agency rules/regulations/policies including those of parent organizations	4.00	1.265	4.5	3.00-5.00	50.00 (5)
103. Adherence to differing rules and regulations	3.83	1.169	4.0	3.00-5.00	33.33 (4, 5)
104. Understand codes of ethics for supervisees which may be in conflict due to an array of credentials held by the supervisee	4.67	0.516	5.0	4.00-5.00	66.67 (5)
105. Understand multiple theories of ethics	4.00	1.265	4.5	3.00-5.00	50.00 (5)
106. Mastery of multiple models of ethical decision making	3.67	1.366	4.0	2.00-5.00	33.33 (2, 4, 5)
107. Teach ethical decision making skills to supervisees	4.50	0.548	4.5	4.00-5.00	50.00 (4, 5)
108. Provide ethical consultative services to the supervisee as needed	4.67	0.516	5.0	4.00-5.00	66.67 (5)
109. Understand the risks of dual roles and relationships with supervisees	4.67	0.516	5.0	4.00-5.00	66.67 (5)

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale.

Table 3

Round 3 Results: Descriptive Statistics, Convergence, and Stability

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)	Change Rate
1. Knowledge of the different drug types (e.g., Cocaine, Oxycontin, Crystal Meth, etc.)	4.50	.837	5.0	4.00-5.00	66.67 (5)	16.67
2. Knowledge of the major functions of drugs	4.33	.816	4.5	4.00-5.00	50.00 (5)	33.33
3. Knowledge of the drug's impact on the user (e.g., psychological, physical, psychosocial)	4.67	.816	5.0	5.00-5.00	83.33 (5)	50.00
4. Knowledge of the drug's impact on persons in the consumer's circle (e.g., family members, peers, employers, etc.)	4.50	.837	5.0	4.00-5.00	66.67 (5)	16.67
5. Knowledge of why individuals avoid using drugs	4.33	.816	4.5	4.00-5.00	50.00 (5)	33.33
6. Understand the power of relapse	4.50	.837	5.0	4.00-5.00	66.67 (5)	16.67
7. Understand the disease model of addiction	4.33	.816	4.5	4.00-5.00	50.00 (5)	16.67
8. Understand the moral model of addiction	4.33	.816	4.5	4.00-5.00	50.00 (5)	33.33
9. Knowledge of alcohol and other drug abuse specific legal/ethical issues	4.50	.837	5.0	4.00-5.00	66.67 (5)	16.67
10. Knowledge of Adult Children of Alcoholics, etc.	4.33	.816	4.5	4.00-5.00	50.00 (5)	16.67
11. Knowledge of follow up	4.17	.983	4.5	3.00-5.00	50.00 (5)	33.33
12. Advanced skills in AODA counseling, assessment, diagnosis, etc.	4.83	.408	5.0	5.00-5.00	83.33 (5)	16.67
13. Content knowledge and skills in assessment	4.67	.816	5.0	5.00-5.00	83.33 (5)	33.33
14. Content knowledge and skills in diagnosis	4.67	.816	5.0	5.00-5.00	83.33 (5)	33.33
15. Content knowledge and skills in treatment	4.67	.816	5.0	5.00-5.00	83.33 (5)	33.33
16. Content knowledge and skills in detox	4.17	.983	4.5	3.00-5.00	50.00 (5)	33.33
17. Content knowledge and skills in individual counseling	4.50	.837	5.0	4.00-5.00	66.67 (5)	16.67
18. Content knowledge and skills in group work	4.50	.837	5.0	4.00-5.00	66.67 (5)	33.33

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale; Change Rate = % representing stability.

Table 3 (continued)

Round 3 Results: Descriptive Statistics, Convergence, and Stability

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)	Change Rate
19. Content knowledge and skills in family work	4.67	.816	5.0	5.00-5.00	83.33 (5)	16.67
20. Knowledge of 12 core functions or knowledge, skills, and abilities	4.00	1.265	4.5	3.00-5.00	50.00 (5)	16.67
21. Knowledge of counseling and behavioral techniques used in treatment of AODA	4.67	.816	5.0	5.00-5.00	83.33 (5)	16.67
22. Knowledge of using evidence-based practices specific to the treatment of AODA	4.00	1.673	5.0	3.00-5.00	66.67 (5)	33.33
23. Experience in using evidence-based practices specific to the treatment of AODA	4.67	.516	5.0	4.00-5.00	66.67 (5)	0.00
24. Knowledge to determine the appropriate treatment modality	4.67	.816	5.0	5.00-5.00	83.33 (5)	16.67
25. Knowledge of treatment modalities	4.50	.837	5.0	4.00-5.00	66.67 (5)	33.33
26. Content knowledge and skills in outpatient	4.00	1.265	4.5	3.00-5.00	50.00 (5)	16.67
27. Content knowledge and skills in inpatient hospital	3.83	1.169	4.0	3.00-5.00	33.33 (4, 5)	16.67
28. Content knowledge and skills in inpatient non-hospital	4.00	1.265	4.5	3.00-5.00	50.00 (5)	16.67
29. Content knowledge and skills in medication	4.00	1.265	4.5	3.00-5.00	50.00 (5)	16.67
30. Advocate for utilization of evidence-based practices in their specific practice	4.50	.837	5.0	4.00-5.00	66.67 (5)	16.67
31. Ability to locate treatment facilities (e.g. SAMHSA's treatment locator)	4.17	1.329	5.0	3.00-5.00	66.67 (5)	0.00
32. Understand the function of a behavior (e.g., attention, sensory/automatic reinforcement, avoidance conditioning, gain something tangible. Understand how function is then linked to treatment intervention. A review of Iwata's functional analysis principles will be helpful)	3.67	1.033	4.0	3.00-4.00	50.00 (4)	33.33
33. Trained as a trainer for AODA specific evidence-based approaches	4.50	.837	5.0	4.00-5.00	66.67 (5)	16.67

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale; Change Rate = % representing stability.

Table 3 (continued)

Round 3 Results: Descriptive Statistics, Convergence, and Stability

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)	Change Rate
34. Knowledge of the general supervision processes (e.g., Bernard and Goodyear book, etc.)	4.67	.516	5.0	4.00-5.00	66.67 (5)	0.00
35. Knowledge of the supervision process more specifically for supervisors working in the AODA arena	4.50	.837	5.0	4.00-5.00	66.67 (5)	33.33
36. Knowledge of Powell's integrated model of clinical supervision	3.83	.753	4.0	3.00-4.00	33.33 (4)	33.33
37. Ability to apply Powell's integrated model of clinical supervision	4.00	.894	4.0	3.00-5.00	33.33 (3, 4, 5)	33.33
38. Awareness of variables including cultural beliefs that can impact the supervision processes (e.g., supervisor's attitudes toward AODA)	4.50	.548	4.5	4.00-5.00	50.00 (4, 5)	0.00
39. Understand factors that enhance or inhibit the relationship between supervisor and supervisee	4.50	.548	4.5	4.00-5.00	50.00 (4, 5)	0.00
40. Competency in the area of crisis management	4.50	.837	5.0	4.00-5.00	66.67 (5)	16.67
41. Competency in the area of conflict resolution	4.33	.816	4.5	4.00-5.00	50.00 (5)	16.67
42. Skill in teaching AODA interventions	4.67	.516	5.0	4.00-5.00	66.67 (5)	0.00
43. Skill in supervising AODA interventions	4.83	.408	5.0	5.00-5.00	83.33 (5)	0.00
44. Skill in harnessing the power of the clinical team to meet organization goals	4.67	.816	5.0	5.00-5.00	83.33 (5)	16.67
45. Skill in collaborating with other providers	4.17	.753	4.0	4.00-5.00	50.00 (4)	16.67
46. Ability to delegate duties ensuring accountability and that plans are empowering and not too burdensome	3.50	1.378	3.5	2.00-5.00	33.33 (2, 5)	16.67
47. Ability to conceptualize AODA cases	3.50	1.378	3.5	2.00-5.00	33.33 (2, 5)	33.33
48. Ability to facilitate supervisees' ability to conceptualize AODA cases	4.00	1.095	4.0	4.00-5.00	50.00 (4)	0.00

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale; Change Rate = % representing stability.

Table 3 (continued)

Round 3 Results: Descriptive Statistics, Convergence, and Stability

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)	Change Rate
49. Ability to facilitate AODA case presentations	3.83	1.169	4.0	3.00-5.00	33.33 (4, 5)	33.33
50. Skill in using strategies to help supervisees avoid burn-out	4.67	.516	5.0	4.00-5.00	66.67 (5)	0.00
51. Knowledge of processes for licensure and/or certification specific for AODA supervisees	4.00	1.095	4.0	4.00-5.00	50.00 (4)	16.67
52. Knowledge of different models, techniques, and practical applications of clinical supervision fundamentals	4.50	.548	4.5	4.00-5.00	50.00 (4, 5)	16.67
53. Understand one's supervisory role in developing novice supervisees	4.67	.516	5.0	4.00-5.00	66.67 (5)	0.00
54. Understand one's supervisory role of helping seasoned supervisees to evolve	4.67	.516	5.0	4.00-5.00	66.67 (5)	16.67
55. Understand the collaborative nature of the supervisory alliance	4.50	.548	4.5	4.00-5.00	50.00 (4, 5)	16.67
56. Attend to the collaborative nature of the supervisory alliance	4.50	.548	4.5	4.00-5.00	50.00 (4, 5)	0.00
57. Facilitate regular structured supervisory sessions	4.50	.548	4.5	4.00-5.00	50.00 (4, 5)	16.67
58. Understand different learning styles	4.17	1.169	4.5	4.00-5.00	50.00 (5)	0.00
59. Respond to different learning styles with different forms of teaching/modeling	3.83	.983	4.0	4.00-4.00	66.67 (4)	16.67
60. Understanding of quantitative and qualitative appraisal techniques for supervisee progress	4.67	.516	5.0	4.00-5.00	66.67 (5)	16.67
61. Utilization of a mixed methods approach to gain a thorough understanding of the supervisees' progress	4.17	.753	4.0	4.00-5.00	50.00 (4)	16.67
62. Awareness of models for communicating counselor progress appraisal results	4.17	.753	4.0	4.00-5.00	50.00 (4)	16.67

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale; Change Rate = % representing stability.

Table 3 (continued)

Round 3 Results: Descriptive Statistics, Convergence, and Stability

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)	Change Rate
63. Understand models for communicating counselor progress appraisal results	4.33	.816	4.5	4.00-5.00	50.00 (5)	33.33
64. Ability to present critical appraisal and evaluation of supervisees in a practical, non-inflammatory way	4.50	.548	4.5	4.00-5.00	50.00 (4, 5)	0.00
65. Ability to build rapport with supervisees	4.83	.408	5.0	5.00-5.00	83.33 (5)	16.67
66. Ability to establish rapport with supervisees	4.83	.408	5.0	5.00-5.00	83.33 (5)	0.00
67. Ability to maintain rapport with supervisees	4.83	.408	5.0	5.00-5.00	83.33 (5)	0.00
68. Ability to model desired behaviors (including ethical behaviors)	4.50	.837	5.0	4.00-5.00	66.67 (5)	33.33
69. Possesses the personal characteristic of empathy	4.50	.837	5.0	4.00-5.00	66.67 (5)	33.33
70. Possesses the personal characteristic of supportiveness	4.50	.837	5.0	4.00-5.00	66.67 (5)	33.33
71. Possesses the personal characteristic of respectfulness	4.50	.837	5.0	4.00-5.00	66.67 (5)	33.33
72. Possesses the personal characteristic of tolerance	4.17	.753	4.0	4.00-5.00	50.00 (4)	16.67
73. Possesses the personal characteristic of valuing diversity	4.67	.816	5.0	5.00-5.00	83.33 (5)	33.33
74. Possesses the personal characteristic of being hopeful	4.33	.816	4.5	4.00-5.00	50.00 (5)	33.33
75. Possesses the personal characteristic of being energetic	3.83	1.169	4.0	3.00-5.00	33.33 (4, 5)	16.67
76. Possesses the personal characteristic of diligence	4.17	.753	4.0	4.00-5.00	50.00 (4)	16.67
77. Possesses the personal characteristic of good team working skills	3.83	1.169	4.0	3.00-5.00	33.33 (4, 5)	16.67
78. Understand the agency mission	4.50	.837	5.0	4.00-5.00	66.67 (5)	33.33
79. Support the agency mission	4.33	.816	4.5	4.00-5.00	50.00 (5)	16.67
80. Make progress toward the agency mission	4.33	.816	4.5	4.00-5.00	50.00 (5)	16.67
81. Adherence to goals	3.83	1.169	4.0	3.00-5.00	33.33 (4, 5)	0.00

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale; Change Rate = % representing stability.

Table 3 (continued)

Round 3 Results: Descriptive Statistics, Convergence, and Stability

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)	Change Rate
82. Recognition that organizational or business oriented skills are pivotal for supervisors to possess	4.50	.548	4.5	4.00-5.00	50.00 (4, 5)	16.67
83. Awareness of organizational techniques such as budgeting, record keeping, case retention, human resources management, understanding the use and limits of technology in substance abuse counseling settings, and personnel development procedures	4.00	1.095	4.0	4.00-5.00	50.00 (4)	0.00
84. Knowledge of organizational techniques such as budgeting, record keeping, case retention, human resources management, understanding the use and limits of technology in substance abuse counseling settings, and personnel development procedures	4.50	.548	4.5	4.00-5.00	50.00 (4, 5)	33.33
85. Skill in organizational techniques such as budgeting, record keeping, case retention, human resources management, understanding the use and limits of technology in substance abuse counseling settings, and personnel development procedures	4.17	.408	4.0	4.00-4.00	83.33 (4)	33.33
86. Ensure quality services are provided extending to areas of counseling services, cultural competence, updates with technology, utilization of evidence based practices, in-service training, and program evaluation activities	4.33	.516	4.0	4.00-5.00	66.67 (4)	16.67
87. Knowledge of coexisting disabilities	4.50	.837	5.0	4.00-5.00	66.67 (5)	16.67
88. Knowledge of special populations within the AODA arena	4.50	.837	5.0	4.00-5.00	66.67 (5)	16.67

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale; Change Rate = % representing stability.

Table 3 (continued)

Round 3 Results: Descriptive Statistics, Convergence, and Stability

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)	Change Rate
89. Knowledge of the vast array of resources that can assist both the supervisor and supervisee (e. g. SAMHSA website, NIDA website, NAMI website, etc.)	4.17	.753	4.0	4.00-5.00	50.00 (4)	16.67
90. Ability to teach AODA specific documentation	4.67	.516	5.0	4.00-5.00	66.67 (5)	16.67
91. Ability to supervise AODA specific documentation	4.83	.408	5.0	5.00-5.00	83.33 (5)	33.33
92. Understanding of payment mechanisms in the AODA arena	4.33	.816	4.5	4.00-5.00	50.00 (5)	16.67
93. Awareness of societal views of drug abuse	4.00	.894	4.0	3.00-5.00	33.33 (3, 4, 5)	16.67
94. Knowledge of ethical issues common to treatment of AODA	4.67	.816	5.0	5.00-5.00	83.33 (5)	16.67
95. Demonstrate knowledge of ethical practices in treatment of AODA	4.50	.837	5.0	4.00-5.00	66.67 (5)	16.67
96. Skill in navigating AODA specific legal/ethical issues	4.67	.816	5.0	5.00-5.00	83.33 (5)	16.67
97. Knowledge of state and federal laws related to the treatment of substance abuse clients. Including protection of clients with HIV/AIDS, medical coverage (Medicaid laws, insurance...), mandated reporting...etc.	4.50	.837	5.0	4.00-5.00	66.67 (5)	33.33
98. Understanding of local, state and federal laws as they relate to the everyday business of the agency	4.67	.816	5.0	5.00-5.00	83.33 (5)	50.00
99. Understanding of local, state and federal laws as they relate to the work of the supervisee	4.67	.816	5.0	5.00-5.00	83.33 (5)	33.33
100. Knowledge of confidentiality as it applies to treatment of AODA	4.67	.816	5.0	5.00-5.00	83.33 (5)	33.33
101. Ethical practice which incorporates specific language utilized in treatment	4.17	1.329	5.0	3.00-5.00	66.67 (5)	16.67

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale; Change Rate = % representing stability.

Table 3 (continued)

Round 3 Results: Descriptive Statistics, Convergence, and Stability

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)	Change Rate
102. Understanding of agency rules/regulations/policies including those of parent organizations	4.17	.983	4.5	3.00-5.00	50.00 (5)	16.67
103. Adherence to differing rules and regulations	4.00	.632	4.0	4.00-4.00	66.67 (4)	33.33
104. Understand codes of ethics for supervisees which may be in conflict due to an array of credentials held by the supervisee	4.83	.408	5.0	5.00-5.00	83.33 (5)	16.67
105. Understand multiple theories of ethics	4.33	1.033	5.0	3.00-5.00	66.67 (5)	33.33
106. Mastery of multiple models of ethical decision making	3.67	1.033	4.0	3.00-4.00	50.00 (4)	33.33
107. Teach ethical decision making skills to supervisees	4.67	.516	5.0	4.00-5.00	66.67 (5)	16.67
108. Provide ethical consultative services to the supervisee as needed	4.67	.516	5.0	4.00-5.00	66.67 (5)	0.00
109. Understand the risks of dual roles and relationships with supervisees	4.67	.516	5.0	4.00-5.00	66.67 (5)	0.00
110. Utilization of time management skills	4.50	.837	5.0	4.00-5.00	66.67 (5)	-
111. Utilization of communication skills	4.50	.837	5.0	4.00-5.00	66.67 (5)	-
112. Knowledgeable in dealing with clinical failure (e. g. client relapse, client death, not coming back to treatment sessions)	4.33	.816	4.5	4.00-5.00	50.00 (5)	-
113. Knowledgeable in addressing client manipulation	4.50	.837	5.0	4.00-5.00	66.67 (5)	-
114. Ability to address questions regarding supervisor's history of substance use or non-use	4.50	.837	5.0	4.00-5.00	66.67 (5)	-
115. Skilled in case management domains	4.17	.753	4.0	4.00-5.00	50.00 (4)	-

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale; Change Rate = % representing stability.

Table 4

Round 4 Results: Descriptive Statistics, Convergence, and Stability

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)	Change Rate
1. Knowledge of the different drug types (e.g., Cocaine, Oxycontin, Crystal Meth, etc.)	4.50	.837	5.0	4.00-5.00	66.67 (5)	0.00
2. Knowledge of the major functions of drugs	4.33	.816	4.5	4.00-5.00	50.00 (5)	0.00
3. Knowledge of the drug's impact on the user (e.g., psychological, physical, psychosocial)	4.67	.816	5.0	5.00-5.00	83.33 (5)	0.00
4. Knowledge of the drug's impact on persons in the consumer's circle (e.g., family members, peers, employers, etc.)	4.50	.837	5.0	4.00-5.00	66.67 (5)	0.00
5. Knowledge of why individuals avoid using drugs	4.17	.983	4.5	3.00-5.00	50.00 (5)	16.67
5b. Knowledge of protective features for substance use	4.33	1.033	5.0	3.00-5.00	66.67 (5)	-
6. Understand the power and many implications of relapse	4.50	.837	5.0	4.00-5.00	66.67 (5)	0.00
7. Understand the disease model of addiction	4.50	.837	5.0	4.00-5.00	66.67 (5)	16.67
8. Understand the moral model of addiction	4.33	.816	4.5	4.00-5.00	50.00 (5)	0.00
8b. Understand the varied models of addiction	4.50	.837	5.0	4.00-5.00	66.67 (5)	-
9. Knowledge of alcohol and other drug abuse specific legal/ethical issues	4.67	.816	5.0	5.00-5.00	83.33 (5)	16.67
10. Knowledge of Adult Children of Alcoholics, etc.	4.33	.816	4.5	4.00-5.00	50.00 (5)	0.00
11. Knowledge of follow up	4.17	.983	4.5	3.00-5.00	50.00 (5)	0.00
11b. Knowledge of follow-up services	4.33	.816	4.5	4.00-5.00	50.00 (5)	-
11c. Knowledge of follow-up for program evaluation purposes	4.50	.548	4.5	4.00-5.00	50.00 (4, 5)	-
11d. Knowledge of the follow-up process	4.50	.837	5.0	4.00-5.00	66.67 (5)	-
12. Advanced skills in AODA counseling, assessment, diagnosis, etc.	4.67	.516	5.0	4.00-5.00	66.67 (5)	16.67
13. Content knowledge and skills in assessment	4.33	1.033	5.0	3.00-5.00	66.67 (5)	16.67
13b. Content knowledge in AODA assessment	4.67	.816	5.0	5.00-5.00	83.33 (5)	-

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale; Change Rate = % representing stability.

Table 4 (continued)

Round 4 Results: Descriptive Statistics, Convergence, and Stability

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)	Change Rate
13c. Skills in AODA assessment	4.67	.816	5.0	5.00-5.00	83.33 (5)	-
14. Content knowledge and skills in diagnosis	4.67	.816	5.0	5.00-5.00	83.33 (5)	0.00
14b. Content knowledge in AODA diagnosis	4.33	.816	4.5	4.00-5.00	50.00 (5)	-
14c. Skills in AODA diagnosis	4.33	.816	4.5	4.00-5.00	50.00 (5)	-
15. Content knowledge and skills in treatment	4.50	.837	5.0	4.00-5.00	66.67 (5)	16.67
15b. Content knowledge in AODA treatment	4.50	.837	5.0	4.00-5.00	66.67 (5)	-
15c. Skills in AODA treatment	4.33	.816	4.5	4.00-5.00	50.00 (5)	-
16. Content knowledge and skills in detoxification services	4.33	.816	4.5	4.00-5.00	50.00 (5)	16.67
16b. Content knowledge of the detoxification process	4.17	.753	4.0	4.00-5.00	50.00 (4)	-
16c. Skills in supporting clients through the detoxification process	4.00	.632	4.0	4.00-4.00	66.67 (4)	-
17. Content knowledge and skills in individual counseling	4.50	.837	5.0	4.00-5.00	66.67 (5)	0.00
17b. Content knowledge in individual counseling techniques	4.50	.837	5.0	4.00-5.00	66.67 (5)	-
17c. Skills in individual counseling techniques	4.50	.837	5.0	4.00-5.00	66.67 (5)	-
18. Content knowledge and skills in group work	4.50	.837	5.0	4.00-5.00	66.67 (5)	0.00
18b. Content knowledge of group work techniques	4.50	.837	5.0	4.00-5.00	66.67 (5)	-
18c. Skills in group work techniques	4.50	.837	5.0	4.00-5.00	66.67 (5)	-
19. Content knowledge and skills in family work	4.67	.816	5.0	5.00-5.00	83.33 (5)	0.00
19b. Content knowledge of family counseling techniques	4.33	.816	4.5	4.00-5.00	50.00 (5)	-
19c. Skills in family counseling techniques	4.17	.753	4.0	4.00-5.00	50.00 (4)	-
20. Knowledge of 12 core functions or knowledge, skills, and abilities (KSAs)	3.83	1.169	4.0	3.00-5.00	33.33 (4, 5)	16.67

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale; Change Rate = % representing stability.

Table 4 (continued)

Round 4 Results: Descriptive Statistics, Convergence, and Stability

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)	Change Rate
20b. Knowledge of the 12 core functions	4.33	.816	4.5	4.00-5.00	83.33 (5)	-
20c. Knowledge of knowledge, skills, and abilities (KSAs)	4.17	.753	4.0	4.00-5.00	50.00 (4)	-
21. Knowledge of counseling and behavioral techniques used in treatment of AODA	4.67	.816	5.0	5.00-5.00	83.33 (5)	0.00
22. Knowledge of evidence-based practices specific to the treatment of AODA	4.50	.837	5.0	4.00-5.00	66.67 (5)	16.67
23. Experience in using evidence-based practices specific to the treatment of AODA	4.67	.516	5.0	4.00-5.00	66.67 (5)	0.00
24. Knowledge to determine the appropriate treatment modality	4.67	.816	5.0	5.00-5.00	83.33 (5)	0.00
25. Knowledge of treatment modalities	4.67	.816	5.0	5.00-5.00	83.33 (5)	16.67
26. Content knowledge and skills in outpatient	4.33	1.033	5.0	3.00-5.00	66.67 (5)	33.33
26b. Content knowledge in providing outpatient level of care	4.50	.837	5.0	4.00-5.00	66.67 (5)	-
26c. Skills in providing AODA counseling within the outpatient level of care	4.50	.837	5.0	4.00-5.00	66.67 (5)	-
26d. Content knowledge of AODA counseling models used within the outpatient level of care	4.50	.837	5.0	4.00-5.00	66.67 (5)	-
26e. Skills in utilizing AODA counseling models within the outpatient level of care	4.50	.837	5.0	4.00-5.00	66.67 (5)	-
27. Content knowledge and skills in inpatient hospital	4.00	.894	4.0	3.00-5.00	33.33 (3, 4, 5)	16.67
27b. Content knowledge in providing inpatient hospital level of care	4.00	.632	4.0	4.00-4.00	66.67 (4)	-
27c. Skills in providing inpatient hospital level of care	4.17	.753	4.0	4.00-5.00	50.00 (4)	-

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale; Change Rate = % representing stability.

Table 4 (continued)

Round 4 Results: Descriptive Statistics, Convergence, and Stability

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)	Change Rate
27d. Content knowledge of AODA counseling models used within the inpatient hospital level of care	4.33	.816	4.5	4.00-5.00	50.00 (5)	-
27e. Skills in utilizing AODA counseling models within the inpatient hospital level of care	4.00	.632	4.0	4.00-4.00	66.67 (4)	-
28. Content knowledge and skills in inpatient non-hospital	4.00	.894	4.0	3.00-5.00	33.33 (3, 4, 5)	33.33
28b. Content knowledge in providing inpatient non-hospital level of care	4.17	.983	4.5	3.00-5.00	50.00 (5)	-
28c. Skills in providing AODA counseling within the inpatient non-hospital level of care	4.17	.983	4.5	3.00-5.00	50.00 (5)	-
28d. Content knowledge of AODA counseling models used within the inpatient non-hospital level of care	4.50	.837	5.0	4.00-5.00	66.67 (5)	-
28e. Skills in utilizing AODA counseling models within the inpatient non-hospital level of care	4.33	.816	4.5	4.00-5.00	50.00 (5)	-
29. Content knowledge and skills in medication	3.83	1.169	4.0	3.00-5.00	33.33 (4, 5)	16.67
29b. Content knowledge in medication assisted treatment	4.17	.753	4.0	4.00-5.00	50.00 (4)	-
29c. Skills in providing medication assisted treatment	3.83	1.169	4.0	3.00-5.00	33.33 (4, 5)	-
30. Advocate for utilization of evidence-based practices in their specific practice	4.50	.837	5.0	4.00-5.00	66.67 (5)	0.00
30b. Advocate for utilization of evidence-based practices	4.67	.816	5.0	5.00-5.00	83.33 (5)	-
31. Ability to locate treatment facilities (e.g. SAMHSA's treatment locator)	4.00	1.265	4.5	3.00-5.00	50.00 (5)	16.67
31b. Ability to locate treatment facilities	4.33	.816	4.5	4.00-5.00	50.00 (5)	-

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale; Change Rate = % representing stability.

Table 4 (continued)

Round 4 Results: Descriptive Statistics, Convergence, and Stability

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)	Change Rate
32. Understand the function of a behavior (e.g., attention, sensory/automatic reinforcement, avoidance conditioning, gain something tangible. Understand how function is then linked to treatment intervention. A review of Iwata's functional analysis principles will be helpful)	3.83	1.169	4.0	3.00-5.00	33.33 (4, 5)	16.67
32b. Understand the function of a behavior and how it can be linked to treatment interventions	4.33	.816	4.5	4.00-5.00	50.00 (5)	-
33. Trained as a trainer for AODA specific evidence-based approaches	4.17	.753	4.0	4.00-5.00	50.00 (4)	33.33
33b. Received education to teach AODA specific evidence-based approaches	4.17	1.169	4.5	4.00-5.00	50.00 (5)	-
33c. Prepared to teach AODA specific evidence-based approaches	4.33	.516	4.0	4.00-5.00	66.67 (4)	-
34. Knowledge of the general supervision process (e.g., Bernard and Goodyear book, etc.)	4.67	.516	5.0	4.00-5.00	66.67 (5)	0.00
35. Knowledge of the supervision process specifically for work in the AODA arena	4.83	.408	5.0	5.00-5.00	83.33 (5)	16.67
36. Knowledge of Powell's integrated model of clinical supervision	3.83	.753	4.0	3.00-4.00	50.00 (4)	0.00
37. Ability to apply Powell's integrated model of clinical supervision	4.00	.894	4.0	3.00-5.00	33.33 (3, 4, 5)	0.00
38. Awareness of variables including cultural beliefs that can impact the supervision process (e.g., supervisor's attitudes toward AODA)	4.67	.516	5.0	4.00-5.00	66.67 (5)	16.67
39. Understand factors that enhance or inhibit the relationship between supervisor and supervisee	4.50	.548	4.5	4.00-5.00	50.00 (4, 5)	0.00
40. Competency in the area of crisis management	4.50	.837	5.0	4.00-5.00	66.67 (5)	0.00
41. Competency in the area of conflict resolution	4.33	.816	4.5	4.00-5.00	50.00 (5)	0.00

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale; Change Rate = % representing stability.

Table 4 (continued)

Round 4 Results: Descriptive Statistics, Convergence, and Stability

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)	Change Rate
42. Skill in teaching AODA interventions	4.67	.516	5.0	4.00-5.00	66.67 (5)	0.00
43. Skill in supervising AODA interventions	4.83	.408	5.0	5.00-5.00	83.33 (5)	0.00
44. Skill in harnessing the power of the clinical team to meet organization goals	4.50	.837	5.0	4.00-5.00	66.67 (5)	16.67
45. Skill in collaborating with other providers	4.17	.753	4.0	4.00-5.00	50.00 (4)	0.00
46. Ability to delegate duties ensuring accountability and that plans are empowering and not too burdensome	3.33	1.211	3.5	2.00-4.00	33.33 (2, 4)	16.67
46b. Ability to delegate duties ensuring accountability and empowerment while avoiding overload for the supervisee	4.17	.983	4.5	3.00-5.00	50.00 (5)	-
47. Ability to conceptualize AODA cases	3.83	1.169	4.0	3.00-5.00	33.33 (4, 5)	16.67
47b. Ability to conceptualize AODA client history, progress, needs, and prognosis	4.33	1.033	5.0	3.00-5.00	66.67 (5)	-
48. Ability to facilitate supervisees' ability to conceptualize AODA cases	3.83	.983	4.0	4.00-4.00	66.67 (4)	16.67
49. Ability to facilitate AODA case presentations	4.17	.753	4.0	4.00-5.00	50.00 (4)	16.67
50. Skill in using strategies to help supervisees avoid burn-out	4.67	.516	5.0	4.00-5.00	66.67 (5)	0.00
51. Knowledge of licensure and/or certification processes specific for AODA supervisees	4.67	.516	5.0	4.00-5.00	66.67 (5)	33.33
52. Knowledge of different models, techniques, and practical applications of clinical supervision fundamentals	4.67	.516	5.0	4.00-5.00	66.67 (5)	16.67
53. Understand one’s supervisory role in developing novice supervisees	4.83	.408	5.0	5.00-5.00	83.33 (5)	16.67
54. Understand one’s supervisory role of helping seasoned supervisees to evolve	4.50	.548	4.5	4.00-5.00	50.00 (4, 5)	16.67

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale; Change Rate = % representing stability.

Table 4 (continued)

Round 4 Results: Descriptive Statistics, Convergence, and Stability

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)	Change Rate
55. Understand the collaborative nature of the supervisory alliance	4.67	.516	5.0	4.00-5.00	66.67 (5)	16.67
56. Attend to the collaborative nature of the supervisory alliance	4.50	.548	4.5	4.00-5.00	50.00 (4, 5)	0.00
57. Facilitate regular structured supervisory sessions	4.33	.516	4.0	4.00-5.00	66.67 (4)	16.67
58. Understand different learning styles	4.17	1.169	4.5	4.00-5.00	50.00 (5)	0.00
59. Respond to different learning styles with different forms of teaching/modeling	4.17	1.169	4.5	4.00-5.00	50.00 (5)	33.33
60. Understanding of quantitative and qualitative appraisal techniques for supervisee progress	4.67	.516	5.0	4.00-5.00	66.67 (5)	0.00
61. Utilization of a mixed methods approach to gain a thorough understanding of the supervisees' progress	4.17	.753	4.0	4.00-5.00	50.00 (4)	0.00
62. Awareness of models for communicating counselor progress appraisal results	4.33	.816	4.5	4.00-5.00	50.00 (5)	16.67
63. Understand models for communicating counselor progress appraisal results	4.17	.753	4.0	4.00-5.00	50.00 (4)	16.67
64. Ability to present critical appraisal and evaluation of supervisees in a practical, non-inflammatory way	4.50	.548	4.5	4.00-5.00	50.00 (4, 5)	0.00
65. Ability to build rapport with supervisees	4.83	.408	5.0	5.00-5.00	83.33 (5)	0.00
66. Ability to establish rapport with supervisees	4.83	.408	5.0	5.00-5.00	83.33 (5)	0.00
67. Ability to maintain rapport with supervisees	4.67	.516	5.0	4.00-5.00	66.67 (5)	16.67
68. Ability to model desired behaviors (including ethical behaviors)	4.50	.837	5.0	4.00-5.00	66.67 (5)	0.00
68b. Ability to model desired behaviors	4.67	.816	5.0	5.00-5.00	83.33 (5)	-
69. Possesses the personal characteristic of empathy	4.33	.816	4.5	4.00-5.00	50.00 (5)	16.67

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale; Change Rate = % representing stability.

Table 4 (continued)

Round 4 Results: Descriptive Statistics, Convergence, and Stability

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)	Change Rate
70. Possesses the personal characteristic of supportiveness	4.50	.837	5.0	4.00-5.00	66.67 (5)	0.00
71. Possesses the personal characteristic of respectfulness	4.50	.837	5.0	4.00-5.00	66.67 (5)	0.00
72. Possesses the personal characteristic of tolerance	4.00	.632	4.0	4.00-4.00	66.67 (4)	16.67
73. Possesses the personal characteristic of valuing diversity	4.67	.816	5.0	5.00-5.00	83.33 (5)	0.00
74. Possesses the personal characteristic of being hopeful	4.17	.753	4.0	4.00-5.00	50.00 (4)	16.67
75. Possesses the personal characteristic of being energetic	4.00	.894	4.0	3.00-5.00	33.33 (3, 4, 5)	16.67
76. Possesses the personal characteristic of diligence	4.17	.753	4.0	4.00-5.00	50.00 (4)	0.00
77. Possesses the personal characteristic of team working skills	4.00	.632	4.0	4.00-4.00	66.67 (4)	33.33
78. Understand the agency mission	4.50	.837	5.0	4.00-5.00	66.67 (5)	0.00
79. Support the agency mission	4.33	.816	4.5	4.00-5.00	50.00 (5)	0.00
80. Make progress toward the agency mission	4.33	.816	4.5	4.00-5.00	50.00 (5)	0.00
81. Adherence to goals	4.00	.894	4.0	3.00-5.00	33.33 (3, 4, 5)	16.67
81b. Adherence to agency goals	4.17	.753	4.0	4.00-5.00	50.00 (4)	-
81c. Adherence to personal goals	4.17	.753	4.0	4.00-5.00	50.00 (4)	-
81d. Adherence to client goals	4.17	.753	4.0	4.00-5.00	50.00 (4)	-
82. Recognition that organizational or business oriented skills are pivotal for supervisors to possess	4.50	.548	4.5	4.00-5.00	50.00 (4, 5)	0.00
83. Awareness of organizational techniques such as budgeting, record keeping, case retention, human resources management, understanding the use and limits of technology in substance abuse counseling settings, and personnel development procedures	4.17	1.169	4.5	4.00-5.00	50.00 (5)	16.67

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale; Change Rate = % representing stability.

Table 4 (continued)

Round 4 Results: Descriptive Statistics, Convergence, and Stability

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)	Change Rate
84. Knowledge of organizational techniques such as budgeting, record keeping, case retention, human resources management, understanding the use and limits of technology in substance abuse counseling settings, and personnel development procedures	4.50	.548	4.5	4.00-5.00	50.00 (4, 5)	0.00
85. Skill in organizational techniques such as budgeting, record keeping, case retention, human resources management, understanding the use and limits of technology in substance abuse counseling settings, and personnel development procedures	4.00	.632	4.0	4.00-4.00	66.67 (4)	16.67
85b. Skill in administrative supervision tasks such as budgeting, record keeping, human resources management etc.	4.33	.516	4.0	4.00-5.00	66.67 (4)	-
85c. Understanding the use and limits of technology in AODA counseling settings	4.33	.816	4.5	4.00-5.00	50.00 (5)	-
86. Ensure quality services are provided extending to areas of counseling services, cultural competence, updates with technology, utilization of evidence based practices, in-service training, and program evaluation activities	4.33	.516	4.0	4.00-5.00	66.67 (4)	0.00
87. Knowledge of coexisting disabilities	4.50	.837	5.0	4.00-5.00	66.67 (5)	0.00
88. Knowledge of special populations within the AODA arena	4.50	.837	5.0	4.00-5.00	66.67 (5)	0.00
89. Knowledge of the vast array of resources that can assist both the supervisor and supervisee (e.g. SAMHSA website, NIDA website, NAMI website, etc.)	4.17	.753	4.0	4.00-5.00	50.00 (4)	0.00
90. Ability to teach AODA specific documentation	4.67	.516	5.0	4.00-5.00	66.67 (5)	0.00

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale; Change Rate = % representing stability.

Table 4 (continued)

Round 4 Results: Descriptive Statistics, Convergence, and Stability

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)	Change Rate
91. Ability to supervise AODA specific documentation	4.83	.408	5.0	5.00-5.00	83.33 (5)	0.00
92. Understanding of payment mechanisms in the AODA arena	4.33	.816	4.5	4.00-5.00	50.00 (4)	0.00
93. Awareness of societal views of drug abuse	4.33	1.033	5.0	3.00-5.00	66.67 (5)	33.33
94. Knowledge of ethical issues common to treatment of AODA	4.67	.816	5.0	5.00-5.00	83.33 (5)	0.00
95. Demonstrate knowledge of ethical practices in treatment of AODA	4.50	.837	5.0	4.00-5.00	66.67 (5)	0.00
96. Skill in navigating AODA specific legal/ethical issues	4.67	.816	5.0	5.00-5.00	83.33 (5)	0.00
97. Knowledge of state and federal laws related to the treatment of substance abuse clients. Including protection of clients with HIV/AIDS, medical coverage (Medicaid laws, insurance...), mandated reporting...etc.	4.17	.983	4.5	3.00-5.00	50.00 (5)	16.67
97b. Knowledge of state and federal laws related to the treatment of substance abuse clients.	4.67	.816	5.0	5.00-5.00	83.33 (5)	-
98. Understanding of local, state and federal laws as they relate to the everyday business of the agency	4.67	.816	5.0	5.00-5.00	83.33 (5)	0.00
99. Understanding of local, state and federal laws as they relate to the work of the supervisee	4.50	.837	5.0	4.00-5.00	66.67 (5)	16.67
100. Knowledge of confidentiality as it applies to treatment of AODA	4.67	.816	5.0	5.00-5.00	83.33 (5)	0.00
101. Ethical practice which incorporates specific language utilized in treatment	4.33	1.033	5.0	3.00-5.00	66.67 (5)	16.67
101b. Utilization of ethical language in treatment	4.33	1.033	5.0	3.00-5.00	66.67 (5)	-

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale; Change Rate = % representing stability.

Table 4 (continued)

Round 4 Results: Descriptive Statistics, Convergence, and Stability

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)	Change Rate
102. Understanding of agency rules/regulations/policies including those of parent organizations	4.17	.753	4.0	4.00-5.00	50.00 (4)	33.33
103. Adherence to differing rules and regulations	4.00	.632	4.0	4.00-4.00	66.67 (4)	0.00
104. Understand codes of ethics for supervisees which may be in conflict due to an array of credentials held by the supervisee	4.83	.408	5.0	5.00-5.00	83.33 (5)	0.00
105. Understand multiple theories of ethics	4.17	.983	4.5	3.00-5.00	50.00 (5)	16.67
106. Mastery of multiple models of ethical decision making	4.17	.753	4.0	4.00-5.00	50.00 (4)	16.67
107. Teach ethical decision making skills to supervisees	4.67	.516	5.0	4.00-5.00	66.67 (5)	0.00
108. Provide ethical consultative services to the supervisee as needed	4.67	.516	5.0	4.00-5.00	66.67 (5)	0.00
109. Understand the risks of dual roles and relationships with supervisees	4.67	.816	5.0	5.00-5.00	83.33 (5)	33.33
110. Utilization of time management skills	4.50	.837	5.0	4.00-5.00	66.67 (5)	0.00
111. Utilization of communication skills	4.67	.816	5.0	5.00-5.00	83.33 (5)	16.67
112. Knowledgeable in dealing with clinical failure (e.g. client relapse, client death, not coming back to treatment sessions)	4.33	.816	4.5	4.00-5.00	50.00 (5)	0.00
113. Knowledgeable in addressing client manipulation	4.50	.837	5.0	4.00-5.00	66.67 (5)	0.00
114. Ability to address questions regarding supervisor's history of substance use or non-use	4.33	.816	4.5	4.00-5.00	50.00 (5)	16.67
115. Skilled in case management domains	4.33	.816	4.5	4.00-5.00	50.00 (5)	16.67

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale; Change Rate = % representing stability.

Table 5

Round 5 Results: Descriptive Statistics, Convergence, and Stability

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)	Change Rate
1. Knowledge of the different drug types (e.g., Cocaine, Oxycontin, Crystal Meth, etc.)	4.50	.837	5.00	4.00-5.00	66.67 (5)	0.00
2. Knowledge of the major functions of drugs	4.33	.816	4.50	4.00-5.00	50.00 (5)	0.00
3. Knowledge of the drug's impact on the user (e.g., psychological, physical, psychosocial)	4.67	.816	5.00	5.00-5.00	83.33 (5)	0.00
4. Knowledge of the drug's impact on persons in the consumer's circle (e.g., family members, peers, employers, etc.)	4.50	.837	5.00	4.00-5.00	66.67 (5)	0.00
5. Knowledge of why individuals avoid using drugs	4.17	.753	4.00	4.00-5.00	50.00 (4)	33.33
5b. Knowledge of protective features for substance use	4.50	.837	5.00	4.00-5.00	66.67 (5)	20.00
5c. Knowledge of protective features for substance use such as having a positive support system, utilization of coping skills, uses time for positive activities, etc.	4.17	.983	4.50	3.00-5.00	50.00 (5)	-
6. Understand the power and many implications of relapse	4.50	.837	5.00	4.00-5.00	66.67 (5)	0.00
7. Understand the disease model of addiction	4.50	.837	5.00	4.00-5.00	66.67 (5)	0.00
8. Understand the moral model of addiction	4.50	.837	5.00	4.00-5.00	66.67 (5)	16.67
8b. Understand the varied models of addiction	4.50	.837	5.00	4.00-5.00	66.67 (5)	0.00
9. Knowledge of alcohol and other drug abuse specific legal/ethical issues	4.67	.816	5.00	5.00-5.00	83.33 (5)	0.00
10. Knowledge of Adult Children of Alcoholics, etc.	4.75	.500	5.00	4.50-5.00	75. 00 (5)	25.00
11. Knowledge of follow up	4.40	.894	5.00	4.00-5.00	60.00 (5)	10.00
11b. Knowledge of follow-up services	4.80	.447	5.00	5.00-5.00	80.00 (5)	30.00

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale; Change Rate = % representing stability; Items 1-9 n = 6, Item 10 n = 4, Items 11-115 n = 5.

Table 5 (continued)

Round 5 Results: Descriptive Statistics, Convergence, and Stability

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)	Change Rate
11c. Knowledge of follow-up for program evaluation purposes	4.80	.447	5.00	5.00-5.00	80.00 (5)	30.00
11d. Knowledge of the follow-up process	4.60	.548	5.00	4.00-5.00	60.00 (5)	30.00
12. Advanced skills in AODA counseling, assessment, diagnosis, etc.	4.80	.447	5.00	5.00-5.00	80.00 (5)	10.00
13. Content knowledge and skills in assessment	4.60	.894	5.00	5.00-5.00	80.00 (5)	10.00
13b. Content knowledge in AODA assessment	5.00	.000	5.00	5.00-5.00	100.00 (5)	10.00
13c. Skills in AODA assessment	4.80	.447	5.00	5.00-5.00	80.00 (5)	30.00
14. Content knowledge and skills in diagnosis	5.00	.000	5.00	5.00-5.00	100.00 (5)	10.00
14b. Content knowledge in AODA diagnosis	4.80	.447	5.00	5.00-5.00	80.00 (5)	30.00
14c. Skills in AODA diagnosis	5.00	.000	5.00	5.00-5.00	100.00 (5)	50.00
15. Content knowledge and skills in treatment	4.80	.447	5.00	5.00-5.00	80.00 (5)	10.00
15b. Content knowledge in AODA treatment	5.00	.000	5.00	5.00-5.00	100.00 (5)	30.00
15c. Skills in AODA treatment	4.60	.548	5.00	4.00-5.00	60.00 (5)	10.00
16. Content knowledge and skills in detoxification services	4.40	.548	4.00	4.00-5.00	60.00 (4)	30.00
16b. Content knowledge of the detoxification process	4.60	.548	5.00	4.00-5.00	60.00 (5)	30.00
16c. Skills in supporting clients through the detoxification process	4.20	.447	4.00	4.00-4.00	80.00 (4)	10.00
17. Content knowledge and skills in individual counseling	5.00	.000	5.00	5.00-5.00	100.00 (5)	30.00
17b. Content knowledge in individual counseling techniques	4.80	.447	5.00	5.00-5.00	80.00 (5)	10.00
17c. Skills in individual counseling techniques	5.00	.000	5.00	5.00-5.00	100.00 (5)	30.00
18. Content knowledge and skills in group work	4.80	.447	5.00	5.00-5.00	80.00 (5)	10.00
18b. Content knowledge of group work techniques	5.00	.000	5.00	5.00-5.00	100.00 (5)	30.00
18c. Skills in group work techniques	5.00	.000	5.00	5.00-5.00	100.00 (5)	30.00

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale; Change Rate = % representing stability; Items 1-9 n = 6, Item 10 n = 4, Items 11-115 n = 5.

Table 5 (continued)

Round 5 Results: Descriptive Statistics, Convergence, and Stability

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)	Change Rate
19. Content knowledge and skills in family work	5.00	.000	5.00	5.00-5.00	100.00 (5)	10.00
19b. Content knowledge of family counseling techniques	4.40	.548	4.00	4.00-5.00	60.00 (4)	30.00
19c. Skills in family counseling techniques	4.60	.548	5.00	4.00-5.00	60.00 (5)	30.00
20. Knowledge of 12 core functions or knowledge, skills, and abilities (KSAs)	4.20	.837	4.00	4.00-5.00	40.00 (4, 5)	10.00
20b. Knowledge of the 12 core functions	4.40	.894	5.00	4.00-5.00	60.00 (5)	10.00
20c. Knowledge of knowledge, skills, and abilities (KSAs)	4.20	.837	4.00	4.00-5.00	40.00 (4, 5)	10.00
21. Knowledge of counseling and behavioral techniques used in treatment of AODA	5.00	.000	5.00	5.00-5.00	100.00 (5)	10.00
22. Knowledge of evidence-based practices specific to the treatment of AODA	4.80	.447	5.00	5.00-5.00	80.00 (5)	10.00
23. Experience in using evidence-based practices specific to the treatment of AODA	5.00	.000	5.00	5.00-5.00	100.00 (5)	30.00
24. Knowledge to determine the appropriate treatment modality	5.00	.000	5.00	5.00-5.00	100.00 (5)	10.00
25. Knowledge of treatment modalities	5.00	.000	5.00	5.00-5.00	100.00 (5)	10.00
26. Content knowledge and skills in outpatient	4.60	.894	5.00	5.00-5.00	80.00 (5)	10.00
26b. Content knowledge in providing outpatient level of care	4.80	.447	5.00	5.00-5.00	80.00 (5)	10.00
26c. Skills in providing AODA counseling within the outpatient level of care	5.00	.000	5.00	5.00-5.00	100.00 (5)	30.00
26d. Content knowledge of AODA counseling models used within the outpatient level of care	5.00	.000	5.00	5.00-5.00	100.00 (5)	30.00

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale; Change Rate = % representing stability; Items 1-9 n = 6, Item 10 n = 4, Items 11-115 n = 5.

Table 5 (continued)

Round 5 Results: Descriptive Statistics, Convergence, and Stability

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)	Change Rate
26e. Skills in utilizing AODA counseling models within the outpatient level of care	5.00	.000	5.00	5.00-5.00	100.00 (5)	30.00
27. Content knowledge and skills in inpatient hospital	4.20	.837	4.00	4.00-5.00	40.00 (4, 5)	10.00
27b. Content knowledge in providing inpatient hospital level of care	4.40	.548	4.00	4.00-5.00	60.00 (4)	30.00
27c. Skills in providing inpatient hospital level of care	4.20	.447	4.00	4.00-4.00	80.00 (4)	30.00
27d. Content knowledge of AODA counseling models used within the inpatient hospital level of care	4.60	.548	5.00	4.00-5.00	60.00 (5)	10.00
27e. Skills in utilizing AODA counseling models within the inpatient hospital level of care	4.40	.548	4.00	4.00-5.00	60.00 (4)	30.00
28. Content knowledge and skills in inpatient non-hospital	4.20	.837	4.00	4.00-5.00	40.00 (4, 5)	10.00
28b. Content knowledge in providing inpatient non-hospital level of care	4.60	.548	5.00	4.00-5.00	60.00 (5)	30.00
28c. Skills in providing AODA counseling within the inpatient non-hospital level of care	4.60	.548	5.00	4.00-5.00	60.00 (5)	30.00
28d. Content knowledge of AODA counseling models used within the inpatient non-hospital level of care	4.80	.447	5.00	5.00-5.00	80.00 (5)	10.00
28e. Skills in utilizing AODA counseling models within the inpatient non-hospital level of care	4.60	.548	5.00	4.00-5.00	60.00 (5)	10.00
29. Content knowledge and skills in medication	4.20	.837	4.00	4.00-5.00	40.00 (4, 5)	10.00
29b. Content knowledge in medication assisted treatment	4.60	.548	5.00	4.00-5.00	60.00 (5)	30.00
29c. Skills in providing medication assisted treatment	4.20	.447	4.00	4.00-4.00	80.00 (4)	50.00

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale; Change Rate = % representing stability; Items 1-9 n = 6, Item 10 n = 4, Items 11-115 n = 5.

Table 5 (continued)

Round 5 Results: Descriptive Statistics, Convergence, and Stability

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)	Change Rate
30. Advocate for utilization of evidence-based practices in their specific practice	4.80	.447	5.00	5.00-5.00	80.00 (5)	10.00
30b. Advocate for utilization of evidence-based practices	4.80	.447	5.00	5.00-5.00	80.00 (5)	30.00
31. Ability to locate treatment facilities (e.g. SAMHSA's treatment locator)	4.60	.548	5.00	4.00-5.00	60.00 (5)	30.00
31b. Ability to locate treatment facilities	4.60	.548	5.00	4.00-5.00	60.00 (5)	10.00
32. Understand the function of a behavior (e.g., attention, sensory/automatic reinforcement, avoidance conditioning, gain something tangible. Understand how function is then linked to treatment intervention. A review of Iwata's functional analysis principles will be helpful)	4.20	.837	4.00	4.00-5.00	40.00 (4, 5)	10.00
32b. Understand the function of a behavior and how it can be linked to treatment interventions	4.60	.548	5.00	4.00-5.00	60.00 (5)	10.00
33. Trained as a trainer for AODA specific evidence-based approaches	4.60	.548	5.00	4.00-5.00	60.00 (5)	30.00
33c. Prepared to teach AODA specific evidence-based approaches	4.60	.548	5.00	4.00-5.00	60.00 (5)	30.00
34. Knowledge of the general supervision process (e.g., Bernard and Goodyear book, etc.)	4.80	.447	5.00	5.00-5.00	80.00 (5)	10.00
35. Knowledge of the supervision process specifically for work in the AODA arena	5.00	.000	5.00	5.00-5.00	100.00 (5)	10.00
36. Knowledge of Powell's integrated model of clinical supervision	4.00	.707	4.00	4.00-4.00	60.00 (4)	10.00
37. Ability to apply Powell's integrated model of clinical supervision	4.00	1.000	4.00	3.00-5.00	40.00 (3, 5)	10.00
38. Awareness of variables including cultural beliefs that can impact the supervision process (e.g., supervisor's attitudes toward AODA)	4.80	.447	5.00	5.00-5.00	80.00 (5)	10.00

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale; Change Rate = % representing stability; Items 1-9 n = 6, Item 10 n = 4, Items 11-115 n = 5.

Table 5 (continued)

Round 5 Results: Descriptive Statistics, Convergence, and Stability

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)	Change Rate
39. Understand factors that enhance or inhibit the relationship between supervisor and supervisee	4.80	.447	5.00	5.00-5.00	80.00 (5)	30.00
40. Competency in the area of crisis management	4.80	.447	5.00	5.00-5.00	80.00 (5)	10.00
41. Competency in the area of conflict resolution	4.80	.447	5.00	5.00-5.00	80.00 (5)	30.00
42. Skill in teaching AODA interventions	5.00	.000	5.00	5.00-5.00	100.00 (5)	30.00
43. Skill in supervising AODA interventions	4.80	.447	5.00	5.00-5.00	80.00 (5)	10.00
44. Skill in harnessing the power of the clinical team to meet organization goals	4.60	.894	5.00	5.00-5.00	80.00 (5)	10.00
45. Skill in collaborating with other providers	4.60	.548	5.00	4.00-5.00	60.00 (5)	30.00
46. Ability to delegate duties ensuring accountability and that plans are empowering and not too burdensome	3.40	1.342	4.00	2.00-4.00	40.00 (2, 4)	10.00
46b. Ability to delegate duties ensuring accountability and empowerment while avoiding overload for the supervisee	4.20	1.095	5.00	3.00-5.00	60.00 (5)	10.00
47. Ability to conceptualize AODA cases	4.00	1.225	4.00	4.00-5.00	40.00 (4, 5)	10.00
47b. Ability to conceptualize AODA client history, progress, needs, and prognosis	4.60	.894	5.00	5.00-5.00	80.00 (5)	10.00
48. Ability to facilitate supervisees' ability to conceptualize AODA cases	4.00	1.225	4.00	4.00-5.00	40.00 (4, 5)	30.00
49. Ability to facilitate AODA case presentations	4.60	.548	5.00	4.00-5.00	60.00 (5)	30.00
50. Skill in using strategies to help supervisees avoid burn-out	4.80	.447	5.00	5.00-5.00	80.00 (5)	10.00
51. Knowledge of licensure and/or certification processes specific for AODA supervisees	4.80	.447	5.00	5.00-5.00	80.00 (5)	10.00

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale; Change Rate = % representing stability; Items 1-9 n = 6, Item 10 n = 4, Items 11-115 n = 5.

Table 5 (continued)

Round 5 Results: Descriptive Statistics, Convergence, and Stability

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)	Change Rate
52. Knowledge of different models, techniques, and practical applications of clinical supervision fundamentals	5.00	.000	5.00	5.00-5.00	100.00 (5)	30.00
53. Understand one's supervisory role in developing novice supervisees	4.80	.447	5.00	5.00-5.00	80.00 (5)	10.00
54. Understand one's supervisory role of helping seasoned supervisees to evolve	4.80	.447	5.00	5.00-5.00	80.00 (5)	30.00
55. Understand the collaborative nature of the supervisory alliance	4.80	.447	5.00	5.00-5.00	80.00 (5)	10.00
56. Attend to the collaborative nature of the supervisory alliance	4.60	.548	5.00	4.00-5.00	60.00 (5)	10.00
57. Facilitate regular structured supervisory sessions	4.80	.447	5.00	5.00-5.00	80.00 (5)	50.00
58. Understand different learning styles	4.00	1.225	4.00	4.00-5.00	40.00 (4, 5)	10.00
59. Respond to different learning styles with different forms of teaching/modeling	4.20	1.304	5.00	4.00-5.00	60.00 (5)	10.00
60. Understanding of quantitative and qualitative appraisal techniques for supervisee progress	4.80	.447	5.00	5.00-5.00	80.00 (5)	10.00
61. Utilization of a mixed methods approach to gain a thorough understanding of the supervisees' progress	4.40	.894	5.00	4.00-5.00	60.00 (5)	30.00
62. Awareness of models for communicating counselor progress appraisal results	4.40	.894	5.00	4.00-5.00	60.00 (5)	10.00
63. Understand models for communicating counselor progress appraisal results	4.20	.837	4.00	4.00-5.00	40.00 (4, 5)	10.00
64. Ability to present critical appraisal and evaluation of supervisees in a practical, non-inflammatory way	4.60	.548	5.00	4.00-5.00	60.00 (5)	10.00

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale; Change Rate = % representing stability; Items 1-9 n = 6, Item 10 n = 4, Items 11-115 n = 5.

Table 5 (continued)

Round 5 Results: Descriptive Statistics, Convergence, and Stability

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)	Change Rate
65. Ability to build rapport with supervisees	4.80	.447	5.00	5.00-5.00	80.00 (5)	10.00
66. Ability to establish rapport with supervisees	4.80	.447	5.00	5.00-5.00	80.00 (5)	10.00
67. Ability to maintain rapport with supervisees	4.80	.447	5.00	5.00-5.00	80.00 (5)	10.00
68. Ability to model desired behaviors (including ethical behaviors)	5.00	.000	5.00	5.00-5.00	100.00 (5)	30.00
68b. Ability to model desired behaviors	5.00	.000	5.00	5.00-5.00	100.00 (5)	10.00
69. Possesses the personal characteristic of empathy	4.80	.447	5.00	5.00-5.00	80.00 (5)	30.00
70. Possesses the personal characteristic of supportiveness	4.80	.447	5.00	5.00-5.00	80.00 (5)	10.00
71. Possesses the personal characteristic of respectfulness	4.60	.548	5.00	4.00-5.00	60.00 (5)	30.00
72. Possesses the personal characteristic of tolerance	4.40	.548	4.00	4.00-5.00	60.00 (4)	30.00
73. Possesses the personal characteristic of valuing diversity	5.00	.000	5.00	5.00-5.00	100.00 (5)	10.00
74. Possesses the personal characteristic of being hopeful	4.80	.447	5.00	5.00-5.00	80.00 (5)	50.00
75. Possesses the personal characteristic of being energetic	4.40	.548	4.00	4.00-5.00	60.00 (4)	30.00
76. Possesses the personal characteristic of diligence	4.20	.447	4.00	4.00-4.00	80.00 (4)	30.00
77. Possesses the personal characteristic of team working skills	4.40	.548	4.00	4.00-5.00	60.00 (4)	30.00
78. Understand the agency mission	4.80	.447	5.00	5.00-5.00	80.00 (5)	10.00
79. Support the agency mission	4.80	.447	5.00	5.00-5.00	80.00 (5)	30.00
80. Make progress toward the agency mission	4.40	.548	4.00	4.00-5.00	60.00 (4)	30.00
81. Adherence to goals	4.60	.548	5.00	4.00-5.00	60.00 (5)	30.00
81b. Adherence to agency goals	4.40	.548	4.00	4.00-5.00	60.00 (4)	10.00
81c. Adherence to personal goals	4.20	.447	4.00	4.00-4.00	80.00 (4)	30.00
81d. Adherence to client goals	4.60	.548	5.00	4.00-5.00	60.00 (5)	30.00

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale; Change Rate = % representing stability; Items 1-9 n = 6, Item 10 n = 4, Items 11-115 n = 5.

Table 5 (continued)

Round 5 Results: Descriptive Statistics, Convergence, and Stability

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)	Change Rate
82. Recognition that organizational or business oriented skills are pivotal for supervisors to possess	4.60	.548	5.00	4.00-5.00	60.00 (5)	10.00
83. Awareness of organizational techniques such as budgeting, record keeping, case retention, human resources management, understanding the use and limits of technology in substance abuse counseling settings, and personnel development procedures	4.80	.447	5.00	5.00-5.00	80.00 (5)	30.00
84. Knowledge of organizational techniques such as budgeting, record keeping, case retention, human resources management, understanding the use and limits of technology in substance abuse counseling settings, and personnel development procedures	4.60	.548	5.00	4.00-5.00	60.00 (5)	10.00
85. Skill in organizational techniques such as budgeting, record keeping, case retention, human resources management, understanding the use and limits of technology in substance abuse counseling settings, and personnel development procedures	4.60	.548	5.00	4.00-5.00	60.00 (5)	50.00
85b. Skill in administrative supervision tasks such as budgeting, record keeping, human resources management etc.	4.40	.548	4.00	4.00-5.00	60.00 (4)	10.00
85c. Understanding the use and limits of technology in AODA counseling settings	4.60	.548	5.00	4.00-5.00	60.00 (5)	10.00

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale; Change Rate = % representing stability; Items 1-9 n = 6, Item 10 n = 4, Items 11-115 n = 5.

Table 5 (continued)

Round 5 Results: Descriptive Statistics, Convergence, and Stability

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)	Change Rate
86. Ensure quality services are provided extending to areas of counseling services, cultural competence, updates with technology, utilization of evidence based practices, in-service training, and program evaluation activities	4.40	.548	4.00	4.00-5.00	60.00 (4)	10.00
87. Knowledge of coexisting disabilities	4.80	.447	5.00	5.00-5.00	80.00 (5)	10.00
88. Knowledge of special populations within the AODA arena	4.80	.447	5.00	5.00-5.00	80.00 (5)	10.00
89. Knowledge of the vast array of resources that can assist both the supervisor and supervisee (e.g. SAMHSA website, NIDA website, NAMI website, etc.)	4.20	.447	4.00	4.00-4.00	80.00 (4)	30.00
90. Ability to teach AODA specific documentation	5.00	.000	5.00	5.00-5.00	100.00 (5)	30.00
91. Ability to supervise AODA specific documentation	5.00	.000	5.00	5.00-5.00	100.00 (5)	10.00
92. Understanding of payment mechanisms in the AODA arena	4.60	.548	5.00	4.00-5.00	60.00 (5)	10.00
93. Awareness of societal views of drug abuse	4.60	.894	5.00	5.00-5.00	80.00 (5)	10.00
94. Knowledge of ethical issues common to treatment of AODA	5.00	.000	5.00	5.00-5.00	100.00 (5)	10.00
95. Demonstrate knowledge of ethical practices in treatment of AODA	4.80	.447	5.00	5.00-5.00	80.00 (5)	10.00
96. Skill in navigating AODA specific legal/ethical issues	5.00	.000	5.00	5.00-5.00	100.00 (5)	10.00
97. Knowledge of state and federal laws related to the treatment of substance abuse clients. Including protection of clients with HIV/AIDS, medical coverage (Medicaid laws, insurance...), mandated reporting...etc.	4.60	.894	5.00	5.00-5.00	80.00 (5)	30.00
97b. Knowledge of state and federal laws related to the treatment of substance abuse clients.	4.80	.447	5.00	5.00-5.00	80.00 (5)	30.00

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale; Change Rate = % representing stability; Items 1-9 n = 6, Item 10 n = 4, Items 11-115 n = 5.

Table 5 (continued)

Round 5 Results: Descriptive Statistics, Convergence, and Stability

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)	Change Rate
98. Understanding of local, state and federal laws as they relate to the everyday business of the agency	5.00	.000	5.00	5.00-5.00	100.00 (5)	10.00
99. Understanding of local, state and federal laws as they relate to the work of the supervisee	5.00	.000	5.00	5.00-5.00	100.00 (5)	30.00
100. Knowledge of confidentiality as it applies to treatment of AODA	4.80	.447	5.00	5.00-5.00	80.00 (5)	30.00
101. Ethical practice which incorporates specific language utilized in treatment	5.00	.000	5.00	5.00-5.00	100.00 (5)	30.00
101b. Utilization of ethical language in treatment	5.00	.000	5.00	5.00-5.00	100.00 (5)	30.00
102. Understanding of agency rules/regulations/policies including those of parent organizations	4.60	.548	5.00	4.00-5.00	60.00 (5)	30.00
103. Adherence to differing rules and regulations	4.40	.548	4.00	4.00-5.00	60.00 (4)	30.00
104. Understand codes of ethics for supervisees which may be in conflict due to an array of credentials held by the supervisee	5.00	.000	5.00	5.00-5.00	100.00 (5)	10.00
105. Understand multiple theories of ethics	4.40	.894	5.00	4.00-5.00	60.00 (5)	10.00
106. Mastery of multiple models of ethical decision making	4.40	.548	4.00	4.00-5.00	60.00 (4)	10.00
107. Teach ethical decision making skills to supervisees	5.00	.000	5.00	5.00-5.00	100.00 (5)	30.00
108. Provide ethical consultative services to the supervisee as needed	5.00	.000	5.00	5.00-5.00	100.00 (5)	30.00
109. Understand the risks of dual roles and relationships with supervisees	4.80	.447	5.00	5.00-5.00	80.00 (5)	30.00
110. Utilization of time management skills	5.00	.000	5.00	5.00-5.00	100.00 (5)	30.00
111. Utilization of communication skills	5.00	.000	5.00	5.00-5.00	100.00 (5)	10.00

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale; Change Rate = % representing stability; Items 1-9 n = 6, Item 10 n = 4, Items 11-115 n = 5.

Table 5 (continued)

Round 5 Results: Descriptive Statistics, Convergence, and Stability

Competency	*M*	*SD*	*Mdn*	IQR	% (Rating)	Change Rate
112. Knowledgeable in dealing with clinical failure (e.g. client relapse, client death, not coming back to treatment sessions)	4.80	.447	5.00	5.00-5.00	80.00 (5)	30.00
113. Knowledgeable in addressing client manipulation	4.80	.447	5.00	5.00-5.00	80.00 (5)	10.00
114. Ability to address questions regarding supervisor's history of substance use or non-use	4.80	.447	5.00	5.00-5.00	80.00 (5)	30.00
115. Skilled in case management domains	4.80	.447	5.00	5.00-5.00	80.00 (5)	30.00

Note. Values are based on a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree); IQR = Tukey's Hinges Interquartile Range; % = Convergence: Highest percentage of panelists endorsing a single rating representing consensus for that competency; Rating: Most frequently selected rating(s) on the 5-point scale; Change Rate = % representing stability; Items 1-9 n = 6, Item 10 n = 4, Items 11-115 n = 5.

Table 6

Results Summary by Round

Result	Round 1	Round 2	Round 3	Round 4	Round 5	Round 5 estimated
Response rate	66.7% (n = 6)	100.0% (n = 6)	100.0% (n = 6)	100.0% (n = 6)	83.3% (n = 5)	-
Competencies (Sub-items)	109	115	115	115 (50)	115 (51)	-
Comments per panelist	-	0-25	0-26	0-3	0-1	-
Total comments	-	40	37	7	1	-
Range of means	-	3.50-4.83	3.50-4.83	3.33-4.83	3.40-5.00	3.33-5.00
Consensus	-	11.9% (n = 13)	19.13% (n = 22)	15.76% (n = 26)	57.23% (n = 95)	24.01% (n = 40)
Stability	-	-	17.34% (n = 19)	53.91% (n = 62)	53.33% (n = 88)	47.88% (n = 79)
Number of days round open	21+3	22	22+1	19+2	22+1	-
Days until next round	2	2	16	19	Discontinued	-

Note. Round 5 estimated based upon assumed Round 4 data to fill incomplete response.

Table 7

Means and Ranks of Competencies Across Rounds

Competency	Round 2		Round3		Round 4		Round 5	
	M	Rank	*M*	Rank	*M*	Rank	*M*	Rank
1. Knowledge of the different drug types (e.g., Cocaine, Oxycontin, Crystal Meth, etc.)	4.33	37	4.50	33	4.50	41	4.50	117
2. Knowledge of the major functions of drugs	4.33	37	4.33	66	4.33	81	4.33	143
3. Knowledge of the drug's impact on the user (e.g., psychological, physical, psychosocial)	4.17	60	4.67	8	4.67	8	4.67	82
4. Knowledge of the drug's impact on persons in the consumer's circle (e.g., family members, peers, employers, etc.)	4.33	37	4.50	33	4.50	41	4.50	117
5. Knowledge of why individuals avoid using drugs	4.17	60	4.33	66	4.17	116	4.17	159
5b. Knowledge of protective features for substance use	-	-	-	-	4.33	81	4.50	117
5c. Knowledge of protective features for substance use such as having a positive support system, utilization of coping skills, uses time for positive activities, etc.	-	-	-	-	-	-	4.17	159
6. Understand the power and many implications of relapse	4.00	82	4.50	33	4.50	41	4.50	117
7. Understand the disease model of addiction	4.17	60	4.33	66	4.50	41	4.50	117
8. Understand the moral model of addiction	4.33	37	4.33	66	4.33	81	4.50	117
8b. Understand the varied models of addiction	-	-	-	-	4.50	41	4.50	117
9. Knowledge of alcohol and other drug abuse specific legal/ethical issues	4.33	37	4.50	33	4.67	8	4.67	82
10. Knowledge of Adult Children of Alcoholics, etc.	4.17	60	4.33	66	4.33	81	4.75	81
11. Knowledge of follow up	4.33	37	4.17	80	4.17	116	4.40	124
11b. Knowledge of follow-up services	-	-	-	-	4.33	81	4.80	36
11c. Knowledge of follow-up for program evaluation purposes	-	-	-	-	4.50	41	4.80	36
11d. Knowledge of the follow-up process	-	-	-	-	4.50	41	4.60	84

Table 7 (continued)

Means and Ranks of Competencies Across Rounds

Competency	Round 2		Round3		Round 4		Round 5	
	M	Rank	*M*	Rank	*M*	Rank	*M*	Rank
12. Advanced skills in AODA counseling, assessment, diagnosis, etc.	4.67	4	4.83	1	4.67	8	4.80	36
13. Content knowledge and skills in assessment	4.33	37	4.67	8	4.33	81	4.60	84
13b. Content knowledge in AODA assessment	-	-	-	-	4.67	8	5.00	1
13c. Skills in AODA assessment	-	-	-	-	4.67	8	4.80	36
14. Content knowledge and skills in diagnosis	4.33	37	4.67	8	4.67	8	5.00	1
14b. Content knowledge in AODA diagnosis	-	-	-	-	4.33	81	4.80	36
14c. Skills in AODA diagnosis	-	-	-	-	4.33	81	5.00	1
15. Content knowledge and skills in treatment	4.33	37	4.67	8	4.50	41	4.80	36
15b. Content knowledge in AODA treatment	-	-	-	-	4.50	41	5.00	1
15c. Skills in AODA treatment	-	-	-	-	4.33	81	4.60	84
16. Content knowledge and skills in detoxification services	4.17	60	4.17	80	4.33	81	4.40	124
16b. Content knowledge of the detoxification process	-	-	-	-	4.17	116	4.60	84
16c. Skills in supporting clients through the detoxification process	-	-	-	-	4.00	145	4.20	144
17. Content knowledge and skills in individual counseling	4.33	37	4.50	33	4.50	41	5.00	1
17b. Content knowledge in individual counseling techniques	-	-	-	-	4.50	41	4.80	36
17c. Skills in individual counseling techniques	-	-	-	-	4.50	41	5.00	1
18. Content knowledge and skills in group work	4.50	17	4.50	33	4.50	41	4.80	36
18b. Content knowledge of group work techniques	-	-	-	-	4.50	41	5.00	1
18c. Skills in group work techniques	-	-	-	-	4.50	41	5.00	1
19. Content knowledge and skills in family work	4.17	60	4.67	8	4.67	8	5.00	1
19b. Content knowledge of family counseling techniques	-	-	-	-	4.33	81	4.40	124
19c. Skills in family counseling techniques	-	-	-	-	4.17	116	4.60	84

Table 7 (continued)

Means and Ranks of Competencies Across Rounds

Competency	Round 2		Round3		Round 4		Round 5	
	M	Rank	*M*	Rank	*M*	Rank	*M*	Rank
20. Knowledge of 12 core functions or knowledge, skills, and abilities (KSAs)	4.17	60	4.00	94	3.83	158	4.20	144
20b. Knowledge of the 12 core functions	-	-	-	-	4.33	81	4.40	124
20c. Knowledge of knowledge, skills, and abilities (KSAs)	-	-	-	-	4.17	116	4.20	144
21. Knowledge of counseling and behavioral techniques used in treatment of AODA	4.50	17	4.67	8	4.67	8	5.00	1
22. Knowledge of evidence-based practices specific to the treatment of AODA	4.50	17	4.00	94	4.50	41	4.80	36
23. Experience in using evidence-based practices specific to the treatment of AODA	4.67	4	4.67	8	4.67	8	5.00	1
24. Knowledge to determine the appropriate treatment modality	4.50	17	4.67	8	4.67	8	5.00	1
25. Knowledge of treatment modalities	4.50	17	4.50	33	4.67	8	5.00	1
26. Content knowledge and skills in outpatient	4.33	37	4.00	94	4.33	81	4.60	84
26b. Content knowledge in providing outpatient level of care	-	-	-	-	4.50	41	4.80	36
26c. Skills in providing AODA counseling within the outpatient level of care	-	-	-	-	4.50	41	5.00	1
26d. Content knowledge of AODA counseling models used within the outpatient level of care	-	-	-	-	4.50	41	5.00	1
26e. Skills in utilizing AODA counseling models within the outpatient level of care	-	-	-	-	4.50	41	5.00	1
27. Content knowledge and skills in inpatient hospital	4.00	82	3.83	105	4.00	145	4.20	144
27b. Content knowledge in providing inpatient hospital level of care	-	-	-	-	4.00	145	4.40	124

Table 7 (continued)

Means and Ranks of Competencies Across Rounds

Competency	Round 2		Round3		Round 4		Round 5	
	M	Rank	*M*	Rank	*M*	Rank	*M*	Rank
27c. Skills in providing inpatient hospital level of care	-	-	-	-	4.17	116	4.20	144
27d. Content knowledge of AODA counseling models used within the inpatient hospital level of care	-	-	-	-	4.33	81	4.60	84
27e. Skills in utilizing AODA counseling models within the inpatient hospital level of care	-	-	-	-	4.00	145	4.40	124
28. Content knowledge and skills in inpatient non-hospital	4.17	60	4.00	94	4.00	145	4.20	144
28b. Content knowledge in providing inpatient non-hospital level of care	-	-	-	-	4.17	116	4.60	84
28c. Skills in providing AODA counseling within the inpatient non-hospital level of care	-	-	-	-	4.17	116	4.60	84
28d. Content knowledge of AODA counseling models used within the inpatient non-hospital level of care	-	-	-	-	4.50	41	4.80	36
28e. Skills in utilizing AODA counseling models within the inpatient non-hospital level of care	-	-	-	-	4.33	81	4.60	84
29. Content knowledge and skills in medication	4.17	60	4.00	94	3.83	158	4.20	144
29b. Content knowledge in medication assisted treatment	-	-	-	-	4.17	116	4.60	84
29c. Skills in providing medication assisted treatment	-	-	-	-	3.83	158	4.20	144
30. Advocate for utilization of evidence-based practices in their specific practice	4.17	60	4.50	33	4.50	41	4.80	36
30b. Advocate for utilization of evidence-based practices	-	-	-	-	4.67	8	4.80	36
31. Ability to locate treatment facilities (e.g. SAMHSA's treatment locator)	4.17	60	4.17	80	4.00	145	4.60	84
31b. Ability to locate treatment facilities	-	-	-	-	4.33	81	4.60	84

Table 7 (continued)

Means and Ranks of Competencies Across Rounds

Competency	Round 2		Round3		Round 4		Round 5	
	M	Rank	*M*	Rank	*M*	Rank	*M*	Rank
32. Understand the function of a behavior (e.g., attention, sensory/automatic reinforcement, avoidance conditioning, gain something tangible. Understand how function is then linked to treatment intervention. A review of Iwata's functional analysis principles will be helpful)	3.50	108	3.67	112	3.83	158	4.20	144
32b. Understand the function of a behavior and how it can be linked to treatment interventions	-	-	-	-	4.33	81	4.60	84
33. Trained as a trainer for AODA specific evidence-based approaches	4.67	4	4.50	33	4.17	116	4.60	84
33b. Received education to teach AODA specific evidence-based approaches	-	-	-	-	4.17	116	4.40	124
33c. Prepared to teach AODA specific evidence-based approaches	-	-	-	-	4.33	81	4.60	84
34. Knowledge of the general supervision process (e.g., Bernard and Goodyear book, etc.)	4.67	4	4.67	8	4.67	8	4.80	36
35. Knowledge of the supervision process specifically for work in the AODA arena	4.50	17	4.50	33	4.83	1	5.00	1
36. Knowledge of Powell's integrated model of clinical supervision	3.83	99	3.83	105	3.83	158	4.00	161
37. Ability to apply Powell's integrated model of clinical supervision	4.00	82	4.00	94	4.00	145	4.00	161
38. Awareness of variables including cultural beliefs that can impact the supervision process (e.g., supervisor's attitudes toward AODA)	4.50	17	4.50	33	4.67	8	4.80	36

Table 7 (continued)

Means and Ranks of Competencies Across Rounds

Competency	Round 2		Round3		Round 4		Round 5	
	M	Rank	*M*	Rank	*M*	Rank	*M*	Rank
39. Understand factors that enhance or inhibit the relationship between supervisor and supervisee	4.50	17	4.50	33	4.50	41	4.80	36
40. Competency in the area of crisis management	4.33	37	4.50	33	4.50	41	4.80	36
41. Competency in the area of conflict resolution	4.17	60	4.33	66	4.33	81	4.80	36
42. Skill in teaching AODA interventions	4.67	4	4.67	8	4.67	8	5.00	1
43. Skill in supervising AODA interventions	4.83	1	4.83	1	4.83	1	4.80	36
44. Skill in harnessing the power of the clinical team to meet organization goals	4.50	17	4.67	8	4.50	41	4.60	84
45. Skill in collaborating with other providers	4.00	82	4.17	80	4.17	116	4.60	84
46. Ability to delegate duties ensuring accountability and that plans are empowering and not too burdensome	3.83	99	3.50	114	3.33	165	3.40	166
46b. Ability to delegate duties ensuring accountability and empowerment while avoiding overload for the supervisee	-	-	-	-	4.17	116	4.20	144
47. Ability to conceptualize AODA cases	3.50	108	3.50	114	3.83	158	4.00	161
47b. Ability to conceptualize AODA client history, progress, needs, and prognosis	-	-	-	-	4.33	81	4.60	84
48. Ability to facilitate supervisees' ability to conceptualize AODA cases	4.00	82	4.00	94	3.83	158	4.00	161
49. Ability to facilitate AODA case presentations	3.83	99	3.83	105	4.17	116	4.60	84
50. Skill in using strategies to help supervisees avoid burn-out	4.67	4	4.67	8	4.67	8	4.80	36
51. Knowledge of licensure and/or certification processes specific for AODA supervisees	4.50	17	4.00	94	4.67	8	4.80	36
52. Knowledge of different models, techniques, and practical applications of clinical supervision fundamentals	4.67	4	4.50	33	4.67	8	5.00	1

Table 7 (continued)

Means and Ranks of Competencies Across Rounds

Competency	Round 2		Round3		Round 4		Round 5	
	M	Rank	*M*	Rank	*M*	Rank	*M*	Rank
53. Understand one's supervisory role in developing novice supervisees	4.67	4	4.67	8	4.83	1	4.80	36
54. Understand one's supervisory role of helping seasoned supervisees to evolve	4.50	17	4.67	8	4.50	41	4.80	36
55. Understand the collaborative nature of the supervisory alliance	4.33	37	4.50	33	4.67	8	4.80	36
56. Attend to the collaborative nature of the supervisory alliance	4.50	17	4.50	33	4.50	41	4.60	84
57. Facilitate regular structured supervisory sessions	4.33	37	4.50	33	4.33	81	4.80	36
58. Understand different learning styles	4.17	60	4.17	80	4.17	116	4.00	161
59. Respond to different learning styles with different forms of teaching/modeling	4.00	82	3.83	105	4.17	116	4.20	144
60. Understanding of quantitative and qualitative appraisal techniques for supervisee progress	4.50	17	4.67	8	4.67	8	4.80	36
61. Utilization of a mixed methods approach to gain a thorough understanding of the supervisees' progress	4.00	82	4.17	80	4.17	116	4.40	124
62. Awareness of models for communicating counselor progress appraisal results	4.00	82	4.17	80	4.33	81	4.40	124
63. Understand models for communicating counselor progress appraisal results	4.00	82	4.33	66	4.17	116	4.20	144
64. Ability to present critical appraisal and evaluation of supervisees in a practical, non-inflammatory way	4.50	17	4.50	33	4.50	41	4.60	84
65. Ability to build rapport with supervisees	4.67	4	4.83	1	4.83	1	4.80	36
66. Ability to establish rapport with supervisees	4.83	1	4.83	1	4.83	1	4.80	36

Table 7 (continued)

Means and Ranks of Competencies Across Rounds

Competency	Round 2		Round3		Round 4		Round 5	
	M	Rank	*M*	Rank	*M*	Rank	*M*	Rank
67. Ability to maintain rapport with supervisees	4.83	1	4.83	1	4.67	8	4.80	36
68. Ability to model desired behaviors (including ethical behaviors)	4.50	17	4.50	33	4.50	41	5.00	1
68b. Ability to model desired behaviors	-	-	-	-	4.67	8	5.00	1
69. Possesses the personal characteristic of empathy	4.17	60	4.50	33	4.33	81	4.80	36
70. Possesses the personal characteristic of supportiveness	4.17	60	4.50	33	4.50	41	4.80	36
71. Possesses the personal characteristic of respectfulness	4.17	60	4.50	33	4.50	41	4.60	84
72. Possesses the personal characteristic of tolerance	4.00	82	4.17	80	4.00	145	4.40	124
73. Possesses the personal characteristic of valuing diversity	4.33	37	4.67	8	4.67	8	5.00	1
74. Possesses the personal characteristic of being hopeful	4.33	37	4.33	66	4.17	116	4.80	36
75. Possesses the personal characteristic of being energetic	4.00	82	3.83	105	4.00	145	4.40	124
76. Possesses the personal characteristic of diligence	3.67	105	4.17	80	4.17	116	4.20	144
77. Possesses the personal characteristic of team working skills	4.00	82	3.83	105	4.00	145	4.40	124
78. Understand the agency mission	4.17	60	4.50	33	4.50	41	4.80	36
79. Support the agency mission	4.17	60	4.33	66	4.33	81	4.80	36
80. Make progress toward the agency mission	4.17	60	4.33	66	4.33	81	4.40	124
81. Adherence to goals	3.83	99	3.83	105	4.00	145	4.60	84
81b. Adherence to agency goals	-	-	-	-	4.17	116	4.40	124
81c. Adherence to personal goals	-	-	-	-	4.17	116	4.20	144
81d. Adherence to client goals	-	-	-	-	4.17	116	4.60	84
82. Recognition that organizational or business oriented skills are pivotal for supervisors to possess	4.33	37	4.50	33	4.50	41	4.60	84

Table 7 (continued)

Means and Ranks of Competencies Across Rounds

Competency	Round 2		Round3		Round 4		Round 5	
	M	Rank	*M*	Rank	*M*	Rank	*M*	Rank
83. Awareness of organizational techniques such as budgeting, record keeping, case retention, human resources management, understanding the use and limits of technology in substance abuse counseling settings, and personnel development procedures	4.00	82	4.00	94	4.17	116	4.80	36
84. Knowledge of organizational techniques such as budgeting, record keeping, case retention, human resources management, understanding the use and limits of technology in substance abuse counseling settings, and personnel development procedures	4.50	17	4.50	33	4.50	41	4.60	84
85. Skill in organizational techniques such as budgeting, record keeping, case retention, human resources management, understanding the use and limits of technology in substance abuse counseling settings, and personnel development procedures	4.17	60	4.17	80	4.00	145	4.60	84
85b. Skill in administrative supervision tasks such as budgeting, record keeping, human resources management etc.	-	-	-	-	4.33	81	4.40	124
85c. Understanding the use and limits of technology in AODA counseling settings	-	-	-	-	4.33	81	4.60	84
86. Ensure quality services are provided extending to areas of counseling services, cultural competence, updates with technology, utilization of evidence based practices, in-service training, and program evaluation activities	4.17	60	4.33	66	4.33	81	4.40	124
87. Knowledge of coexisting disabilities	4.33	37	4.50	33	4.50	41	4.80	36

Table 7 (continued)

Means and Ranks of Competencies Across Rounds

Competency	Round 2		Round3		Round 4		Round 5	
	M	Rank	*M*	Rank	*M*	Rank	*M*	Rank
88. Knowledge of special populations within the AODA arena	4.33	37	4.50	33	4.50	41	4.80	36
89. Knowledge of the vast array of resources that can assist both the supervisor and supervisee (e.g. SAMHSA website, NIDA website, NAMI website, etc.)	4.00	82	4.17	80	4.17	116	4.20	144
90. Ability to teach AODA specific documentation	4.33	37	4.67	8	4.67	8	5.00	1
91. Ability to supervise AODA specific documentation	4.33	37	4.83	1	4.83	1	5.00	1
92. Understanding of payment mechanisms in the AODA arena	4.00	82	4.33	66	4.33	81	4.60	84
93. Awareness of societal views of drug abuse	3.83	99	4.00	94	4.33	81	4.60	84
94. Knowledge of ethical issues common to treatment of AODA	4.50	17	4.67	8	4.67	8	5.00	1
95. Demonstrate knowledge of ethical practices in treatment of AODA	4.33	37	4.50	33	4.50	41	4.80	36
96. Skill in navigating AODA specific legal/ethical issues	4.50	17	4.67	8	4.67	8	5.00	1
97. Knowledge of state and federal laws related to the treatment of substance abuse clients. Including protection of clients with HIV/AIDS, medical coverage (Medicaid laws, insurance...), mandated reporting...etc.	4.50	17	4.50	33	4.17	116	4.60	84
97b. Knowledge of state and federal laws related to the treatment of substance abuse clients.	-	-	-	-	4.67	8	4.80	36
98. Understanding of local, state and federal laws as they relate to the everyday business of the agency	4.17	60	4.67	8	4.67	8	5.00	1

Table 7 (continued)

Means and Ranks of Competencies Across Rounds

Competency	Round 2		Round3		Round 4		Round 5	
	M	Rank	*M*	Rank	*M*	Rank	*M*	Rank
99. Understanding of local, state and federal laws as they relate to the work of the supervisee	4.67	4	4.67	8	4.50	41	5.00	1
100. Knowledge of confidentiality as it applies to treatment of AODA	4.33	37	4.67	8	4.67	8	4.80	36
101. Ethical practice which incorporates specific language utilized in treatment	3.67	105	4.17	80	4.33	81	5.00	1
101b. Utilization of ethical language in treatment	-	-	-	-	4.33	81	5.00	1
102. Understanding of agency rules/regulations/policies including those of parent organizations	4.00	82	4.17	80	4.17	116	4.60	84
103. Adherence to differing rules and regulations	3.83	99	4.00	94	4.00	145	4.40	124
104. Understand codes of ethics for supervisees which may be in conflict due to an array of credentials held by the supervisee	4.67	4	4.83	1	4.83	1	5.00	1
105. Understand multiple theories of ethics	4.00	82	4.33	66	4.17	116	4.40	124
106. Mastery of multiple models of ethical decision making	3.67	105	3.67	112	4.17	116	4.40	124
107. Teach ethical decision making skills to supervisees	4.50	17	4.67	8	4.67	8	5.00	1
108. Provide ethical consultative services to the supervisee as needed	4.67	4	4.67	8	4.67	8	5.00	1
109. Understand the risks of dual roles and relationships with supervisees	4.67	4	4.67	8	4.67	8	4.80	36
110. Utilization of time management skills	-	-	4.50	33	4.50	41	5.00	1
111. Utilization of communication skills	-	-	4.50	33	4.67	8	5.00	1

Table 7 (continued)

Means and Ranks of Competencies Across Rounds

Competency	Round 2		Round3		Round 4		Round 5	
	M	Rank	*M*	Rank	*M*	Rank	*M*	Rank
112. Knowledgeable in dealing with clinical failure (e.g. client relapse, client death, not coming back to treatment sessions)	-	-	4.33	66	4.33	81	4.80	36
113. Knowledgeable in addressing client manipulation	-	-	4.50	33	4.50	41	4.80	36
114. Ability to address questions regarding supervisor's history of substance use or non-use	-	-	4.50	33	4.33	81	4.80	36
115. Skilled in case management domains	-	-	4.17	80	4.33	81	4.80	36

Table 8

Sub-item Means and Ranks

Competency and Sub-items	Round 2		Round3		Round 4		Round 5	
	M	Rank	*M*	Rank	*M*	Rank	*M*	Rank
5. Knowledge of why individuals avoid using drugs	4.17	60	4.33	66	4.17	116	4.17	159
5b. Knowledge of protective features for substance use	-	-	-	-	4.33	81	4.50	117
5c. Knowledge of protective features for substance use such as having a positive support system, utilization of coping skills, uses time for positive activities, etc.	-	-	-	-	-	-	4.17	159
8. Understand the moral model of addiction	4.33	37	4.33	66	4.33	81	4.50	117
8b. Understand the varied models of addiction	-	-	-	-	4.50	41	4.50	117
11. Knowledge of follow up	4.33	37	4.17	80	4.17	116	4.40	124
11b. Knowledge of follow-up services	-	-	-	-	4.33	81	4.80	36
11c. Knowledge of follow-up for program evaluation purposes	-	-	-	-	4.50	41	4.80	36
11d. Knowledge of the follow-up process	-	-	-	-	4.50	41	4.60	84
13. Content knowledge and skills in assessment	4.33	37	4.67	8	4.33	81	4.60	84
13b. Content knowledge in AODA assessment	-	-	-	-	4.67	8	5.00	1
13c. Skills in AODA assessment	-	-	-	-	4.67	8	4.80	36
14. Content knowledge and skills in diagnosis	4.33	37	4.67	8	4.67	8	5.00	1
14b. Content knowledge in AODA diagnosis	-	-	-	-	4.33	81	4.80	36
14c. Skills in AODA diagnosis	-	-	-	-	4.33	81	5.00	1

Table 8 (continued)

Sub-item Means and Ranks

Competency and Sub-items	Round 2		Round3		Round 4		Round 5	
	M	Rank	*M*	Rank	*M*	Rank	*M*	Rank
15. Content knowledge and skills in treatment	4.33	37	4.67	8	4.50	41	4.80	36
15b. Content knowledge in AODA treatment	-	-	-	-	4.50	41	5.00	1
15c. Skills in AODA treatment	-	-	-	-	4.33	81	4.60	84
16. Content knowledge and skills in detoxification services	4.17	60	4.17	80	4.33	81	4.40	124
16b. Content knowledge of the detoxification process	-	-	-	-	4.17	116	4.60	84
16c. Skills in supporting clients through the detoxification process	-	-	-	-	4.00	145	4.20	144
17. Content knowledge and skills in individual counseling	4.33	37	4.50	33	4.50	41	5.00	1
17b. Content knowledge in individual counseling techniques	-	-	-	-	4.50	41	4.80	36
17c. Skills in individual counseling techniques	-	-	-	-	4.50	41	5.00	1
18. Content knowledge and skills in group work	4.50	17	4.50	33	4.50	41	4.80	36
18b. Content knowledge of group work techniques	-	-	-	-	4.50	41	5.00	1
18c. Skills in group work techniques	-	-	-	-	4.50	41	5.00	1
19. Content knowledge and skills in family work	4.17	60	4.67	8	4.67	8	5.00	1
19b. Content knowledge of family counseling techniques	-	-	-	-	4.33	81	4.40	124
19c. Skills in family counseling techniques	-	-	-	-	4.17	116	4.60	84

Table 8 (continued)

Sub-item Means and Ranks

Competency and Sub-items	Round 2		Round3		Round 4		Round 5	
	M	Rank	*M*	Rank	*M*	Rank	*M*	Rank
20. Knowledge of 12 core functions or knowledge, skills, and abilities (KSAs)	4.17	60	4.00	94	3.83	158	4.20	144
20b. Knowledge of the 12 core functions	-	-	-	-	4.33	81	4.40	124
20c. Knowledge of knowledge, skills, and abilities (KSAs)	-	-	-	-	4.17	116	4.20	144
26. Content knowledge and skills in outpatient	4.33	37	4.00	94	4.33	81	4.60	84
26b. Content knowledge in providing outpatient level of care	-	-	-	-	4.50	41	4.80	36
26c. Skills in providing AODA counseling within the outpatient level of care	-	-	-	-	4.50	41	5.00	1
26d. Content knowledge of AODA counseling models used within the outpatient level of care	-	-	-	-	4.50	41	5.00	1
26e. Skills in utilizing AODA counseling models within the outpatient level of care	-	-	-	-	4.50	41	5.00	1
27. Content knowledge and skills in inpatient hospital	4.00	82	3.83	105	4.00	145	4.20	144
27b. Content knowledge in providing inpatient hospital level of care	-	-	-	-	4.00	145	4.40	124
27c. Skills in providing inpatient hospital level of care	-	-	-	-	4.17	116	4.20	144
27d. Content knowledge of AODA counseling models used within the inpatient hospital level of care	-	-	-	-	4.33	81	4.60	84
27e. Skills in utilizing AODA counseling models within the inpatient hospital level of care	-	-	-	-	4.00	145	4.40	124

Table 8 (continued)

Sub-item Means and Ranks

Competency and Sub-items	Round 2		Round3		Round 4		Round 5	
	M	Rank	*M*	Rank	*M*	Rank	*M*	Rank
28. Content knowledge and skills in inpatient non-hospital	4.17	60	4.00	94	4.00	145	4.20	144
28b. Content knowledge in providing inpatient non-hospital level of care	-	-	-	-	4.17	116	4.60	84
28c. Skills in providing AODA counseling within the inpatient non-hospital level of care	-	-	-	-	4.17	116	4.60	84
28d. Content knowledge of AODA counseling models used within the inpatient non-hospital level of care	-	-	-	-	4.50	41	4.80	36
28e. Skills in utilizing AODA counseling models within the inpatient non-hospital level of care	-	-	-	-	4.33	81	4.60	84
29. Content knowledge and skills in medication	4.17	60	4.00	94	3.83	158	4.20	144
29b. Content knowledge in medication assisted treatment	-	-	-	-	4.17	116	4.60	84
29c. Skills in providing medication assisted treatment	-	-	-	-	3.83	158	4.20	144
30. Advocate for utilization of evidence-based practices in their specific practice	4.17	60	4.50	33	4.50	41	4.80	36
30b. Advocate for utilization of evidence-based practices	-	-	-	-	4.67	8	4.80	36
31. Ability to locate treatment facilities (e.g. SAMHSA's treatment locator)	4.17	60	4.17	80	4.00	145	4.60	84
31b. Ability to locate treatment facilities	-	-	-	-	4.33	81	4.60	84

Table 8 (continued)

Sub-item Means and Ranks

Competency and Sub-items	Round 2		Round3		Round 4		Round 5	
	M	Rank	*M*	Rank	*M*	Rank	*M*	Rank
32. Understand the function of a behavior (e.g., attention, sensory/automatic reinforcement, avoidance conditioning, gain something tangible. Understand how function is then linked to treatment intervention. A review of Iwata's functional analysis principles will be helpful)	3.50	108	3.67	112	3.83	158	4.20	144
32b. Understand the function of a behavior and how it can be linked to treatment interventions	-	-	-	-	4.33	81	4.60	84
33. Trained as a trainer for AODA specific evidence-based approaches	4.67	4	4.50	33	4.17	116	4.60	84
33b. Received education to teach AODA specific evidence-based approaches	-	-	-	-	4.17	116	4.40	124
33c. Prepared to teach AODA specific evidence-based approaches	-	-	-	-	4.33	81	4.60	84
46. Ability to delegate duties ensuring accountability and that plans are empowering and not too burdensome	3.83	99	3.50	114	3.33	165	3.40	166
46b. Ability to delegate duties ensuring accountability and empowerment while avoiding overload for the supervisee	-	-	-	-	4.17	116	4.20	144
47. Ability to conceptualize AODA cases	3.50	108	3.50	114	3.83	158	4.00	161
47b. Ability to conceptualize AODA client history, progress, needs, and prognosis	-	-	-	-	4.33	81	4.60	84

Table 8 (continued)

Sub-item Means and Ranks

Competency and Sub-items	Round 2		Round3		Round 4		Round 5	
	M	Rank	*M*	Rank	*M*	Rank	*M*	Rank
68. Ability to model desired behaviors (including ethical behaviors)	4.50	17	4.50	33	4.50	41	5.00	1
68b. Ability to model desired behaviors	-	-	-	-	4.67	8	5.00	1
81. Adherence to goals	3.83	99	3.83	105	4.00	145	4.60	84
81b. Adherence to agency goals	-	-	-	-	4.17	116	4.40	124
81c. Adherence to personal goals	-	-	-	-	4.17	116	4.20	144
81d. Adherence to client goals	-	-	-	-	4.17	116	4.60	84
85. Skill in organizational techniques such as budgeting, record keeping, case retention, human resources management, understanding the use and limits of technology in substance abuse counseling settings, and personnel development procedures	4.17	60	4.17	80	4.00	145	4.60	84
85b. Skill in administrative supervision tasks such as budgeting, record keeping, human resources management etc.	-	-	-	-	4.33	81	4.40	124
85c. Understanding the use and limits of technology in AODA counseling settings	-	-	-	-	4.33	81	4.60	84

Table 8 (continued)

Sub-item Means and Ranks

Competency and Sub-items	Round 2		Round3		Round 4		Round 5	
	M	Rank	*M*	Rank	*M*	Rank	*M*	Rank
97. Knowledge of state and federal laws related to the treatment of substance abuse clients. Including protection of clients with HIV/AIDS, medical coverage (Medicaid laws, insurance...), mandated reporting...etc.	4.50	17	4.50	33	4.17	116	4.60	84
97b. Knowledge of state and federal laws related to the treatment of substance abuse clients.	-	-	-	-	4.67	8	4.80	36
101. Ethical practice which incorporates specific language utilized in treatment	3.67	105	4.17	80	4.33	81	5.00	1
101b. Utilization of ethical language in treatment	-	-	-	-	4.33	81	5.00	1

Table 9

Competencies by Category and Percent of Inter-rater Agreement

Competency	Percent Agreement
Legal and Ethical Concerns (18 items)	
9. Knowledge of alcohol and other drug abuse specific legal/ethical issues	100.0
94. Knowledge of ethical issues common to treatment of AODA	100.0
95. Demonstrate knowledge of ethical practices in treatment of AODA	100.0
96. Skill in navigating AODA specific legal/ethical issues	100.0
97. Knowledge of state and federal laws related to the treatment of substance abuse clients. Including protection of clients with HIV/AIDS, medical coverage (Medicaid laws, insurance...), mandated reporting...etc.	100.0
97b. Knowledge of state and federal laws related to the treatment of substance abuse clients.	100.0
98. Understanding of local, state and federal laws as they relate to the everyday business of the agency	100.0
99. Understanding of local, state and federal laws as they relate to the work of the supervisee	100.0
100. Knowledge of confidentiality as it applies to treatment of AODA	100.0
101. Ethical practice which incorporates specific language utilized in treatment	100.0
101b. Utilization of ethical language in treatment	100.0
103. Adherence to differing rules and regulations	100.0
104. Understand codes of ethics for supervisees which may be in conflict due to an array of credentials held by the supervisee	100.0
105. Understand multiple theories of ethics	100.0
106. Mastery of multiple models of ethical decision making	100.0
107. Teach ethical decision making skills to supervisees	100.0
108. Provide ethical consultative services to the supervisee as needed	100.0
109. Understand the risks of dual roles and relationships with supervisees	66.7
Organizational Management, Administration, and Program Development (20 items)	
11c. Knowledge of follow-up for program evaluation purposes	66.7
30. Advocate for utilization of evidence-based practices in their specific practice	66.7
30b. Advocate for utilization of evidence-based practices	66.7
46. Ability to delegate duties ensuring accountability and that plans are empowering and not too burdensome	66.7
46b. Ability to delegate duties ensuring accountability and empowerment while avoiding overload for the supervisee	66.7
51. Knowledge of licensure and/or certification processes specific for AODA supervisees	100.0
78. Understand the agency mission	100.0

Table 9 (continued)

Competencies by Category and Percent of Inter-rater Agreement

Competency	Percent Agreement
Organizational Management, Administration, and Program Development (continued)	
79. Support the agency mission	66.7
80. Make progress toward the agency mission	66.7
81b. Adherence to agency goals	100.0
82. Recognition that organizational or business oriented skills are pivotal for supervisors to possess	66.7
83. Awareness of organizational techniques such as budgeting, record keeping, case retention, human resources management, understanding the use and limits of technology in substance abuse counseling settings, and personnel development procedures	100.0
84. Knowledge of organizational techniques such as budgeting, record keeping, case retention, human resources management, understanding the use and limits of technology in substance abuse counseling settings, and personnel development procedures	100.0
85. Skill in organizational techniques such as budgeting, record keeping, case retention, human resources management, understanding the use and limits of technology in substance abuse counseling settings, and personnel development procedures	100.0
85b. Skill in administrative supervision tasks such as budgeting, record keeping, human resources management etc.	100.0
85c. Understanding the use and limits of technology in AODA counseling settings	66.7
86. Ensure quality services are provided extending to areas of counseling services, cultural competence, updates with technology, utilization of evidence based practices, in-service training, and program evaluation activities	66.7
92. Understanding of payment mechanisms in the AODA arena	100.0
102. Understanding of agency rules/regulations/policies including those of parent organizations	66.7
115. Skilled in case management domains	66.7
Personal Characteristics and Skills of Leadership (15 items)	
33. Trained as a trainer for AODA specific evidence-based approaches	66.7
44. Skill in harnessing the power of the clinical team to meet organization goals	66.7
45. Skill in collaborating with other providers	66.7
69. Possesses the personal characteristic of empathy	66.7
70. Possesses the personal characteristic of supportiveness	66.7
71. Possesses the personal characteristic of respectfulness	66.7
72. Possesses the personal characteristic of tolerance	66.7

Table 9 (continued)

Competencies by Category and Percent of Inter-rater Agreement

Competency	Percent Agreement
Personal Characteristics and Skills of Leadership (continued)	
73. Possesses the personal characteristic of valuing diversity	66.7
74. Possesses the personal characteristic of being hopeful	66.7
75. Possesses the personal characteristic of being energetic	100.0
76. Possesses the personal characteristic of diligence	100.0
77. Possesses the personal characteristic of team working skills	100.0
81c. Adherence to personal goals	66.7
110. Utilization of time management skills	66.7
111. Utilization of communication skills	66.7
Supervisee Performance Evaluation and Feedback (7 items)	
58. Understand different learning styles	66.7
59. Respond to different learning styles with different forms of teaching/modeling	66.7
60. Understanding of quantitative and qualitative appraisal techniques for supervisee progress	100.0
61. Utilization of a mixed methods approach to gain a thorough understanding of the supervisees' progress	100.0
62. Awareness of models for communicating counselor progress appraisal results	100.0
63. Understand models for communicating counselor progress appraisal results	100.0
64. Ability to present critical appraisal and evaluation of supervisees in a practical, non-inflammatory way	100.0
Supervisory Relationship (10 items)	
38. Awareness of variables including cultural beliefs that can impact the supervision process (e.g., supervisor's attitudes toward AODA)	100.0
39. Understand factors that enhance or inhibit the relationship between supervisor and supervisee	100.0
41. Competency in the area of conflict resolution	66.7
55. Understand the collaborative nature of the supervisory alliance	66.7
56. Attend to the collaborative nature of the supervisory alliance	100.0
65. Ability to build rapport with supervisees	66.7
66. Ability to establish rapport with supervisees	66.7
67. Ability to maintain rapport with supervisees	66.7
81. Adherence to goals	67.7
114. Ability to address questions regarding supervisor's history of substance use or non-use	66.7

Table 9 (continued)

Competencies by Category and Percent of Inter-rater Agreement

Competency	Percent Agreement
Theory, Roles, and Interventions of Clinical Supervision (20 items)	
33b. Received education to teach AODA specific evidence-based approaches	66.7
33c. Prepared to teach AODA specific evidence-based approaches	66.7
34. Knowledge of the general supervision process (e.g., Bernard and Goodyear book, etc.)	100.0
35. Knowledge of the supervision process specifically for work in the AODA arena	100.0
36. Knowledge of Powell's integrated model of clinical supervision	100.0
37. Ability to apply Powell's integrated model of clinical supervision	100.0
42. Skill in teaching AODA interventions	100.0
43. Skill in supervising AODA interventions	100.0
48. Ability to facilitate supervisees' ability to conceptualize AODA cases	66.7
49. Ability to facilitate AODA case presentations	67.7
50. Skill in using strategies to help supervisees avoid burn-out	66.7
52. Knowledge of different models, techniques, and practical applications of clinical supervision fundamentals	100.0
53. Understand one's supervisory role in developing novice supervisees	66.7
54. Understand one's supervisory role of helping seasoned supervisees to evolve	66.7
57. Facilitate regular structured supervisory sessions	66.7
68. Ability to model desired behaviors (including ethical behaviors)	66.7
68b. Ability to model desired behaviors	66.7
89. Knowledge of the vast array of resources that can assist both the supervisor and supervisee (e.g. SAMHSA website, NIDA website, NAMI website, etc.)	66.7
90. Ability to teach AODA specific documentation	66.7
91. Ability to supervise AODA specific documentation	66.7
Treatment Related Knowledge and Skills (76 items)	
1. Knowledge of the different drug types (e.g., Cocaine, Oxycontin, Crystal Meth, etc.)	100.0
2. Knowledge of the major functions of drugs	100.0
3. Knowledge of the drug's impact on the user (e.g., psychological, physical, psychosocial)	100.0
4. Knowledge of the drug's impact on persons in the consumer's circle (e.g., family members, peers, employers, etc.)	100.0
5. Knowledge of why individuals avoid using drugs	100.0
5b. Knowledge of protective features for substance use	100.0

Table 9 (continued)

Competencies by Category and Percent of Inter-rater Agreement

Competency	Percent Agreement
Treatment Related Knowledge and Skills (continued)	
5c. Knowledge of protective features for substance use such as having a positive support system, utilization of coping skills, uses time for positive activities, etc.	100.0
6. Understand the power and many implications of relapse	100.0
7. Understand the disease model of addiction	100.0
8. Understand the moral model of addiction	100.0
8b. Understand the varied models of addiction	100.0
10. Knowledge of Adult Children of Alcoholics, etc.	100.0
11. Knowledge of follow up	100.0
11b. Knowledge of follow-up services	100.0
11d. Knowledge of the follow-up process	66.7
12. Advanced skills in AODA counseling, assessment, diagnosis, etc.	66.7
13. Content knowledge and skills in assessment	100.0
13b. Content knowledge in AODA assessment	100.0
13c. Skills in AODA assessment	100.0
14. Content knowledge and skills in diagnosis	100.0
14b. Content knowledge in AODA diagnosis	100.0
14c. Skills in AODA diagnosis	100.0
15. Content knowledge and skills in treatment	100.0
15b. Content knowledge in AODA treatment	100.0
15c. Skills in AODA treatment	100.0
16. Content knowledge and skills in detoxification services	100.0
16b. Content knowledge of the detoxification process	100.0
16c. Skills in supporting clients through the detoxification process	100.0
17. Content knowledge and skills in individual counseling	100.0
17b. Content knowledge in individual counseling techniques	100.0
17c. Skills in individual counseling techniques	100.0
18. Content knowledge and skills in group work	100.0
18b. Content knowledge of group work techniques	100.0
18c. Skills in group work techniques	100.0
19. Content knowledge and skills in family work	100.0
19b. Content knowledge of family counseling techniques	100.0
19c. Skills in family counseling techniques	100.0
20. Knowledge of 12 core functions or knowledge, skills, and abilities (KSAs)	100.0
20b. Knowledge of the 12 core functions	100.0
20c. Knowledge of knowledge, skills, and abilities (KSAs)	100.0

Table 9 (continued)

Competencies by Category and Percent of Inter-rater Agreement

Competency	Percent Agreement
Treatment Related Knowledge and Skills (continued)	
21. Knowledge of counseling and behavioral techniques used in treatment of AODA	100.0
22. Knowledge of evidence-based practices specific to the treatment of AODA	100.0
23. Experience in using evidence-based practices specific to the treatment of AODA	100.0
24. Knowledge to determine the appropriate treatment modality	100.0
25. Knowledge of treatment modalities	100.0
26. Content knowledge and skills in outpatient	100.0
26b. Content knowledge in providing outpatient level of care	100.0
26c. Skills in providing AODA counseling within the outpatient level of care	100.0
26d. Content knowledge of AODA counseling models used within the outpatient level of care	100.0
26e. Skills in utilizing AODA counseling models within the outpatient level of care	100.0
27. Content knowledge and skills in inpatient hospital	100.0
27b. Content knowledge in providing inpatient hospital level of care	100.0
27c. Skills in providing inpatient hospital level of care	100.0
27d. Content knowledge of AODA counseling models used within the inpatient hospital level of care	100.0
27e. Skills in utilizing AODA counseling models within the inpatient hospital level of care	100.0
28. Content knowledge and skills in inpatient non-hospital	100.0
28b. Content knowledge in providing inpatient non-hospital level of care	100.0
28c. Skills in providing AODA counseling within the inpatient non-hospital level of care	100.0
28d. Content knowledge of AODA counseling models used within the inpatient non-hospital level of care	100.0
28e. Skills in utilizing AODA counseling models within the inpatient non-hospital level of care	100.0
29. Content knowledge and skills in medication	100.0
29b. Content knowledge in medication assisted treatment	100.0
29c. Skills in providing medication assisted treatment	100.0
31. Ability to locate treatment facilities (e.g. SAMHSA's treatment locator)	100.0
31b. Ability to locate treatment facilities	100.0

Table 9 (continued)

Competencies by Category and Percent of Inter-rater Agreement

Competency	Percent Agreement
Treatment Related Knowledge and Skills (continued)	
32. Understand the function of a behavior (e.g., attention, sensory/automatic reinforcement, avoidance conditioning, gain something tangible. Understand how function is then linked to treatment intervention. A review of Iwata's functional analysis principles will be helpful)	100.0
32b. Understand the function of a behavior and how it can be linked to treatment interventions	100.0
40. Competency in the area of crisis management	66.7
47. Ability to conceptualize AODA cases	66.7
47b. Ability to conceptualize AODA client history, progress, needs, and prognosis	66.7
81d. Adherence to client goals	67.7
87. Knowledge of coexisting disabilities	100.0
88. Knowledge of special populations within the AODA arena	100.0
93. Awareness of societal views of drug abuse	66.7
112. Knowledgeable in dealing with clinical failure (e.g. client relapse, client death, not coming back to treatment sessions)	66.7
113. Knowledgeable in addressing client manipulation	100.0

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APPENDICES

Appendix A
Initial Expert Email Invitation

Dear Dr. {LASTNAME},

I am writing to ask for your help in identifying competencies of alcohol and other drug abuse (AODA) clinical supervisors for integration into rehabilitation counselor training programs. You were selected as a potential panelist for the study as it has been suggested that you are one of a small number of professionals who have expert knowledge of AODA clinical supervision competencies as well as rehabilitation counseling.

To be eligible for the present study you must have earned a doctoral degree in rehabilitation counseling or a related field. In addition, you must meet at least two of the five criteria since 2005 (unless otherwise noted) in order to qualify as a panelist.

1. Taught a course focused on alcohol or drug abuse treatment at the undergraduate or graduate school level
2. Published peer reviewed work on the topic of AODA clinical supervision
3. Presented at a national refereed conference on AODA clinical supervision
4. Supervised a minimum of five counselors in training and/or supervisors in training in the AODA field at the graduate school level or in the clinical field
5. Served on an editorial board of a journal and personally reviewed at least two articles pertaining to AODA clinical supervision

This study will gather knowledge of AODA clinical supervision competencies via an online Delphi technique. If you elect to participate as a panelist, I am requesting that you participate in a minimum of three rounds of questionnaires in order to work toward consensus. Please send a copy of you vita to mfmckee@siu.edu to verify that you meet eligibility criteria for the study. **Please provide suggestions of other experts in the field who may meet the above criteria whom would have valuable insight to add to this project even if you yourself choose to not participate in the Delphi rounds.**

Your answers and participation in this study will not be publicly attributed to you. However, at the end of the study you may choose to have your name listed in the acknowledgements of the study. In addition, all participants will receive a final summary report as a thank you for your participation. Your answers from previous rounds will be tracked via a token that will be assigned to you through LimeSurvey® which will be used to conduct the survey. Only my supervising professor and I will have access to the list linking your name to your individualized token which will be destroyed at the conclusion of the study. Your participation is voluntary and you may withdraw without penalty at any time. All reasonable steps will be taken to protect your identity. Questions or comments can be directed to me, Marissa McKee (mfmckee@siu.edu), or my supervising professor Dr. D. Shane Koch, Associate Professor, Rehabilitation Institute, SIUC, MC 4609, Carbondale, IL 62901. Phone: 618-453-8284. Email: dskoch@siu.edu

I hope you will be able to assist me in identifying needed AODA clinical supervision competencies for rehabilitation counselor training. **Please reply back to this email indicating if you meet eligibility criteria and whether you are willing to participate in this study or**

not. In addition please provide your vita within one week if you choose to participate. Please suggest other experts that should be invited to participate in the Delphi study even if you do not choose to participate in the Delphi study. In approximately one month, you will receive an email with either the invitation to complete the Round 1 questionnaire or notification that you were not selected as a panelist.

Sincerely,

Marissa McKee
Doctoral Candidate
Rehabilitation Institute
Southern Illinois University Carbondale
mfmckee@siu.edu

This project has been reviewed and approved by the SIUC Human Subjects Committee. Questions concerning your rights as a participant in this research may be addressed to the Committee Chairperson, Office of Research Development and Administration, Southern Illinois University, Carbondale, IL 62901-4709. Phone 618-453-4533. Email: siuhsc@siu.edu

Appendix B
Initial Email Contact to Suggested Experts

Dear Dr. {LASTNAME},

[Per our phone conversation earlier today/I attempted to reach you by phone but was unable. Thus,] I am writing to ask for your help in identifying competencies of alcohol and other drug abuse (AODA) clinical supervisors for integration into rehabilitation counselor training programs. You were selected as a potential panelist for the study as it has been suggested that you are one of a small number of professionals who have expert knowledge of AODA clinical supervision competencies and rehabilitation counseling.

To be eligible for the present study you must have earned a doctoral degree in rehabilitation counseling or a related field. In addition, you must meet at least two of the five criteria since 2005 (unless otherwise noted) in order to qualify as a panelist.

1. Taught a course focused on alcohol or drug abuse treatment at the undergraduate or graduate school level
2. Published peer reviewed work on the topic of AODA clinical supervision
3. Presented at a national refereed conference on AODA clinical supervision
4. Supervised a minimum of five counselors in training and/or supervisors in training in the AODA field at the graduate school level or in the clinical field
5. Served on an editorial board of a journal and personally reviewed at least two articles pertaining to AODA clinical supervision

This study will gather knowledge of AODA clinical supervision competencies via an online Delphi technique. If you elect to participate as a panelist, I am requesting that you participate in a minimum of three rounds of questionnaires in order to work toward consensus. Please send a copy of you vita to mfmckee@siu.edu to verify that you meet eligibility criteria for the study.

Your answers and participation in this study will not be publicly attributed to you. However, at the end of the study you may choose to have your name listed in the acknowledgements of the study. In addition, all participants will receive a final summary report as a thank you for your participation. Your answers from previous rounds will be tracked via a token that will be assigned to you through LimeSurvey® which will be used to conduct the survey. Only my supervising professor and I will have access to the list linking your name to your individualized token which will be destroyed at the conclusion of the study. Your participation is voluntary and you may withdraw without penalty at any time. All reasonable steps will be taken to protect your identity. Questions or comments can be directed to me, Marissa McKee (mfmckee@siu.edu), or my supervising professor Dr. D. Shane Koch, Associate Professor, Rehabilitation Institute, SIUC, MC 4609, Carbondale, IL 62901. Phone: 618-453-8284. Email: dskoch@siu.edu

I hope you will be able to assist me in identifying needed AODA clinical supervision competencies for rehabilitation counselor training. **Please reply back to this email indicating if you meet eligibility criteria and are willing to participate in this study or not. If so, please provide your vita within one week.**

In approximately two weeks, you will receive an email with either the invitation to complete the Round 1 questionnaire or notification that you were not selected as a panelist.

Sincerely,

Marissa McKee
Doctoral Candidate
Rehabilitation Institute
Southern Illinois University Carbondale
mfmckee@siu.edu

This project has been reviewed and approved by the SIUC Human Subjects Committee. Questions concerning your rights as a participant in this research may be addressed to the Committee Chairperson, Office of Research Development and Administration, Southern Illinois University, Carbondale, IL 62901-4709. Phone 618-453-4533. Email: siuhsc@siu.edu

Appendix C
Round 1 Invitation Email

Dear Dr. {LASTNAME},

You have been selected to participate as a panelist for the survey titled: "Competencies of AODA Clinical Supervisors". This study is an effort to identify competencies of Alcohol and Other Drug Abuse (AODA) Clinical Supervisors as part of my dissertation research at Southern Illinois University Carbondale. You have been selected as a panelist for this Delphi study as you are considered to be an expert in AODA clinical supervision from an educational/research viewpoint. Results from this study will be used to suggest items for inclusion in rehabilitation counselor training curriculum to prepare future AODA clinical supervisors.

As this is a Delphi study, the exact amount of time it will take to participate is unknown, but is estimated to take no more than one hour per round. A minimum of three rounds of the Delphi will be completed electronically via LimeSurvey®. Please note, if you do not complete a round of the study, you will not be asked to complete subsequent rounds. Your answers and participation in this study will not be publicly attributed to you. Your answers from previous rounds will be tracked via a token that will be assigned to you through LimeSurvey®. Only my supervising professor and I will have access to the list linking your name to your individualized token which will be destroyed at the conclusion of the study. Your participation is voluntary and you may withdraw without penalty at any time. All reasonable steps will be taken to protect your identity.

If you have any questions or comments about this study, I would be happy to speak with you. If you chose to withdraw at any time, you may do so by contacting me directly so I may remove you from future mailings. Questions or comments can be directed to me, Marissa McKee (mfmckee@siu.edu), or my supervising professor Dr. D. Shane Koch, Associate Professor, Rehabilitation Institute, SIUC, MC 4609, Carbondale, IL 62901. Phone: 618-453-8284. Email: dskoch@siu.edu.

Please click here to complete the survey: Round 1: Competencies of AODA Clinical Supervisors

Sincerely,

Marissa McKee
Doctoral Candidate
Rehabilitation Institute
Southern Illinois University Carbondale
mfmckee@siu.edu

This project has been reviewed and approved by the SIUC Human Subjects Committee. Questions concerning your rights as a participant in this research may be addressed to the Committee Chairperson, Office of Research Development and Administration, Southern Illinois University, Carbondale, IL 62901-4709. Phone 618-453-4533. Email: siuhsc@siu.edu

Appendix D
Round 1 Questionnaire Sample Screen Shots

Round 1: Competencies of AODA Clinical Supervisors

This is a controlled survey. You need a valid token to participate.
If you have been issued a token, please enter it in the box below and click continue.

Token

Continue

*

This study is an effort to identify competencies of Alcohol and Other Drug Abuse (AODA) Clinical Supervisors as part of my dissertation research at Southern Illinois University Carbondale. You have been selected as a panelist for this Delphi study as you are considered to be an expert in AODA clinical supervision from an educational/research viewpoint. Results from this study will be used to suggest items for inclusion in rehabilitation counselor training curriculum to prepare future AODA clinical supervisors.

As this is a Delphi study, the exact amount of time it will take to participate is unknown. A minimum of three rounds of the Delphi will be completed electronically via LimeSurvey®. Please note, if you do not complete a round of the study, you will not be asked to complete subsequent rounds. Your answers and participation in this study will not be publicly attributed to you. Your answers from previous rounds will be tracked via a token that will be assigned to you through LimeSurvey®. Only my superivising professor and I will have access to the list linking your name to your individualized token. All reasonable steps will be taken to protect your identity.

If you have any questions or comments about this study, I would be happy to speak with you. Questions or comments can be directed to me, Marissa McKee (mfmckee@siu.edu), or my supervising professor Dr. D. Shane Koch, Associate Professor, Rehabilitation Institute, SIUC, MC 4609, Carbondale, IL 62901. Phone: 618-453-8284. Email: dskoch@siu.edu

By answering yes below, you are providing your voluntary informed consent to participate as a panelist in this study. If you chose to withdraw at any time, you may do so by contacting me directly so I may remove you from future mailings.

This project has been reviewed and approved by the SIUC Human Subjects Committee. Questions concerning your rights as a participant in this research may be addressed to the Committee Chairperson, Office of Research Development and Administration, Southern Illinois University, Carbondale, IL 62901-4709. Phone 618-453-4533. Email: siuhsc@siu.edu

○ Yes ○ No

Load unfinished survey | Resume later | Submit | [Exit and clear survey]

○ Female ○ Male

As of December 1, 2010, how old will you be?

Which of the following best describes your racial/ethnic background?

Choose one of the following answers

- ○ White
- ○ Black or African American
- ○ Hispanic or Latino
- ○ American Indian or Alaska Native
- ○ Asian
- ○ Native Hawaiian or other Pacific Islander
- ○ Some other race
- ○ Two or more races

What state are you currently employed in?

Please develop and write below a list below of competencies specific to alcohol and other drug abuse clinical supervisors that should be included in rehabilitation counselor training programs. Please include knowledge, skills, abilities or personal characteristics. Please do not include competencies that could be generalized to other types of clinical supervision (e.g., social work, psychology, rehabilitation counseling, and mental health counseling). You may provide any comments or explanation that you wish with the knowledge that your comments may be included in future rounds of the survey to clarify or assist others. Your individual responses will not be publically attributed to you in subsequent rounds or in the published results.

Load unfinished survey | Resume later | Submit | [Exit and clear survey]

Appendix E
Round 1 Final Follow-up Email

Dear Dr. {LASTNAME},

You recently received an invitation to participate in a survey titled: "Competencies of AODA Clinical Supervisors." This study is an effort to identify competencies of Alcohol and Other Drug Abuse (AODA) Clinical Supervisors as part of my dissertation research at Southern Illinois University Carbondale. **Your response is very valuable as you are one of only a few individuals across the country that is an expert in this area of study.**

We note that you have not yet completed the survey, and want to inform you that the survey availability **has been extended until Friday April 8, 2011**. Please assist us in identifying competencies of AODA clinical supervisors in order to better prepare rehabilitation counseling students for clinical practices.

Please click here to complete the survey: Round 1: Competencies of AODA Clinical Supervisors. As a reminder, your personal token needed to access the survey is {TOKEN}.

Sincerely,

Marissa McKee
Doctoral Candidate
Rehabilitation Institute
Southern Illinois University Carbondale
mfmckee@siu.edu

This project has been reviewed and approved by the SIUC Human Subjects Committee. Questions concerning your rights as a participant in this research may be addressed to the Committee Chairperson, Office of Research Development and Administration, Southern Illinois University, Carbondale, IL 62901-4709. Phone 618-453-4533. Email: siuhsc@siu.edu

Appendix F
Memo

- Construed "Why do people use drugs?" as "Knowledge of why individuals use drugs"
- Construed "Why do people avoid using drugs?" as "Knowledge of why individuals avoid using drugs"
- Construed "What are the major functions of drugs?" as "Knowledge of major drug functions"
- Construed "Understand the function of a behavior (e.g., attention, sensory/automatic reinforcement,Avoidance conditioning, gain someting tangible- Understand how function is then linked to treatment intervention. A review of Iwata\'s functional analysis principles will be helpful)" as "Understand the function of a behavior (e.g., attention, sensory/automatic reinforcement, avoidance conditioning, gain something tangible. Understand how function is then linked to treatment intervention. A review of Iwata's functional analysis principles will be helpful)"
- Edited and split "Knowledge to determine appropriate treatment modality. Then, be able to locate this facilty. For example, SAMHSA\'s treatment locator could be used." To "Knowledge to determine the appropriate treatment modality" "Ability to locate treatment facilities."
- Construed "How does society view drug abuse?" as "Awareness of societal views of drug abuse"
- Combined "knowledge of AODA credentials" and "Knowledge of processes for licensure and/or certification specific for AODA counselors." into "Knowledge of processes for licensure and/or certification specific for AODA counselors"
- Combined and split "Evidenced based practices" and "Knowledge of and experience using evidence-based practices specific to the treatment of substance abuse" into "Knowledge of using evidence-based practices specific to the treatment of substance abuse" and "Experience in using evidence-based practices specific to the treatment of substance abuse"
- Construed "Clinical supervision fundamentals: Including different models, techniques and practical applications." as "Knowledge of different models, techniques, and practical applications of clinical supervision fundamentals."
- Split "Knowledge of the drug's impact on the user (e.g., psychological, physical, psychosocial) and persons in the consumer's circle (e.g., family members, peers, employers, etc.) into "Knowledge of the drug's impact on the user (e.g., psychological, physical, psychosocial)" and "Knowledge of the drug's impact on persons in the consumer's circle (e.g., family members, peers, employers, etc.)"
- Construed "What variables can impact the supervision process (e.g., supervisor's attitudes towards substance abuse) as "Awareness of variables that can impact the supervision process (e.g., supervisor's attitudes toward substance abuse)"
- Construed "Counseling and behavioral techniques used to treat SUD" as "Knowledge of counseling and behavioral techniques used to treat SUD"
- Construed "Payment mechanisms in the SUD arena" as "Understanding of payment mechanisms in the SUD arena"
- Construed "Confidentiality and SUD" as "Knowledge of confidentiality as it applies to SUD treatment"

- Split “Skill in teaching and supervising AODA interventions” into “Skill in teaching AODA interventions” and “Skill in supervising AODA interventions”
- Construed and Split “Leadership of AODA clinical teams and collaboration with other providers” into “Skill in leading AODA clinical teams” and “Skill in collaborating with other providers”
- Split “Ability to teach and supervise AODA specific documentation” into “Ability to teach AODA specific documentation” and “Ability to supervise AODA specific documentation”
- Split “Ability to conceptualize and facilitate counselors' ability to conceptualize AODA cases” into “Ability to conceptualize AODA cases” and “Ability to facilitate counselors' ability to conceptualize AODA cases”
- Split “Knowledge of and ability to apply Powell's integrated model of clinical supervision” into “Knowledge of Powell's integrated model of clinical supervision” and “Ability to apply Powell's integrated model of clinical supervision”
- Construed “training in how to train others to use evidence-based approaches specific to substance abuse” as “Recipient of training in how to train others to use evidence-based approaches specific to substance abuse“
- Construed “Strategies to help supervisees avoid burn-out (There is a lot of turn-over among substance abuse counselors).” as “Skill in using strategies to help supervisees avoid burn-out”
- Combined “At least a minimum awareness for the supervisor as to how their own cultural beliefs towards “AODA will impact their supervision style or their relationship with their supervisee” and “Awareness of variables that can impact the supervision process (e.g., supervisor's attitudes toward substance abuse)” into “Awareness of variables including cultural beliefs that can impact the supervision process (e.g., supervisor's attitudes toward substance abuse)”
- Split “Competency in the area of crisis management and conflict resolution” into “Competency in crisis management” and “Competency in conflict resolution”
- Construed and split “Clinical supervision fundamentals: Supervisors need to understand their role in developing novice counselors as well as helping seasoned counselors to evolve.” into ”Understand one’s supervisory role in developing novice counselors” and “Understand one’s supervisor role helping seasoned counselors to evolve”
- Construed “Clinical supervision fundamentals: Development might include regular structured supervisory sessions” as “Facilitate regular structured supervisory sessions”
- Split “Understanding and responding to different learning styles with different forms of teaching/modeling” into “Understand different learning styles” and “Respond to different learning styles with different forms of teaching/modeling”
- Split and construed “Appraisal techniques: An obvious part of supervision is evaluating the progress that supervisees are making. As such a supervisor needs to be familiar with different forms of appraisal and evaluation of subordinates: Quantitative and qualitative techniques should be explored and understood by the supervisor.” As “Understand quantitative and qualitative appraisal techniques for supervisee progress” and “Exploration of quantitative and qualitative appraisal techniques for supervisee progress”
- Construed “Appraisal techniques: An obvious part of supervision is evaluating the progress that supervisees are making. As such a supervisor needs to be familiar with different forms of appraisal and evaluation of subordinates: Similarly a mixed-method

approach is paramount to gaining a thorough understanding of the counselors' progress." as "Utilization of a mixed methods approach to gain a thorough understanding of the counselors' progress."

- Split and construed "Appraisal techniques: An obvious part of supervision is evaluating the progress that supervisees are making. As such a supervisor needs to be familiar with different forms of appraisal and evaluation of subordinates: Providing accurate and useful feedback is an often difficult step; being able to present critical results in a practical non-inflammatory way can be difficult. Multiple methods exist for communicating appraisal results and supervisors should be aware of and having an understanding for the different models." as "Awareness of models for communicating counselor progress appraisal results" "Understand models for communicating counselor progress appraisal results" And "Ability to present critical appraisal and evaluation of subordinates in a practical, non-inflammatory way."
- Split and construed "Building, establishing, and maintaining rapport with supervisees is paramount. You can't simply tell counselors what to do to improve; supervisors must be able to model the desired behaviors effectively." as "Ability to build rapport with supervisees" "Ability to establish rapport with supervisees" "Ability to maintain rapport with supervisees" and "Ability to model desired behaviors"
- Construed "Similarly leadership requires the supervisor to harness the power of the clinical team to meet the organizational goals. These could differ significantly depending on what type of agency and funding streams. For example, a non-profit agency may draw financial lines from multiple sources. In that case there could be several sets of organizational goals that need to be tended to. A state funded only facility may only need to adhere to that state's department of health (or related services) goals." as "Harness the power of the clinical team to meet the organization goals."
- Combined "Harness the power of the clinical team to meet the organization goals." and "Skill in leading AODA clinical teams" into "Skill in harnessing the power of the clinical team to meet organization goals"
- Construed and split "supporting and making progress towards the agency mission should be well understood" into "Understand the agency mission" "Support the agency mission" "Make progress toward the agency mission"
- Construed and split "Not only adhering to goals, but also differing rules & regulations is an important part of supervision." As "Adherence to differing rules & regulations" and "Adherence to goals"
- Construed "Delegating duties should be addressed as well, but similar to most interdisciplinary treatment plans, the supervisor needs to ensure accountability exists and that plans are empowering and not too burdensome." as "Ability to delegate duties ensuring accountability and that plans are empowering and not too burdensome"

Split and construed "Understanding and attending to the collaborative nature of the alliance." into "Understand the collaborative nature of the supervisory alliance" and "Attend to the collaborative nature of the supervisory alliance"

- Construed "demonstrating a thorough knowledge of ethical practices in substance abuse counseling" into "Demonstrate knowledge of ethical practices in substance abuse counseling"

- Combined “modeling appropriate ethical behaviors” and “Ability to model desired behaviors” into “Ability to model desired behaviors (including ethical behaviors)”
- Construed “Recognize that organizational or business oriented skills are pivotal for supervisors to possess.” as “Recognition that organizational or business oriented skills are pivotal for supervisors to possess”
- Split “Understanding of local, state and federal laws as they relate to the everyday business of the agency and the work of counselors” into “Understanding of local, state and federal laws as they relate to the everyday business of the agency” and “Understanding of local, state and federal laws as they relate the work of counselor”
- Construed “Have a thorough understanding of relevant codes of ethics for supervisees. Often a supervisor may oversee substance abuse counselors with an array of credentials. Each of those credentials have ethics codes and occasionally may be in conflict.” as “Understand codes of ethics for supervisees which may be in conflict due to an array of credentials held by the supervisee”
- Construed “Other functions under organizational techniques include: budgeting, record keeping, case retention, human resources management, understanding the use and limits of technology in substance abuse counseling settings, and personnel development procedures.” as “Knowledge of organizational techniques such as budgeting, record keeping,[…]” “Awareness of organizational techniques such as budgeting, record keeping,[…]” and “Skill in organizational techniques such as budgeting, record keeping,[…]”
- Split and construed “understanding of several theories of ethics as well as mastery of several models of ethical decision making.” as “Understand multiple theories of ethics” and “Mastery of multiple models of ethical decision making”
- Construed “the supervisor is in a role to offer this assistance to subordinates” as “Provide ethical consultative services to the subordinate as needed”
- Construed “supervisor needs to stay abreast of the latest evidence-based approaches as well as how to advocate for those and to implement them into their specific practice” as “Advocate for utilization of evidence-based practices in their specific practice” as well as combined the original statement into “Knowledge of using evidence-based practices specific to the treatment of substance abuse”
- Construed “ensure that quality services are being provided. This extends into the areas of counseling services, cultural competence, updates with technology, utilization of evidence-based practices, in-service training, and program evaluation activities” as “Ensure quality services are provided extending to areas of counseling services, cultural competence, updates with technology, utilization of evidence-based practices, in-service training, and program evaluation activities”
- Split “Knowledge of the supervision process in general (e.g., Bernard and Goodyear book, etc) and then more specifically for supervisors working in the substance abuse arena” into “Knowledge of the supervision process in general (e.g., Bernard and Goodyear book, etc)” and “Knowledge of the supervision process more specifically for supervisors working in the substance abuse arena”
- Combined “subordinate” “supervisee” “counselor” and “student” into “supervisee”
- Combined “treatment of substance abuse” “treat SUD” “alcohol and other drug treatment” “substance abuse counseling” and “SUD treatment” into “treatment of AODA”

- Combined “substance abuse” and “AODA” into “AODA”
- Split “Understand the disease and moral models of addiction” into “Understand the disease model of addition” and “Understand the moral model of addiction”
- Construed “Education re:” as “Knowledge of”
- Combined “Knowledge of Legal Aspects” into “Knowledge of AODA specific legal/ethical issues”
- Construed “Personal characteristics: […]” as “Possesses personal characteristic of being […]”
- Split “Competency is the area of crisis management and conflict resolution” to “Competency in the area of crisis management” and “Competency in the area of conflict resolution”

Following Round 2:

- Spelled out “AODA” as “alcohol and other drug abuse”
- Spelled out “ACOA” as Adult Children of Alcoholics”
- Spelled out “KSA” as “knowledge, skills, and abilities”
- Reworded “Recipient of training in how to train others to use evidence-based approaches specific to AODA“ to “Trained as a trainer for AODA specific evidence-based approaches”
- Reworded “Knowledge of the supervision process in general (e.g., Bernard and Goodyear book, etc.)” to “Knowledge of the general supervision process (e.g., Bernard and Goodyear book, etc.)”
- Reworded “Possesses the personal characteristic of being empathetic” to “Possesses the personal characteristic of empathy”
- Reworded “Possesses the personal characteristic of being supportive” to ” Possesses the personal characteristic of supportiveness”
- Reworded “Possesses the personal characteristic of being respectful” to “Possesses the personal characteristic of respectfulness”
- Reworded “Possesses the personal characteristic of being tolerant” to “Possesses the personal characteristic of tolerance”
- Reworded “Possesses the personal characteristic of being hard working” to “Possesses the personal characteristic of diligence”
- Construed Time management skills and communication skills as “Utilization of time management skills” and “Utilization of communication skills”
- Construed “I would involve one section on how to deal with clincal failure or client relapse. Maybe death. How many clients never come back to session? Address that. Some counselors like to have a clean cut ending. As you know, that certainly is not the case with drug abuse.” as “Knowledgeable in dealing with clinical failure (e.g. client relapse, client death, not coming back to treatment sessions)”
- Construed “How about how to address manipulation. That is rampid with this population.” as “Knowledgeable in addressing client manipulation”
- Construed “How to address questions regarding the superviors drug or lack of drug past/history.” as “Ability to address questions regarding supervisor’s history of substance use or non-use”

Following Round 3:

- Construed “protective features” as “protective factors for substance use”
- Reworded “Understand the power of relapse” into “Understand the power and implications of relapse”
- “Understand the moral model of addiction” multiplied into “Understand the moral model of addiction” and “Understand varied models of addiction”
- “ Knowledge of follow up” multiplied into “Knowledge of follow up” “Knowledge of follow-up services” “Knowledge of follow-up for program evaluation purpose” and “Knowledge of the follow-up process”
- “Content knowledge and skills in assessment” multiplied into “Content knowledge and skills in assessment” “Content knowledge of AODA assessment” “Skills in AODA assessment”
- “Content knowledge and skills in diagnosis” multiplied into “Content knowledge and skills in diagnosis” “Content knowledge in AODA diagnosis” and “Skills in AODA diagnosis”
- “Content knowledge and skills in treatment” multiplied into “Content knowledge and skills in treatment” and “Content knowledge in AODA treatment” and “Skills in AODA treatment”
- “Content knowledge and skills in detox” multiplied into “Content knowledge and skills in detox” “Content knowledge of the detoxification process” and “Skills in supporting clients through the detoxification process”
- “Content knowledge and skills in individual counseling” multiplied into “Content knowledge and skills in individual counseling” “Content knowledge of individual counseling techniques” and “Skills in individual counseling techniques”
- “Content knowledge and skills in group work” multiplied into “Content knowledge and skills in group work” “Content knowledge of group work techniques” and “Skills in group work techniques”
- “Content knowledge and skills in family work” multiplied into “Content knowledge and skills in family work” “Content knowledge of family counseling techniques” and “Skills in family counseling techniques”
- “Knowledge of 12 core functions or knowledge, skills, and abilities (KSAs) ” multiplied into “Knowledge of 12 core functions or knowledge, skills, and abilities (KSAs) ” “Knowledge of the 12 core functions” and “Knowledge of knowledge, skills, and abilities (KSAs)”
- Reworded “Knowledge of using evidence-based practices specific to the treatment of AODA “ into Knowledge of evidence-based practices specific to the treatment of AODA”
- “Content knowledge and skills in outpatient” multiplied into “Content knowledge and skills in outpatient” “Content knowledge in providing outpatient level of care” “Skills in providing AODA counseling within the Outpatient Level of Care” “Content knowledge of AODA counseling models used within the outpatient level of care” and “Skills in utilizing AODA counseling models within the outpatient level of care”
- “Content knowledge and skills in inpatient hospital” multiplied into “Content knowledge and skills in inpatient hospital” “Content knowledge in providing inpatient hospital level of care” “Skills in providing AODA counseling within the inpatient hospital level of care” “Content knowledge of AODA counseling models used within the inpatient

hospital level of care" and "Skills in utilizing AODA counseling models within the inpatient hospital level of care"

- "Content knowledge and skills in inpatient non-hospital" multiplied into "Content knowledge and skills in inpatient non-hospital" "Content knowledge in providing inpatient non-hospital level of care" "Skills in providing AODA counseling within the inpatient non-hospital level of care" "Content knowledge of AODA counseling models used within the inpatient non-hospital level of care" and "Skills in utilizing AODA counseling models within the inpatient non-hospital level of care"
- "Content knowledge and skills in medication" multiplied into "Content knowledge and skills in medication" "Content knowledge in medication assisted treatment" and "Skills in providing medication assisted treatment"
- "Advocate for utilization of evidence-based practices in their specific practice" multiplied into "Advocate for utilization of evidence-based practices in their specific practice" and "Advocate for utilization of evidence-based practices"
- "Ability to locate treatment facilities (e.g. SAMHSA's treatment locator)" multiplied into "Ability to locate treatment facilities (e.g. SAMHSA's treatment locator)" and "Ability to locate treatment facilities"
- Multiplied "Understand the function of a behavior (e.g., attention, sensory/automatic reinforcement, avoidance conditioning, gain something tangible. Understand how function is then linked to treatment intervention. A review of Iwata's functional analysis principles will be helpful)" into "Understand the function of a behavior (e.g., attention, sensory/automatic reinforcement, avoidance conditioning, gain something tangible. Understand how function is then linked to treatment intervention. A review of Iwata's functional analysis principles will be helpful)" and "Understand the function of a behavior and how it can be linked to treatment interventions"
- Multiplied "Trained as a trainer for AODA specific evidence-based approaches" into "Trained as a trainer for AODA specific evidence-based approaches" and "Received education to teach AODA specific evidence-based approaches"
- Reworded "Knowledge of the supervision process more specifically for supervisors working in the AODA arena" into "Knowledge of the supervision process specifically for work in the AODA arena"
- "Ability to delegate duties ensuring accountability and that plans are empowering and not too burdensome" multiplied into "Ability to delegate duties ensuring accountability and that plans are empowering and not too burdensome " and "Ability to delegate duties ensuring accountability and empowerment while avoiding overload for the supervisee"
- "Ability to conceptualize AODA cases" multiplied into "Ability to conceptualize AODA cases" and "Ability to conceptualize AODA client history, progress, needs, and prognosis"
- Reworded "Knowledge of processes for licensure and/or certification specific for AODA supervisees" into "Knowledge of licensure and/or certification processes specific to AODA supervisees"
- Multiplied "Ability to model desired behaviors (including ethical behaviors)" into "Ability to model desired behaviors (including ethical behaviors)" and "Ability to model desired behaviors"
- "Possesses the personal characteristic of good team working skills" into "Possesses the personal characteristic of team working skills"

- “Adherence to goals” multiplied into “Adherence to goals” “Adherence to agency goals” “Adherence to personal goals” and “Adherence to client goals”
- “Skill in organizational techniques such as budgeting, record keeping, case retention, human resources management, understanding the use and limits of technology in substance abuse counseling settings, and personnel development procedures” multiplied into “Skill in organizational techniques such as budgeting, record keeping, case retention, human resources management, understanding the use and limits of technology in substance abuse counseling settings, and personnel development procedures” “Skill in administrative supervision tasks such as budgeting, record keeping, human resources management etc.” and “Understanding the use and limits of technology in AODA counseling settings”
- “Knowledge of state and federal laws related to the treatment of substance abuse clients. Including protection of clients with HIV/AIDS, medical coverage (Medicaid laws, insurance...), mandated reporting...etc.” multiplied into “Knowledge of state and federal laws related to the treatment of substance abuse clients. Including protection of clients with HIV/AIDS, medical coverage (Medicaid laws, insurance...), mandated reporting...etc.” and “Knowledge of state and federal laws related to the treatment of substance abuse clients.”
- “Ethical practice which incorporates specific language utilized in treatment” multiplied into “Ethical practice which incorporates specific language utilized in treatment” and “Utilization of ethical language in treatment”

Following Round 4:

- “Knowledge of protective features for substance use” multiplied into “Knowledge of protective features for substance use “ and “Knowledge of protective features for substance use such as having a positive support system, utilization of coping skills, uses time for positive activities, etc.”

Appendix G

Round 2 Invitation Email

Dear Dr. {LASTNAME},

Thank you for your responses in the first round of the Delphi study titled: "Competencies of AODA Clinical Supervisors." The Round 1 responses have been collated in order to develop the Round 2 survey. Please click the link below, read the instructions, and then complete the Round 2 survey. Your responses are vital in assisting us in determining competencies needed in rehabilitation counselor training programs. **The survey will be available until Monday, May 2, 2011. As soon as all responses have been received, the responses will be collated and the Round 3 survey will commence as I am aware the end of the semester is drawing near.**

Please note that a technological error was reported in the first round. If you receive a message stating your token has already been used, please try again. If you continue to receive this message please notify me so I may assist you. The survey is set so you may access your responses at a later time so that message should not occur.

Click here to complete the survey: Round 2: Competencies of AODA Clinical Supervisors. Your individualized token to access the survey is {TOKEN}.

Sincerely,

Marissa McKee
Doctoral Candidate
Rehabilitation Institute
Southern Illinois University Carbondale
mfmckee@siu.edu

This project has been reviewed and approved by the SIUC Human Subjects Committee. Questions concerning your rights as a participant in this research may be addressed to the Committee Chairperson, Office of Research Development and Administration, Southern Illinois University, Carbondale, IL 62901-4709. Phone 618-453-4533. Email: siuhsc@siu.edu

Appendix H
Round 2 Questionnaire Sample Screen Shots

Round 2: Competencies of AODA Clinical Supervisors

This study is an effort to identify competencies of Alcohol and Other Drug Abuse (AODA) Clinical Supervisors as part of my dissertation research at Southern Illinois University Carbondale. You have been selected as a panelist for this Delphi study as you are considered to be an expert in AODA clinical supervision from an educational/research viewpoint. Results from this study will be used to suggest items for inclusion in rehabilitation counselor training curriculum to prepare future AODA clinical supervisors.

As this is a Delphi study, the exact amount of time it will take to participate is unknown. **Please note that you are able to save your response and complete the survey round at a later time.** A minimum of three rounds of the Delphi will be completed electronically via LimeSurvey®. Please note, if you do not complete a round of the study, you will not be asked to complete subsequent rounds. Your answers and participation in this study will not be publicly attributed to you. Your answers from previous rounds will be tracked via a token that will be assigned to you through LimeSurvey®. Only my supervising professor and I will have access to the list linking your name to your individualized token which will be destroyed at the conclusion of the study. Your participation is voluntary and you may withdraw without penalty at any time. All reasonable steps will be taken to protect your identity.

If you have any questions or comments about this study, I would be happy to speak with you. Questions or comments can be directed to me, Marissa McKee (mfmckee@siu.edu), or my supervising professor Dr. D. Shane Koch, Associate Professor, Rehabilitation Institute, SIUC, MC 4609, Carbondale, IL 62901. Phone: 618-453-8284 . Email: dskoch@siu.edu

By entering this survey, you are providing your voluntary informed consent to participate as a panelist in this study. If you chose to withdraw at any time, you may do so by contacting me directly so I may remove you from future mailings.

This project has been reviewed and approved by the SIUC Human Subjects Committee. Questions concerning your rights as a participant in this research may be addressed to the Committee Chairperson, Office of Research Development and Administration, Southern Illinois University, Carbondale, IL 62901-4709. Phone 618-453-4533 . Email: siuhsc@siu.edu

Load unfinished survey | Next >> | [Exit and clear survey]

Round 2: Competencies of AODA Clinical Supervisors

0% 100%

Please rate your level of agreement for each competency on a five point Likert scale as to <u>whether the item listed is a competency specific to AODA clinical supervisors.</u>

Please provide any wording suggestions or explanations of your ratings in the box below each Likert scale.

	1 = Strongly disagree	2 = Disagree	3 = Neither agree nor disagree	4 = Agree	5 = Strongly agree
1. Knowledge of the different drug types (e.g., Cocaine, Oxycontin, Crystal Meth, etc.)	○	○	○	○	○

	1 = Strongly disagree	2 = Disagree	3 = Neither agree nor disagree	4 = Agree	5 = Strongly agree
2. Knowledge of the major functions of drugs	○	○	○	○	○

. . .

Please suggest up to 5 other competencies specific to AODA Clinical Supervisors that were not mentioned above.

Resume later | << Previous | Submit | [Exit and clear survey]

Appendix I
Round 2 Follow-up Email

Dear Dr. {LASTNAME},

Thank you for your responses in the first round of the Delphi study titled: "Competencies of AODA Clinical Supervisors." We have yet to receive your responses for Round 2 of this Delphi study.

The Round 1 responses have been collated in order to develop the Round 2 survey. Please click the link below, read the instructions, and then complete the Round 2 survey. Your responses are vital in assisting us in determining competencies needed in rehabilitation counselor training programs. **The survey will be available until Monday, May 2, 2011. As soon as all responses have been received, the responses will be collated and the Round 3 survey will commence as I am aware the end of the semester is drawing near.**

Please click here to complete the survey: Round 2: Competencies of AODA Clinical Supervisors .Your individualized token to access the survey is **{TOKEN}**

Sincerely,

Marissa McKee
Doctoral Candidate
Rehabilitation Institute
Southern Illinois University Carbondale
mfmckee@siu.edu

This project has been reviewed and approved by the SIUC Human Subjects Committee. Questions concerning your rights as a participant in this research may be addressed to the Committee Chairperson, Office of Research Development and Administration, Southern Illinois University, Carbondale, IL 62901-4709. Phone 618-453-4533. Email: siuhsc@siu.edu

Appendix J
Round 3 Invitation Email

Dear Dr. {LASTNAME},

Thank you for your responses in the previous rounds of the Delphi study titled: "Competencies of AODA Clinical Supervisors." The Round 2 responses have been analyzed in order to develop the Round 3 survey. Please click the link below, read the instructions, and complete the Round 3 survey. Your responses are vital in assisting us in determining competencies needed in rehabilitation counselor training programs. The survey will be available until May 26, 2011. There is the potential for this to be the final round of the Delphi. You will receive email notification when the study has concluded.

Your individualized token needed to access the survey is **{TOKEN}**. Please click here to complete the survey: Round 3: Competencies of AODA Clinical Supervisors.

Please do not hesitate to contact me with any questions, including difficulties with the survey software.

Sincerely,

Marissa McKee
Doctoral Candidate
Rehabilitation Institute
Southern Illinois University Carbondale
mfmckee@siu.edu

This project has been reviewed and approved by the SIUC Human Subjects Committee. Questions concerning your rights as a participant in this research may be addressed to the Committee Chairperson, Office of Research Development and Administration, Southern Illinois University, Carbondale, IL 62901-4709. Phone 618-453-4533. Email: siuhsc@siu.edu

Appendix K
Round 3 Questionnaire Sample Screen Shots

Round 3: Competencies of AODA Clinical Supervisors

0% 100%

Please review your previous rating, group comments, and the group responses. Then, rate your level of agreement for each competency on a five point Likert scale as to whether the item listed is a competency specific to AODA clinical supervisors.

Please provide any wording suggestions or explanations of your ratings in the box below each Likert scale especially if your rating falls outside of the interquartile range.

1. Your previous response:

Group comments: (a) Counselors as well as supervisors, and other AODA need to know this information.

Group responses:

Mean	Standard Deviation	Median	Interquartile Range
4.33	1.211	5	4.00-5.00

Response	Frequency	Percent
2 = Disagree	1	16.7
4 = Agree	1	16.7
5 = Strongly agree	4	66.7

	1 = Strongly disagree	2 = Disagree	3 = Neither agree nor disagree	4 = Agree	5 = Strongly agree
1. Knowledge of the different drug types (e.g., Cocaine, Oxycontin, Crystal Meth, etc.)	○	○	○	○	○

2. Your previous response:

Group comments: (a) Counselors as well as supervisors, and other AODA need to know this information. (b) What is meant by "major functions" of drugs? Is that different than the impact on the user? Below question. (c) This I think is vital because a person teaching these classes or working with supervisees need to know how these drugs have an impact on the body ...

Group responses:

Mean	Standard Deviation	Median	Interquartile Range
4.33	1.211	5	4.00-5.00

Response	Frequency	Percent
2 = Disagree	1	16.7
4 = Agree	1	16.7
5 = Strongly agree	4	66.7

	1 = Strongly disagree	2 = Disagree	3 = Neither agree nor disagree	4 = Agree	5 = Strongly agree
2. Knowledge of the major functions of drugs	○	○	○	○	○

Appendix L
Round 3 Follow-up Email

Dear Dr. {LASTNAME},

Thank you for your responses in the previous rounds of the Delphi study titled: "Competencies of AODA Clinical Supervisors." The Round 2 responses have been analyzed in order to develop the Round 3 survey. Please click the link below, read the instructions, and complete the Round 3 survey. Your responses are vital in assisting us in determining competencies needed in rehabilitation counselor training programs. The survey will be available until **May 26, 2011.** There is the potential for this to be the final round of the Delphi. You will receive email notification when the study has concluded.

Your individualized token needed to access the survey is {TOKEN}. Please click here to complete the survey: Round 3: Competencies of AODA Clinical Supervisors.

Please do not hesitate to contact me with any questions, including difficulties with the survey software.

Sincerely,

Marissa McKee
Doctoral Candidate
Rehabilitation Institute
Southern Illinois University Carbondale
mfmckee@siu.edu

This project has been reviewed and approved by the SIUC Human Subjects Committee. Questions concerning your rights as a participant in this research may be addressed to the Committee Chairperson, Office of Research Development and Administration, Southern Illinois University, Carbondale, IL 62901-4709. Phone 618-453-4533. Email: siuhsc@siu.edu

Appendix M
Round 4 Invitation Email

Dear Dr. {LASTNAME},

Thank you for your responses in the previous rounds of the Delphi study titled: "Competencies of AODA Clinical Supervisors." The Round 3 responses have been analyzed in order to develop the Round 4 survey. Please click the link below, read the instructions, and complete the Round 4 survey. Your responses are vital in assisting us in determining competencies needed in rehabilitation counselor training programs. **The survey will be available through July 1, 2011**. There is the potential for this to be the final round of the Delphi dependent on a predetermined level of consensus or stability of responses. You will receive email notification when the study has concluded.

Your individualized token needed to access the survey is **{TOKEN}.** Please click here to complete the survey: Round 4: Competencies of AODA Clinical Supervisors.

Please do not hesitate to contact me with any questions, including difficulties with the survey software.

Sincerely,

Marissa McKee
Doctoral Candidate
Rehabilitation Institute
Southern Illinois University Carbondale
mfmckee@siu.edu

This project has been reviewed and approved by the SIUC Human Subjects Committee. Questions concerning your rights as a participant in this research may be addressed to the Committee Chairperson, Office of Research Development and Administration, Southern Illinois University, Carbondale, IL 62901-4709. Phone 618-453-4533. Email: siuhsc@siu.edu

Appendix N
Round 4 Questionnaire Sample Screen Shots

Round 4: Competencies of AODA Clinical Supervisors

0% 100%

Please review your previous rating, group comments, and the group responses.
Then, rate your level of agreement for each competency on a five point Likert scale as to whether the item listed is a competency specific to AODA clinical supervisors.

Please provide any wording suggestions or explanations of your ratings in the box below each Likert scale especially if your rating falls outside of the interquartile range.

1. Your previous response:

Group comments:

Group responses:

Mean	Standard Deviation	Median	Interquartile Range
4.50	.837	5	4.00-5.00

Response	Frequency	Percent
3 = Neither agree nor disagree	1	16.7
4 = Agree	1	16.7
5 = Strongly agree	4	66.7

	1 = Strongly disagree	2 = Disagree	3 = Neither agree nor disagree	4 = Agree	5 = Strongly agree
1. Knowledge of the different drug types (e.g., Cocaine, Oxycontin, Crystal Meth, etc.)	○	○	○	○	○

2. Your previous response:

Group comments: a) The point about "functions" is noted. Are we saying pharmacological, pharmacodynamic, behavioral, funcitons??

Group responses:

Mean	Standard Deviation	Median	Interquartile Range
4.33	.816	4.5	4.00-5.00

Response	Frequency	Percent
3 = Neither agree nor disagree	1	16.7
4 = Agree	2	33.3
5 = Strongly agree	3	50.0

	1 = Strongly disagree	2 = Disagree	3 = Neither agree nor disagree	4 = Agree	5 = Strongly agree
2. Knowledge of the major functions of drugs	○	○	○	○	○

Appendix O
Round 4 Final Follow-up Email

Dear Dr. {LASTNAME},

Thank you for your responses in the previous rounds of the Delphi study titled: "Competencies of AODA Clinical Supervisors." The Round 3 responses have been analyzed in order to develop the Round 4 survey. Please click the link below, read the instructions, and complete the Round 4 survey. Your responses are vital in assisting us in determining competencies needed in rehabilitation counselor training programs. There is the potential for this to be the final round of the Delphi. You will receive email notification when the study has concluded. The survey was originally scheduled to conclude on July 1, 2011. However, due to a technology glitch for another panelist, I am keeping the survey round open until July 6, 2011. Thus, you have another chance to respond as well.

Your individualized token needed to access the survey is **{TOKEN}.** Please click here to complete the survey: Round 4: Competencies of AODA Clinical Supervisors.

Please do not hesitate to contact me with any questions, including difficulties with the survey software.

Sincerely,

Marissa McKee
Doctoral Candidate
Rehabilitation Institute
Southern Illinois University Carbondale
mfmckee@siu.edu

This project has been reviewed and approved by the SIUC Human Subjects Committee. Questions concerning your rights as a participant in this research may be addressed to the Committee Chairperson, Office of Research Development and Administration, Southern Illinois University, Carbondale, IL 62901-4709. Phone 618-453-4533. Email: siuhsc@siu.edu

Appendix P
Round 5 Invitation Email

Dear Dr. {LASTNAME},

Thank you for your responses in the previous rounds of the Delphi study titled: "Competencies of AODA Clinical Supervisors." The Round 4 responses have been analyzed in order to develop the Round 4 survey. Please click the link below, read the instructions, and complete the Round 5 survey. Your responses are vital in assisting us in determining competencies needed in rehabilitation counselor training programs. **The survey will be available through August 12, 2011**. There is the potential for this to be the final round of the Delphi dependent on a predetermined level of consensus or stability of responses. You will receive email notification when the study has concluded.

Your individualized token needed to access the survey is **{TOKEN}**. Please click here to complete the survey: Round 5: Competencies of AODA Clinical Supervisors.

Please do not hesitate to contact me with any questions, including difficulties with the survey software.

Sincerely,

Marissa McKee
Doctoral Candidate
Rehabilitation Institute
Southern Illinois University Carbondale
mfmckee@siu.edu

This project has been reviewed and approved by the SIUC Human Subjects Committee. Questions concerning your rights as a participant in this research may be addressed to the Committee Chairperson, Office of Research Development and Administration, Southern Illinois University, Carbondale, IL 62901-4709. Phone 618-453-4533. Email: siuhsc@siu.edu

Appendix Q
Round 5 Questionnaire Sample Screen Shots

Round 5: Competencies of AODA Clinical Supervisors

0% 100%

Please review your previous rating, group comments, and the group responses.
Then, rate your level of agreement for each competency on a five point Likert scale as to
whether the item listed is a competency specific to AODA clinical supervisors.

Please provide any wording suggestions or explanations of your ratings in the box below each Likert scale especially if your rating falls outside of the interquartile range.

1. Your previous response: 1

Group comments:a) I am confused by the question because such knowledge is not specific to AODA clinical supervisors; other clinicians need such knowledge. Thus, I put 3= neither agree/disagree for these

Group responses:

Mean	Standard Deviation	Median	Interquartile Range
4.50	.837	5.0	4.00-5.00

Response	Frequency	Percent
3 = Neither agree nor disagree	1	16.7
4 = Agree	1	16.7
5 = Strongly agree	4	66.7

	1 = Strongly disagree	2 = Disagree	3 = Neither agree nor disagree	4 = Agree	5 = Strongly agree
1. Knowledge of the different drug types (e.g., Cocaine, Oxycontin, Crystal Meth, etc.)	○	○	○	○	○

2. Your previous response: 2

Group comments: a) See comments for question 1.

Group responses:

Mean	Standard Deviation	Median	Interquartile Range
4.33	.816	4.5	4.00-5.00

Response	Frequency	Percent
3 = Neither agree nor disagree	1	16.7
4 = Agree	2	33.3
5 = Strongly agree	3	50.0

	1 = Strongly disagree	2 = Disagree	3 = Neither agree nor disagree	4 = Agree	5 = Strongly agree
2. Knowledge of the major functions of drugs	○	○	○	○	○

Appendix R
Round 5 Follow-up Email

Dear Dr. {LASTNAME},

Thank you for your responses in the previous rounds of the Delphi study titled: "Competencies of AODA Clinical Supervisors." The Round 4 responses have been analyzed in order to develop the Round 5 survey. Please click the link below, read the instructions, and complete the Round 5 survey. Your responses are vital in assisting us in determining competencies needed in rehabilitation counselor training programs. There is the potential for this to be the final round of the Delphi. You will receive email notification when the study has concluded. Round 5 will be available until August 12, 2011.

Your individualized token needed to access the survey is **{TOKEN}**. Please click here to complete the survey: Round 5: Competencies of AODA Clinical Supervisors.

Please do not hesitate to contact me with any questions, including difficulties with the survey software.

Sincerely,

Marissa McKee
Doctoral Candidate
Rehabilitation Institute
Southern Illinois University Carbondale
mfmckee@siu.edu

This project has been reviewed and approved by the SIUC Human Subjects Committee. Questions concerning your rights as a participant in this research may be addressed to the Committee Chairperson, Office of Research Development and Administration, Southern Illinois University, Carbondale, IL 62901-4709. Phone 618-453-4533. Email: siuhsc@siu.edu

Appendix S
Study Completion Email

Hello!

As a result of the most recent round of the survey "Competencies of AODA Clinical Supervisors," **no further data will be collected**. Thank you for your participation in this valuable study!

The summary report of the research will be emailed to you upon its completion.

Please reply to this email and indicate whether you would like your name included in the acknowledgements of this study as a panelist. If so, please state how you would like your name presented (e.g. first and middle initials, first name and middle initial, title, etc.).

Sincerely,

Marissa F. McKee
Doctoral Candidate
Rehabilitation Institute
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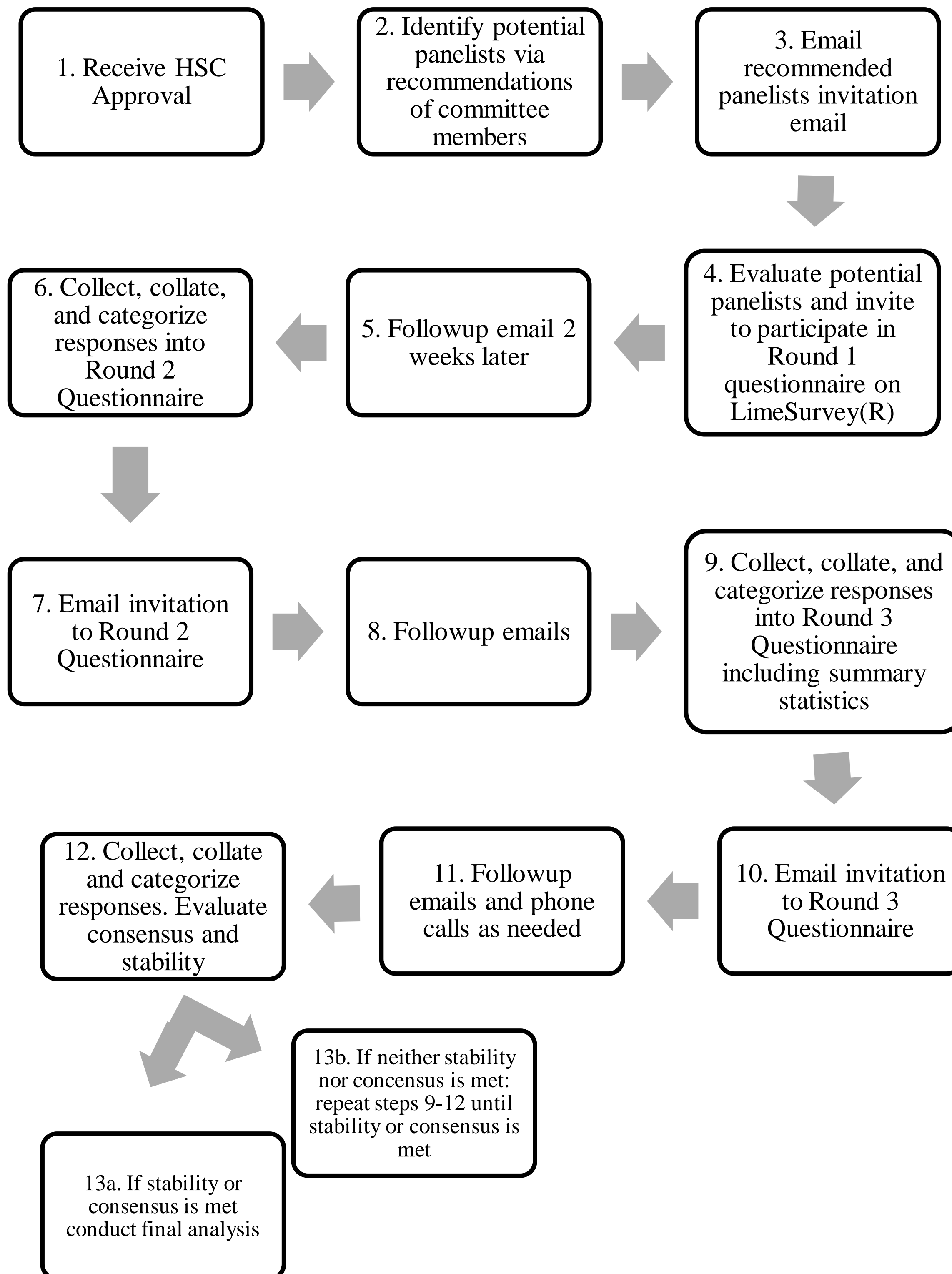
This project has been reviewed and approved by the SIUC Human Subjects Committee. Questions concerning your rights as a participant in this research may be addressed to the Committee Chairperson, Office of Research Development and Administration, Southern Illinois University, Carbondale, IL 62901-4709. Phone 618-453-4533. Email: siuhsc@siu.edu

Appendix T
Revised Methods Flow Chart



VITA

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McKendree College
Bachelor of Arts, Psychology, May 2005

Arkansas State University
Master of Rehabilitation Counseling, May 2007

Special Honors and Awards:
- Graduate School Tuition Scholarship
- Golden Key International Honor Society
- Doctoral Fellowship (awarded, but did not accept)
- Lorenz/Baker Student Award

Dissertation Title:
Identifying Competencies of AODA Clinical Supervisors for Integration into Rehabilitation Counselor Training Curriculum: A Delphi Study

Major Professor: Darwin Shane Koch, Rh.D.

Publications:
Peer Reviewed Publications:

Davis, S. J., Koch, D. S, McKee, M. F., & Nelipovich, M. (2009). AODA training experiences of blindness professionals. *Journal of Teaching in the Addictions*, *8*(1). 42-50. doi**:** 10.1080/15332700903396614

McKee, M. F., Boston, Q., & Dallas, B. (2009). Multiple supervisory relationships in AODA counseling: A need for organizational ethics. *Journal of Rehabilitation Administration*, *33*(1), 33-43.

McKee, M. F., Pearce, A. R., & Breeding, R. R. (2009). Developing a GRE review workshop: Assessing needs for persons with and without disabilities. *American Journal of Psychological Research, 5*(1), 20-30.

Non-Refereed Publications:
Article

Heern, M. F. (2005, Winter). The potential for alcohol abuse among first year college students. *Scholars: The McKendree College Journal of Undergraduate Research,* Issue 5. Retrieved from http://faculty.mckendree.edu/scholars/winter2005/heern.htm

Technical and Research Reports

Davis, S. J., McKee, M., Johnson, A., & Koch, D. S. (2008). *HIV needs assessment: Evaluation report.* Carbondale, IL: Rehabilitation Institute at Southern Illinois University.

Davis, S. J., McKee, M. F., & Koch, D. S. (2007). *HIV needs assessment: 30 day report.* Carbondale, IL: Rehabilitation Institute at Southern Illinois University.

Davis, S. J., McKee, M. F., & Koch, D. S. (2007). *The Matrix of Hope: Client characteristics six month report.* Carbondale, IL: Rehabilitation Institute at Southern Illinois University.