MASSACHUSETTS BOARD OF SUBSTANCE ABUSE COUNSELOR CERTIFICATION, INC.

MBSACC

CLINICAL SUPERVISOR EVALUATION FORM

CONFIDENTIAL

TO BE COMPLETED BY APPLICANT

APPLICANT'S NAME: ____________________________________ *DATE:* __________________
(PLEASE PRINT)

I authorize the Massachusetts Board of Substance Abuse Counselor Certification to seek additional information about my work and counseling skills from the evaluator listed below.

______________________________ ______________________________
PRINT NAME OF CLINICAL SUPERVISOR APPLICANT'S SIGNATURE

I hereby waive my right to inspect this evaluation form and any subsequent information provided by the evaluator in connection with my application for Certification.

____
APPLICANT'S SIGNATURE

To the Clinical Supervisor:

The individual named above is applying to the Massachusetts Board of Substance Abuse Counselor Certification (MBSACC) for certification as a substance abuse counselor (CAC, CADC, or CADC-II). The information requested from you is an essential part of the Board's evaluation of the competence of this applicant, and this completed form must be on file before the application can be reviewed and processed.

The Board believes that your evaluation from direct observation and supervision of the applicant's work will contribute to a more complete and accurate impression of the knowledge and skill of the applicant. The Board appreciates your accurate and truthful reporting. This form is considered by the Board to be ***confidential****. As Supervisor, you may keep a photocopy of this evaluation for your files, but you must* ***not*** *provide a copy of this form, nor disclose its contents, to the applicant. You must mail it directly back to MBSACC. Failure to comply with this directive could void the entire application. MBSACC thanks you for your cooperation.*

PLEASE MAIL THIS EVALUATION DIRECTLY TO MBSACC AT:

MBSACC, 560 Lincoln St., P.O. Box 7070, Worcester, MA 01605

CLINICAL SUPERVISOR EVALUATION FORM **PART – A –**

SUPERVISOR'S NAME: ______________________

SUPERVISOR'S JOB TITLE: ______________________

CURRENT AGENCY NAME & ADDRESS: ______________________

AGENCY PHONE # (PLEASE INCLUDE AREA CODE): (   ) ______________________

HIGHEST DEGREE HELD: ______________________

STATE LINCENSE(S)/CERTIFICATIONS HELD: ______________________

RELATIONSHIP TO APPLICANT (PLEASE CHECK AS MANY AS APPLY):

- ❑ CONSULTANT
- ❑ PAST SUPERVISOR
- ❑ PRESENT SUPERVISOR
- ❑ OTHER (PLEASE SPECIFY) ______________________

AGENCY WHERE SUPERVISION OCCURRED (PLEASE INCLUDE ADDRESS): ______________________

WAS THIS AGENCY LICENSED? ❑ Y ❑ N   AS A SUBSTANCE ABUSE TREATMENT AGENCY?: ❑ Y ❑ N

IF NOT SUBSTANCE ABUSE TREATMENT, PLEASE SPECIFY (BELOW) TYPE OF LICENSED AGENCY:

____

YOUR POSITION AT TIME OF SUPERVISION: ______________________

APPLICANT'S POSITION AT TIME OF SUPERVISION: ______________________

SUPERVISION OF THE APPLICANT'S WORK OCCURRED:

FROM: ____________ (MONTH/YEAR)   TO: ____________ (MONTH/YEAR)

NUMBER OF DIRECT (FACE-TO-FACE) SUPERVISED HOURS PER WEEK FOR PERIOD LISTED ABOVE: ________

AVERAGE NUMBER OF HOURS APPLICANT WORKED PER WEEK: ____________

TOTAL NUMBER OF HOURS PER WEEK IN DIRECT CLIENT SUBSTANCE ABUSE COUNSELING: ______________
DO *NOT* INCLUDE HOURS THAT ARE NOT SPECIFICALLY SPENT IN COUNSELING (I.E., STAFF MEETINGS, TRAININGS, ETC.)

WHAT IS/WAS THE SIZE OF THE APPLICANT'S CASE LOAD? ______________

AVERAGE NUMBER OF HOURS PER WEEK OF SUBSTANCE ABUSE COUNSELING PROVIDED IN THE FOLLOWING AREAS:

INDIVIDUAL COUNSELING ________   GROUP COUNSELING _______   FAMILY/SIGNIFICANT OTHER COUNSELING ________

PERCENTAGE OF TIME SPENT IN THE FOLLOWING CASELOAD AREAS:

PRIMARY DIAGNOSIS OF ALCOHOLISM/DRUG ABUSE __________%

PRIMARY DIAGNOSIS OF OTHER _________%   (PLEASE SPECIFY) ______________________

SECONDARY DIAGNOSIS OF ALCOHOLISM/DRUG ABUSE _________%

IN THE LINES BELOW, PLEASE PROVIDE A BRIEF DESCRIPTION OF THE APPLICANT'S PRIMARY JOB RESPONSIBLITIES AS AN ALCOHOL/ DRUG ABUSE COUNSELOR AT THE TIME OF SUPERVISION:

____

____

____

DESCRIBE BELOW THE PROCEDURE USED IN SUPERVISION WITH THE APPLICANT. YOUR COMMENTS IN THIS PORTION ARE CONSIDERED ***VERY*** *IMPORTANT. PLEASE COMPLETE THIS SECTION CAREFULLY.*

CLINICAL SUPERVISOR EVALUATION FORM **PART – C –**

PLEASE READ THE STATEMENTS BELOW WHICH DESCRIBE VARIOUS SKILLS NEEDED BY A SUBSTANCE ABUSE COUNSELOR. RATE THE APPLICANT'S ABILITY USING THE FOLLOWING SCALE, AND PLACE AN APPROPRIATE NUMBER VALUE ON THE BLANK TO THE RIGHT OF EACH STATEMENT.

SCORING SCALE:

0 = NO BASIS FOR JUDGEMENT	***2 = NEEDS IMPROVEMENT***	***4 = ABOVE AVERAGE***
1 = INADEQUATE	***3 = COMPETENT***	***5 = OUTSTANDING***

I. SCREENING –

1. *EVALUATE PSYCHOLOGICAL, SOCIAL, AND PHYSIOLOGICAL SIGNS AND SYSMPTOMS OF ALCOHOL AND OTHER DRUG ABUSE.* ________
2. *DETERMINE THE CLIENT'S APPROPRIATENESS FOR ADMISSION OR REFERRAL.* ________
3. *DETERMINE THE CLIENT'S ELIGIBILITY FOR ADMISSION OR REFERRAL* ________
4. *IDENTIFY ANY COEXISTING CONDITIONS (I.E., MEDICAL, PSYCHIATRIC, PHYSICAL, ETC.) THAT INDICATE NEED FOR ADDITIONAL PROFESSIONAL ASSESSMENT AND/OTR SERVICES.* ________
5. *ADHERE TO APPLICABLE LAWS, REGULATIONS, AND AGENCY POLICIES GOVERNING ALCOHOL AND OTHER DRUG ABUSE SERVICES.* ________

II. INTAKE –

1. *COMPLETE REQUIRED DOCUMENTS FOR ADMISSION TO THE PROGRAM.* ________
2. *COMPLETE REQUIRED DOCUMENTS FOR PROGRAM ELIGIBILITY AND APPROPRIATENESS.* ________
3. *OBTAIN APPROPRIATELY SIGNED CONSENTS WHEN SOLICITING FROM OR PROVIDING INFORMATION TO OUTSIDE SOURCES IN ORDER TO PROTECT CLIENT CONFIDENTIALITY AND RIGHTS.* ________

III. ORIENTATION –

1. *PROVIDE AN OVERVIEW TO THE CLIENT BY DESCRIBING PROGRAM GOALS AND OBJECTIVES FOR CLIENT CARE.* ________
2. *PROVIDE AN OVERVIEW TO THE CLIENT BY DESCRIBING PROGRAM RULES AND CLIENT OBLIGATIONS AND RIGHTS.* ________
3. *PROVIDE AN OVERVIEW TO THE CLIENT OF PROGRAM OPERATIONS.* ________

IV. ASSESSMENT –

1. *GATHER RELEVANT HISTORY FROM THE CLIENT INCLUDING, BUT NOT LIMITED TO, ALCOHOL AND OTHER DRUG ABUSE USING APPROPRIATE INTERVIEW TECHNIQUES.* ________
2. *IDENTIFY METHODS AND PROCEDURES FOR OBTAINING CORROBORATIVE INFORMATION FROM SIGNIFICANT SOURCES REGARDING CLIENT'S ALCOHOL AND OTHER DRUG ABUSE AND PSYCHOLOGICAL HISTORY.* ________
3. *IDENTIFY APPROPRIATE ASSESSMENT TOOLS.* ________
4. *EXPLAIN TO THE CLIENT THE RATIONALE FOR THE USE OF ASSESSMENT TECHINIQUES IN ORDER TO FACILITATE UNDERSTANDING.* ________
5. *DEVELOP A DIAGNOSTIC EVALUATION OF THE CLIENT'S SUBSTANCE ABUSE AND ANY COEXISTING CONDITIONS BASED ON THE RESULTS OF ALL ASSESSMENTS IN ORDER TO PROVIDE AND INTEGRATED APPROACH TO TREATMENT PLANNING BASED ON THE CLIENT'S STRENGTHS, WEAKNESSES, AND IDENTIFIED PROBLEMS AND NEEDS.* ________

V. TREATMENT PLANNING –

1. *EXPLAIN ASSESSMENT RESULTS TO THE CLIENT IN AN UNDERSTANDABLE MANNER.* _______
2. *IDENTIFY AND RANK PROBLEMS BASED ON INDIVIDUAL CLIENT NEEDS IN THE WRITTEN TREATMENT PLAN.* _______
3. *FORMULATE AGREED-UPON IMMEDIATE AND LONG-TERM GOALS USING BEHAVIORAL TERMS IN THE WRITTEN TREATMENT PLAN.* _______
4. *IDENTIFY THE TREATMENT METHODS AND RESOURCES TO BE UTILIZED AS APPROPRIATE FOR THE INDIVIDUAL CLIENT.* _______

VI. COUNSELING –

1. *SELECT THE COUNSELING THEORY(IES) THAT APPLY(IES).* _______
2. *APPLY TECHNIQUES TO ASSIST THE CLIENT, GROUP, AND/OR FAMILY IN EXPLORING PROBLEMS.* _______
3. *APPLY TECHNIQUE(S) TO ASSIST THE CLIENT, GROUP, AND/OR FAMILY IN EXAMINING THE CLIENT'S BEHAVIOR, ATTITUDE, AND/OR FEELINGS IF APPROPRIATE IN THE TREATMENT SETTING.* _______
4. *INDIVIDUALIZE COUNSELING IN ACCORDANCE WITH CULTURAL, GENDER, AND LIFESTYLE DIFFERENCES.* _______
5. *INTERACT WITH THE CLIENT IN AN APPROPRIATE THERAPEUTIC MANNER.* _______
6. *ELICIT SOLUTIONS AND DECISIONS FROM THE CLIENT.* _______

VII. CASE MANAGEMENT –

1. *COORDINATE SERVICES FOR CLIENT CARE.* _______
2. *EXPLAIN THE RATIONALE OF CASE MANAGEMENT ACTIVITIES TO THE CLIENT.* _______

VIII. CRISIS INTERVENTION –

1. *RECOGNIZE THE ELEMENTS OF THE CLIENT CRISIS.* _______
2. *IMPLEMENT AN IMMEDIATE COURSE OF ACTION APPROPRIATE TO THE CLIENT.* _______
3. *ENHANCE OVERALL TREATMENT BY UTILIZING CIRSIS EVENTS.* _______

IX. CLIENT EDUCATION –

1. *PRSENT RELEVANT ALCOHOL AND OTHER DRUGE USE/ABUSE INFORMATION TO THE CLIENT THROUGH FORMAL AND/OR INFORMAL PROCESSES.* _______
2. *PRESENT INFORMATION ABOUT AVAILABLE ALCOHOL AND OTHER DRUG SERVICES AND RESOURCES.* _______

X. REFERRAL –

1. *IDENTIFY NEEDS AND/OR PROBLEMS THAT THE AGENCY AND/OR COUNSELOR CANNOT MEET.* _______
2. *EXPLAIN THE RATIONALE FOR THE REFERRAL TO THE CLIENT.* _______
3. *MATCH CLIENT NEEDS AND/OR PROBLEMS TO APPROPRIATE RESOOURCES.* _______
4. *ADHERE TO APPLICABLE LAWS, REGULATIONS, AND AGENCY POLICIES COVERING PROCEDURES RELATED TO THE PROTECTION OF THE CLIENT'S CONFIDENTIALITY.* _______
5. *ASSIST THE CLIENT IN UTILIZING THE SUPPORT SYSTEMS AND COMMUNITY RESOURCES AVAILABLE.* _______

CLINICAL SUPERVISOR EVALUATION FORM **PART – C –**

XI. REPORT AND RECORD KEEPING –

1. *PREPARE REPORTS AND RELEVANT RECORDS INTEGRATING AVAILABLE INFORMATION TO FACILITATE THE CONTINUUM OF CARE.* _______
2. *CHART ONGOING INFORMATION PERTAINING TO THE CLIENT.* _______
3. *UTILIZE RELEVANT INFORMATION FROMWRITTEN DOCUMENTS FOR CLIENT CARE.* _______

XII. CONSULTATION WITH OTHER PROFESSIONALS –

1. *RECOGNIZE ISSUES THAT ARE BEYOND THE COUNSELOR'S BASE OF KNOWLEDGE AND/OR SKILL..* _______
2. *CONSULT WITH APPROPRIATE RESOURCES TO INSURE THE PROVISION OF EFFECTIVE TREATMENT SERVICES..* _______
3. *ADHERE TO APPLICABLE LAWS, REGULATIONS, AND AGENCY POLICIES GOVERNING THE DISCLOSURE OF CLIENT IDENTIFYING DATA..* _______
4. *EXPLAIN THE RATIONALE FOR THE CONSULTATION TO THE CLIENT.* _______

CLINICAL SUPERVISOR EVALUATION FORM **PART – D –**

PLEASE DESCRIBE ANY SPECIAL SKILLS OF THE COUNSELOR –

COMMENTS AND/OR ADDITIONAL INFORMATION YOU FEEL MAY BE PERTINENT –

I CERTIFY THAT I WAS EMPLOYED AS A SUPERVISOR OF THE APPLICANT NOTED BELOW BY THE AGENCY ALSO NOTED BELOW AND WAS, THEREFORE, IN A POSITION TO DIRECTLY OBSERVE THE APPLICANT'S WORK AT THAT AGENCY.

______________________	______________________
APPLICANT'S NAME (PLEASE PRINT)	*AGENCY NAME (PLEASE PRINT)*
______________________	______________________
SUPERVISOR'S NAME (PLEASE PRINT)	*SUPERVISOR'S SIGNATURE*
	______________________
	DATE

*PLEASE CHECK THE STATEMENT BELOW THAT APPLIES (PLEASE CHECK ONLY **ONE** STATEMENT):*

___ *I RECOMMEND THIS APPLICANT FOR CERTIFICATION.*

___ *I HAVE SOME RESERVATIONS IN RECOMMENDING THIS APPLICANT.*

___ *I DO NOT RECOMMEND THIS APPLICANT FOR CERTIFICATION.*

THE SUPERVISOR COMPLETING THIS EVALUATION MUST READ AND SIGN THE FOLLOWING STATEMENT:

I ATTEST THAT ALL OF THE INFORMATION THAT I HAVE PROVIDED IN THIS EVALUATION FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

____

*SUPERVISOR'S NAME (**PLEASE PRINT HERE**)*

____

SUPERVISOR'S SIGNATURE

____

SUPERVISOR'S JOB TITLE *DATE*

THIS CLINICAL SUPERVISOR EVALUATION FORM IS CONFIDENTIAL.

THE APPLICANT HAS WAIVED HIS/HER RIGHT TO VIEW ITS CONTENTS.

THE SUPERVISOR MAY MAKE A PHOTOCOPY OF THIS FORM FOR HIS/HER RECORDS, BUT NO COPY MAY BE PROVIDED TO THE APPLICANT, NOR SHOULD THE APPLICANT BE ALLOWED TO VIEW ITS CONTENTS.

PLEASE COMPLETE AND SIGN THIS FORM, AND MAIL IT DIRECTLY BACK TO:

MBSACC
560 LINCOLN STREET
P.O. BOX 7070
WORCESTER, MA 01605

AN APPLICATION IS CONSIDERED INCOMPLETE WITHOUT THIS FORM, AND, IN MOST INSTANCES, MUST BE POSTMARKED BY A CERTAIN DEADLINE DATE. PLEASE CONFIRM WITH THE APPLICANT THE DEADLINE DATE BY WHICH THIS *EVALUATION FORM MUST BE POSTMARKED, AND POSTMARK THIS FORM ON OR BEFORE THAT DATE. THANK YOU FOR YOUR COOPERATION.*