This is Study Guide 2 of Course 4S. You may take your quiz for Study Guide 1 now or later. To locate the quizzes, return to your My Home Page and click the name of the course. It's a blue active link. You must pass the quiz for Study Guide 1 and the quiz for Study Guide 2, and complete the Feedback Form, in order to earn your CE Certificate.

5. Evaluating Performance

The goal of supervision is to ensure quality care for the client, which entails monitoring the clinical performance of staff. Your first step is to educate supervisees in what to expect from clinical supervision. Once the functions of supervision are clear, you should regularly monitor and evaluate the supervisee's progress in meeting organizational and clinical goals as set forth in an Individual Development Plan (IDP) as described below. Just as clients have an individual treatment plan, supervisees also need a plan to promote skill development.

Behavioral Contracting in Supervision

Among the first tasks in supervision is to establish a contract for supervision that outlines realistic accountability for both yourself and your supervisee. The contract should be in writing and should include the purpose, goals, and objectives of supervision; the context in which supervision is provided; ethical and institutional policies that guide supervision and clinical practices; the criteria and methods of evaluation and outcome measures; the duties and responsibilities of the supervisor and supervisee; procedural considerations (including the format for taping and opportunities for live observation); and the supervisee's scope of practice and competence.

The contract for supervision should state the rewards for fulfillment of the contract (such as clinical privileges or increased compensation), the length of supervision sessions, and sanctions for noncompliance by either the supervisee or supervisor. The agreement should be compatible with the developmental needs of the supervisee and address the obstacles to progress (lack of time, performance anxiety, resource limitations). Once a behavioral contract has been established, the next step is to develop an IDP.

Individual Development Plan (IDP)

The Individual Development Plan (IDP) is a detailed plan for supervision that includes the goals that you and the supervisee wish to address over a certain time period (perhaps 3 months). Each of you should sign and keep a copy of the IDP for your records. The goals are normally stated in terms of skills the supervisee wishes to build or professional resources he or she wishes to develop. These skills and resources are generally oriented to the supervisee's job in the program or activities that would help the supervisee develop professionally. The IDP should specify . . .

- the timelines for change,
- the observation methods that will be employed,

- expectations for the supervisee and the supervisor,
- the evaluation procedures that will be employed, and
- the activities that will be expected to improve knowledge and skills.

As a supervisor, you should have your own IDP, based on the supervisory competencies that addresses your training goals. This IDP can be developed in cooperation with your supervisor, or in external supervision, peer input, academic advisement, or mentorship.

Evaluation of Behavioral Health Supervisees

Supervision inherently involves evaluation, building on a collaborative relationship between you and the supervisee. Evaluation may not be easy for some supervisors. Although everyone wants to know how they are doing, supervisees are not always comfortable asking for feedback. And, as most supervisors prefer to be liked, you may have difficulty giving clear, concise, and accurate evaluations to staff.

The two types of evaluation are formative and summative.

- ***Formative evaluation*** is an ongoing status report of the supervisee's skill development, exploring the questions "Are we addressing the skills or competencies you want to focus on?" and "How do we assess your current knowledge and skills and areas for growth and development?"
- ***Summative evaluation*** is a more formal rating of the supervisee's overall job performance, fitness for the job, and job rating. It answers the question, "How does the supervisee measure up?" Typically, summative evaluations are done annually and focus on the supervisee's overall strengths, limitations, and areas for future improvement.

Before formative evaluations begin, *methods of evaluating performance should be discussed, clarified in the initial sessions, and included in the initial contract so that there will be no surprises***.** It is important to acknowledge that supervisee evaluation is essentially a subjective process involving supervisors' opinions of the supervisees' competence.

- **The Formative Evaluations should focus on changeable behavior** and, whenever possible, be separate from the overall annual performance appraisal process (i.e., the Summative Evaluation). To determine the supervisee's skill development, you should use written competency tools, direct observation, supervisee self-assessments, client evaluations, work samples (files and charts), and peer assessments. Examples of work samples and peer assessments can be found in Bernard and Goodyear (2004), Powell and Brodsky (2004), and Campbell (2000).

- **Clients are often the best assessors of the skills of the supervisee. Supervisors should routinely seek input from the clients as to the outcome of treatment, which can then be explored during formative evaluations.** The method of seeking input should be discussed in the initial supervisory sessions and be part of the supervision contract. In a residential substance abuse treatment program,

you might regularly meet with clients after sessions to discuss how they are doing, how effective the counseling is, and the quality of the therapeutic alliance with the supervisee.

It should be acknowledged that supervision is inherently **an unequal relationship**. In most cases, the supervisor has positional power over the supervisee. Therefore, it is important to establish clarity of purpose and a positive context for observation and evaluation. Procedures should be spelled out in advance, and the evaluation process should be mutual, flexible, and continuous.

- The evaluation process inevitably brings up supervisee anxiety and defensiveness that need to be addressed openly. It is also important to note that each individual will react differently to feedback; some will be more open to the process than others.

Direct observation of the supervisee's work is the foundation for evaluation, and it facilitates the most meaningful form of input from the supervisor. Although direct observation has historically been the exception in the substance abuse counseling field, ethical and legal considerations and research evidence support direct observation as preferable. *Section 6 and Figure 7 in this Study Guide 2 explore specific methods of direct observation.*

There has been considerable research on supervisory evaluation, with these findings:

- The supervisee's confidence and efficacy are correlated with the quality and quantity of feedback the supervisor gives to the supervisee (Bernard & Goodyear, 2004).
- Ratings of skills are highly variable between thesupervisors who work for the organization, and oftentimes the supervisor's and supervisee's ratings differ or conflict (Eby, 2007).
- Good feedback is provided frequently, clearly, and consistently and is SMART (specific, measurable, attainable, realistic, and timely) (Powell & Brodsky, 2004).

The least desirable approach to providing feedback to the supervisee is . . .

- *feedback based upon unannounced observation* bysupervisors
- vague, perfunctory, indirect, or hurtful delivery (Powell & Brodsky, 2004).

Addressing Burnout and Compassion Fatigue

Supervisees sometimes say, 'I came into counseling for the right reasons. At first I loved seeing clients. But the longer I stay in the field, the harder it is to care. The joy seems to have gone out of my job. Should I get out of counseling as many of my colleagues are doing?'

Most substance abuse counselors come into the field with a strong sense of calling and the desire to be of service to others, with a strong pull to use their gifts and make themselves instruments of service and healing. But the substance abuse treatment field risks losing many skilled and compassionate healers when the life goes out of their work. Some counselors simply withdraw, care less, or get out of the field entirely.

Most just complain or suffer in silence. Given the caring and dedication that brings counselors into the field, it is important for you to help them address their questions and doubts. (See Lambie, 2006, and Shoptaw, Stein, & Rawson, 2000.)

You can help supervisees with self-care; help them look within; become resilient again; and rediscover what gives them joy, meaning, and hope in their work. You can help them redevelop their innate capacity for compassion, to be an openhearted presence for others.

You can help supervisees develop a life that does not revolve around work. This has to be supported by the organization's culture and policies that allow for appropriate use of time off and self-care without punishment. Aid them by encouraging them to take earned leave and to take "mental health" days when they are feeling tired and burned out. Remind staff to spend time with family and friends, exercise, relax, read, or pursue other life-giving interests. Rest is good; self-care is important.

It is important for the clinical supervisor to *normalize the supervisee's reactions to stress and compassion fatigue i*n the workplace as a *natural part* of being an empathic and compassionate person and not a personal failing or pathology. (See Burke. Carruth. & Prichard.2006.)

It is not enough for you to help supervisees understand "how" to counsel, you can also help them with the "why." Why are they in this field? What gives them meaning and purpose at work? When all is said and done, when they have seen their last client, how do they want to be remembered? What do they want said about them as aprofessional?

Usually, supervisees' responses to this question are fairly simple: "I want to be thought of as a caring, compassionate person, a skilled helper." These are important spiritual questions that you can discuss with your supervisees.

Other suggestions include:

- Help staff identify *what is happening within the organization* that might be contributing to their stress and learn how to address the situation in a way that is productive to the client, the supervisee, and the organization.
- Get training in *identifying the signs of primary stress reactions, secondary trauma, compassion fatigue, vicarious traumatization, and burnout*. Help staff match up self-care tools to specifically address each ofthese experiences.
- Support staff in advocating for *organizational change* when appropriate and feasible as part of your role as liaison between administration and clinical staff.
- Assist staff in adopting *lifestyle changes to increase their emotional resilience* by reconnecting to their world (family, friends, sponsors, mentors), spending time alone for self-reflection, and forming habits that re- energize them.
- Help them eliminate the "what ifs" and *negative self-talk*. Help them *let go of their idealism* that they can save the world.

- If possible in the current work environment, set parameters on their work by helping them adhere to *scheduled time off*, keep lunch time personal, *set reasonable deadlines* for work completion, and keep work away from personal time.

- Teach and support *generally positive work habits*. Some supervisees lack basic organizational, team-work, phone, and time management skills (ending sessions on time and scheduling to allow for documentation). The development of these skills helps to reduce the daily wear that erodes well-being and contributes to burnout.

  Ask them "When was the last time you had fun?" "When was the last time you felt fully alive?" Suggest they write a list of things about their job about which they are grateful. List five people they care about and love. List five accomplishments in their professional life. Ask "Where do you want to be in your professional life in 5 years?"

  Critical Point: You have a fiduciary responsibility given to you by clients to ensure supervisees are healthy and whole. It is your responsibility to aid supervisees in addressing their fatigue and burnout. Failure to fulfill your fiduciary duty in this regard can result in adverse legal action against you and an ethics allegation of failure to act in the best interest of clients.

[Fiduciary: 'A fiduciary is a person who holds a legal or ethical relationship of trust with one or more other parties (person or group of persons).' – Wikipedia 2020]

Gatekeeping Functions of Supervision

Remember that the number one goal of a clinical supervisor is to protect the welfare of the client, which, at times, can mean enforcing the gatekeeping function of supervision.

In monitoring supervisee's performance, an important and often difficult supervisory task is managing problem staff and counseling those who should not be behavioral health providers out of the field. *This is the gatekeeping function*. Part of the dilemma is that most likely you were first trained as a behavioral health provider, and your values lie within that domain. You were taught to acknowledge and work with individual limitations, always respecting the individual's goals and needs. However, you also carry a responsibility to maintain the quality of the profession and to protect the welfare of clients. Thus, you are charged with the task of assessing the supervisee for fitness for duty and have an obligation to uphold the standards of the profession.

Experience, credentials, and academic performance are not the same as clinical competence. In addition to technical counseling skills, many important therapeutic qualities affect the outcome of counseling, including insight, respect, genuineness, concreteness, and empathy. Research consistently demonstrates that personal characteristics of the provider are highly predictive of client outcome (Herman, 1993, Hubble, Duncan & Miller, 1999).

- The essential questions are: Who should or should not be a licensed or certified behavioral health provider? What behaviors or attitudes are unacceptable? How would a clinical supervisor address these issues in supervision?

Unacceptable behavior might include actions hurtful to the client, boundary violations with clients or program standards, illegal behavior, significant psychiatric impairment, consistent lack of self-awareness, inability to adhere to professional codes of ethics, or consistent demonstration of attitudes that are not conducive to work with clients in substance abuse treatment.

You will want to have clear policies and procedures in place before taking disciplinary action with an impaired, non-compliant, or dysfunctional professional. For example, progressive disciplinary policies must clearly state the procedures to follow when impairment or inappropriate behavior is identified. Consultation with the organization's attorney and familiarity with State case law are important. It is advisable for the agency to be familiar with and have contact with your State Impaired Professionals organization if it exists.

- How impaired or dysfunctional must a supervisee be before disciplinary action is needed? Clear job descriptions and statements of scope of practice and competence are important when facing an impaired individual.
- How tired or distressed can an individual be before a supervisor takes the person off-line for these or similar reasons? You need administrative support with such interventions and to identify approaches to managing worn-out professionals.
- *The Consensus Panel recommends that your organization have an employee assistance program (EAP) in place so you can refer staff outside the agency.*
- It is also important for you to learn the distinction between a supervisory referral and a self-referral. Self-referral may include a recommendation by the supervisor, whereas a supervisory referral usually occurs with a job performance problem.

You will need to provide verbal and written evaluations of the supervisee's performance and actions to ensure that the staff member is aware of the behaviors that need to be addressed. Treat all supervisees the same, following agency procedures and timelines. Follow the organization's progressive disciplinary steps and document carefully what is said, how the person responds, and what actions are recommended. You can discuss organizational issues or barriers to action with the supervisee (such as personnel policies that might be exacerbating the employee's issues). Finally, it may be necessary for you to take the action that is in the best interest of the clients and the profession, which might involve counseling your supervisee out of the field.

6. Methods and Techniques of Observation in Supervision

Direct observation is the foundation for supervisory evaluation of the supervisee. It is important that the supervisor directly observe the work of the supervisee over an extended period of time. Beyond live observation of counseling sessions through one-way mirrors and the presence of the supervisor in the room, a number of methods and techniques are available for direct observation – including audio and videotaping, remote audio devices, interactive videos, live feeds, and web-based cameras. Description of these methods and techniques is seen at **Figure 7.**

Methods and *Techniques* are not the same function. *Methods* include case consultation, written activities such as verbatims and process recordings, audio and videotaping, and live observation. *Techniques* include modeling, skill demonstrations, and role playing. (See descriptions of these and other methods and techniques in Bernard & Goodyear, 2004; Borders & Brown, 2005; Campbell, 2000; and Powell & Brodsky, 2004.)

Supervisors in the substance abuse treatment field have traditionally relied on *indirect methods* of supervision (process recordings, case notes, verbal reports by the supervisees, and verbatims). However, the Consensus Panel for this publication recommends that supervisors use *direct observation* of supervisees through recording devices (such as video and audio taping) and one-way mirrors when possible.

Indirect methods of observation have significant drawbacks, including:

- A supervisee will recall a session as he or she experienced it. If a supervisee experiences a session positively or negatively, the report to the supervisor will reflect that. The report is also affected by the supervisee's level of skill and experience.
- The supervisee's report is affected by his or her biases and distortions (both conscious and unconscious). The report does not provide a thorough sense of what really happened in the session because it relies too heavily on the supervisee's recall.
- Indirect methods include a time delay in reporting.
- The supervisee may withhold clinical information due to evaluation anxiety or naiveté.

Your understanding of the session will be improved by *direct observation* of the supervisee. Direct observation is much easier today, as a variety of technological tools are available, including audio and videotaping, remote audio devices, interactive videos, live feeds, and even supervision through web-based cameras.

Guidelines that apply to all methods of direct observation in supervision:

- Ideally, the supervisee should know at the outset of employment that observation and/or taping will be required as part of informed consent to supervision.
- Simply by observing a counseling session, the dynamics will change. Your presence as an observer may change how both the client and supervisee react. You are therefore getting only a snapshot of how sessions progress. Counselors will say, "it was not a representative session." However, if

you observe the supervisee frequently, you will get a fairly accurate picture of the individual's competencies.

- You and your supervisee must agree on procedures for observation to determine why, when, and how direct methods of observation will be used.
- The supervisee should provide a context for the session.
- The *client should give written consent for observation and/or taping at intake,* before beginning counseling. Clients must know all the conditions of their treatment before they consent to counseling. Additionally, clients need to be notified of an upcoming observation by a supervisor before the observation occurs.
- Sessions and clients selected for observation *should include a variety of challenges, clients, and successes* because they provide teaching moments. You should ask the supervisee to select what cases he or she wishes you to observe and explain why those cases were chosen.
- Direct observation should not be a weapon for criticism but a constructive tool for learning: an opportunity for the supervisee to do things right and well, so that positive feedback follows.
- *When observing a session, you gain a wealth of information about the supervisee. Use this information wisely, and provide gradual feedback, not a litany of judgments and directives. Ask the salient question, "What is the most important issue here for us to address insupervision?"*
- A supervisee might claim *client resistance to direct observation*, saying, "It will make the client nervous. The client does not want to be taped." However, "client resistance" is more likely to be reported when the supervisee is anxious about being taped. It is important for you to respectfully address the supervisee's resistance, while maintaining the position that direct observation is an integral component of his or her supervision.
- *Given the nature of the issues in drug and alcohol counseling, you and your supervisee need to be sensitive to increased client anxiety about direct observation because of the client's fears about job or legal repercussions, legal actions, criminal behaviors, violence and abuse situations, and the like*.

In instances where there is overwhelming anxiety regarding observation, you should pace the observation to reduce the anxiety, giving the supervisee adequate time for preparation. Often enough, supervisees will feel more comfortable with observation equipment (such as a video camera or recording device) rather than direct observation with the supervisor in the room.

The choice of observation methods in a particular situation will depend on the need for an accurate sense of counseling, the availability of equipment, the context in which the supervision is provided, and the supervisee's and your skill levels. A key factor in the choice of methods might be the resistance of the supervisee to being observed. For some supervisors, direct observation also puts the supervisor's skills on the line too, as they might be required to demonstrate or model their clinical competencies.

Recorded Observation

Audiotaped supervision has traditionally been a primary medium for supervisors and remains a vital resource for therapy models such as motivational interviewing. *Videotape Tape Supervision (VTS)* has been a primary method of direct observation in both the marriage and family therapy and social work fields (Munson, 1993; Nichols, Nichols, & Hardy, 1990). Video cameras are increasingly commonplace in professional settings. VTS is easy, accessible, and inexpensive. However, it is also a complex, powerful and dynamic tool, and one that can be challenging, threatening, anxiety-provoking, and humbling.

Several issues related to Video Tape Supervision (VTS) are unique to the substance abuse field:

- Many substance abuse counselors "grew up" in the field without taping and may be resistant to the medium;
- Many agencies operate on limited budgets and administrators may see the expensive equipment as prohibitive and unnecessary; and
- Many substance abuse supervisors have not been trained in the use of videotape equipment or in VTS.

Yet, VTS offers nearly unlimited potential for creative use in staff development. To that end, you need training in how to use VTS effectively.

The following are guidelines for VTS:

- *Clients must sign releases before taping*. Most programs have a release form that the client signs on admission. Supervisee informs the client that videotaping will occur and reminds the client about the signed release form.
- *The release should specify that the taping will be done exclusively for training purposes* and will be reviewed only by the supervisee, the supervisor, and other supervisees in group supervision. Permission will most likely be granted if the request is made in a sensitive and appropriate manner.
- It is critical to note that even if permission is initially given by the client, *this permission can be withdrawn. You cannot force compliance*.
- The use and rationale for taping needs to be clearly explained to clients. This will forestall a client's questioning as to why a particular session is being taped.
- ***Important Legal Issue:*** *Risk-management and confidentiality considerations in today's litigious climate necessitate that all tapes be erased after the supervision session. This must be stated in agency policies. If there are exceptions, those need to be described in the agency policy.*
- Too often, supervisors watch long, uninterrupted segments of tape with little direction or purpose. To avoid this, you may want to ask your supervisee to *cue the tape to the segment he or she wishes to address in supervision*, focusing on the goals established in the Individual Development Plan (IDP).

- Having said this, listening only to segments selected by the supervisee *can create some of the same disadvantages as self-report:* the supervisee chooses selectively, even if not consciously. Therefore, the supervisor *may occasionally choose to watch entire sessions*. You need to evaluate session flow, pacing, and how supervisees begin and end sessions.

Some clients may not be comfortable being videotaped but may be more comfortable with audio taping. Videotaping is not permitted in most prison settings and EAP services. *Videotaping may not be advisable when treating patients with some diagnoses, such as paranoia or some schizophrenic illnesses***.** In such cases, either live observation or less intrusive measures, such as audio taping, may be preferred.

Live Observation

With live observation, the supervisor typically sits in on a counseling session with the supervisee and observes the session firsthand. *The client will need to provide informed consent before being observed.* Although one-way mirrors are not readily available in many agencies for live observation, they are an alternative to actually sitting in on the session. A videotape may also be used either from behind the one-way mirror (with someone else operating the videotaping equipment) or physically located in the counseling room, with the supervisor sitting in the session.

This combination of mirror, videotaping, and live observation may be the best of all worlds, allowing for unobtrusive observation of a session, immediate feedback to the supervisee, modeling by the supervisor (if appropriate), and a record of the session for subsequent review in supervision. Live supervision may involve some intervention by the supervisor during the session.

Live observation is effective for the following reasons:

1. It allows you to get a true picture of the supervisee in action.
2. It gives you an opportunity to *model techniques* during an actual session, thus serving as a role model for both the supervisee and the client.
3. Should a session become countertherapeutic, *you can intervene for the well-being of the client.*
4. Counselors often say they feel supported when a supervisor joins the session, and clients periodically say, "This is great! I got two for the price of one."
5. It allows for specific and focused feedback.
6. It is more efficient for understanding the counseling process.
7. It helps to connect the Individual Development Plan to supervision.

To maximize the effectiveness of live observation, supervisors must stay primarily in an observer role so as to not usurp the leadership or undercut the credibility and authority of the supervisee.

Live observation has some disadvantages:

- It is time consuming.
- It can be intrusive and alter the dynamics of the counseling session.
- It can be anxiety-provoking for all involved.
- Some mandated clients may be particularly sensitive to live observation. This becomes essentially a clinical issue to be addressed by the supervisee with the client. Where is this anxiety coming from, how does it relate to other anxieties and concerns, and how can it best be addressed in counseling?

Where to sit: Supervisors differ on where they should sit in a live observation session. Some suggest that the supervisor sit so as to not interrupt or be involved in the session. Others suggest that the supervisor sit in a position that allows for inclusion in the counselingprocess.

Here are some guidelines for conducting live observation:

- *As preparation*, the supervisor and supervisee should briefly discuss the background of the session, the salient issues the supervisee wishes to focus on, and the plans for the session. *The role of the supervisor should be clearly stated and agreed on before the session.*
- Periodically, the supervisee should begin the session with a *statement of confidentiality*, reiterating the limits of confidentiality and the duty to warn, to ensure that the client is reminded of what is reportable by the supervisor and/or supervisee.
- *Sitting outside the group* undermines the human connection between you, the supervisee, and the client(s) and makes it more awkward for you to make a comment, if you have not been part of the process until then.
- *Although sitting outside the group* (or an individual session between supervisee and client)may undermine the group process, *it is a method selected by some*. Position yourself in a way that does not interrupt the counseling process.
- *For individual or family sessions*, it is also recommended that the supervisor sit *beside the supervisee* to fully observe what is occurring in the counselingsession.
- *The client should be informed about the process of supervision and the supervisor's role and goals, essentially that the supervisor is there to observe the supervisee's skills and not necessarily the client.*
- You and the supervisee may create criteria for observation, so that *specific feedback is provided for specific areas of the session.*
- *Intervening in the session.* Your comments during the session should be limited to lessen the risk of disrupting the flow or taking control of the session. *Intervene only to protect the welfare of the client (should something adverse occur in the session) or if a moment critical to client welfare arises*.

- *In deciding to intervene or not*, consider these questions: What are the consequences if I don't intervene? What is the probability that the supervisee will make the intervention on his or her own or that my comments will be successful? Will I create an undue dependence on the part of clients or supervisee?

- *Provide feedback to the supervisee as soon as possible after the session.* Ideally, the supervisor and supervisee(s) should meet privately immediately afterward, outlining the key points for discussion and the agenda for the next supervision session, based on the observation. Specific feedback is essential; "You did a fine job" is not sufficient. Instead, the supervisor might respond by saying, "I particularly liked your comment about . . ." or "What I observed about your behavior was . . ." or "Keep doing more of_____."

See Figure 7 for Methods and Techniques of Clinical Supervision On the Following Three Pages

Figure 7 - Methods and Techniques of Clinical Supervision

	Description	Advantages	Disadvantages
Verbal Reports	Verbal reports of clinical situations Group discussion of clinical situations	• Informal • Time efficient • Often spontaneous in response to clinical situation • Can hear counselor's report, what he or she includes, thus learn of the counselor's awareness and perspective, what he or she wishes to report, contrasted with supervisory observations	• Sessions seen through eyes of beholder • Nonverbal cues missed • Can drift into case management, hence it is important to focus on the clinical nature of chart reviews, reports, etc., linking to the treatment plan and EBPs
Verbatim Reports	Process recordings Verbatim written record of a session or part of session Declining method in the behavioral health field	• Helps track coordination and use of treatment plan with ongoing session • Enhances conceptualization and writing skills • Enhances recall and reflection skills • Provides written documentation of sessions	• Nonverbal cues missed • Self-report bias • Can be very tedious to write and to read
Written/File Review	Review of the progress notes, charts, documentation	• An important task of a supervisor to ensure compliance with accreditation standards for documentation • Provides a method of quality control • Ensures consistency of records and files	• Time consuming • Notes often miss the overall quality and essence of the session • Can drift into case management rather than clinical skills development

	Description	Advantages	Disadvantages
Case Consultation/ Case Management	Discussion of cases Brief case reviews	• Helps organize information, conceptualize problems, and decide on clinical interventions • Examines issues (e.g., cross-cultural issues), integrates theory and technique, and promotes greater self-awareness • An essential component of treatment planning	• The validity of self-report is dependent on counselor developmental level and the supervisor's insightfulness • Does not reflect broad range of clinical skills of the counselor
Direct Observation	The supervisor watches the session and may provide periodic but limited comments and/or suggestions to the clinician	• Allows teaching of basic skills while protecting quality of care • Counselor can see and experience positive change in session direction in the moment • Allows supervisor to intervene when needed to protect the welfare of the client, if the session is not effective or is destructive to the client	• May create anxiety • Requires supervisor caution in intervening so as to not take over the session or to create undue dependence for the counselor or client • Can be seen as intrusive to the clinical process • Time consuming
Audiotaping	Audiotaping and review of a counseling session	• Technically easy and inexpensive • Can explore general rapport, pace, and interventions • Examines important relationship issues • Unobtrusive medium • Can be listened to in clinical or team meetings	• Counselor may feel anxious • Misses nonverbal cues • Poor sound quality often occurs due to limits of technology
Videotaping	Videotaping and review of a counseling session	• A rich medium to review verbal and nonverbal information • Provides documentation of clinical skills • Can be viewed by the treatment team during group clinical supervision session • Uses time efficiently • Can be used in conjunction with direct observation • Can be used to suggest different interventions • Allows for review of content, affective and cognitive aspects, process relationship issues in the present	• Can be seen as intrusive to the clinical process • Counselor may feel anxious and self-conscious, although this subsides with experience • Technically more complicated • Requires training before using • Can become part of the clinical record and can be subpoenaed (should be destroyed after review)

	Description	**Advantages**	**Disadvantages**
Webcam	Internet supervision, synchronistic and asynchronistic Teleconferencing	• Can be accessed from any computer • Especially useful for remote and satellite facilities and locations • Uses time efficiently • Modest installation and operation costs • Can be stored or downloaded on a variety of media, watched in any office, then erased	• Concerns about anonymity and confidentiality • Can be viewed as invasive to the clinical process • May increase client or counselor anxiety or self-consciousness • Technically more complicated • Requires assurance that downloads will be erased and unavailable to unauthorized staff
Cofacilitation and Modeling	Supervisor and counselor jointly run a counseling session Supervisor demonstrates a specific technique while the counselor observes This may be followed by roleplay with the counselor practicing the skill with time to process learning and application	• Allows the supervisor to model techniques while observing the counselor • Can be useful to the client ("two counselors for the price of one") • Supervisor must demonstrate proficiency in the skill and help the counselor incrementally integrate the learning • Counselor sees how the supervisor might respond • Supervisor incrementally shapes the counselor's skill acquisition and monitors skill mastery • Allows supervisor to aid counselor with difficult clients	• Supervisor must demonstrate proficiency in the skill and help the counselor incrementally integrate the learning • The client may perceive counselor as less skilled than the supervisor • Time consuming
Role Playing	Role play a clinical situation	• Enlivens the learning process • Provides the supervisor with direct observation of skills • Helps counselor gain a different perspective • Creates a safe environment for the counselor to try new skills	• Counselor can be anxious • Supervisor must be mindful of not overwhelming the counselor with information

Source: Adapted from Mattel, 2007.

Structuring the Initial Supervision Sessions

As discussed earlier (in Study Guide 1), your first tasks in clinical supervision are to establish a behavioral contract, get to know your supervisees, and outline the requirements of supervision. Before the initial session, you should send a supportive letter to the supervisee expressing the agency's desire to provide him or her with a quality clinical supervision experience. You might request that the supervisee give some thought to what he or she would like to accomplish in supervision, what skills to work on, and which core functions used in the addiction counselor certification process he or she feels most comfortable performing.

In the first few sessions, helpful practices include:

- *Briefly describe your role as both administrative and clinical supervisor* (if appropriate) and discuss these distinctions with the supervisee.
- *Briefly describe your model of counseling and learn about the supervisee's frameworks and models* for her or his counseling practice. For beginning professionals this may mean helping them define their model.
- *Describe your model of supervision.*
- State that *disclosure of one's supervisory training, experience, and model is an ethical duty of clinical supervisors.*
- *Discuss methods of supervision, the techniques to be used, and the resources* available to the supervisee (e.g., agency in-service seminar, community workshops, professional association memberships, and professional development funds or training opportunities).
- *Explore the supervisee's goals* for supervision and his or her particular interests (and perhaps some fears) in clinical supervision.
- *Boundaries: Explain the difference between providing supervision and providing therapy to the supervisee (i.e., avoiding 'counseling the counselor')*, establishing clear boundaries in this relationship. Work to establish a climate of cooperation, collaboration, trust, and safety.
- Create an opportunity for *rating the supervisee's knowledge and skills* based on competencies. [For SUD programs, see Competencies in TAP 21 (CSAT,2007).]
- Explain the *methods by which formative and summative evaluations will occur*. Discuss the legal and ethical expectations and responsibilities of supervision. Take time to decrease the anxiety associated with being supervised and build a positive working relationship.

It is important to determine the knowledge and skills, learning style, and conceptual skills of your supervisees, along with their suitability for the work setting, motivation, self-awareness, and ability to function autonomously.

- *A basic Individual Development Plan (IDP) for each supervisee should emerge from the initial supervision sessions.*

- You and your supervisee need to assess the learning environment of supervision by determining:
  - Is there sufficient challenge to keep the supervisee motivated?
  - Are the theoretical differences between you and the supervisee manageable?
  - Are there limitations in the supervisee's knowledge and skills, personal development, self-efficacy, self- esteem, and investment in the job that would limit the gains from supervision?
  - Does the supervisee possess the affective qualities (empathy, respect, genuineness, concreteness, warmth) needed for the counseling profession?
  - Are the goals, means of supervision, evaluation criteria, and feedback process clearly understood by the supervisee?
  - Does the supervisory environment encourage and allow risk taking?

Documenting Clinical Supervision

Correct documentation and recordkeeping are essential aspects of supervision. Mechanisms must be in place to demonstrate the accountability of your role. These systems should document:

- Informal and formal evaluation procedures.
- Frequency of supervision, issues discussed, and the content and outcome of sessions.
- Due process rights of supervisees (such as the right to confidentiality and privacy, to informed consent).
- Risk management issues (how to handle crises, duty-to-warn situations, breaches of confidentiality).

One comprehensive documentation system is Falvey's (2002) *Focused Risk Management Supervision System* (FoRMSS), which provides templates to record emergency contact information, supervisee profiles, a logging sheet for supervision, an initial case review, supervision records, and a client termination form.

It is imperative to maintain accurate and complete notes on the supervision. Formal supervisory documents (both formative and summative) are open to management, administration, and human resources (HR) personnel for performance appraisal and merit pay increases and are admissible in court proceedings. In some agencies, informal supervision notations – especially those related to work with specific clients – are kept separately and are intended for the supervisor's personal use in helping the supervisee improve clinical skills and monitor client care. This practice varies from agency to agency and from state to state.

An example of a formative notation by a supervisor might be "The supervisee responsibly discussed countertransferential issues occurring with a particular client and was willing to take supervisory direction," or "We worked out an action plan, and I will follow this closely." This wording avoids concerns by the supervisor and supervisee as to the confidentiality of supervisory notes.

Documentation of Supervision for Administrative Purposes

One of the most important administrative tasks of a supervisor is that of documentation and recordkeeping, especially of clinical supervision sessions. Unquestionably, documentation is a crucial risk-management tool. Supervisory documentation can help promote the growth and professional development of the supervisee (Munson, 1993).

- However, adequate documentation is not a high priority in some organizations. For example, when disciplinary action is needed with an employee, your organization's attorney or human resources department will ask for the paper trail, or documentation of prior performance issues. If appropriate documentation to justify disciplinary action is missing from the employee's record, it may prove more difficult to conduct the appropriate disciplinary action (See Falvey, 2002; Powell & Brodsky, 2004.)

Documentation is no longer an option for supervisors. It is a critical link between work performance and service delivery. You have a legal and ethical requirement to evaluate and document the supervisee's performance. A complete record is a useful and necessary part of supervision.

Records of supervision sessions should include:

- The supervisor–supervisee contract, signed by both parties.
- A brief summary of the supervisee's experience, training, and learning needs.
- The current IDP.
- A summary of all performance evaluations.
- Notations of all supervision sessions, including cases discussed and significant decisions made.
- Notation of cancelled or missed supervision sessions.
- Progressive discipline steps taken.
- Significant problems encountered in supervision and how they were resolved.
- Supervisor's clinical recommendations provided tosupervisees.
- Relevant case notes and impressions.

The following should not be included in a supervision record:

- Disparaging remarks about staff or clients.
- Extraneous or sensitive supervisee information.
- Alterations in the record after the fact or premature destruction of supervision records.
- Illegible information and nonstandard abbreviations.

Several authors have proposed a standardized format for documentation of supervision, including Falvey (2002b), Glenn and Serovich (1994), and Williams (1994).

7. Boundary Issues and Countertransference in Clinical Supervision

Distinguishing Between Supervising and Counseling the Supervisee – a Boundary Issue.

In facilitating professional development, one of the critical boundary issues is *understanding and differentiating between 'counseling the counselor'* (i.e., providing therapy to the supervisee) *and providing supervision*. Some of the major differences between provision of supervision and provision of therapy or counseling to the supervisee are summarized in **Figure 2** in Study Guide 1.

In ensuring quality client care and facilitating professional development, the process of clinical supervision sometimes encroaches on personal issues. The goal of clinical supervision must always be to assist supervisees in becoming better clinicians, not seeking to resolve their personal issues. *The dividing line between therapy and supervision is that supervision must be restricted to identifying how the supervisee's personal issues and problems affect their work.*

- **However, the boundary between counseling/therapy with the supervisee and clinical supervision of the supervisee may not always be clearly marked, for it is necessary, at times, to explore supervisees' limitations as they deliver services to their clients. Address supervisees' personal issues only in so far as they create barriers or affect their performance.**

When personal issues emerge, the key question you should ask the supervisee is how does this affect the delivery of quality client care? What is the impact of this issue on the client? What resources are you using to resolve this issue outside of the counseling dyad?

When personal issues emerge that might interfere with quality care, your role may be to transfer the case to a different provider. Most important, you should make a strong case that the supervisee should seek outside counseling or therapy.

Problems related to *countertransference* (projecting unresolved personal issues onto a client or supervisee) often make for difficult therapeutic relationships. The following are signs of countertransference to look for:

- A feeling of loathing, anxiety, or dread at the prospect of seeing a specific client or supervisee.
- Unexplained anger or rage at a particular client.
- Distaste for a particular client.
- Mistakes in scheduling clients, missed appointments.
- Forgetting client's name, history.
- Drowsiness during a session or sessions ending abruptly.
- Billing mistakes.
- Excessive socializing.

When countertransferential issues between supervisee and client arise, some of the important questions you, as a supervisor, might explore with the supervisee include:

- How is this client affecting you? What feelings does this client bring out in you? What is your behavior toward the client in response to these feelings?
- What is it about the substance abuse behavior of this client that brings out a response in you?
- What is happening now in your life, but more particularly between you and the client that might be contributing to these feelings, and howdoes this affect your counseling?
- In what ways can you address these issues in your counseling?
- What strategies and coping skills can assist you in your work with this client?

Transference and countertransference also occur in the relationship between supervisee and supervisor. Examples of supervisee transference include:

- The supervisee's idealization of the supervisor.
- Distorted reactions to the supervisor based on the supervisee's reaction to the power dynamics of the relationship.
- The supervisee's need for acceptance by or approval from an authority figure.
- The supervisee's reaction to the supervisor's establishing professional and social boundaries with the supervisee.

Supervisor countertransference with supervisees **is another issue that needs to be considered. Categories of supervisor countertransference include:**

- The need for approval and acceptance as a knowledgeable and competent supervisor. Unresolved personal conflicts of the supervisor activated by the supervisory relationship.
- Reactions to individual supervisees, such as dislike or even disdain, whether the negative response is "legitimate" or not. In a similar vein, aggrandizing and idealizing some supervisees (again, whether or not warranted) in comparison to other supervisees.
- Sexual or romantic attraction to certain supervisees.
- Cultural countertransference, such as catering to or withdrawing from individuals of a specific cultural background in a way that hinders the professional development of the supervisee.

To understand these countertransference reactions means recognizing clues (such as dislike of a supervisee or romantic attraction), doing careful self-examination, personal counseling, and receiving supervision of your supervision. In some cases, it may be necessary for you to request a transfer of supervisees with whom you are experiencing countertransference, if that countertransference hinders the supervisee's professional development.

Finally, supervisees will be more open to addressing difficulties such as countertransference and compassion fatigue with you if you communicate understanding and awareness that *these experiences are a normal part of being a behavioral health provider.* Counselors should be rewarded in performance evaluations for raising these issues in supervision and demonstrating a willingness to work on them as part of their professional development.

8. Balancing Clinical and Administrative Functions

The context in which supervision is provided affects how it is carried out. A critical issue is how to manage your supervisory workload and make a reasonable effort to supervise. The contextual issues that shape the techniques and methods of supervision include:

- **Clinical and management responsibilities of a supervisor.** Supervisors have varied responsibilities, including *administrative tasks*, limiting the amount of time available for clinical supervision.
- **The allocation of time for clinical supervision.** If the 20:1 rule of client hours to supervision time is followed, you will want to allocate sufficient time for supervision each week so that it is a high priority, regularly scheduled activity.
- **The unique conditions, limitations, and requirements of the agency**. Some organizations may lack the physical facilities or hardware to use videotaping or to observe sessions. Some organizations may be limited by confidentiality requirements, such as working within a criminal justice system where taping may be prohibited.
- **The number of supervisees reporting to a supervisor.** It is difficult to provide the scope of clinical supervision discussed in this course if a supervisor has more than ten supervisees. In such a case, another supervisor could be named or peer supervision could be used for advanced staff.

Texts on supervision sometimes overlook the supervisor's administrative tasks, but supervisors oftentimes structure staff work; evaluate personnel for pay and promotions; define the scope of clinical competence; perform tasks involving planning, organizing, coordinating, and delegating work; select, hire, and fire personnel; and manage the organization. Clinical supervisors are often responsible for overseeing the quality assurance and improvement aspects of the agency and may also carry a case-load. For many of you, juggling administrative and clinical functions is a significant balancing act.

Particularly in substance abuse treatment agencies (but also in mental health programs with limited funding), ***the clinical supervisor may also be the administrative supervisor***, responsible for overseeing managerial functions of the organization. Many organizations cannot afford to hire two individuals for these tasks. Hence, it is essential that you are aware of what role you are playing and how to exercise the authority given you by the administration.

Tips for juggling these functions include:

- Try to be clear about the "hat you are wearing." Are you speaking from an administrative or clinical perspective?
- Be aware of your own biases and values that may be affecting your administrative opinions.
- Delegate the administrative functions that you need not necessarily perform, such as human resources, financial, or legal functions.
- Get input from others to be sure of your objectivity and your perspective.

There may be some ***inherent problems with performing both functions***, such as dual relationships. Counselors may be cautious about acknowledging difficulties they face in counseling because these may affect their performance evaluation or salary raises. On the other hand, having separate clinical and administrative supervisors can lead to inconsistent messages about priorities, and the clinical supervisor is not in the chain of command for disciplinary purposes.

Finding the Time to Do Clinical Supervision When You Have Administrative Duties

Having read this far, you may be wondering, "Where do I find the time to conduct clinical supervision as described here? How can I do direct observation of supervisees within my limited time schedule?" Or, "I work in an underfunded program with substance abuse clients. I have way too many tasks to also observe staff in counseling."

- One suggestion is to begin an implementation process that involves adding components of a supervision model one at a time. For example, scheduling supervisory meetings with each supervisee is a beginning step. It is important to meet with each supervisee on a regular, scheduled basis to develop learning plans and review professional development.
- Observations of supervisees in their work might be added next.
- Another component might involve group supervision. In group supervision, time can be maximized by teaching and training supervisees who have common skill development needs.
- Observation can be brief. Rather than sitting in on a full hour of group, spend 20 minutes in the observation and an additional 20 providing feedback to the supervisee.

Your choice of a supervision modality (individual, group, peer, etc.) is influenced by several factors including time constraints: Your administrative duties, your supervisees' learning goals, their experience and developmental levels, their learning styles, your goals for supervisees, your theoretical orientation, and your own learning goals for the supervisory process.

To select a modality of supervision (within your time constraints and those of your supervisee), first pinpoint the immediate function of supervision, as different modalities fit different functions. For example, a supervisor might wish to conduct group supervision when the team is intact and functioning well, and individual supervision when specific skill development or countertransferential issues need additional attention.

- Given the variety of treatment environments in substance abuse treatment (e.g., therapeutic communities, intensive outpatient services, transitional living settings, correctional facilities) and varying time constraints on supervisors, several alternatives to structure supervision are available.

Examples of Flexible Supervision Modalities

Peer supervision is not hierarchical and does not include a formal evaluation procedure, but it offers a means of accountability for supervisees that they might not have in other forms of supervision.

- Peer supervision may be particularly significant among well-trained, highly educated, and competent individuals. Peer supervision is a growing medium, given the clinical supervisors' duties.
- Although peer supervision has received limited attention in literature, the Consensus Panel believes it is a particularly effective method, especially for small group practices and agencies with limited funding for supervision. Peer supervision groups can either *evolve* from supervisor-led groups or individual sessions, into peer supervision groups – or they can begin as peer supervision.
- For peer supervision groups offered within an agency, there may be some history to overcome among the group members, such as political entanglements, competitiveness, or personality concerns. (Bernard and Goodyear [2004] has an extensive review of the process and the advantages and disadvantages of peer supervision.)

Triadic supervision is a tutorial and mentoring relationship among three supervisees. This model of supervision involves three individuals who, on a rotating basis, assume the roles of the supervisee, the commentator, and the supervision session facilitator.

- Spice and Spice (1976) describe this form of peer supervision with three supervisees.
- In current counseling literature, triadic supervision involves two supervisees with one supervisor. There is limited empirical or conceptual literature on this arrangement.

Individual supervision, where a supervisor works with the supervisee in a one-to-one relationship, is considered the cornerstone of professional skill development. Individual supervision is the most labor-intensive and time-consuming method for supervision. Credentialing requirements in a particular discipline or graduate studies may mandate individual supervision with a supervisor from the same discipline.

Intensive supervision with selected supervisees is helpful in working with a difficult client (such as one with a history of violence), a client using substances unfamiliar to the supervisee, or a highly resistant client.

- Because of a variety of factors (credentialing requirements, skill deficits of some individuals, the need for close clinical supervision), you may opt to focus, for concentrated periods of time, on the needs of one or two supervisees as others participate in peer supervision. Although this is not necessarily a long-term solution to the time constraints of a supervisor, intensive supervision provides an opportunity to address specific staffing needs while still providing a "reasonable effort to supervise" all personnel.

Group clinical supervision is a frequently used and efficient format for supervision, team building, and staff growth. One supervisor assists supervisee development in a group of supervisee peers. The recommended group size is four to six persons to allow for frequent case presentations by each group member. With this number of supervisees, each person can present a case every other month—an ideal situation, especially when combined with individual and/or peer supervision.

- *The benefits of group supervision* are that it is cost-effective, members can test their perceptions through peer validation, learning is enhanced by the diversity of the group, it creates a working alliance and improves teamwork, and it provides a microcosm of group process for participants.
- *Group supervision gives supervisees a sense of commonality with others in the same situation*. Because the formats and goals differ, it is helpful to think through why you are using a particular format. (Examples of group formats with different goals can be found in Borders and Brown, 2005, and Bernard & Goodyear, 2004.)

Sample Schedule When Time for Clinical Supervision is Limited

Given the realities of the substance abuse treatment field and some mental health programs including small rural programs (limited funding, priorities competing for time, and clients with pressing needs in a brief-treatment environment), *the plan described below may be a useful structure for supervision.* It is based on a scenario where a supervisor oversees one to five supervisees. This plan **[Figure 8]** is based on several principles:

- All supervisees, regardless of years of experience or academic training, will receive at least 1 hour of supervision for every 20 to 40 hours of clinical practice.
- Direct observation is the backbone of a solid clinical supervision model.
- Group supervision is a viable means of engaging all staff in dialog, sharing ideas, and promoting team cohesion.

With the formula diagramed below in Figure 8, next page:

- Each supervisee receives a minimum of 1 hour of *group clinical supervision* per week.
- Each week you, the supervisor, will have 1 hour of observation, 1 hour of individual supervision with one of your supervisees, and 1 hour of group supervision with five supervisees.
- Each week, one supervisee will be observed in an actual counseling session, followed by an individual supervision session with you. If the session is videotaped, the supervisee can be asked to cue the tape to the segment of the session he or she wishes to discuss with you.
- Afterwards, the observed supervisee presents this session in group clinical supervision.

When it is a supervisee's week to be observed or taped and meet for individual supervision, he or she will receive 3 hours of supervisions, total: 1 hour of direct observation, 1 hour of individual/one-on-one

supervision, and 1 hour of group supervision when he or she presents a case to the group. Over the course of months, with vacation, holiday, and sick time, it should average out to approximately 1 hour of supervision per supervisee per week. **Figure 8** shows this schedule.

Figure 8
Sample Clinical Supervision Schedule

Counselor	Week 1	Week 2	Week 3	Week 4	Week 5
A	1 hour direct observation 1 hour individual supervision 1 hour group supervision of A's case (3 hours)	1 hour group	1 hour group	1 hour group	1 hour group
B	1 hour group	3 hour group	1 hour group	1 hour group	1 hour group
C	1 hour group	1 hour group	3 hour group	1 hour group	1 hour group
D	1 hour group	1 hour group	1 hour group	3 hour group	1 hour group
E	1 hour group	1 hour group	1 hour group	1 hour group	3 hour group

When you are working with a supervisee who needs special attention or who is functioning under specific requirements for training or credentialing, 1 additional hour per week can be allocated for this individual, increasing the total hours for clinical supervision to 4 – still a manageable amount of time.

Administrative Supervision

As noted above, clinical and administrative supervision overlap in the real world. *Most clinical supervisors also have administrative responsibilities*, including team building, time management, addressing agency policies and procedures, recordkeeping, human resources management (hiring, firing, disciplining), performance appraisal, meeting management, oversight of accreditation, maintenance of legal and ethical standards, compliance with State and Federal regulations, communications, overseeing staff cultural competence issues, quality control and improvement, budgetary and financial issues, problem solving, and documentation. Keeping up with these duties is not an easy task.

This document addressed two of the most frequently voiced concerns of supervisors: documentation and time management. Supervisors say, "We are drowning in paperwork. I don't have the time to adequately document my supervision as well," and "How do I manage my time so I can provide quality clinical supervision?"

Time Management

By some estimates, people waste about two hours every day doing tasks that are not of high priority. In your busy job, you may find yourself at the end of the week with unfinished tasks or matters that have not been tended to. The choices which many supervisors see as options are (1) stop performing some tasks (often training or supervision) or (2) take work home and work longer days. In the long run, neither of these choices is healthy or effective for your organization. The Figure 8 formula for restructuring your supervision tasks, and the Flexible Supervision Modalities described above may offer some alternatives.

Being successful does not make you manage your time well. Managing your time well makes you successful. Ask yourself these questions about your priorities:

- Why am I doing this? What is the goal of this activity?
- How can I best accomplish this task in the least amount of time?
- What will happen if I choose not to do this?

It is wise to develop systems for managing time-wasters such as endless meetings held without notes or minutes, playing telephone or email tag, and so on. Effective supervisors find their times in the day when they can be most productive. Time management is essential if you are to set time aside and dedicate it to supervisory tasks.

Resources

The following are resources for supervision:

- Code of Ethics from the Association of Addictions Professionals (NAADAC)
- National Board for Certified Counselors (NBCC)
- Certification & Reciprocity Consortium's Code of Ethics (IC&RC)
- National Association of Social Workers (NASW)
- Codes of ethics from other professional groups such as American Association for Marriage and Family Therapy, the American Counseling Association, the Association for Counselor Education and Supervision, and the American Psychological Association
- ACES Standards for Counseling Supervisors; ACES Ethical Guidelines for Counseling Supervisors (http://www.acesonline.net/ethical_guidelines.asp); and NBCC Standards for the Ethical Practice of Clinical Supervision.

For SUD Program providers: 'TAP 21-A' provides detailed appendices of suggested reading and other resources (CSAT, 2007). The following are examples of online classroom training programs in clinical supervision in the substance abuse field:

- *Clinical Supervision for Substance Abuse Treatment Practitioners Series.*
- *Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency.*
- *Clinical Supervision to Support the Implementation, Fidelity and Sustaining Evidence-Based Practices.*
- *Northwest Addiction Technology Transfer Center (Northwest ATTC)*
- *Clinical Supervision, Part 2: What Happens in Good Supervision.*

Other SUD training programs are given in professional graduate schools, such as New York University School of Social Work; Smith College School for Social Work; University of Nevada, Reno, Human and Community Sciences; and Portland State University Graduate School of Education.

For information about tools to measure supervisee competencies and supervisor self-assessment tools, along with samples, see the following:

- David J. Powell and Archie Brodsky, *Clinical Supervision in Alcohol and Drug Abuse Counseling,* 2004.
- L. DiAnne Borders and Lori L. Brown, *The New Handbook of Counseling Supervision*,
- 2005 Jane M. Campbell, *Becoming an Effective Supervisor*, 2000.
- Janet Elizabeth Falvey, *Managing Clinical Supervision: Ethical Practice and Legal Risk*
- *Management,* 2002. Carol A. Falender and Edward P. Shafranske,
- *Clinical Supervision: A Competency-Based Approach,* 2004.
- Cal D. Stoltenberg, Brian McNeill, and Ursula Delworth, *IDM Supervision: An Integrated Developmental Model for Supervising Counselors and Therapists,* 1998.

End of Course

This is the END of sponsored CE Course 4S, ***'Developmental Model of Behavioral Health Supervision.'*** The course has been divided into two Study Guides, with a quiz for each Study Guide. The course is sponsored and offered online for Continuing Education Credit by ***CEU ByNet***.

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