Distinguishing Between Supervision and Therapy

In facilitating professional development, one of the critical issues is understanding and differentiating between therapy and providing supervision. In ensuring quality client care and facilitating professional clinician development, the process of clinical supervision sometimes encroaches on personal issues. The dividing line between therapy and supervision is how the supervisee’s personal issues and problems affect their work. The goal of clinical supervision must always be to assist therapists in becoming better clinicians, not seeking to resolve their personal issues. Some of the major differences between supervision and counseling are summarized in figure 6.

**Figure 6. Differences Between Supervision and Counseling**

<table>
<thead>
<tr>
<th></th>
<th>Clinical Supervision</th>
<th>Administrative Supervision</th>
<th>Counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose</strong></td>
<td>• Improved client care&lt;br&gt;• Improved job performance</td>
<td>• Ensure compliance with agency and regulatory body's policies and procedures</td>
<td>• Personal growth&lt;br&gt;• Behavior changes&lt;br&gt;• Better self-understanding</td>
</tr>
<tr>
<td><strong>Outcome</strong></td>
<td>• Enhanced proficiency in knowledge, skills, and attitudes essential to effective job performance</td>
<td>• Consistent use of approved formats, policies, and procedures</td>
<td>• Open-ended, based on client needs</td>
</tr>
<tr>
<td><strong>Timeframe</strong></td>
<td>• Short-term and ongoing</td>
<td>• Short-term and ongoing</td>
<td>• Based on client needs</td>
</tr>
<tr>
<td><strong>Agenda</strong></td>
<td>• Based on agency mission and clinician needs</td>
<td>• Based on agency needs</td>
<td>• Based on client needs</td>
</tr>
<tr>
<td><strong>Basic Process</strong></td>
<td>• Teaching/learning specific skills, evaluating job performance, negotiating learning objectives</td>
<td>• Clarifying agency expectations, policies and procedures, ensuring compliance</td>
<td>• Behavioral, cognitive, and affective process including listening, exploring, teaching</td>
</tr>
</tbody>
</table>

*Source: Adapted from Dixon, 2004*

The boundary between therapy and clinical supervision may not always be clearly marked, for it is necessary, at times, to explore supervisees’ limitations as they deliver services to their clients. Address clinicians’ 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 clinician. 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 countertransferral issues between clinician and client arise, some of the important questions you, as a supervisor, might explore with the therapist 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 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 how does 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 clinician.

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 clinician's professional development.

Finally, therapists 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 therapist. Clinicians 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.

**Balancing Clinical and Administrative Functions**

In the typical agency, 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. Texts on supervision sometimes overlook the supervisor's administrative tasks, but supervisors 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 most of you, juggling administrative and clinical functions is a significant balancing act. 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. Clinicians 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**

After reading 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 clinicians within my limited time schedule?” Or, “I work in an underfunded program. 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 staff on a regular, scheduled basis to develop learning plans and review professional development. Observations of clinicians in their work might be added next. Another component might involve group supervision. In group supervision, time can be maximized by teaching and training professional counselors who have common skill development needs.

As you develop a positive relationship with supervisees based on cooperation and collaboration, the anxiety associated with observation will decrease. Therapists frequently enjoy the feedback and support so much that they request observation of their work. 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 clinician.

Your choice of modality (individual, group, peer, etc.) is influenced by several factors: 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 countertransferring issues need additional attention. Given the variety of treatment environments and varying time constraints on supervisors, several alternatives to structure supervision are available.

*Peer supervision* is not hierarchical and does not include a formal evaluation procedure, but offers a means of accountability for clinicians that they might not have in other forms of supervision. Peer supervision may be particularly significant among well-trained, highly educated, and competent clinicians. Peer supervision is a growing medium, given the clinical supervisors’ duties. Although peer supervision has received limited attention in literature, it is a particularly effective method, especially for small group practices and agencies with limited funding for supervision. Peer supervision groups can evolve from
supervisor-led groups or individual sessions to peer groups or 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.

*Triadic supervision* is a tutorial and mentoring relationship among three staff. This model of supervision involves three staff who, on a rotating basis, assume the roles of the supervisee, the commentator, and the supervision session facilitator. Spice and Spice (1976) describe peer supervision with three supervisees getting together. In current counseling literature, triadic supervision involves two staff with one supervisor. There is very little 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 clinicians is helpful in working with a difficult client (such as one with a history of violence), a client using substances unfamiliar to the clinician, or a highly resistant client. Because of a variety of factors (credentialing requirements, skill deficits of some clinicians, the need for close clinical supervision), you may opt to focus, for concentrated periods of time, on the needs of one or two clinicians 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 clinician 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 clinicians, 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 clinicians 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.)

Given the realities of the mental health field (limited funding, priorities competing for time, clinicians and supervisors without advanced academic training, 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 clinicians. This plan is based on several principles:
• All clinicians, 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, each clinician receives a minimum of 1 hour of group clinical supervision per week. Each week you 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 clinician 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 clinician presents this session in group clinical supervision.

When it is a clinician’s week to be observed or taped and meet for individual supervision, he or she will receive 3 hours of supervision: 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 clinician per week. Figure 7 shows this schedule.

<table>
<thead>
<tr>
<th>Figure 7. Sample Clinical Supervision Schedule</th>
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<tbody>
<tr>
<td>Clinician</td>
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<tr>
<td>A</td>
</tr>
<tr>
<td>B</td>
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<tr>
<td>C</td>
</tr>
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<td>D</td>
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<td>E</td>
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</table>

When you are working with a clinician 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 clinician, increasing the total hours for clinical supervision to 4, still a manageable amount of time.

**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 (2002a) 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.

Supervisory documents and notes are open to management, administration, and human resources (HR) personnel for performance appraisal and merit pay increases and are admissible in court proceedings. Supervision notes, especially those related to work with clients, are kept separately and are intended for the supervisor’s use in helping the clinician improve clinical skills and monitor client care. It is imperative to maintain accurate and complete notes on the supervision. However, as discussed above, documentation procedures for formative versus summative evaluation of staff may vary. Typically, HR accesses summative evaluations, and supervisory notes are maintained as formative evaluations.

An example of a formative note by a supervisor might be “The clinician responsibly discussed countertransference 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. From a legal perspective, the supervisor needs to be specific about what was agreed on and a timeframe for following up.

**Structuring the Initial Supervision Sessions**

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 clinician give some thought to what he or she would like to accomplish in supervision and what skills to work on.

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 clinician.
• Briefly describe your model of counseling and learn about the clinician’s frameworks and models for her or his counseling practice. For beginning clinicians 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 inservice seminar, community workshops, professional association memberships, and professional development funds or training opportunities).
• Explore the clinician’s goals for supervision and his or her particular interests (and perhaps some fears) in clinical supervision.
• Explain the differences between supervision and therapy, establishing clear boundaries in this relationship.
• Work to establish a climate of cooperation, collaboration, trust, and safety.
• Create an opportunity for rating the clinician’s knowledge and skills based on the 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 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?

**Methods and Techniques of Clinical Supervision**

A number of methods and techniques are available for clinical supervision, regardless of the modality used. Methods include (as discussed previously) 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.) Figure 8 outlines some of the methods and
techniques of supervision, as well as the advantages and disadvantages of each method.

Figure 8. Methods and Techniques in Clinical Supervision

<table>
<thead>
<tr>
<th>Description</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
</table>
| **Verbal Reports** | Verbal reports of clinical situations | • Informal  
• Time efficient  
• Often spontaneous in response to clinical situation  
• Can hear clinician’s report, what he or she includes, thus learn of the clinician’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 |
| Group discussion of clinical situations | • 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 |
| **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 | • The validity of self-report is dependent on clinician developmental level and the supervisor’s insightfulness  
• Does not reflect broad range of clinical skills of the clinician |
<table>
<thead>
<tr>
<th>Method</th>
<th>Description</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
</table>
| **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  
• Clinician 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 clinician 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 | • Clinician 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  
• Clinician 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) |
<table>
<thead>
<tr>
<th><strong>Description</strong></th>
<th><strong>Advantages</strong></th>
<th><strong>Disadvantages</strong></th>
</tr>
</thead>
</table>
| **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 clinician anxiety or self-consciousness  
• Technically more complicated  
• Requires assurance that downloads will be erased and unavailable to unauthorized staff |
| **Cofacilitation and Modeling** | Supervisor and clinician jointly run a counseling session  
Supervisor demonstrates a specific technique while the clinician observes This may be followed by roleplay with the clinician practicing the skill with time to process learning and application | • Allows the supervisor to model techniques while observing the clinician  
• Can be useful to the client (“two clinicians for the price of one”)  
• Supervisor must demonstrate proficiency in the skill and help the clinician incrementally integrate the learning  
• Clinician sees how the supervisor might respond  
• Supervisor incrementally shapes the clinician’s skill acquisition and monitors skill mastery  
• Allows supervisor to aid clinician with difficult clients | • Supervisor must demonstrate proficiency in the skill and help the clinician incrementally integrate the learning  
• The client may perceive clinician 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 clinician gain a different perspective  
• Creates a safe environment for the clinician to try new skills | • Clinician can be anxious  
• Supervisor must be mindful of not overwhelming the clinician with information |
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:

- The allocation of time for 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 supervision discussed in this TIP 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.
- Clinical and management responsibilities of a supervisor. Supervisors have varied responsibilities, including administrative tasks, limiting the amount of time available for clinical supervision.

**Administrative Supervision**

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 text addresses 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?”

**Documentation 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 clinician (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 clinician 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 to supervisees.
- 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).

**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. Your choices? Stop performing some tasks (often training or supervision) or take work home and work longer days. In the long run, neither of these choices is healthy or effective for your organization. Yet, 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,
junk mail, and so on. Effective supervisors find their times in the day when they are most productive. Time management is essential if you are to set time aside and dedicate it to supervisory tasks.

**Foundation Areas and Performance Domains of Supervision**

Effective clinical supervisors are skilled, experienced clinicians. They are knowledgeable about disorders and generally accepted research-based assessment, intervention, and treatment strategies. It is important that supervisees believe that their supervisors have substantial knowledge and skill to pass along. However, knowledge and skill as a therapist are not enough to ensure success as a clinical supervisor.

The specific tasks, responsibilities, and roles of supervisors vary depending on agency mission, target population, theoretical model, treatment modality, and general structure. However, some basic competencies are common to a variety of settings and professional disciplines. These basic concepts are reflected in the foundation area competencies in this document. They are common across the variety of disciplines and interest groups that provide care for clients with mental health and substance use disorders. Clinical supervisors in mental health and substance use disorder treatment settings should be familiar with these trans-disciplinary foundations.

The framework used here identifies five foundation areas in clinical supervision:

1. Theories, Roles, and Modalities of Clinical Supervision;
2. Leadership;
3. Supervisory Alliance;
4. Critical Thinking; and
5. Organizational Management and Administration.

Each contains several competencies that, taken together, define the work of the clinical supervisor.

**THEORIES, ROLES, AND MODALITIES OF CLINICAL SUPERVISION**

*Introduction*

Although some similarities exist between therapy and supervising, there are many important differences. Clinical supervision has its own knowledge base, and supervisors must understand different theoretical perspectives. They also must understand the roles clinical supervisors are expected to fill and the various modalities, or ways of implementing supervision, that are available.

*The Competencies*

- Understand the role of clinical supervision as the principal method for monitoring and ensuring the quality of clinical services.
- Appreciate the systemic role of the clinical supervisor as a primary link between management and direct services.
• Understand the multiple roles of the clinical supervisor, including consultant, mentor, teacher, team member, evaluator, and administrator.
• Be able to define the purpose of clinical supervision specific to the organization’s clinical and administrative contexts, including supervisory goals and methods.
• Be familiar with a variety of theoretical models of clinical supervision, including (but not limited to) psychotherapy-based, developmental, multicultural, integrative, and blended models.
• Be able to articulate one’s model of supervision.
• Be familiar with modalities of clinical supervision, including individual, group, direct observation, and consultation.
• Be familiar with the current research literature related to recommended practices in both mental health treatment and clinical supervision.
• Be familiar with the literature regarding multiple learning strategies (e.g., instructions, demonstrations, role plays, critiques).
• Recognize the importance of establishing with the supervisee a productive, healthy learning alliance focused on improving client services and job performance.
• Understand and reinforce the complementary roles of members on a multidisciplinary team.
• Understand the importance of assessing needs and carefully planning and systematically implementing individual and group supervisory activities that promote clinical and program service improvement.

LEADERSHIP

Introduction

Leadership is an important element of clinical supervision. Leadership may be defined as a bidirectional social influence process in which supervisors seek voluntary participation of supervisees to achieve organizational goals, while providing leadership in the management structure of the agency. Leaders mentor, coach, inspire, and motivate. They build teams, provide structure, create cohesion, and resolve conflict. In addition, leaders build organizational culture, facilitate individual and organizational growth and change, and foster a culturally sensitive service delivery system by consistently advocating, at all levels of the organization, the need for high-quality clinical care for all patients or clients of the agency.

The Competencies

• Use a leadership style that creates and maintains an environment based on mutual respect, trust, and teamwork.
• Be a role model by taking full responsibility for one’s decisions, supervisory practices, and personal wellness.
• Seek job performance feedback from supervisees, peers, and managers to improve supervisory practices.
• Create, regularly assess, and revise a personal leadership plan to provide direction for one’s continuing professional development.
• Seek out and use leadership mentors to assist with one’s personal development, knowledge acquisition, and skill development.
• Understand the historical context of treatment for mental health disorders and use that understanding to participate in developing the agency’s guiding vision and its related mission, principles, and sense of purpose.
• Clarify agency vision, mission, and service goals and objectives for the supervisee.
• Interpret agency mission, policies, procedures, and critical events. Effectively communicate those interpretations to supervisees and foster an organizational climate that promotes continuous improvement and excellence in client care.
• Understand, monitor, and ensure compliance with State and Federal regulations and accrediting body (e.g., Commission on Accreditation of Rehabilitation Facilities, Joint Commission on Accreditation of Healthcare Organizations, Council on Accreditation) standards for the delivery of treatment.
• Recognize the safety and security issues facing the organization and participate in enforcing and enhancing organizational policies that ensure the safety and security of clients, personnel, and facilities.
• Understand and acknowledge the power differential inherent in the supervisor–supervisee relationship, using power fairly and purposefully avoiding the abuse of power.
• Proactively structure and schedule clinical supervision activities.
• Teach, mentor, and coach in the context of the organization’s core values.
• Provide honest feedback—positive, constructive, and corrective.
• Guide through motivational empowerment rather than control. Facilitate work through team building, training, coaching, and support.
• Plan and organize for orderly workflow, controlling details without being overbearing.
• Empower and delegate key duties to others while maintaining goal clarity and commitment. Delegate mindfully, considering both the supervisee’s professional development and the agency’s needs.
• Encourage supervisee participation in communicating observations, ideas, and suggestions to agency management.

SUPERVISORY ALLIANCE

Introduction
Clinical supervision takes place in the context of the supervisor–supervisee relationship. A positive supervisory alliance includes mutual understanding of the goals and tasks of supervision and a strong professional bond between supervisor and supervisee. To be effective, a supervisor must have a clear understanding of the nature and dynamics of this relationship.
The Competencies

- Be familiar with the literature about supervisory alliance, including key factors that strengthen or compromise the supervisory alliance, supervisory contracting, and relational issues (e.g., transference and countertransference).
- Understand the complex, multilevel, and bidirectional nature of the supervisory triad of client, therapist, and supervisor. Maintain an awareness of potential dual relationships and boundary violations within the triad.
- Recognize that the supervisor–supervisee relationship develops over time and that the stage of relationship development influences the rules, roles, and expectations of the alliance.
- Conceptualize the supervisor–supervisee relationship as a learning alliance that provides for role induction, includes agreement on goals and tasks, and recognizes the bond that develops between the supervisor and the supervisee.
- Understand the value of mentoring as a dynamic way of forming an alliance, teaching counseling skills through encouragement, and giving suggestions for accomplishing goals.
- Create an explicit supervisory contract that clarifies expectations and goals, the relationship’s structure and evaluative criteria, and the limits of supervisor–supervisee confidentiality.
- Present as a credible professional who possesses knowledge and expertise relevant to the setting and the population being served.
- Model ethical behavior vis-à-vis the supervisee and reinforce ethical standards in the relationship between the supervisee and the supervisee’s clients.
- Be continually alert to the effects of one’s interpersonal style on the supervisee.
- Maintain appropriate boundaries in forming and maintaining a safe and trusting professional relationship.
- Attend to cultural, racial, gender, age, and other diversity variables essential to a productive supervisor–supervisee relationship.
- Understand, recognize, and know how to ameliorate the effects of personal countertransference triggered by the supervisee’s interpersonal style, the supervisee’s developmental issues, or the supervisee’s unresolved personal issues.
- Recognize interpersonal conflict and supervisory impasses, accept appropriate responsibility, and actively participate in resolving difficulties.

THINKING CRITICAL

Introduction

Critical thinking refers to the cognitive processes of conceptualizing, analyzing, applying information, synthesizing, and evaluating. Supervisors are expected to use critical thinking to make sound decisions and solve problems on a regular basis; they also must help supervisees hone critical thinking skills.
The Competencies

- Understand the various contexts (e.g., organizational, political, societal, cultural) in which supervision is conducted.
- Analyze and evaluate agency issues and policies to better understand, clarify, and participate in the continuous improvement of agency and staff performance and service outcomes.
- Evaluate and select written and oral communication strategies appropriate to the audience and purpose.
- Select, adapt, implement, and evaluate appropriate problem solving, decision making, and conflict resolution techniques.
- Apply experience, insight, and lessons learned to new situations.
- Apply critical thinking to information gathering by evaluating the content of the information and the credibility of its source.
- Ask supervisees relevant and clarifying questions and listen critically for content and underlying issues in their self-disclosure.
- Help supervisees develop skills in case conceptualization and analysis of client-clinician interactions.
- Negotiate, communicate, and document the resolution of conflicts or disagreements and strategies for resolving performance problems. Document outcomes.
- Develop sound criteria for self-evaluation and clarify personal beliefs, values, and biases.
- Help supervisees develop sound criteria for self-evaluation and clarify their beliefs, values, and biases.

ORGANIZATIONAL MANAGEMENT AND ADMINISTRATION

Introduction

Management can be defined as the process of working with and through others to achieve organizational objectives in an efficient, legal, and ethical manner. Administration, in the context of this document, is the day-to-day implementation of the organization’s policies and procedures.

Although clinical supervision is distinguished from administrative supervision in some models of supervisory practice, the two significantly overlap in the real world. Virtually all clinical supervisors have responsibility for some management and administrative activities, but the scope of these activities can vary widely depending on the organization.

The Competencies

- Recognize that organizational and managerial skills and tasks enhance clinical supervision.
- Understand and consistently apply agency policies, procedures, organizational structure, and communication protocols.
• Understand the legal demands and liabilities inherent in supervisory and clinical services, including the vicarious liabilities incurred in supervising interns and students.

• Be familiar with and abide by current principles, laws, ethical guidelines, and agency policies regarding personnel management.

• Learn to implement effective disciplinary and administrative management techniques that enhance clinical supervision and accomplishment of the organization’s mission.

• Understand and ensure supervisee compliance with State program licensing requirements and with other State and Federal laws and statutes.

• Understand and ensure supervisee compliance with the treatment standards of the organization’s healthcare accrediting body (e.g., Commission on Accreditation of Rehabilitation Facilities, Joint Commission on Accreditation of Health-care Organizations).

• Monitor and maintain the human and technical resources needed to meet organizational and program objectives.

• Evaluate and contribute to improving the organization’s cultural proficiency.

• Possess and continually improve organizational and time management skills.

• Understand and work within the organization’s budgetary constraints.

• Effectively apply technology, within agency and regulatory limits, for communication, program monitoring, report writing, problem solving, recordkeeping, case management, and other activities.

• Ensure the maintenance, storage, and security of employee records and protected health information consistent with the organization’s policies and procedures, government regulations, and ethical principles.