

**Clinical Supervision:  
A Practice Specialty of Clinical Social Work**

*A Position Statement of the  
American Board of Examiners in Clinical Social Work*

**Adopted October 8, 2004**

Executive Summary of  
**Clinical Supervision:  
A Practice Specialty of Clinical Social Work**

This position statement is intended to be definitive and comprehensive in its treatment of Clinical Supervision as a specialty within the overall practice of Clinical Social Work. It was undertaken to address, from the practitioners' perspective, the salient features of clinical supervision and its impact on quality of care and public protection. No area of practice has more power to affect the competent delivery of mental-emotional health services in America. With more than 180,000 practitioners in virtually every county of every state, clinical social workers make up the nation's largest group of providers of those services. At least 40,000 of them receive ongoing clinical supervision. Further, every year, roughly 10,000 new graduates of master's-level programs enter the field, to be trained by clinical social worker supervisors for the next two years. During that time, most of the graduates' school-learning will be challenged by the realities of serving actual people in need who look to them for help and healing.

For the new practitioner, this phase is the crucible of competent practice: in it, he or she will be transformed from an anxious novice into an effective care-giver—but only if the clinical supervisor is highly competent and capable of providing high levels of guidance, instruction, and support. Much of the burden of competence—clinical as well as legal—falls on the clinical supervisor during the supervisee's training. The supervisor's ability to impart the knowledge, traditions, values, approaches, and skills of clinical social work will be thoroughly tested. The well-being of many clients—individuals and couples and groups, spanning all ages and conditions, with all manner of problems and disorders—will depend largely on the supervisor's effectiveness. The young clinicians will absorb the fundamentals of practice and become familiar with the skills and techniques that they will use in a profession in which they may change thousands of lives for the better.

With so much at stake, this paper seeks to identify the characteristics of practice by which a supervisor may be recognized for advanced competence, and to explore the many issues that affect the supervisor, the supervisee, and their clients. In doing so, the paper's authors drew on much of the published literature on this topic, and incorporated the writings and comments of leading practitioners and academics. The paper is intended to stand up to intense scholarly and empirical scrutiny, and has been written with full annotation as to sources and a rigorous commitment to be inclusive and objective. It is hoped that the paper will serve to focus the interest of many audiences on an area of practice, clinical supervision, which carries with it the future of the entire field of clinical social work.

## **Purposes of Supervision**

Clinical supervision is conducted by an experienced and skilled clinical social worker in order to assist a less-advanced practitioner to form a clinical social work identity, and to develop the knowledge and skills to be able to practice effectively. Not least in this process is the supervisor's role as the guarantor of public protection against sub-standard practice and undesirable outcomes—a role that is recognized in every state and province in the U.S. and Canada, whose laws require that clinical social workers be supervised for specified periods (usually two years) prior to applying for a license to practice autonomously.

## **Domains of Supervision**

Clinical social work supervision addresses four domains: direct practice, treatment-team collaboration, continued learning, and job management. Within these domains, supervisors practice in two ways, each requiring formal agreements and externally derived authority: in the employment setting or under contract to an agency (Note: When a supervisee hires a supervisor directly, the relationship *de facto* becomes one of consultation and not supervision). A brief exposition of each of the domains follows.

***Clinical supervision of direct practice*** refers to activities in which the supervisor guides and educates the clinical social worker supervisee in assessment, treatment/intervention, identification and resolution of ethical issues, and evaluation of client interventions.

***Clinical supervision of treatment-team collaboration*** refers to client-oriented activities in which the supervisor guides and educates the clinical social worker supervisee in interacting with other professionals in the service environment, influencing policies and procedures in the professional environment, and affecting political systems whose policies have an impact on client treatment/interventions.

***Clinical supervision of continued learning*** refers to activities in which the supervisor guides and educates the clinical social worker supervisee to develop the skills required for life-long continued professional learning.

***Clinical supervision of job management*** refers to activities in which the supervisor guides and educates the clinical social worker supervisee in work-related issues that frame the clinical work: record-keeping, fees, handling of phone calls and missed sessions, timeliness, report-writing, caseload management, and resolution of ethical issues.

## **Approaches to Supervision**

Supervision has no single, unifying theory: supervisors are guided in their work by different models, which feature certain techniques. The different models all have a core set of principles for the supervisor to follow: ethical and legal practice; a commitment to improve programs and social policy; and recognition of the client's rights to self-determination, to respect for potential/limitations, and to be addressed as a whole person. In traditional models, the supervisor-supervisee relationship is based on the supervisor's taking legal and professional authority for the supervisee's performance, as sanctioned by the employing agency or organization. The supervisor, dealing constantly with the complex responsibilities toward both the supervisee and the client, must also address the demands of the employing organization, including fiscal constraints, large caseloads, and administrative functions.

## **Preparation for Advanced Clinical Supervision**

Over time, the practitioner who becomes an advanced clinical supervisor will have undergone the transformation through being supervised in his/her supervisory practice, interacting with supervisees and clients, and receiving relevant continuing education. Advanced supervisors are different from intermediate-level supervisors in being more effective in the interpretation of practice, more skillful in interaction with supervisees, and better able to generalize from specific practice issues. Experience—length of time in practice, special attention to supervisee-client issues, and development of wisdom over the course of repeatedly applying knowledge, skill, and judgment—does count in clinical supervision. An advanced supervisor should have at least five years' practice as a clinical supervisor with a significant portion of his/her work being provision of supervision.

## **Ongoing Commitments of Advanced Supervisors**

Once established as a clinical supervisor at the advanced level, the practitioner will continue to receive supervision or consultation and will keep learning through continuing education or certificate programs, reading current literature, attending professional conferences, and examining his/her own supervisory practice. The advanced supervisor will conduct practice guided by an understanding of the impact of culture (i.e. norms of behavior for a particular population) as it refers to ethnicity, race, age, class, gender, sexual orientation, religion, immigration status, literacy, and mental or physical disability. The advanced supervisor will practice legally and ethically and, whenever possible, will apply evidence-based best practices to the work of supervision. . Ethical practice, among many other things, requires that the supervisor not become involved in any problems of the supervisee to the extent of risking the welfare of the client, whose well-being must be paramount.

## **Advanced Clinical Social Work Supervision Defined**

Clinical supervision in clinical social work is the provision of clinical supervisory services which are informed by advanced training, years of experience, and mastery of a range of competencies (identified in detail in the Clinical Supervision position statement). These services are imparted by an advanced clinical social worker supervisor to a clinical social worker who, being less advanced in practice, needs of the knowledge and skill of the supervisor in order to provide optimal services to clients. The clinical supervisor takes formal, legal responsibility for the quality and outcome of the supervisee's work with clients. The supervisor specialist has mastery of the relevant knowledge and skills of clinical supervision, and excels in helping supervisees to develop clinical skills in their work with clients in many settings and contexts. Further, the supervisor specialist applies core social work principles to his/her work, and helps the supervisee to do the same.

## **Competencies of the Advanced Clinical Supervisor**

A proficient clinical supervisor's professional knowledge and skills can be identified as reflecting an advanced level of competency. The supervisor understands theoretical concepts and how to apply them flexibly to practice, and has practice wisdom gained from years of experience in this field. The supervisor monitors his/her own direct and supervisory practice, pursues professional development, and knows when to seek consultation and/or supervision. The supervisor may also serve as mentor or consultant to colleagues, and may model and teach what is needed for autonomous practice. In determining the proficiency of the supervisor, nothing is more telling than competency in professional knowledge and practice skills, each of which can be measured by detailed characteristics of practice (listed and discussed in Clinical Supervision position statement) as they are related to the following terms:

- Creation of a Supervision Contract
- Supervision of the Processes of Intake, Assessment, and Diagnosis
- Supervision of Treatment Planning
- Creation of Supervision Plan
- Supervision Process
- Supervision of Appropriate Professional Impact
- Evaluation of Practice Outcome
- Evaluation of Supervision Outcome
- Consultation, Teaching, and Writing.

## **Conclusions**

ABE concludes:

1. It is possible to describe and define the nature and value of advanced clinical social work supervision.
2. There is a continued need for research in clinical social work supervision
3. Changes in many work settings have forced some clinicians to seek outside supervision at their own expense and at the risk of circumventing the responsibilities inherent in the relationship of a clinician and a formal organization-based supervisor. These arrangements raise issues of accountability, confidentiality and liability, which need to be addressed by regulatory agencies, service agencies, and professional associations
4. There are inadequate and inconsistent standards for regulation and training of clinical social work supervisors
5. It is difficult to achieve the necessary training to become an advanced practitioner in clinical social work with the current:
  - Lack of financial support for supervision in social work agencies
  - Limited coursework in supervision in graduate schools of social work
  - Insufficient post-masters' training opportunities

## **Recommendations**

ABE therefore recommends

1. That further research be done in the areas of evidence-based best practices in clinical social work supervision
2. That post-master's training in clinical supervision be made widely available.
3. That standards and regulations for the providers of pre-licensure clinical supervision be established by regulatory agencies as a means of public protection.
4. Clinical supervision be a funded service in any comprehensive mental health or social service delivery plan.

5. That graduate schools and bodies that accredit graduate schools strengthen the curriculum and training for supervision for students and field instructors.
6. That the profession advance post-graduate education and training opportunities for the continuum of clinical social work supervision.

(end of executive summary)

**Editors Note 4/2006**

Since this paper was adopted, it has become clear to the American Board of Examiners that there are some subject areas that have not been fully addressed. The most notable of these are the problems presented by the lack of consistency among state licensure laws regarding clinical supervision, and the existing state of clinical social work supervision in the job setting. ABE is currently researching these areas and for this reason, this paper should be considered as “under revision.”

## **Clinical Supervision: A Practice Specialty of Clinical Social Work**

### *A Position Statement of the American Board of Examiners in Clinical Social Work*

#### **I. Introduction**

The American Board of Examiners in Clinical Social Work (ABE) presents this paper as a position statement on the advanced practice of clinical social work supervision. In its exposition of the elements of clinical social work, this paper draws on an earlier position statement, *Professional Development and Practice Competencies in the Practice of Clinical Social Work* (1995, 2002). The present paper seeks to identify the advanced practice characteristics of clinical supervision, to examine many of the issues and influences relative to this specialty, and to provide a framework for standard-setting toward the certification of skilled supervisors.

In light of the comprehensive nature of the subject matter, and the breadth and specificity of the advanced practice characteristics, this position statement is not intended as a description of any individual's practice; rather it seeks to explore the entire scope of a wide-ranging practice area in all of its complexities and settings. It should be noted that consultation is considered a separate area of practice from supervision (Barretta-Herman, 2001; Bernard & Goodyear, 1992; Munson, 2002) and so is not addressed in these pages.

The major objectives of this position statement are:

- to examine the background of clinical supervision in clinical social work (purposes, domains, approaches, history, and contemporary context)
- to examine the nature of clinical supervision in clinical social work (preparation, cultural competencies, guided practice, evidence-based practice, consultation, and legal and ethical issues)
- to define clinical supervision as a practice specialty of advanced clinical social work
- to trace the clinical supervisor's professional development in terms of practice competencies and areas of knowledge and skill.

Briefly defined, clinical supervision in clinical social work is the provision of supervisory services which are informed by advanced training, years of experience, and mastery of a range of competencies (identified in this paper) (Barretta-Herman, 2001; Munson, 2000, 2002). These services are imparted by an advanced clinical social worker supervision specialist to a clinical social worker who, being less advanced in practice, stands in need of the knowledge and skill of the supervisor in order to provide optimal services to client(s) (Barretta-Herman, 2001; Bernard & Goodyear, 1992; Kadushin & Harkness,

2002; Munson, 2002). The clinical supervisor takes formal, legal responsibility for the quality and outcome of the supervisee's work with the client (Gibelman & Schervish, 1997), a function that has been recognized in most states as being fundamental to protection of the public. Clinical supervision, an advanced practice specialty, is conducted within the larger context of clinical social work (Kadushin & Harkness, 2002; Munson, 2002; Shulman, 1993; Tsui, 2005).

At the level of general (non-specialist) advanced practice, clinical social work is described in the following paragraphs. Clinical social work itself is a practice specialty of the social work profession. Clinical social work's purpose is to help people with bio-psychosocial problems and disorders. Clinical social work builds on the core values, ethics, practice principles, and person-in-environment perspective of the social work profession, yet it is a distinctive specialty. Clinical social work practitioners apply unique practice methods and perspectives based on a program of specialized graduate education (clinical internships required), specialized post-graduate supervised training, and ongoing practice experience and clinical continuing education.

The advanced clinical social worker's knowledge base includes theories of bio-psychosocial development. It encompasses (in varying degrees of depth according to specialization) normal and abnormal human development and behavior; disorders and addictions; consequences of trauma, illness, or injury; intrapersonal, interpersonal, and family dynamics; and the impacts of physical, social, cultural, and economic environment. The advanced clinician is highly knowledgeable about the following areas: multi-dimensional assessment, differential diagnosis, treatment planning, treatment/intervention, case management, professional use of self (including empathy and therapeutic alliance), disciplined approach to the practice environment, interdisciplinary collaboration, and best practices in initiating change and ameliorating complex problems.

The advanced clinician has acquired the skills for effective practice in the areas mentioned above. Since skills are developed over time and as a result of experience and continuing education, the clinician must have at least two years of practice under supervision, and a total of five years of post-master's clinical practice, before he/she achieves the level of advanced practice. Thereafter, the practitioner continues to learn and apply new theories and methods, to utilize consultation and continuing education, to develop expertise in specialized areas and to evaluate the effectiveness of his/her interventions. The advanced supervisor has the skills to collaborate with other professionals and to supervise, consult, teach, or otherwise contribute to the professional development of colleagues.

Combining high levels of knowledge and proficiency in practice skills, advanced clinical social workers practice effectively with many types of client in various settings. The competent clinician diagnoses and treats people with bio-psychosocial impairments, including mental and emotional disorders and, in some cases, developmental disabilities or other disruptions of normal development and functioning. The competent clinician also

helps to prevent bio-psychosocial dysfunction, and supports and enhances the client's strengths and functioning. In all interventions, the advanced clinical social worker places a high value on cultural, ethnic, and environmental factors, and on the client's right to self-determination.

In addition to their role as practitioners, clinical social workers recognize their role as members of a profession that adheres to a code of ethics, including concern for clients' rights and self-determination, and for the protections and limitations of privacy and confidentiality in practice.

## ***A. Background of Clinical Social Work Supervision***

### **1. Purposes of Supervision**

Clinical supervision is conducted by an experienced and skilled clinical social worker in order to assist a less-advanced practitioner to form a clinical social work identity, and to develop his/her knowledge and skills in direct practice, treatment collaboration, continued learning, and job management (Munson, 2002; Rich, 1993; Tsui, 2005). Clinical social work places extraordinary reliance on supervision, in the practice setting, as essential to the clinician's progress toward professional mastery, and requires that, on occasion, the supervisor recommend the removal of incompetent practitioners (Gibelman & Schervish, 1997; Kadushin & Harkness, 2002; Shulman, 1993).

Not least in this process is the supervisor's role as the guarantor of public and consumer protection against sub-standard practice and undesirable outcomes (Barretta-Herman, 2001; Bernard & Goodyear, 1992; Brown & Bourne, 1996; Kadushin & Harkness, 2002; Munson, 2002; Rich, 1993; Tsui, 2005). The crucial importance of competent clinical supervision is acknowledged by the laws of every state and province in the U.S. and Canada, which require that each clinical social worker be supervised for specified periods of time (usually two years) prior to applying for a license to practice autonomously. In addition, some states have adopted regulation outlining the specific training and experience for clinical supervisors of pre-licensed interns.

A clinical social worker supervisor, who provides supervision for purposes of licensure, as required in many states, is accountable to the licensing board for providing an objective evaluation of each supervisee's functioning and ability to practice without risk of harm to the public.

### **2. Domains of Supervision**

In general, clinical social work supervision addresses four main domains or areas: direct practice, treatment collaboration, continued learning, and job management (Shulman, 1993). These areas will tend to overlap in any given situation. Within these domains, there are two types of clinical supervision: supervision in the employment setting (usually

an agency or organization), and supervision under contract to an agency (Note: When hired by a supervisee, the supervisor *de facto* provides consultation, not supervision). In the first case, the terms of supervision-supervisee accountability are set by the authority of the agency. In the second case, a formal, written agreement among agency-supervisor-supervisee is required, in which the agency grants formal supervisory authority and permission to access confidential client information. In the third case, a similar formal written agreement is required between the supervisor and supervisee. In some states, the supervisee must be formally employed by the supervisor, even if the relationship takes place in a private-practice setting. These formalized and legally binding arrangements clarify the agreements and protect all of the parties involved, including the clients.

A brief exposition of each of the domains follows.

***Clinical supervision of direct practice*** refers to all activities designed to guide and educate the clinical social worker in assessment, treatment/intervention, identification and resolution of ethical issues, and evaluation of client interventions. Such guidance involves regularly scheduled individual or group conferences with case-presentations and process-presentations. Case presentations address issues of assessment and treatment planning and can be opportunities for teaching the professional use of self. Process presentations involve analyzing records of interactions with clients, using media such as memory work (recalling the process from memory); process recording; observation; or audio- or video-taping (Munson, 2000, 2002).

***Clinical supervision of treatment collaboration*** refers to all client-oriented activities designed to guide the clinician in dealing with other professionals (e.g. psychiatrists, non-clinical social workers, teachers, healthcare practitioners, treatment team), influencing policies and procedures in the professional environment, and affecting political systems whose policies have an impact on client treatment/interventions (Brashears, 1995; Cohen, 2004; Kerson, 2004; O'Donoghue, 2003; Tsui, 2005; Tsui & Ho, 1997). In each of these areas, the supervisor is expected to apply the same principles and procedures as in the supervision of direct practice, guiding both the process of interaction and the management of the "case," including assessment and intervention strategies, and becoming an effective team member (Kopfstein, 1998; Vinokur-Kaplin & Miller, 2004).

***Clinical supervision of continued learning*** involves working with the practitioner to help develop the skills required for life-long continued professional learning. This may include fostering professional use of self and self-scrutiny, and tolerance for ambiguity, and openness to a variety of models and concepts. It may also include helping clinicians to articulate learning objectives and the steps for attaining them (see Caspi & Reid, 2002, for an elaboration in this area) and to use other sources of learning (i.e. colleagues, group supervision, consultants, workshops, the literature) to enhance practice knowledge and skills. In addition, the supervisor may guide the clinician in making better use of supervision and consultation and in taking control of the process (Barretta-Herman, 1993; Brashears, 1995).

*Clinical supervision of job management* refers to guiding the supervisee in work-related issues, which create a frame for the clinical work (Kadushin & Harkness, 2002; Munson, 2002; Shulman, 1993). Many such issues can impact the supervisee's effectiveness with clients: record-keeping, matters relating to fees, handling of phone calls and missed sessions, timeliness, report-writing, and caseload management. Job-management also refers to the supervisor's guidance relating to the supervisee's resolution of ethical issues, such as those arising from third-party matters (e.g. managed-care requirements, insurance reimbursement) that can adversely affect service to clients. Some of these issues are addressed later in this paper.

### **3. Approaches to Clinical Social Work Supervision**

In supervision, there is no single, unifying theory; but clinical supervisors may be guided in their work by models, or approaches, in which certain techniques are employed in service to a theory. These approaches, however different, have a core set of principles for the supervisor to follow: ethical and legal practice; a commitment to improve programs and social policy; and recognition of the client's rights to self-determination, to respect for potential/limitations, and to be addressed as a whole person. No individual supervisor will have mastery of all or even many of the various approaches; however, for purposes of inclusiveness—and recognizing that each approach has its adherents—this paper includes descriptions of the best-known approaches to supervision.

Most supervisory approaches emphasize “relationship” (Kadushin & Harkness, 2002; Kaiser 1997; Munson, 2002; Shulman, 1993) and are dynamic, evolving to meet the changing needs of the developing supervisee (Baker, Exum, & Tyler, 2002). In traditional models of supervision, the supervisor-supervisee relationship is premised on the employing entity's sanction of the supervisor as taking legal and professional authority for the supervisee's performance. Some other models are premised on the supervisee's recognition of the supervisor's superior experience and competence, in which the supervisor retains legal and professional authority over the supervisee. It should be noted that some feminist theorists criticize authority-based models (Chernesky, 1986).

The various approaches have different emphases: the primacy of the supervisor-supervisee relationship (traditional), the primacy of client outcomes (client-focused), the primacy of attending to the supervisee's interaction with other systems (dynamic). The diversity of models is nearly endless: some approaches use spirituality (Polanski, 2003) and Jungian psychology (Pajak, 2002), while a relational approach is used by some trauma therapists (Wells, Trad, & Alves, 2003) and those whose AIDS clients are “in the shadow of death” (Ringel, 2001). Building on the work of William Schwartz (1960), Shulman (1993, 1999) identifies an “interactional model” in which the supervisor-supervisee relationship is examined across time phases: preliminary, beginning, middle, and ending/transition. Most approaches address the importance of integration of the personal and the professional, as in the focus of Aponte and Winter (2000) on “use of

self.” Attempts at integrating different models have been made by Stoltenberg, McNeill, and Crethar (1994) as well as Barretta-Herman (1993), Brashears (1995), Rich (1993), and Tsui (2005).

Educational approaches to supervision tend to be highly valued by supervisees, who want their supervisors to be adept at teaching clinical social work knowledge and skill and at helping them grow as professionals. Moreover, the supervisor-supervisee relationship should foster communication and alliance-building skills that are critical to the practitioner-client relationship. As Shulman (1993) observes, “more is ‘caught’ by staff than ‘taught’ by the supervisor” (p. 7).

Beyond the educational approach, Kadushin and Harkness (2002) describe the expressive-supportive leadership function in which supervisees are given support and assistance when they have job-related discouragements. But the supervisees are not the only ones in need of support, for job of the supervisor—agency-based supervisors especially—is inherently stressful. The supervisor, dealing constantly with the complex responsibilities toward both the supervisee and the client, must also address the demands of the employing organization and serve as a mediator between the two interests. These challenges are increased by a typical agency’s fiscal constraints and large caseloads, coupled with the traumatic and intractable nature of many client issues. Many clinical supervisors find themselves struggling to perform sufficient clinical work when they must also perform administrative functions focused on controlling practitioners, managing cases, and maintaining the organization.

### ***B. History of Clinical Supervision in Clinical Social Work***

Since the beginning of social work practice in the early 1900s, neophyte practitioners have relied on the guidance and supervision of those with more experience (Brashears, 1995; Kadushin & Harkness, 2002; Munson, 1979, 2002; Tsui, 2005). Unlike other mental healthcare disciplines, clinical social work continues to rely on such workplace-based supervision, provided consistently for at least two years, to round out the education and training of the graduate of an academic master’s-level program. Without such supervision, the intermediate clinical social worker lacks the experience to proceed with the more demanding aspects of clinical social work and to reach the competency levels of an advanced practitioner (Barretta-Herman, 1993, 2001).

In reviewing the brief history of clinical supervision, the work of Carlton E. Munson (1979, 2002) is instructive. Into the 1930s, when there were few graduate schools of social work, supervisors were virtually the only means of providing new clinicians with the training and education they needed to become effective, autonomous practitioners (Kadushin & Harkness, 2002). Clinical supervisors were key team members in all family agencies and hospitals, and also staffed the “training organizations” that then prepared most social workers for clinical practice. Thus, social-work supervision was initially seen as “an educational process” (Robinson, 1936). Over time, this process was combined

with responsibilities focused on management of supervisees to enhance the efficiency of the workplace. To this day, most clinical supervisors have such administrative duties in addition to their clinical roles.

The Great Depression of the 1930s caused a split in purpose between public and private agencies: the public function was to provide financial relief, while the private function was to provide treatment. Under these circumstances, clinical supervisors found that their services were valued in private agencies only. The trauma created by the Depression caused a greater need for social workers and resurgence in social work education, with more graduate schools opening and more people enrolling. This in turn created a larger role for field instructors, or supervisors of students who were placed in internships and worked with people while still in graduate school. In the schools and with the field instructors and the agency and hospital clinical supervisors, there was much reliance on teaching psychoanalytic theory and technique, since it was widely recognized as credible and it offered a “practical theory of interpersonal relationship” that met “the personality needs of the client.” (Munson, 2002, p. 61).

During the 1940s, clinical schools and supervisors tended to adopt a more eclectic approach to interventions that was client-focused and drew on different models and theories in service to the individual’s unique needs. This eclectic practice approach naturally required supervisors drawing from a broad palette of approaches, and it tended to reduce the importance of the single psychoanalytic mode. At the same time, concerned about the effect on children and their families of the ongoing war, there was a greater emphasis on providing family therapy, which required a new set of supervisory knowledge and skills.

In the 1950s, graduate schools and agencies tightened their bonds, and supervised field work became an integral part of the academic regimen. Annette Garrett’s *Learning Through Supervision* was published in 1954 (as cited in Munson, 2002), with its insistence on the importance of theory informing supervised case-work. In general, behavior was seen as determined by a combination of sociological and psychological imperatives, and supervision of practice was conducted accordingly. The explosion of knowledge, social movements, and lifestyles of the 1960s brought many challenges to supervision, including a debate as to the efficacy of individual versus group supervision, and the general question of the role of supervision at a time that extolled the autonomy of the individual. The field was open to new forms and experimentation, as faculty-based field instructors worked alongside agency-based supervisors, and new theories and models were tried out. Clinical social workers tended to pursue practice specialties by the 1970s—in distinction from the many new bachelor’s-degree social workers doing generic work—and clinical supervisors had to adjust their abilities to these specializations. In some states, licensure was adopted at this time, with supervision identified as a requirement in order to protect the public from fraudulent or abusive practice. Private practice, which became popular in the 1980s, posed a major challenge for the concept of supervision, since private practitioners had no base in the agencies and

hospitals that had traditionally been the discipline's primary practice settings. Toward the end of that decade, the concept of self-insurance for employee healthcare benefits became popular among the nation's large employers, and various forms of profit-making delivery companies were awarded contracts to manage the provision of care nationwide. Most of those companies, organized as HMOs or MCOs, had less interest in clinical supervision, since it was not a reimbursable service. At the same time, the federal and state governments slowed the rate of funding social-services agencies, including those in which most clinical social workers find their first jobs and receive the clinical supervision that is needed to enable them to achieve a level of competence in practice (see also below, Contemporary Context section).

### *C. Contemporary Context of Clinical Social Work Supervision*

In clinical social work, the master's-level graduate follows a career path that includes at least two years of intensive post-graduate supervision. This is required, in most states, in order to reach the "intermediate" level of practice, in which the clinician may be licensed to practice autonomously. The advanced clinician will need to continue to receive consultation or supervision; and such guidance should continue for the rest of the clinician's career (Barretta-Herman, 1993; Brashears, 1995; Bruce & Austin, 2000; Cohen & Laufer, 1999; Hensley, 2002; Kadushin & Harkness, 2002; Kaiser & Barretta-Herman, 1999; Munson, 2002).

This model of clinical supervision and professional development is threatened by several trends and practices in today's delivery environment. For example, as health-care delivery systems have "re-sized" their staffs to decrease costs and improve efficiency (Berger & Mizrahi, 2001), clinical supervisors have been eliminated and clinical social workers are often left with "peer supervision" and supervision by other professionals (e.g. director of nursing) (Giberman & Shervish, 1997; O'Donoghue, 2004; Stephenson, Rondeau, Michaud, & Fiddler, 2000). Berger and Mizrahi (2001) demonstrated in a study of supervision models at 750 hospitals, that most clinical social workers were supervised by clinical social workers (the traditional model), but the use of that model has been decreasing since 1992. Berger and Mizrahi point out that in some medical settings, supervision of practice has been shifted to the level of the inter-disciplinary team, often resulting in the loss of centralized clinical supervision of clinical social workers by other clinical social workers. Such changes, which have occurred in many settings, have forced some clinicians to seek outside supervision at their own expense and at the risk of circumventing the responsibilities inherent in the relationship of a clinician and a formal organization-based supervisor. These arrangements raise issues of accountability and liability.

These trends represent a mounting threat to clinical supervision, which presumes a strong relationship between supervisor and supervisee (Kadushin & Harkness, 2002; Munson, 2002). Kaiser (1997) maintains that "most would agree that a positive relationship between supervisor and supervisee is important if the supervision is to be effective.

Although the tasks of supervision appear to follow common sense, those who have been either supervisors or supervisees observe that these tasks are often quite complicated in the real world. Two major blocks to the effective and smooth functioning of supervision are contextual issues, such as agency mission and funding restrictions, and relational issues” (p. 3).

The dominant “managed-care” delivery system affects both the supervision model and the decision-making authority of the supervisor and the practitioner (Bruce & Austin, 2000; Gibelman & Schervish, 1997; Munson, 1996, 2000; 2004). Cost-containment measures may affect private practitioners as well as agency-based and organization-based clinicians, as when he/she is required to seek approval, often in a phone conversation with a managed-care employee, for continuation of service or referral to supplementary services. Munson (1996, 2000) highlighted this loss of professional autonomy as a growing threat that can adversely affect ethical decisions, practice relationships, fee setting, privacy and confidentiality, supervision issues, professional language, professional status/identity and professional organizations. While some forces damage clinical supervision, others increase its importance: since clinical social workers are the most numerous of the direct practice groups that provide reimbursable mental-emotional health services, the need for skilled clinical supervision and consultation is growing. These often-conflicting contextual factors and pressures argue the need for clear criteria for effective advanced clinical supervision.

## **II. The Nature of Clinical Social Work Supervision**

Supervision is based on the concept of an experienced practitioner helping a less-advanced practitioner to become more proficient. There are two main contexts in which clinical supervisors work with supervisees: practice within an organizational structure such as a hospital, and practice occurring outside of any organizational influence (Tsui, 2005). It is only in the organizational context that a clinical social worker supervisor has “external authority.” Derived from the agency or host setting, this authority endows the supervisor with accountability for the supervisee’s activities, and allows the supervisor to set expectations which the supervisee is obliged to try to meet. The typical clinical social worker who works as a clinical supervisor has a three-fold identity as teacher of clinical knowledge and skills, direct-service practitioner, and agency administrator. As clinical supervisor, he/she assigns the supervisee’s cases, makes final decisions about case activities, and conducts performance evaluations, among other duties. As administrator, the supervisor is usually required to perform a wide range of functions related to record-keeping and managing supervisees’ compliance with the organization’s policies and procedures. Effective supervision flows from mutuality in the working relationship, in which the supervisee concedes the supervisor’s “expert authority” in addition to his/her external authority.

In settings that do not confer external authority, the expert practitioner serves as a consultant rather than a supervisor. While the roles of supervisor and of consultant have much in common—skills, purposes, and dynamics—the supervisor alone has the externally derived authority that creates a profound difference in the relationship between the teacher and the learner.

In grasping the nature of clinical supervision, it is important to understand how the practitioner prepares, over time, to become adept at supervision. This process requires that he/she grow in the supervisory role and sustain it through continuing education and through guidance from others, as well as through mastery of the cultural competencies, legal and ethical issues, and best practices that must become part of the skill-set of the supervisee (Munson, 2002; Shulman, 1993; Tsui, 2005)

### ***A. Preparation for Clinical Supervision***

Over time, the practitioner interested in becoming an advanced clinical supervisor will learn a good deal about the effective practice of this specialty through interactions with supervisees and clients, through being supervised in his/her supervisory practice, and through relevant continuing education (Brown & Bourne, 1996; Munson, 2002). While the core dynamics and skills of supervision are similar in the cases of intermediate-level and advanced supervisors, the latter’s extensive experience should enable them to be more effective in the interpretation of practice, more skillful in interaction with supervisees, and better able to generalize from specific practice issues. In the instance of clinical field supervisors of social work graduate students, the Council on Social Work

Education (CSWE) has set no standards for supervision training. It has, however, set an accreditation standard requiring field instructors to have at least two years of post-master's experience, which permits neophyte clinical social workers to receive their supervision from recent graduates who are in no position to impart the knowledge and skill required for competent practice.

Although there are many parallels between direct practice and supervision, and the relationship skills (e.g. empathy, facilitative confrontation) are similar, the supervisory function requires special attention and skills (Barretta-Herman, 1993, 2001; Brown & Bourne, 1996; Erera & Lazar, 1993; Hensley, 2002; Kadushin & Harkness, 2002; Kaiser & Barretta-Herman, 1999; Munson, 2000, 2002; Shulman 1993; Spence, Wilson, Kavanagh, Strong, & Worrall, 2001). This is especially important because there has always been a paucity of experienced clinicians willing to work as supervisors and initiate the next generation of practitioners. Few agencies or institutions provide extra compensation, either in money or in reduced caseloads, to their supervisors, nor do agencies usually provide support for the clinician making the transition to supervisor. This transition process includes important changes in attitude: from non-judgmental clinician to judgmental supervisor; from client-focus to multiple-focus on supervisee, client, and agency; and from colleague of other staffers to authority figure.

In some states, neither laws nor regulations require clinical supervision in the facility-licensing standards; however, the recent trend at the state regulatory level has in fact been toward such state-mandated supervisory training. Since clinical social work's terminal practice-related degree is the master's, and since it has always been expected that new graduates would learn most of their practice skills and much of their knowledge while in supervised practice, there is an obvious need for training in supervision and a commitment to clinical supervision as fundamental to the systems in which clinicians learn how to practice.

### ***B. Cultural Competencies***

In clinical social work, the importance of cultural competency cuts across all other competencies required for clinical supervision practice in the United States, with its "progressively more diverse population" (Hardy, 1992) (Bruce & Austin, 2000; McPhatter, 2004; Munson, 2000, 2002; Tsui, 2005; Tsui & Ho, 1997). Values related to cultural competency are imparted early in graduate schools of social work, as all students are taught about diversity and oppression.

In this paper, culture refers to ethnicity, race, age, class, gender, sexual orientation, religion, immigration status, literacy, mental or physical disability and other diversity factors. Cultural competence is defined as practice guided by an understanding of the impact of culture (i.e., norms of behavior for a particular population). There are no empirical studies investigating multicultural issues in supervision (Tsui, 1997, 2004). Regrettably, it is widely and incorrectly accepted within the clinical social work

community that the astute clinical supervisor has the power to deepen the practitioner's understanding of how difference is treated in our society and how clients experience oppression. A diagnosis or treatment plan that does not address culture should be considered incomplete.

Cultural competency includes an understanding of diversity within diversity (Kaiser, 1997; Shulman, 1993). The tendency to generalize about a particular population leads to stereotyping, which is often a problem for beginning practitioners. Within a group's culture there is diversity, and differences that make a client an individual. The clinical supervisor needs to recognize that some students have had experiences that led them to close off exploration of sensitive and taboo areas, including courses on oppression that were themselves oppressive. The impact of openness in the discussion of ethnic, gender, and sexual orientation variables leads to supervisees' increased satisfaction with supervision (Gatmon et al, 2001).

Cultural competency also refers to addressing culture in a direct, thoughtful, supportive manner. Cultural issues will be present in every supervisor-supervisee relationship, and supervisees will need help to find ways of empathizing and confronting and of addressing issues relating to "inter-ethnic" and "intra-ethnic" supervisory pairings (Shulman, 1993). Each instance may offer barriers to effective clinical supervision and opportunities to enhance supervision. Communication theorists have referred to this as developing a "third culture" that arises between supervisor and supervisee (Caspi & Reid, 1992).

### ***C. Guided Practice and Continuing Education***

Professional competency is not achieved by preparation alone: even advanced supervisors need the support and consultation of others. Good preparation will give the clinical supervisor the basic competencies needed for practice, and tolerance for ambiguity and openness on issues of practice or supervision. Such a supervisor becomes a life-long learner, continually profiting from mistakes and developing the ability to deal with events differently—and then making "more sophisticated" mistakes. Whether the support comes from a supervisor, consultant, or peer, the supervisor must engage in continuous examination of his/her supervision practice.

Clinical supervisors must continue to enhance their knowledge and skills for direct practice. Research constantly offers new insights into competency-based practices as well new theoretical frameworks that help us to understand our work. Competent clinical supervisors must continue their own education through continuing education or certificate programs, staying current with the literature, attending professional conferences, and ongoing examination of his/her own direct practice.

#### ***D. Evidence-based Best Practices and Other Areas for Research***

All too little research has been devoted to supervision in the field of bio-psychosocial services, regardless of the professional discipline (i.e. clinical social workers, physicians, psychologists, psychiatric nurses, counselors, etc.) (Spence et al, 2000). In the United States, there is new interest in rigorous evidence-based research about approaches to practice, but few results as yet. Such research has been more of a focus in the United Kingdom, where an evidenced-based experiential model of clinical supervision, emphasizing instructional and methodological components, was formulated and tested in the field of mental-health nursing (Milne & Westerman, 2001). The researchers concluded that clinical supervision could be measured systematically and supervisory practice could be enhanced through evidence-based practice.

Clinical social work supervision is no exception to the general lack of evidence-based research in best practices. Much more scholarly and scientific research is needed in this field, to improve outcomes and to increase our knowledge of what practices are being employed in the field of clinical supervision, what findings are being disseminated and applied, and which techniques might be adopted to improve the quality of practice (Harkness & Poertner, 1989; Hensley, 2002; Tsui, 2004, 2005).

Even basic tenets of clinical supervision are untested. The supervisor's mediating or "advocacy" role (negotiator of issues between agency and supervisee), much-described as essential in the literature, is unsubstantiated for lack of any research. Similarly, the concept of "parallel process," which posits that practitioner-client processes are re-enacted at the supervisor-supervisee level, has never been verified by the evidence of research .

In the large body of literature on social work supervision, one finds few studies of best practices based on evidence. Some non-evidence-based studies address good supervisory practice, such as supervisor's functions and time allotted to them, supervisor-supervisee satisfaction, work evaluation, and educational tools. Kadushin found in his research that supervisors tend not to provide feedback, including critical feedback, which leaves supervisees unaware of the adequacy of their work and therefore frustrated and disappointed. Some research indicates that supervisors prefer to perform the educational function but spend more time on administrative tasks (Kadushin, 1992). Despite this preference, supervisors make minimal use of the large body of educational research and theory (e.g. learning styles and theory, multiple intelligence, emotional intelligence) or of the large body of research in organizational theory. Supervisors, as educators, need to be aware of findings regarding supervisees' learning styles and abilities. Research in that area is found in the field of education, as in the examples of the adult learning model (Knowles, Holton, & Swanson, 1998) and the teaching models (Joyce, Weil, & Calhoun, 2000), which provide theory and evidenced-based instructional tools for use in supervisory practice.

### ***E. Consultation***

Endowed with external authority in an organizational setting, the clinical supervisor has binding authority over the supervisee; but in the private practice setting or in “peer supervision,” the clinical supervisor has no external authority and therefore serves as a consultant, with expert authority only to the extent that it is granted by the consultee(s). In consultation, the ultimate responsibility for the case resides with the consultee; in supervision, it resides with the supervisor. In such instances, the client should be informed of the relationship and should provide written permission for the consultant to have access to client information.

The confusion between the role of the supervisor and the consultant can create some serious problems (Barretta-Herman, 2001; Munson, 2002): for example, when agencies hire consultants and call them “supervisors” even though they have no formal and accountable role in the agency staff system. In such instances, the formal accountability for practice passes to a senior supervisor or administrator who is not directly involved in the supervision. The advisability of an agency’s using outside consultants is also affected by the rules of the Health Insurance Portability and Accountability Act (HIPAA), which require the “de-identifying” of all client information, and so can result in a loss of significant information upon which the consultation is based.

### ***F. Legal and Ethical issues***

The practice of clinical supervision is conducted within the framework of a legal, contractual relationship and under several legal and ethical constraints (Munson, 2002). The supervisor takes formal responsibility for the work of the supervisee and therefore assumes legal liability for it, along with the agency that confers authority on the supervisor. Constant vigilance is required of the supervisor in risk-assessment and risk-management of issues like domestic violence, duty-to-warn, duty-to-report, perceived threat to the supervisee, etc. In addition to civil law, the practice of clinical social work is regulated by most states to prevent fraudulent and abusive practice, and in many jurisdictions, the clinical supervisor is legally accountable to the state licensing board. Malpractice may be alleged for many causes, from failure to exercise due care to financial improprieties to breach of confidentiality. Not all legal issues relate specifically to the supervisory relationship, for job-management activities come with their own set of legal concerns, including the impact of HIPAA rules and styles of record-keeping. Even outside of an agency or organizational setting, “vicarious liability” may be alleged, in which the supervisor who benefits from the supervisee’s actions is legally responsible for incorrect acts or omissions. The complexity of these legal concerns points to the need for a formal, written agreement among the supervisor, supervisee, and agency, specifying the elements and limits of the supervisor-supervisee relationship (Munson, 2002).

Because clinical supervisors must be extraordinarily alert to legal and ethical issues of practice, and have a controlling authority over the supervisee and therefore accountability

for the well-being of the client, some state licensing boards have set guidelines for the proper practice of clinical supervision and have published lists of the names of clinical social workers who are qualified to provide clinical supervision to social workers who are candidates for clinical licensure. This carries out the state's mandate of protecting the public from fraudulent and abusive practice. Some states have gone so far as to require, in their licensure regulations, that would-be clinical supervisors demonstrate a certain level of practice competence and awareness of the legal/ethical issues in order to provide supervisory services.

Clinical supervisors must also be aware of the ethical implications of their work and the work they supervise. Frequently, the relationship between supervisor and supervisee raises boundary issues, including dual relationships (e.g. supervisor plays the roles of both supervisor and therapist). The supervisor has an ethical responsibility to the supervisee to provide guidance rather than to conduct therapy; but there is a considerable gray area between the two, and the supervisor's efforts to be supportive must be tempered by restraint (Bernard & Goodyear, 1992; Brown & Bourne, 1996; Shulman 1993). A supervisor who becomes too involved in the problems of the supervisee runs the risk of losing sight of the welfare of the client, whose well-being must be paramount.

### **III. Definition of Supervision as a Practice Specialty of Advanced Clinical Social Work**

As previously stated in this paper, clinical supervision in clinical social work is the provision of supervisory services which are informed by advanced training, years of experience, and mastery of a range of competencies (identified in this paper). These services are imparted by an advanced clinical social worker supervisor to a clinical social worker who, being less advanced in practice, needs the knowledge and skill of the supervisor in order to provide optimal services to clients. The clinical supervisor takes formal, legal responsibility for the quality and outcome of the supervisee's work with the client, a function that has been recognized in most states as being fundamental to protection of the public. Clinical supervision, an advanced practice specialty, is conducted within the larger context of clinical social work.

The supervisor specialist has mastery of the relevant knowledge and skills of clinical supervision, and excels in helping supervisees to develop clinical skills in their work with clients in many settings and contexts. Further, the supervisor specialist applies core social work principles to his/her work (ABE, 2002), and helps the supervisee to do the following:

- demonstrates an appreciation and acceptance of the dignity and well-being of the individual and his/her right to self-determination, privacy, confidentiality, and informed choice
- advocates for clients in service provision, access to care, and program evaluation
- practices ethically and legally, with competence and integrity
- practices with respect and sensitivity for culture and diversity
- contributes to a society that offers opportunities to all of its members in a just and non-discriminatory fashion
- delivers the most appropriate service and level of care, according to client needs and informed consent.

These principles, elucidated in ABE's position statement, *Professional Development and Practice Competencies in Clinical Social Work* (2002) connect the specialty practitioner to other clinical social workers and help him/her maintain professional identity, as does use-of-self or self-awareness. Use-of-self helps one to understand clients better and to avoid projecting onto them one's own biases and personal challenges. It is learned through clinical supervision, personal psychotherapy, self-observation, ongoing reflection on professional interactions and their outcomes, and continuing education. The supervisor seeks formal consultation and supervision when indicated. He or she uses a bio-

psychosocial perspective in approaching the service environment as well as client's own environment. The supervisor helps the supervisee to do all in his/her power to remove barriers to treatment and to help clients secure their rights to effective care.

Through an understanding of the parallel process, in which the supervisor models appropriate and ethical behavior, the supervisor can use the relationship as an important teaching tool. While the supervisor may discuss a supervisee's personal reactions to a client's problems, the supervisor will protect the "contract" by not turning the supervision into personal therapy. The supervisor will also avoid inappropriate personal contacts with the supervisee, including those of a sexual nature, thus demonstrating the importance of respecting professional boundaries (Brown & Bourne, 1996; Fox, 1998; Munson, 2002).

In determining the proficiency of the supervisor and his/her ability to conceptualize clinical practice, nothing is more telling than competency in professional knowledge and practice skills, each of which can be measured in the following terms (discussed in detail in section IV):

- Creation of a Supervision Contract
- Supervision of the Processes of Intake, Assessment, and Diagnosis
- Supervision of Treatment Planning
- Creation of Supervision Plan
- Supervision Process
- Supervision of Appropriate Professional Impact
- Evaluation of Practice Outcome
- Evaluation of Supervision Outcome
- Consultation, Teaching, and Writing.

## IV. Development of Clinical Supervision Practice Competencies

The advanced clinical supervisor's professional knowledge and skills can be identified as reflecting an advanced level of competency. The supervisor understands theoretical concepts and how to apply them flexibly to practice, and has practice wisdom gained from years of experience in this field. The supervisor monitors his/her own direct and supervisory practice, pursues professional development, and knows when to seek consultation and/or supervision. The advanced practitioner may serve as mentor, supervisor, or consultant to colleagues, and may model and teach what is needed for autonomous practice. The following is a discussion of the advanced practice characteristics of the clinical supervisor (summarized in Appendix I).

### *A. Creation of a Supervision Contract*

#### **1. Knowledge**

**a. Understands the importance of creating structure through the process of contracting with the supervisee.** Contracting assumes that there is a productive balance between what the supervisor wishes to share and what the supervisee feels he/she needs. In a manner that parallels clinical practice, this balance or overlap constitutes the "working agreement" (Brown & Bourne, 1996; Shulman, 1993; Kadushin & Harkness, 2002; Munson, 2002; Shulman, 1981; Shulman, Pierce & McNeill, 1981).

**b. Can evaluate the level of need and the knowledge and skills required for effective practice among a range of clinical social workers.** There is wide variation in the supervision needs of those at the entry, intermediate, and advanced levels of practice. The supervisor must be prepared to understand and address these needs, ranging from more structure and frequency for neophytes to a consulting role with experienced practitioners who can identify their specific concerns.

**c. Understands the importance of obtaining supervisee input and integrating supervisee issues and agenda into the supervision contract.** The supervisor, who understands the supervisee's agenda, helps to construct a learning program based on the proper level of knowledge and skill associated with the supervisee's stage of professional development.

**d. Is aware of issues of authority and accountability in supervision.** The supervisor is aware of the potential for impacts (positive and negative) on the working relationship as they arise from authority that is externally sanctioned or granted by the supervisee or some combination of both. For example, in formal supervision, the supervisor is aware that his/her role as performance-evaluator may affect the supervisee's willingness to share mistakes, failures, and concerns. Even in consultation or informal supervision, the supervisor's expert authority may intimidate a supervisee and result in an "illusion of work" in which the supervisee says what he/she thinks the supervisor wants to hear (Schwartz, 1971; Shulman, 1993). Both supervisor and supervisee must keep thorough records, in compliance with state

and/or agency standards, including a discussion and understanding confidentiality, and related issues.

**e. The supervisor understands the responsibility to create and maintain an ongoing record of the supervision.** Records must be kept in accordance with state and federal laws as well as agency policy. Accurate and thorough record-keeping is an important aspect of job management, and provides protection in case of a legal challenge to the quality of the services provided.

## **2. Skills**

**a. Can describe clearly the purposes of clinical supervision.** The advanced practitioner is skilled in describing to the supervisee the multiple purposes of supervision in terms of activities (e.g. reviewing cases). This helps the supervisee to consider a range of intervention options or to analyze the efficacy of certain approaches to intervention.

**b. Can describe his or her role and purpose as part of the contracting process.** The “role” refers to the content of the supervision, while the supervisor’s “purpose” refers to helping the supervisee work on the content. A simple statement of these functions helps the supervisee know how to use the supervisor and understand the supervisor’s behaviors.

**c. Can use the supervisee’s issues and concerns in developing the supervision contract.** Using the knowledge described above, the supervisor relates his/her understanding of the working agreement with an emphasis on the areas of the supervisee’s concerns. As the supervisee develops and the supervisory relationship changes over time, this working agreement is restated.

**d. Addresses issues of authority ranging from the informal authority invested by the supervisee to the formal authority assigned to the supervisor by the agency or setting.** In a first session, the supervisor should acknowledge the authority issues and recognize how they may facilitate or impede the process. Issues of authority also exist and need to be thoroughly addressed when supervision is for the purposes of meeting the requirements for clinical licensure.

**e. Can discuss openly the issues of formative and formal evaluations.** Formative, periodic evaluations are conducted regularly, so that the supervisee becomes familiar with the issues to be addressed in a formal evaluation. Feedback on practice needs to be both timely and specific, with the active involvement of the clinician. In both formative and formal evaluations, the supervisor should clearly identify the supervisee’s strengths and deficits as well as objectives for future supervision.

**f. Establishes clear parameters regarding the supervision plan, including setting time and frequency, fees for services, goals and objectives, and expected length of service and outcome.** In all settings—in a private practitioner’s office as in an agency—the supervisor

should model clarity in setting structural relationships, just as the supervisee should set these with clients.

**g. Maintains a professional relationship with the supervisee and recognizes the integrity of a range of supervisee boundaries throughout the supervision process.** A professional relationship is defined by the functional role of the supervisor in relation to the purpose of supervision. A supervisor will protect this contract by engaging in proper activities. While the supervisor-supervisee may engage in a less formal relationship, it must not impinge on the professional role. Boundaries must be respected and the supervisor needs to be especially alert to the impact of his or her authority. In doubtful cases, the supervisor should err on the side of caution. Unless it has a direct impact on practice, the personal life of the supervisee should not be discussed. Intimate social or sexual contact between a supervisor and supervisee is inappropriate and violates the profession's code of ethics.

**h. Recognizes and respects the boundary between supervision and personal therapy.** It can be tempting for the supervisor to respond to a supervisee's personal disclosures (e.g. adult child of an alcoholic, survivor of sexual abuse) or to make assumptions about personal issues affecting the supervisee's practice even when not openly raised. The supervisor must respect these areas and others as personal to the supervisee, who controls when and if they are raised. The supervisor must protect the purpose of supervision and his/her role. For example, if a supervisee discloses that he/she has alcoholic parents, the supervisor must focus on how this issue affects the supervisee's work with current clients. By focusing on the case and the interview, the supervisor guards the contract and does not become a personal therapist. If painful personal issues and feelings become an obstacle to practice, the supervisor should assist the supervisee in considering various options including therapy but not take on the therapist's role (Yegdich, 1999).

## ***B. Supervision of the Processes of Intake, Assessment, and Diagnosis***

### **1. Knowledge**

**a. Understands that the helping process begins with contracting with an individual to become a client.** The supervisor guides the supervisee in the process of meeting the applicant at the point of intake, and through the process of gathering personal data about the applicant, their situation, resources, history and issues of concern, assists the supervisee in the creation of a clinical relationship.

**b. Uses advanced knowledge base and bio-psychosocial framework to ensure that supervisee arrives at a conceptual diagnostic assessment of the client.** The supervisor needs to be familiar with a wide range of frameworks in order to assist the supervisee to assess the client. This knowledge extends to clinical interviews and rapid assessment tools and their proper use, including when to administer them and how to explain why the tool is being used and how to process the results with clients.

**c. Understands the use of an assessment process that is guided by a range of models and includes input from the client, the family, and other sources.** No matter what model is used, the supervisor knows the importance of incorporating a “strengths perspective” as a core principle in assessment.

**d. Has a knowledge base of specific categories of emotional disorders and disturbances, as in the DSM IV-TR or NASW’s Person In Environment (PIE), as well as setting specific types of expertise.** The supervisor needs to know about the specific diagnostic categories in these systems, and to be aware of the dangers of misusing such diagnoses, such as premature closure on the assessment process or relating to the diagnosis instead of the client. In every service setting there are areas of knowledge and skill that, in addition to the areas identified in this paper, will be specific to the supervisor in that setting, e.g. supervisors in health settings need to be knowledgeable about medical disorders and illnesses.

**e. Demonstrates knowledge of multiple treatment modalities within their scope of practice and can help the supervisee to learn to use them well.** The supervisor has expertise in helping the supervisee to select among modalities—individual, couple, family, or group—as most appropriate for the client situation (Munson, 2002; Shulman, 1993). Knowledge also extends to various treatment models such as cognitive-behavioral therapy, solution focused therapy, systemic family therapy, and other treatment methods.

**f. Recognizes when consultation is needed in instances of a client’s biological, psychiatric or physical difficulty.** Experienced clinical supervisors have a level of diagnostic skill that enables them to assess their own limitations and welcome input from other sources. This assures that the clinician is open to new learning in their professional development.

## **2. Skills**

**a. As part of the assessment process, the supervisor informs, guides, and evaluates the supervisee’s performance of a comprehensive evaluation of the client’s strengths, weaknesses, cultural influences, interpersonal influences, and environmental stressors.** In helping the supervisee with the process of assessment, the supervisor needs to consider issues of strategy and ethics, and to assist the supervisee in dealing with the constraints of agency policy or the demands of other entities such as managed-care systems. The supervisee needs guidance choosing the assessment that best meets the needs of the client while still maintaining ethical standards.

**b. In the context of diagnostic formulations, the supervisor informs, guides, and evaluates the supervisee in the course of his/her consideration of the interplay of internal and external factors, bio-psychosocial and cultural influences, and past and present experiences.** The supervisor helps the supervisee to recognize the relevant factors that affect the diagnostic formulation. The supervisee needs guidance in understanding assessment as a dynamic process, not static. While formal assessments may be needed for agency or funding

purposes, the supervisee needs to be helped to examine and re-examine the assessment almost constantly in the work with the client.

**c. Informs, guides, and evaluates the supervisee's ability to factor into assessment the impact of developmental maturation, biological, environmental, and socio-cultural considerations.** The supervisee needs to understand the normative life-cycle issues that the client may be experiencing and to distinguish them from other unusual or crisis-related problems. It is important to consider environmental factors, and socio-cultural context assessing what is or is not normative.

**d. Informs, guides, and evaluates the supervisee's ability to assess the client's capacity for developing insights into the nature of the problem.** Clients enter therapy with varying awareness and insight into their behavior, thoughts, and feelings. The supervisor assists the supervisee in assessing their clients' abilities to understand the nature of their problems and participate in formulating a treatment plan. The client's abilities to develop such insights will influence the selection of the treatment approach

**e. Informs, guides, and evaluates the supervisee's identification of possible or suspected physiological and other variables (e.g. medical factors, substance abuse, learning disabilities) that require collaboration with other professionals.** The advanced clinical supervisor helps the supervisee use individual cases to develop a general framework for making such decisions. In situations in which other professionals will be involved, the supervisor also teaches the supervisee strategies for consultation without engendering a conflict over "ownership" of the client (Shulman, 1993).

**f. Informs, guides, and evaluates the supervisee's use of a standard diagnostic classification system to make differential diagnoses, ruling out other diagnoses, and evaluating for co-morbidity.** The supervisee must be able to use these systems to make differential diagnoses that are subject to modification as new facts emerge. In addition to evaluating for co-morbidity, the supervisee needs to be able to assess the interaction between problems or between diagnoses. For example, a person with mental illness and substance abuse needs to be treated for each issue independently but also for the interaction between issues. This meta-level of diagnosis deepens the supervisee's understanding of the client's issues.

**g. Informs, guides, and evaluates the supervisee's continual use of clients' responses and other client indicators to refine the conceptual assessment and diagnosis in consultation with the client.** Supervisee skills in the middle phase of direct practice include "sessional contracting, reading indirect cues and responding directly, listening skills and skills of empathy" (Shulman, 1993). The supervisee is guided in using the productions of the client (both direct and indirect) to refine the conceptual assessment. In consulting with the client, the supervisee shares his/her dynamic assessment openly and frequently and uses the client's response to refine it.

**h. Informs, guides, and evaluates the supervisee's systematic analysis of the multiple contexts affecting the client's functioning.** A broad view of context deepens the supervisee's understanding of client functioning. Developmental, historical, psycho-physiological, socio-cultural, religious, economic, and political forces can affect the level of service offered to the client by other support systems. Policy decisions, such as the de-institutionalizing of patients without providing adequate community care, can be the most significant factor in a client's functioning.

**i. Informs, guides, and evaluates the supervisee's ability to reflect on and self-evaluate performance and to remain open to the "ambiguities" of practice and to question assumptions.** The supervisee is guided in using various forms of self-evaluation, including audio- or video-taped sessions, process recordings, single session tools for analysis, observations through one-way mirrors, and client feedback questionnaires. A caveat: some studies suggest that mirrors and audiotapes and videotapes created anxiety and hindered the supervisee's performance, while other studies did not reach similar conclusions (Ellis, Krenzel, & Beck, 2002).

### *C. Supervision of Treatment Planning*

#### **1. Knowledge**

**a. Is knowledgeable as to level of care and type of intervention based on the diagnostic assessment.** The supervisor is aware of standard practice interventions based on diagnostic assessments and of the level of intervention indicated by the assessment (e.g. in-patient, out-patient). The supervisor understands the importance of determining treatment based on factors such as the nature of the client's problem (duration, severity, and environmental contributions), stage of problem-acceptance, degree of internalized difficulty and resistance, and factors associated with past attempts to cope with the problem.

**b. Understands the use of theory in the treatment planning process based on the needs of the client.** The supervisor should be aware of a range of theoretical formulations and should be capable of developing an integrated model that may incorporate elements from a number of theories. Theory may also contribute to an understanding of the client-clinician relationship. The clinician applies basic concepts of the stages of change to assess client readiness or applies systems theory to understand the environmental issues. Family-of-origin theory is another example (Munson, 2002).

**c. Understands how the working alliance is affected by the client's language, interests, culture, and other elements of diversity.** Many of these issues also pertain to the supervisory relationship. For example, inter-ethnic issues may affect the working relationship between supervisor and supervisee as well as between clinician and client. Open discussion of these issues can diminish their negative effects and enhance their positive impact on relationship (Davis & Proctor, 1989; Kadushin & Harkness, 2002; Kaiser, 1997; Shulman, 1978, 1999)

**d. Is aware of how client outcomes can be affected by supervisor's and supervisee's biases about social work practice modalities when formulating recommendations for interventions.** The “generalist’s perspective” in social work education has led to a diminishing of skill-development in modalities such as group or community work. For example, social work graduates receive little education and less experience in group work practice even as the field is moving toward an increased use of this modality, especially for vulnerable populations (Gitterman & Shulman, 1994). The supervisor must be aware of how his or her bias (and the supervisee’s) can lead to a treatment recommendation that is comfortable for the clinician but does not fit the needs of the client. Agency bias can also impact these decisions if a better modality of service (e.g. conjoint family work, group work) is not available, in which case the supervisor and supervisee should develop a new modality of service or refer the client to another agency or provider.

**e. With regard to establishing a treatment plan, the supervisor understands the importance of assessing the client's resources, social supports, network, and other factors.** Research about resiliency shows that key protective factors for vulnerable clients are the available external resources such as family, friends, and support groups (Bell, 2001; Conan, 2002; Janas, 2002). In some cultures, the extended family may be crucial to the plan and needs to be involved in the process. Availability of community resources (e.g. a drug treatment program with a long wait list) also affects planning. The supervisor needs to know about the importance of the advocacy process in clinical practice. Such knowledge includes the understanding of the change process in dealing with other systems and in developing strong working relationships with other professionals, agencies, and organizations, subject to concerns about confidentiality and privacy.

**f. Must be aware of issues regarding confidentiality arising from HIPAA (Health Insurance Portability and Accountability Act of 1996), and other legislation.** Supervisors, supervisees, and agencies need to be fully aware of the implications of the HIPAA and other state and federal laws and how they may affect the supervisor, supervisee or client. While confidentiality has always been an important ethical issue, these laws can constrain or mandate the clinician’s ability to share client information with other practitioners, family members, agencies or organizations, law enforcement, or, in some cases, with the supervisor. For example, if the client reveals that he/she or someone else is in danger or if he/she is involved in activities that violate the law in other ways, the supervisee is required to report to the proper authorities. Disclosures to insurance companies, as part of the client’s contractual agreement for coverage, are another example. At the outset of the contracting phase, supervisors need to help supervisees make this clear to clients.

## **2. Skills**

**a. Helps supervisee form a verifiable professional opinion, based on clinical assessment and in collaboration with the client, about level of care and type of intervention.** Through the use of assessment reports, observations of practice, or other methods (e.g. process recordings), the supervisee is guided in using the knowledge base to determine the level and

type of intervention and to examine the process of consultation with the client. A key component is the supervisee's ability to obtain informed consent by clearly explaining the evaluation results, diagnosis and treatment options (including risks and benefits) and thereby enabling the client to make choices and exert control over the process.

**b. Helps supervisee to integrate theory in the treatment planning process based on the needs of the client.** This process requires the supervisor to connect theoretical constructs to the particulars of the client's situation. Conversely, the supervisor often moves from the specific to the general in educating the supervisee about applying a concept or theory, used in connection with a single client, to the larger client population.

**c. Helps supervisee address issues such as client's language, interests, culture, and other elements of diversity, in order to facilitate communication and to develop and maintain a therapeutic alliance.** The supervisor examines these issues in the clinician-client dyad, and models the skills in the supervisor-worker relationship.

**d. Helps supervisee determine appropriate intervention based on factors such as the nature of the client's problem (duration, severity, and environmental contributions), the client's stage of problem acceptance, as well as respect for the client's autonomy.** The supervisor oversees and guides the choice of the service model, helping to incorporate relevant variables and features of problems to be addressed.

**e. Helps supervisee examine own biases about modalities when formulating service recommendations with client and understand how this can impact client outcomes.** The supervisor must be skillful in making it safe for the supervisee to be honest and direct about his or her biases and to become comfortable with different modalities.

**f. In establishing the treatment plan, the supervisor assesses client resources, support network, and other factors.** This process comprehends several approaches. In one example, the supervisee "maps" the extended family in order to highlight the importance of support networks in the life of the client.

#### *D. The Supervision Process*

##### **1. Knowledge**

**a. Is aware of the parallel process in which the interaction with the supervisee can be acknowledged and serve as an appropriate teaching tool.** The supervisor understands that there is a connection between content and process. When the supervisor addresses relationship dynamics and utilizes the skills of practice in the supervision role, these concepts and skills are being modeled for the supervisee.

**b. Has the self-awareness to recognize his or her own emotional response to the supervisee's anxiety.** Many situations in practice can provoke or reawaken the clinician's

anxieties. Understanding one's own emotional response to the supervisee can be an important tool in understanding the supervisee's feelings at the moment.

**c. Recognizes and understands how to address inter-ethnic and intra-ethnic issues that emerge in the supervisory relationship.** As noted earlier, these issues are defined broadly to include such factors as race, gender, age, sexual orientation, spiritual beliefs or religious affiliation.

## **2. Skills**

**a. The supervisor demonstrates mastery of the methods of supervision utilizing skills in communications, relationships, learning styles and problem-solving.** The clinical supervisor has mastered these skills in practice and understands their appropriate use attached to the supervision functional role. These skills have been described and illustrated in a number of publications (Kadushin & Harkness, 2002; Kaiser, 1997; Munson, 1981, 2002; Shulman, 1969, 1981, 1993, 1999). Communications skills include listening, requesting elaboration, asking questions, moving from the general to the specific, and exploring silences. Empathic skills that are crucial for establishing and maintaining a strong working relationship include reaching for, acknowledging, and articulating feelings, slightly ahead of the supervisee. The supervisor avoids mechanical responses. According to some communications models, the helping professional should not articulate the client's or supervisee's feelings for them; according to others, supervisors and practitioners make more errors of omission, by withholding the intuitive response, than errors of commission. It may be difficult to articulate underlying feelings, particular in the area of taboo subjects, but expressing them can be crucial: two studies have found that such communication is one of the important predictors of a number of positive outcomes including the development of a positive working relationship (Shulman, 1979, 1993; Shulman et al, 1981).

**b. The supervisor uses the supervision process to model professional practice.** The supervisor is cognizant of his/her function as a role model. As such, the supervisor brings a high degree of self-awareness to the relationship, and can combine teaching by example with direct explanation in providing socialization of the professional clinical social worker. Reflecting sensitivity to the "parallel process" (Kadushin & Harkness, 2002), the supervisor also helps keep the supervision "on task" and reflecting the learning objectives and learning style of the supervisee (Brown & Bourne, 1996; Shulman, 1993).

**c. Guides and evaluates the supervisee toward better carrying out the treatment plan and greater effectiveness in working with a broad range of emotions and intensity of affect.** The following of a treatment plan is subject to numerous disruptions. For example, a beginning supervisee will have limited ability to respond directly to intense affect. The use of the "tuning in" skills is one way to help supervisees get in touch with their own past affect when faced with similar (not the same) situations (Germain & Gitterman, 1980; Gitterman, 1991; Gitterman & Shulman, 1994; Schwartz, 1961; Shulman, 1999). Beginning clinicians tend to use the mechanical responses (e.g. reflection, "I hear you saying...") learned in school,

so the supervisor needs to help the supervisee “find his or her own voice” by actually experiencing the affect and articulating it in a manner that is genuine and eventually to acknowledge and articulate negative and hostile feelings, even those directed at the clinician.

**d. Guides and evaluates the supervisee’s ability to use a range of tools (process recordings, memory work, audio- and video-tapes, and observation) to share the details of the practice for analysis with the supervisor.** The supervisor should not limit supervision to discussing the “case” without expanding into a discussion of the “process” Some form of recall or direct observation of the interaction is needed in order to examine practice over time with a particular client, using a tool such as the “record of service” (Berman-Rossi, 1994) in which work on a client’s particular problem is examined over time using process-recording excerpts. This summary of work is followed by an analysis of what the current situation is and by strategies for intervention.

**e. Guides and evaluates the supervisee’s ability to respect the centrality of the therapeutic relationship and to sustain a therapeutic alliance.** The supervisor helps the supervisee to respond empathically to the client and to develop an increased understanding of the client's needs, conflicts, cultural influences and preferences.

**f. Guides and evaluates the ability of the supervisee to integrate feelings effectively into the professional function and role.** The supervisor first creates the climate in which the supervisee can be honest about her/his own intense emotions and cultural biases. This is achieved by accepting such feelings in a non-critical manner and crediting the supervisee for honesty. In order to avoid turning supervision into therapy, the supervisor examines this affect by closely tying it to work with clients or other professionals and systems. The next step is to help the supervisee to understand the false dichotomy between “personal” and “professional” expression and to learn to share appropriate personal feelings in a spontaneous yet professional manner.

**g. Guides and evaluates the supervisee’s ability to permit the client’s expression of intense affect states, both positive and negative, as he/she learns to manage extreme behaviors while maintaining a therapeutic stance.** The supervisor helps the supervisee to understand the meaning of what may seem to be “deviant” behavior. The supervisee learns to view the client’s expression of intense emotional affect as a form of communication (at times maladaptive). Thereafter, the supervisee clinician can permit clients to express affective states and use these expressions to help them understand and resolve problems.

**h. Guides and evaluates the supervisee’s ability to engage the client and to develop a working agreement in the beginning phase of practice.** The contracting skills described in the section on supervision contracting are the same as in work with clients: clarifying purpose and role, reaching for feedback and dealing with issues of authority and confidentiality. The structure of the work (i.e., timing, frequency, fees) is also included in this early negotiation.

**i. Guides and evaluates the supervisee’s ability to work in response to client productions (direct and indirect) in the middle phase of practice.** The practitioner must maintain a tentative stance at the start of each client session. Even when the “agenda” seems apparent as a continuation of last week’s work, the practitioner must ask, “What is this client working on right now?” This has been termed “sessional contracting” (Shulman, 1999). Elaboration and empathy skills help the supervisee to understand the client’s immediate sense of urgency and how this relates to the contract. Through retrospective analysis, the supervisor helps the supervisee to understand the “offerings” shared by the client, starting with the most indirect at the outset of the session and leading to the “door-knob therapy” comments at the end. Crucial to this skill is helping the supervisee be free enough to let go of the “treatment plan” or “diagnosis” in order to hear the client’s productions. Once again, the supervisor most effectively teaches this skill by modeling it and responding to the direct and indirect productions of the supervisee.

**j. Guides and evaluates the supervisee’s ability to assess readiness for termination (in collaboration with client) in terms of goals and objectives of the service and level of functioning.** The supervisee needs to be able to consider the original working agreement with the client to know when the work has ended.

**k. Guides and evaluates the supervisee’s ability to recognize the potential significance of the termination process and to assist client in dealing with the issues it may provoke.** Urgent and difficult issues can arise at the “end” of treatment. The supervisee needs help in not withdrawing just as the client is most ready to do intense work.

**l. Evaluates the need for adjunct services and arranges for them, in conjunction with the supervisee and client, when indicated.** In the termination phase—really the “termination and transition phase”—the supervisee needs guidance in developing skills to help the client to assess the level of learning and change, credit the hard work, recognize areas for future work, and explore opportunities for adjunct services. The supervisor and the supervisee may be directly involved in attempting to arrange such services as participation in a support group.

### ***E. Supervision of Appropriate Professional Impact***

#### **1. Knowledge**

**a. Understands organizational structure and dynamics and is able to view the organization as a dynamic system.** A clinical supervisor needs to be able to step back from the organization of which he/she is a part, in order to assess structural issues and apply knowledge about systems and context (Brager & Holloway, 1978; Holloway & Brager, 1989; Shulman, 1970, 1993).

**b. Has an understanding of the complex dynamics of inter-professional and inter-organizational interactions.** A clinical supervisor is aware of the nexus of issues and potential obstacles encountered in the course of inter-professional and inter-organizational

collaboration. The supervisor must be able to use practice skills to see through varying behaviors (e.g. defensiveness, hostility) to assess the underlying issues. The supervisor is able to identify and evaluate ethical dilemmas inherent in organizational systems.

**c. Explores the supervisee's tendency to over identify with the client or to over identify with the system.** The supervisor understands that over-identifying with a client or service, and then acting on that position, may be counter-productive to the client's interests. The supervisee needs to know how to integrate the "two clients" concept and to "tune in" to the other professional or system, while knowing when to advocate for the client and when to use skillful confrontation as a method (Holloway & Brager, 1989; Shulman, 1970, 1993).

## 2. Skills

**a. Facilitates the supervisee understanding of complex systems and inter-professional relationships.** The supervisor uses specific examples emerging from practice to help the supervisee understand the meaning of the behavior of other professionals and organizations. The supervisee is trained to be aware of possible stereotyping of other professionals or organizations and the effects thereof on his/her interventions.

**b. Demonstrates empathy for the difficulties facing the supervisee in dealing with "hard-to-reach" systems or professionals.** The supervisor models empathy and the understanding of difficult behavior by demonstrating them when assisting the supervisee in exploring difficult interactions. For example, the supervisor may express understanding of the supervisee's frustration and how that may have led to unproductive exchanges with other professionals. Only after empathizing with the supervisee is the supervisor able to ask her or him to empathize with the other professional. The supervisor must credit the supervisee's efforts to advocate for the client even while helping the supervisee to master more skillful advocacy interventions.

The supervisor helps the supervisee develop intervention strategies and practices that work to engage the other (sometimes recalcitrant) professionals in an alliance on behalf of the client. Expressing support and empathy for the supervisee increases the possibility that he/she will do the same with other professionals and systems important to the client. Yet, the supervisee must be able to identify and challenge unethical clinician or agency practices.

**c. Analyzes the clinical social worker's interactions with other systems and professionals using the same tools and methods employed in examining direct practice with clients.** The supervisor must use very specific examples to teach the general concepts of effective professional practice. Supervisees may be asked to recall conversations with other professionals or the interaction at an interdisciplinary team meeting. The use of a modified brief process-recording can help. In another example, the supervisor has the supervisee write a brief paragraph describing how the other professional or organization might view the supervisee's behavior. After identifying areas for change, the supervisor can assist the

supervisee in developing specific strategies to evaluate the effectiveness of the teamwork process.

**d. Clearly states the expectation that the supervisee will work professionally with other systems and professionals.** In cases where the supervisee resists in examining his/her own part in the interaction, the supervisor may have to make “a demand for work” (Schwartz, 1961). The supervisor issues a formal written expectation, related to evaluation, that the supervisee will strengthen skills in this area.

## *F. Practice Process and Outcome Evaluation*

### **1. Knowledge**

**a. Must be aware of appropriate tools and procedures for evaluating practitioner-client process as well as outcomes of practice.** Evaluation tools have been developed, ranging from single-case designs to post-intervention client questionnaires. One model for evaluating clinical decision-making and practice outcomes is the systematic planned-practice approach (Rosen, 1992), in which treatment is seen as having three components (problems, outcomes, interventions), each with decision-support tools.

Effective evaluation is achieved when the supervisee understands the original agreed-upon intervention goals and identifies measures that assess whether they have been reached. Outcome-of-practice measures can be “hard” (e.g. maintaining sobriety, getting a job, succeeding at school) or “soft” (e.g. feeling satisfied with the practitioner, having made progress toward long-term goals, feeling less negative about oneself and one’s self image). The supervisee needs guidance to be realistic in measuring the outcome of practice.

The supervisor needs to be aware of the importance and use of client feedback in practice. Feedback can be of a formal nature, using instruments, or informal, encouraging the client to share thoughts or feelings about the work and the clinician.

**b. Must understand the differential use of such tools.** Outcome tools should not be used automatically with all clients. For example, a questionnaire that measures client perception of the quality-of-life will not be universally applicable. Further, any such tools need to be selected with sensitivity to the client’s understanding, literacy, language, culture, involvement, and informed consent.

### **2. Skills**

**a. Elicits supervisee feedback in evaluating client readiness to move from one task or phase of treatment to the next.** The supervisor encourages and supports the supervisee in exercising his own independent judgment to gauge the timeliness of clinical interventions; to determine the client's receptivity to such interventions; and to recognize the client's self-directed push to address and resolve issues.

**b. Must be skilled at implementing such tools.** The supervisor models the use of such tools in his/her own practice. The supervisee must understand that evaluating practice with individual clients and evaluating the development of practice skill are life-long professional tasks.

**c. Must be skilled at assisting supervisees to be comfortable using such tools and receiving and sharing practice feedback.** If the proper “culture” is established in the supervisory relationship, the supervisee will feel free to use the evaluation tools and to share the results with the supervisor. In some situations, the results should be shared to involve the client more actively in the evaluation process. In this respect, an evaluation tool may serve a clinical function, providing a structured overview of the intervention, inviting the client to reflect on progress and areas for further work.

**d. Supervisor assists the supervisee in critically analyzing the literature and identifying practice interventions that have received empirical support.** The emphasis here is on “critically analyzing the literature”. With the movement toward “evidenced-based practice” and the resulting growth in research, a priority is placed on the supervisee’s ability to discern the quality of the research and its effect on practice. The supervisee needs to be helped to analyze the strength of the research design and the findings, and encouraged to test the ideas against his/her own practice experience and wisdom. At the same time, the supervisee has to be able to assess and use practices that are supported by sound research. A supervisee needs to be helped to judge the content of any approach and to be flexible enough to incorporate new ideas.

## *G. Evaluation of Supervision Outcomes*

### **1. Knowledge**

**a. defined desired outcomes and the means to evaluate whether such outcomes have been achieved.** Supervision includes agreeing on a plan that states desired outcomes and goals, and evaluating whether they are met. While collaborative in nature, the plan will be influenced by the practice-setting’s requirements and by the supervisee’s levels of knowledge and skill.

**b. Must be aware of methods for evaluating the effectiveness of supervision.** Tools are available for evaluating the “single session” supervision process, mid-supervision corrections, and termination. The supervisor is familiar with the range of tools and helps the supervisee to select the best ones (e.g. the measurement scale that rates the supervisee’s progress, per McNeill, Stoltenberg & Romans, 1992).

### **2. Skills**

**a. Must be able to evaluate supervision based on progress toward goals and to modify goals.** Goals include the supervisee’s attainment of skill and knowledge as well as the progress of the supervision itself. Evaluation focuses on the supervisor’s effectiveness and the

supervisee's growth in using the supervision, step by step. This skill is especially relevant to situations in which the supervisor must meet state licensure guidelines for supervision of pre-licensure practitioners.

**b. Works with supervisee to agree on achievements of supervision and remaining problem areas and learning needs, and to review contracted goals and renegotiate future work.** Through periodic discussion and evaluation, the supervisor and supervisee address problem areas and learning needs, and seek to agree on what has been achieved and what remains to be done. Time-related objectives, such as quarterly, semi-annual, or annual reviews, can be very useful.

**c. Helps supervisee to be constructive in disagreeing with outcome assessments.** The supervisory relationship includes creating the conditions in which supervisees can express disagreements. Supervisors must be open to the idea that their assessments might be wrong, that supervisees should be able to point that out, and that changes should be made accordingly. In some situations, the supervisor and supervisee may agree to disagree, realizing that open disagreements are greatly preferable to a supervisee's false agreement. The supervisor models the acceptance of difference in judgment and interpretation that is also crucial in the clinician's practice with clients.

## *H. Consultation, Training, Writing*

### **1. Knowledge**

**a. Is recognized as an expert by peers and the professional community.** This may be demonstrated by conducting workshops, engaging in scholarly endeavors, and providing consultation to individuals or agencies.

**b. Has sufficient knowledge to provide consultation, and to educate social work practitioners about practice and supervision.** In addition to the knowledge and skills already listed, the supervisor is knowledgeable about models of supervision. Individual clinicians and the profession itself are advanced by the supervisor's consultation, training, and writing about supervision or practice.

**c. Has sufficient knowledge to provide education, consultation, and training to other professionals and to the public.** The clinical supervisor's knowledge is broad and deep enough to enable him/her to contribute to the growth of the larger professional and lay community.

**d. Stays abreast of the professional and scientific literature.** The supervisor must be aware of the new knowledge that arises constantly from theory development and research and that is disseminated in scholarly publications, workshops, on-line resources, and books in their area of practice and in supervision. Participation in certificate programs can reinforce this knowledge.

## 2. Skills

**a. Imparts knowledge to others with objectivity, respect, and skill.** The supervisor demonstrates in consultation, supervision, and teaching (e.g. workshops) the same skills and attitudes she/he wishes to impart.

**b. Engages in activities that enhance professional knowledge.** The supervisor uses his/her practice and supervision experiences to advance knowledge in either area, through leading and participating in discussion groups, seminars, and colloquia that explore difficult areas of practice. The supervisor may undertake research or agree to participate in the research of others. The key idea is that the supervisor's role includes advancing knowledge as well as transmitting it.

**c. May serve on professional boards or provide community service representing the discipline of clinical social work and the specialty of supervision.** Opportunities exist for clinical supervisors to become members of social service boards, ad-hoc committees, governmental task forces, licensing boards, and other such organizations. As a member, the clinical supervisor can influence other participants on issues of quality practice and supervision and the importance of setting and monitoring standards.

**d. May participate as evaluator of services or programs.** Local and national accreditation bodies often turn to experienced practitioners and supervisors to assist in evaluating services and programs. The clinical supervisor who develops program-evaluation skills may use these same skills within his/her own organization or in consulting to other organizations.

**e. Exercises leadership as a clinical social worker.** The supervisor may demonstrate leadership by writing, speaking, teaching, role modeling, researching, serving on editorial boards, conference planning, and/or publishing.

**f. May assume political and educational positions to advance the field of clinical social work and supervision.** In professional organizations or on politically focused sub-groups, the supervisor advances support for standards of practice and supervision. This may include participating in lobbying efforts, contacting elected officials and their staffers, writing letters to the editor, and offering op-ed pieces to newspapers and articles to magazines and on-line media.

**g. May publish in the field of clinical supervision.** The clinical supervisor can contribute to the advancement of knowledge by publishing in peer reviewed professional journals.

## **V. Conclusions and Recommendations**

*ABE concludes:*

1. It is possible to describe and define the nature and value of advanced clinical social work supervision.
2. There is a continued need for research in clinical social work supervision
3. Changes in many work settings have forced some clinicians to seek outside supervision at their own expense and at the risk of circumventing the responsibilities inherent in the relationship of a clinician and a formal organization-based supervisor. These arrangements raise issues of accountability, confidentiality and liability, which need to be addressed by regulatory agencies, service agencies, and professional associations
4. There are inadequate and inconsistent standards for regulation and training of clinical social work supervisors

It is difficult to achieve the necessary training to become an advanced practitioner in clinical social work with the current:

- Lack of financial support for supervision in social work agencies
- Limited coursework in supervision in graduate schools of social work
- Insufficient post-masters' training opportunities

*ABE therefore recommends:*

1. That further research be done in the areas of evidence-based best practices in clinical social work supervision
2. That post-master's training in clinical supervision be made widely available.
3. That standards and regulations for the providers of pre-licensure clinical supervision be established by regulatory agencies as a means of public protection.
4. Clinical supervision be a funded service in any comprehensive mental health or social service delivery plan.

5. That graduate schools and bodies that accredit graduate schools strengthen the curriculum and training for supervision for students and field instructors.
6. That the profession advance post-graduate education and training opportunities for the continuum of clinical social work supervision.

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## **VII. Appendix–Summary of Competencies (recapitulates section IV.)**

### ***A. Creation of a Supervision Contract***

#### ***1. Knowledge***

**Understands the importance of creating structure through the process of contracting with the supervisee.**

**Can evaluate the level of need and the knowledge and skills required for effective practice among a range of clinical social workers.**

**Understands the importance of obtaining supervisee input and integrating supervisee issues and agenda into the supervision contract.**

**Is aware of issues of authority and accountability in supervision.**

**The supervisor understands the responsibility to create and maintain an ongoing record of the supervision**

#### ***2. Skills***

**Can describe clearly the purposes of clinical supervision.**

**Can describe his or her role and purpose as part of the contracting process.**

**Can use the supervisee’s issues and concerns in developing the supervision contract.**

**Addresses issues of authority ranging from the informal authority invested by the supervisee to the formal authority assigned to the supervisor by the agency or setting**

**Can discuss openly the issues of formative and formal evaluations.**

**Establishes clear parameters regarding the supervision plan, including setting time and frequency, fees for services, goals and objectives, and expected length of service and outcome.**

**Maintains a professional relationship with the supervisee and recognizes the integrity of a range of supervisee boundaries throughout the supervision process.**

**Recognizes and respects the boundary between supervision and personal therapy.**

## ***B. Supervision of the Processes of Intake, Assessment, and Diagnosis***

### ***1. Knowledge***

**Understands that the helping process begins with contracting with an individual to become a client.**

**Uses advanced knowledge base and bio-psychosocial framework to ensure that supervisee arrives at a conceptual diagnostic assessment of the client.**

**Understands the use of an assessment process that is guided by a range of models and includes input from the client the family and other sources.**

**Has a knowledge base of specific categories of emotional disorders and disturbance, such as in the DSM IV-TR or NASW's Person In Environment (PIE), as well as setting specific types of expertise.**

**Demonstrates knowledge of multiple treatment modalities within their scope of practice and can help the supervisee to learn to use them well.**

**Recognizes when consultation is needed in instances of a client's biological, psychiatric or physical difficulty.**

### ***2. Skills***

**As part of the assessment process, the supervisor informs, guides, and evaluates the supervisee's performance of a comprehensive evaluation of the client's strengths, weaknesses, cultural influences, interpersonal influences, and environmental stressors.**

**In the context of diagnostic formulations, the supervisor informs, guides, and evaluates the supervisee in the course of his/her consideration of the interplay of internal and external factors, bio-psychosocial and cultural influences, and past and present experiences.**

**Informs, guides, and evaluates the supervisee's ability to factor into assessment the impact of developmental maturation, biological, environmental, and socio-cultural considerations.**

**Informs, guides, and evaluates the supervisee's ability to assess the client's capacity for developing insights into the nature of the problem.**

**Informs, guides, and evaluates the supervisee's identification of possible or suspected physiological and other variables (e.g. medical factors, substance abuse, learning disabilities) that require collaboration with other professionals.**

**Informs, guides, and evaluates the supervisee's use of a standard diagnostic classification system to make differential diagnoses, ruling out other diagnoses, and evaluating for co-morbidity.**

**Informs, guides, and evaluates the supervisee's continual use of clients' responses and other client indicators to refine the conceptual assessment and diagnosis in consultation with the client.**

**Informs, guides, and evaluates the supervisee's systematic analysis of the multiple contexts affecting the client's functioning.**

**Informs, guides, and evaluates the supervisee's ability to reflect on and self-evaluate performance and to remain open to the "ambiguities" of practice and to question assumptions.**

## *C. Supervision of Treatment Planning*

### *1. Knowledge*

**Is knowledgeable as to level of care and type of intervention based on the diagnostic assessment.**

**Understands the use of theory in the treatment planning process based on the needs of the client.**

**Understands how the working alliance is affected by the client's language, interests, culture, and other elements of diversity.**

**Is aware of how client outcomes can be affected by supervisor's and supervisee's biases about social work practice modalities when formulating recommendations for intervention.**

**With regard to establishing a treatment plan, the supervisor understands the importance of assessing the client's resources, social supports, networks, and other factors.**

**Must be aware of issues regarding confidentiality arising from HIPAA (Health Insurance Portability and Accountability Act of 1996), and other legislation.**

### *2. Skills*

**Helps supervisee form a verifiable professional opinion, based on clinical assessment and in collaboration with the client, about level of care and type of intervention.**

**Helps supervisee to integrate theory in the treatment planning process based on the needs of the client.**

**Helps supervisee address issues such as client's language, interests, culture, and other elements of diversity, in order to facilitate communication and to develop and maintain a therapeutic alliance.**

**Helps supervisee determine appropriate intervention based on factors such as the nature of the client's problem (duration, severity, and environmental contributions), the client's stage of problem acceptance or resistance, as well as respect for the client's autonomy.**

**Helps supervisee examine own biases about modalities when formulating service recommendations with client and understand how this can impact client outcomes.**

**In establishing the treatment plan, the supervisor assesses client resources, support network, and other factors.**

## *D. The Supervision Process*

### *1. Knowledge*

**Is aware of the parallel process in that the interaction with the supervisee can be acknowledged and serve as an appropriate teaching tool.**

**Has the self-awareness to recognize his or her own emotional response to the supervisee's anxiety.**

**Recognizes and understands how to addresses inter-ethnic and intra-ethnic issues that emerge in the supervisory relationship.**

### *2. Skills*

**The supervisor demonstrates mastery of the methods of supervision utilizing skills in communications, relationships, learning styles and problem-solving.**

**The supervisor uses the supervision process to model professional practice.**

**Guides and evaluates the supervisee toward better carrying out the treatment plan and greater effectiveness in working with a broad range of emotions and intensity of affect.**

**Guides and evaluates the supervisee's ability to use a range of tools (process recordings, memory work, audio- and video-tapes, and observation) to share the details of the practice for analysis with the supervisor.**

**Guides and evaluates the supervisee's ability to respect the centrality of the therapeutic relationship and to sustain a therapeutic alliance.**

**Guides and evaluates the ability of the supervisee to integrate feelings effectively into the professional function and role.**

**Guides and evaluates the supervisee's ability to permit the client's expression of intense affect states, both positive and negative, as he/she learns to manage extreme behaviors while maintaining a therapeutic stance.**

**Guides and evaluates the supervisee's ability to engage the client and to develop a working agreement in the beginning phase of practice.**

**Guides and evaluates the supervisee's ability to work in response to client productions (direct and indirect) in the middle phase of practice.**

**Guides and evaluates the supervisee's ability to assess readiness for termination (in collaboration with client) in terms of goals and objectives of the service and level of functioning.**

**Guides and evaluates the supervisee's ability to recognize the potential significance of the termination process and to assist client in dealing with the issues it may provoke.**

**Evaluates the need for adjunct services and arranges for them, in conjunction with the supervisee and client, when indicated.**

## *E. Supervision of Appropriate Professional Impact*

### *1. Knowledge*

**Understands organizational structure and dynamics and is able to view the organization as a dynamic system.**

**Has an understanding of the complex dynamics of inter-professional and inter-organizational interactions.**

**Explores the supervisee's tendency to over identify with the client or to over identify with the system.**

### *2. Skills*

**Facilitates the supervisee understanding of complex systems and inter-professional relationships.**

**Demonstrates empathy for the difficulties facing the supervisee in dealing with "hard-to-reach" systems or professionals.**

**Analyzes the clinical social worker's interactions with other systems and professionals using the same tools and methods employed in examining direct practice with clients.**

**Clearly states the expectation that the supervisee will work professionally with other systems and professionals.**

## *F. Practice Process and Outcome Evaluation*

### *1. Knowledge*

**Must be aware of appropriate tools and procedures for evaluating practitioner-client process as well as outcomes of practice.**

**Must understand the differential use of such tools.**

### *2. Skills*

**Elicits supervisee feedback in evaluating client readiness to move from one task or phase of treatment to the next.**

**Must be skilled at implementing such tools.**

**Must be skilled at assisting workers to be comfortable using such tools and receiving and sharing practice feedback.**

**Supervisor assists the supervisee in critically analyzing the literature and identifying practice interventions that have received empirical support.**

## *G. Evaluation of Supervision Outcomes*

### *1. Knowledge*

**Must have the knowledge to develop an agreed-upon supervision plan with defined desired outcomes and the means to evaluate whether such outcomes have been achieved.**

**Must be aware of existing tools for evaluating supervision.**

### *2. Skills*

**Must be able to evaluate supervision based on progress toward goals and to modify goals.**

**Works with supervisee to agree on achievements of supervision and remaining problem areas and learning needs, and to review contracted goals and renegotiate future work.**

**Helps supervisee to be constructive in disagreeing with outcome assessments.**

## *H. Consultation, Training, Writing*

### *1. Knowledge*

**Is recognized as an expert by peers and the professional community.**

**Has sufficient knowledge to provide consultation, and to educate social work practitioners about practice and supervision.**

**Has sufficient knowledge to provide education, consultation, and training to other professionals and to the public.**

**Stays abreast of the scientific and professional literature.**

### *2. Skills*

**Imparts knowledge to others with objectivity, respect and skill.**

**Engages in activities that enhance professional knowledge.**

**May serve on professional boards or provide community service representing the discipline of clinical social work and the specialty of supervision.**

**May participate as evaluator of services or programs.**

**Exercises leadership as a clinical social worker.**

**May assume political and educational positions to advance the field of clinical social work and supervision.**

**May publish in the field of clinical supervision.**

## **Publisher's Note with Acknowledgments**

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