

Providing and Documenting Effective Supervision

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Training Goals

- Introduce participants to Core Rules and expectations from the public sector
- Introduce and provide overview of some widely published “models” or approaches in clinical supervision
- Help participants gain an understanding of the 4 main foci of supervision and how to balance them
- Help participants self-examine to learn more about their supervisory orientation and application
- Help participants understand how to develop supervision plans that include SMART goals that focus on both administrative and clinical functions and outcomes

Why This Subject Matters

- Core Rules – APSM 30-01 (e.g., for Associate Professionals – “Supervision shall be provided by a qualified professional with the population served until the individual meets one year of experience [2 yrs for non-grad; 4 yrs for non-human service degree; etc.) The supervisor and the employee shall develop an individualized supervision plan ***upon hiring***. The parties shall review the plan annually”)
- Required as part of Quality Management and Assurance
- Required as part of the Full Endorsement process
- Endorsement required for State licensure and Medicaid/DMA certification
- Feeds national accreditation (e.g., CARF, COA, ASQ)

Why This Subject Matters -2

- Core Rules – APSM 30-01....

"Clinical/professional supervision" means regularly scheduled assistance by a qualified professional or associate professional to a staff member who is providing direct, therapeutic intervention to a client or clients. The purpose of clinical supervision is to ensure that each client receives treatment or habilitation which is consistent with accepted standards of practice and the needs of the client

Why This Subject Matters -3

Core Rules – APSM 30-01....

- Competencies required of Qualified, Associate and Paraprofessional Staff:

- (1) technical knowledge;
- (2) cultural awareness;
- (3) analytical skills;
- (4) decision-making;
- (5) interpersonal skills;
- (6) communication skills; and
- (7) clinical skills.

...Note that the supervisor's CLINICAL job requires the coaching, modeling, teaching, observing and documentation of these core competencies as defined by the APSM.

Basic Definitions - 1

- **“Supervision is an intervention that is provided by a senior member of a profession to a junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the junior members(s), monitoring the quality of professional services offered to the clients she, he, or they see(s), and serving as the gatekeeper of those who are to enter the particular profession.”** (Bernard and Goodyear, 1998)

Another Definition - 2

“Clinical supervision is a disciplined, tutorial process wherein principles are transformed into practical skills, with four overlapping foci: administrative, evaluative, clinical and supportive.”

(Powell, D. & Brodsky A. (2004))

Still Another Definition

- In Falender and Shafranske (2007), the authors define competency-based supervision as “..an approach that explicitly identifies the **knowledge, skills, and values** that are assembled to form a clinical competency and develops learning strategies and evaluation procedures to meet criterion-referenced competence standards in keeping with evidence-based practices and requirements of the local clinical setting” (p. 233).

“Emphasis is on the ability to apply knowledge and skills in the real world and use performance outcomes as criteria for evaluating supervisees and programs” (p. 7 in Falender and Shafranske, 2008)

Supervision is ??? (4 foci of Powell)

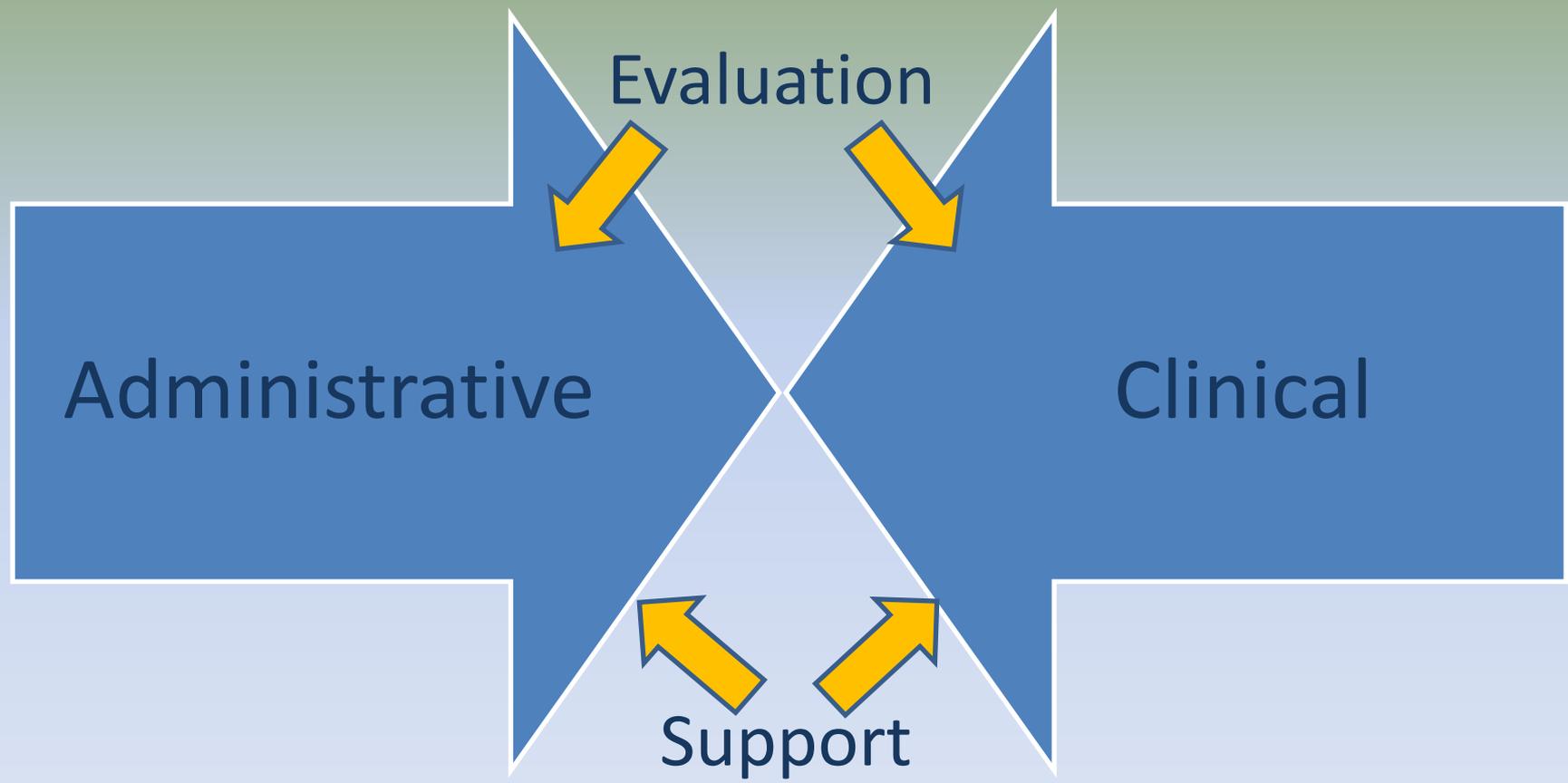
Supportive

Administrative

Evaluative

Clinical

Evaluation Pervades All Levels Within the Supervisor-Supervisee Relationship, as Does Support



In Social Work Practice, the Domains Look Like (ABECSW 2004):

- Direct practice supervision - refers to all activities designed to guide and educate the clinical social worker in assessment, treatment/intervention, identification and resolution of ethical refers to guiding the supervisee in work-related issues, which create a frame for the clinical work issues, and evaluation of client interventions
- Treatment collaboration supervision - refers to all client-oriented activities designed to guide the clinician in dealing with other professionals (including policy, procedure, politics)
- Continued learning supervision - involves working with the practitioner to help develop the skills required for life-long continued professional learning
- Job management supervision - refers to guiding the supervisee in work-related issues, which create a frame for the clinical work

Basic Goals of Supervision

- **Assure the delivery of high quality interventions (e.g., “treatment”)**
- **Create a positive work environment**
- **Develop staff clinical and administrative skills**

Administrative Supervision Examples

- New staff orientation
- Reviewing organizational policies and procedures
- Documenting time, work, expenses
- Documenting training experiences
- Conducting performance and/or contractor reviews
- Reporting on client's rights, incidents, or ethics issues

Goal: to help supervisee meet organizational and/or agency requirements, expectations, standards—compliance is a key issue under the administrative process

Clinical Supervision Examples

- Case reviews – PCP documentation, completion, reviews
- Exploration of psychodynamics
- Examination of cultural biases and issues
- Modeling, observing techniques
- Listening to audiotapes, or viewing videotapes of sessions with supervisory feedback
- Team or peer clinical scenario training
- Exploring and consulting re: ethical & legal issues
- Clinical supervision is not counseling or therapy although a supervisor does counsel their supervisee at various points – know the differences between supervisory counseling and clinical counseling!

Goal: develop competence in clinical and interpersonal skills, grow self-awareness, knowledge re: clinical tools, competencies, techniques, etc.

Supervision Formats/Modes

- Individual supervision
- Peer/group supervision
- Audiotape reviews
- Videotape reviews
- Telemedicine/teleconferencing
- Transcript reviews
- Direct observation
 - NOTE: one cannot effectively supervise without some direct observation.

Exercise 1 – Small Groups

Group 1...What are the most common barriers and challenges you may face in being an effective clinical supervisor?

Group 2...What are the most common barriers and challenges you may face in being an effective administrative supervisor?

Comparative Features (Gallon, 2002)

	Counseling	Clinical Supervision	Administrative Supervision
Purpose	Personal growth; behavior changes; decision-making; better self-understanding	Improved job performance	Assure compliance with agency policy and procedure
Outcome	Open ended based on client's needs	Enhanced proficiency in knowledge, skills, and abilities/attitudes essential to high job performance (observed competencies)	Consistent use of approved formats, policies and procedures (observed competencies)
Time frame	Self-paced; longer term	Short-term and ongoing	Short-term and ongoing
Agenda	Based on client needs	Based on service mission and design	Based on agency needs
Basic process	Affective process which includes listening, exploring, teaching	Assessing worker performance; negotiating learning objectives; teaching/learning specific skills	Clarifying agency expectations, policy and procedures; assuring compliance

Exercise 2

Part 1: From the basic model descriptions thus far, what skills and/or strengths are needed to be an effective supervisor versus an effective counselor? How are these skills and roles different? Similar?

Part 2: Give examples of the following competencies needed by clinical supervisors, to the group: (1) Knowledge (2) Skills (3) Values (4) Social context/overarching issues

From Skinner, Roche, O'Connor, Pollard & Todd (2005), (with R. Jenkins edits). Effective Clinical Supervision ---

Clinical

An effective clinical supervisor does not just instruct the supervisee, but teaches by example by modeling clinical competencies. The clinical supervisor's role as a clinical instructor is to:

- Evaluate clinical interactions (in all situations and capacities)
- Identify and reinforce effective actions by the supervisee
- Correct and improve problematic or potentially ineffective treatment actions in a caring, supportive, evidence-based manner
- Teach and demonstrate counseling techniques
- Explain the rationale of strategies and interventions using appropriate literature and/or research basis where possible
- Interpret significant events in the counseling process
- Challenge the supervisee in a constructive manner
- Identify and reduce liability (vicarious or direct)

From Skinner, Roche, O'Connor, Pollard & Todd (2005), (with R. Jenkins edits). Effective Administrative Supervision ---

Administrative

An effective administrative supervisor does not just instruct the supervisee, but manages their role by ensuring their own current training and expertise in, as well as applications of:

- All agency policies and procedures, as in compliance with...
- All exigent (e.g., contractor, 3rd party payer, regulator, etc.) rules and policies/guidelines, confidentiality/HIPAA, HIV, 42 CFR regulations-----as in compliance with...
- All standards of care that the profession agrees upon as high / acceptable standards for clinical care
- All performance appraisal procedures and formats
- Management or administrative-focused risk and liability (**vicarious** or direct)

In Supervision Plans....

- Should identify percentages and goals for how much time will be spent on which functions.

For example:

Administrative = % of time spent together

-- Evaluative = % of time assessing admin issues

Clinical = % of time spent together

-- Evaluative = % of time assessing clinical issues

Overview of Supervision Models

Developmental Model (IDM, or Integrated Developmental Model -- Stoltenberg, McNeil, and Delworth [1998])

3 levels of Supervisor development:

1. Level 1: New to the supervisor roles/functions, these individuals tend to be mechanistic in their supervisory approaches, more rigid in their strategies and tools, and characterized by a sense of insecurity and/or naiveté. However, their motivation levels are quite high.
2. Level 2: Somewhat of a transitional level, persons here tend to harbor confusion, doubt, self-conflict and some frustration (are the theories right? Am I competent? Can I do all of this? Can I really help this supervisee effectively?) According to Stoltenberg et al., supervisors don't stay in this stage very long – they either resolve conflicts or exit the role(s)
3. Level 3: Characterized by a resolve that they are comfortable in their roles as supervisors. They actively use self-appraisal and exploration, have strong empathy and communications skills, and feel competent to work with supervisees at all levels.

Overview - 2

Developmental Model (IDM, or Integrated Developmental Model -- Stoltenberg, McNeil, and Delworth [1998])

3 levels (distinct or noticeable) levels of supervisee/counselor development:

1. Level 1: just entering the field. Staff tend to be anxious about their skills, doubtful as to their knowledge base and competencies but motivated to use their experiences and training to date in an effective manner. They can be highly dependent on others, imitative in their work and behaviors, categorical and “rule bound” in their thinking, and tend to “cook book” their solutions. May prefer more directive, skill-based, problem-focused interventions.
2. Level 2: a year or two after formal training and into the field, this worker is becoming more comfortable with the application of training, case conceptualization, field experience and effective use of supervision. S/he may begin to explore various approaches, current trends in the literature, and have basic skills in managing a counseling relationship beyond the basic competencies required – they vacillate between autonomy and dependence..sometimes they tend to become too client-focused – their early knowledge can make them too over-confident and prescriptive.
3. Level 3: counseling staff at this level have developed a sense of empathy that is more effective and related to consumer needs/perspectives. They express and exhibit a sense of self-confidence, autonomy and comfort. They are comfortable with the core skills & competencies (and styles) that enable them to explore important information in counseling interactions while discarding the irrelevant facts/processes/dynamics; and they tend to be realistic about their jobs and the expectations that apply to behavioral health counseling. They prefer more collegial, consultative, exploratory, honest interventions that recognize their styles, skills, self-awareness and autonomy.

Exercise 3

- On a blank piece of paper, write your own conceptualization of the level of supervisor you are – think about your experience level, your knowledge, your skills in working with supervisees, your sense of confidence, your self-awareness, your training, etc. What makes you think you are at Level ___? How does your Level as supervisor contrast with your Level as a Counselor?

Overview - 3

Other Integrated Models (Powell; Perlmutter; Shulman) include interactional, interpersonal and skill development approaches -

Common features:

- Use a developmental approach (i.e., developmental psychology) & emphasize stages of change over the life course of experience, training and supervisor-supervisee interactions
- Emphasize core functions including behavioral change and skill acquisition (not just insight or self-awareness development) as well as motivation to engage/change
- Powell, esp., believes that supervision should be employed to help the supervisee “use oneself in counseling to promote behavioral change in the client” – Historically, supervision models have emphasized either skill development or interpersonal change. Powell’s approach is an integrated model emphasizing both (skill building and interpersonal growth)

The “Discrimination Model” – Bernard & Goodyear, 1992

- “A-theoretical” or eclectic
- Combines 3 supervisory roles (teachers, counselors, consultants) with 3 areas of focus (process, conceptualization and personalization)
- Process = examine how communication takes place
- Conceptualization = examines how well supervisee can explain applications of theory to practice (e.g., diagnosis, case formulation, treatment approaches matched to diagnosis)
- Personalization = deal with how the supervisee uses their “sense of person” in treatment/therapy (understanding of body language, grooming, presentation, style, etc.)
(This is primarily a training model and less a “practice” model)

Basic Points

- Models vary on differing pivot or focal points:
 - Role of authority and degree of power involving the supervisor-supervisee relationship
 - Expectations or outcomes of the relationship (skills development, personal growth, empathy development, administrative conformance)
 - Competencies are variously defined by the theoretical approach one takes (competence in self-recognition and case conceptualization; competence in managing caseloads and client flow; etc.)
 - Vary on how important the characteristics of autonomy, self/other awareness and motivation are in the supervisor-supervisee relationship
- The MAIN POINT HERE is that you must become comfortable with a model and theoretical framework, or your approach to supervision will be patchwork-like and may not make sense to the supervisee. This is VERY SIMILAR to psychotherapy/counseling --- most supervisors come to some sort of eclectic approach as they move from stages 1 & 2 to stage 3 if thinking from a developmental perspective.

Core Tests of The Effectiveness of Supervision

- Does it grow the supervisee and supervisor?
- Does it encourage and ensure conformity to agency and organizational standards and expectations?
- Does it result in improved consumer outcomes?
- Does it provide both support and challenge to the supervisee?
- Does it help make the work more manageable (e.g., a more positive work environment for productivity and quality outcomes)?

Powell & Brodsky, 1998 – More on Characteristics of Effective Supervisors

The “Four A’s of clinical supervision” describe a good clinical supervisor:

1. **Available: open, receptive, trusting, non-threatening**
2. **Accessible: easy to approach and speak freely with**
3. **Able: having real knowledge and skills to transmit**
4. **Affable: pleasant, friendly, reassuring.**

In addition, supervision sessions should be **supervisee-centered – this way the supervisee is able to** own the process, rather than feel that the process is driven and dominated by external factors. Supervisors should guarantee uninterrupted time, a clear focus on the goals and objectives of the supervisee, adopt an attitude of empathy and caring toward growing the professional competencies of the supervisee, and serve as the collegial sounding board for the supervisee. Supervisees report that the best supervisors have a combination of mentoring, counseling, education and supportive characteristics on top of their strong management and organizational skills. Cultural competencies and critical thinking skills are also highly valued.

Also, good supervisors: are effective communicators, understand how people change, provide a supportive & respectful environment, engage with the supervisee in the developmental change process (not just teaches or tells), follow through via observation, provides feedback in *timely and respectful manner*, checks assumptions (thoughts) about supervision and you as their supervisor, sets clear expectations that are validated through effective communication practices

Supervisor Challenges

- Time (is there ever enough???!!!!)
- Training (are you receiving enough; is the supervisee?)
- Rewards (can you really reward or incentivize positive practice and conformity to high standards)
- Peers (are there colleagues you can turn to? Have you as a supervisor moved from peer to administrator/supervisor?)
- Focus (where to prioritize projects and energies)
- Agency (balancing the needs of the organization with supervisee's needs, and that of own)
- Intrapersonal (keeping your own "stuff" in check; are you aware of the press and stress of your own dynamics as related to supervisee, clients, management?)
 - **What others can you think of?**

Exercise 4

From the basic model descriptions thus far, what features of each do you see in the way that you are supervising your employees or contractors? Are there some elements that are hybrid or mixed (e.g., “eclectic”)? What do you see in your own values as a supervisor that are top priorities when supervising others?

Competencies

- From the “Competencies for SA Treatment Clinical Supervisors” (TAP 21-A, SAMHSA)– there are basic competencies in “Foundational” and “Performance” domains
 - Foundational Domains = those fundamental areas of training, leadership, critical thinking and management that makes one a strong candidate for supervisory work
 - Performance Domains = fundamental areas of skills/competencies that address counseling skills development, ethics/standards, QA/QM, performance management/evaluation and general administration

Competencies-2

- Foundational Domains
 - FA1: Theories, Roles, and Modalities of Clinical Supervision;
 - FA2: Leadership;
 - FA3: Supervisory Alliance;
 - FA4: Critical Thinking; and
 - FA5: Organizational Management and Administration.

Competencies-3

- Performance Domains
 - PD1: Counselor Development;
 - PD2: Professional and Ethical Standards;
 - PD3: Program Development and Quality Assurance;
 - PD4: Performance Evaluation; and
 - PD5: Administration.

Mentoring Competencies and Clinical Supervision

1. **Agree to work together**

Agree on working together toward improving the supervisee's counseling skills.

2. **Define and agree on a learning goal**

The learning goal must be clearly defined, and there needs to be agreement to work together to help the counselor attain proficiency in the skill chosen.

3. **Understand the value of the goal**

The counselor needs to understand the value of achieving the agreed upon goal.

4. **Break goal into manageable parts**

The overall goal needs to be broken down into its constituent parts: a) the knowledge, b) the skills, c) the attitudes necessary to attain proficiency.

5. **Pick styles and methods of learning**

The supervisor needs to elicit from and negotiate with the counselor his or her preferred styles and methods of learning.

6. **Observe and evaluate**

How progress will be observed and evaluated needs to be discussed and agreed upon. What criteria used to evaluate competence?

7. **Provide feedback**

The supervisor needs to know how to give feedback which guides, corrects, and at the same time encourages.

8. **Demonstrate competency & celebrate**

An outcome demonstration of the newly acquired skill which confirms success needs to be designed, followed by a celebration of the accomplishment.

* In Lindbloom, Ten Eyck and Gallon (2005)--Adapted from Stiehl, R. and Bessey, B (1994). *The Green Thumb Myth: Managing Learning in High Performance Organizations – A Success Strategy for Trainers and Managers*. Second Edition, Corvallis, Oregon: The Learning Organization.

Communications Exercise (5) – ORAL Model of Giving Feedback (Groups of 3; a “supervisor”, “supervisee”, and observer)

- O – Observer
- R – Report
- A – Assume
- L – Level



Goes like this:

“When I saw (heard) you
I assumed (thought)
and my reaction was”

Oral Process =

- 1. Ask permission**
- 2. Report the behavior being observed**
- 3. Relate the assumptions or thoughts you have upon observing it**
- 4. Share your feelings and/or concerns**
- 5. Report impact on clients, colleagues, agency**
- 6. Clarify misunderstandings and omissions**
- 7. Confirm mutual understanding**

OARS – Motivational Interviewing

- Open questions
 - Affirmation
 - Reflective listening
 - Summary reflections (OARS)
-
- *(Adapted from handouts by David Rosengren and from Miller & Rollnick, Motivational Interviewing, 2nd, Edition, 2002) – see session handout*

Assessing Supervisee Performance – Evaluation and Goal Writing

- Starts with clear expectations as to time tables, tools, methods and an understanding as to the basis of merit – what is being evaluated, by whom, by when, and by what standards?
- Begins at date of hire – transitional supervision plan followed by the permanent one

Assessing Supervisee Performance – Evaluation and Objectives Writing - 2

- Administrative Goals and Clinical Goals --- remember the evaluative component in each?
- One method of goal setting uses SMART goals as written for each domain.

S – Specific

M – Measurable

A – Attainable

R – Relevant

T - Timeliness

Assessing Supervisee Performance—Evaluation/Objectives Writing - 2

- **Specific – *What exactly are we going to do, with or for whom?***

The performance statement includes a specific outcome, or a *precise objective to be accomplished*. The outcome is stated in numbers, percentages, frequency, reach, scientific outcome, etc. The objective is clearly defined.

- **Measurable – *Is it measurable & can WE measure it?***

This means that the objective can be measured and the measurement source is identified. All activities should be measurable at some level.

- **Achievable – *Can we get it done in the proposed timeframe/in this organizational climate/ for this amount of money?***

The objective or expectation of what will be accomplished must be realistic given the organization, consumer, supervisor and supervisee conditions, time period, resources allocated, etc.

- **Relevant – *Will this objective lead to the desired results?***

This means that the outcome or results of the objective and supervisory activity directly support the outcomes of the organization's long range plan or goals

- **Time-framed – *When will be accomplish this objective?***

This means stating clearly when the objective will be achieved.

Assessing Supervisee Performance – Evaluation and Objectives Writing - 3

- Example goal:
 - “Jim will increase his knowledge of evidence-based counseling skills over the next review period”
 - SMART Objective: “Jim will learn and master 2 or more EBP’s in the next 6-12 months as documented by post-tests and competency assessments in his training files, supervision notes, and by direct observation of his clinical supervisor.”

Assessing Supervisee Performance – Evaluation and Objectives Writing - 4

- Example goal:
 - “Sheila will strengthen her knowledge of clinically effective anger management techniques so that her effectiveness as a Community Support provider will measurably increase.”
 - SMART Objective: “Sheila will participate in 3 or more anger management workshops during the next 12 months, such as Aggression Replacement Therapy; PACT; or related programs, and achieve competence in them as documented by post-testing and/or clinical observations and workshop certifications.

Assessing Supervisee Performance – Evaluation and Objectives Writing - 5

- Example goal:
 - “Bob will complete all progress notes within agency standard time frames, following the appropriate rules for documentation and formats.”
 - SMART objective: “To ensure compliance with agency policy and other (e.g., state) guidelines, Bob will complete all direct service notes within 48 hours (or whatever your policy is) with the appropriate documentation elements, signatures, and credentials affixed. Any variances to this objective must be preapproved by the supervisor in advance.

Assessing Supervisee Performance – Evaluation and Objectives Writing – 6 -- Groups

- In groups of 3, write 2 to 3 SMART objectives for both administrative and clinical staff focusing on the following issues:
 - Effective skill building in community support services
 - Compliance with core rules training around clients rights, HIV/bloodborne pathogens/bodily fluids, crisis intervention, etc.
 - Developing counseling techniques, skills, and models for paraprofessional, associate professional, and qualified providers

Sample Supervision Plans

(See Handouts for Samples)

Required Reading from the “Division” and DMA

[Rules for MH/DD/SA Facilities & Services](#)

APSM 30-1 (4/06) (Includes Administrative Rules for Substance Abuse Services / DWI Offenders)

[Confidentiality Rules](#)

APSM 45-1 (1/05)

[Client Rights Rules in Community Mental Health, Developmental Disabilities & Substance Abuse Services](#)

APSM 95-2 (11/07)

<http://www.dhhs.state.nc.us/MHDDSAS/statspublications/manualsforms/rmd11-1-07manual.pdf> |

[Appendices APSM 45-2](#) (11/07)

(Because of the large size of the new manual it has been separated into two parts. Be sure to print out both the manual and the appendices.) [Outline of Changes Memo](#) (10/07)

And ...

Incident and Death Response System.

[Incident and Death Response System Manual](#) (11-04)

[Incident and Death Reporting Forms Changes](#) (memo dated 1-06)

[Incident Reporting Changes for DHHS Incident and Death Report \(Form QM02\)](#) (1-06)

[DHHS Incident and Death Form \(QM02\)](#) (3-8-06)

And ...

From DMA:

Clinical Coverage Policy and Provider Manual: Enhanced Mental Health and Substance Abuse Services

<http://www.dhhs.state.nc.us/dma/bh/8A.pdf> (currently under revision)

DMA Clinical Coverage Policy for Outpatient Behavioral Health Services – 8C:

<http://www.ncdhhs.gov/dma/bh/8C.pdf>

Thank You and Good Luck!

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