Clin Soc Work J (2014) 42:171–181
DOI 10.1007/s10615-013-0466-x

ORIGINAL PAPER

Strengthening Supervision in Systems of Care: Exemplary Practices in Empirically Supported Treatments

Michael A. Hoge · Scott Migdole · Elisabeth Cannata · David J. Powell

Published online: 27 November 2013
© Springer Science+Business Media New York 2013

Abstract The last few decades have witnessed major growth in the evidence base on effective client interventions used by social workers and other health and social service professionals. As the pressure for service agencies to offer empirically supported treatments has been increasing, financial and time constraints have driven a decline in the frequency and amount of supervision provided within many of these organizations. While the reduction in staff supervision presents a challenge for effective implementation of all treatments, there are comprehensive empirically supported treatment models for clients that serve as exemplars of supervisory practice through their explicit requirements, processes and tools for supervision and supervisor development. After a review of the current status of supervision nationally, an implementation science-based approach is described, which builds organizational support for supervision and promotes optimal supervisory practice through training and consultation of supervisors and supervisees. The elements of this comprehensive approach, developed by the Yale Program on Supervision, are detailed. Supervisory policies, practices, and tools created by the developers of empirically supported treatments and similarly grounded in the principles of implementation science are offered as further examples of strategies for ensuring effective supervision.

Keywords Supervision · Empirically supported treatment · Staff development · Organizational change

M. A. Hoge
Yale University School of Medicine, 300 George Street, Suite 901, New Haven, CT 06511, USA
e-mail: Michael.hoge@yale.edu

S. Migdole (✉)
Yale University School of Medicine, 55 Church Street, Suite 403, New Haven, CT 06511, USA
e-mail: Scott.migdole@yale.edu

E. Cannata
Wheeler Clinic, 91 Northwest Drive, Plainville, CT 06062, USA
e-mail: ecannata@wheelerclinic.org

D. J. Powell
Yale University School of Medicine, P.O. Box 831, East Granby, CT 06026, USA
e-mail: djpowell@yahoo.com

Introduction

The President's New Freedom Commission Report on Mental Health stressed the need to deliver excellent mental health services (New Freedom Commission on Mental Health 2003). This included advancing the development of empirically supported treatments (ESTs) and expanding the workforce skilled and able to provide them (Bellamy et al. 2006). The movement towards ESTs in social work began in the 1970s after the effectiveness of typical clinical practice was questioned. Two decades later, the evidence base had expanded greatly and concern had shifted to the lag, estimated at 10–15 years, between significant evidence of a treatment's effectiveness and its widespread adoption by professionals (Bellamy et al. 2006). Equally sobering was research revealing that among clinicians trained in ESTs, few continued to use them 6 months to 3 years post-training (Spence et al. 2001). For social workers, the gap between research and practice has been of particular concern given the size of the discipline and the large role that these professionals play in providing direct services to persons with mental health conditions.

Supervision is viewed as the crucible in which providers in all disciplines acquire knowledge and skills. It is the principal bridge between the classroom and the clinic (Center for Substance Abuse Treatment 2009). The importance of supervision is supported by its own emerging evidence base, which attests to its potential impact on staff retention, staff skill, adherence to ESTs, and quality of care (Hoge et al. 2011). However, using supervision to promote any practice, including ESTs, faces steep challenges, since in the typical service agency most individuals promoted into supervisory roles receive no training for these new responsibilities, supervision is frequently provided on an ad hoc basis, if at all, and the content of supervision seems to be dominated by administrative as opposed to clinical and quality of care issues (Hoge et al. 2011).

This article examines approaches to strengthening supervision in social work, with a particular focus on ESTs delivered in organized systems of healthcare. The term ESTs is used to refer to interventions documented in a treatment manual that have evidence of effectiveness from more than one controlled experimental trial conducted by more than one team of scientists (American Psychological Association 2013). The article begins with a review of the status of supervision in mental health organizations, provides a model of staff and organizational development strategies to promote supervision grounded in implementation science, and presents optimal approaches within EST models for supervisory practice. This is drawn from the work of the Yale Program on Supervision and its efforts to strengthen supervisory practice with social workers and other disciplines in the fields of mental health, addictions, child welfare, and corrections (www.supervision.yale.edu).

The Status of Supervision

It seems self-evident that supervision would be used to promote the delivery of effective healthcare services, particularly for those ESTs that call for fidelity to carefully prescribed interventions. Supervision complements classroom instruction in all professional schools. Similarly, supervisory structures exist in all healthcare systems.

The Evidence Base on Supervision

Optimism about supervision as an essential professional tool is supported by the extensive literature on supervisory practice that spans many decades. The vast majority of publications on this topic are descriptive, conceptual, or theoretical. Of those that involved a more systematic approach to examining the impact of supervision, qualitative methods have been used most frequently. These qualitative studies have reported on a broad range of positive effects on professionals who are supervised, including: decreased stress and burnout; decreased professional isolation; enhanced feelings of competence, efficacy, and well being; and greater acquisition, retention, and application of new knowledge (Hoge et al. 2011).

At the next level of methodological sophistication, quantitative studies without control groups have examined the relationship of supervision to other dependent variables. The findings from this research mirror the qualitative reports, and provide evidence of the positive impact of supervision on job satisfaction, intentions to remain in the job, measures of staff competence, reduced symptoms among clients, and adherence to ESTs (Hoge et al. 2011).

There are relatively few quantitative studies of supervision with control groups. However, the strength of their methodology gives considerable weight to their findings. Sholomskas et al. (2005) demonstrated the positive impact of supervision on clinician skill and adherence to a cognitive behavioral therapy intervention. Bambling et al. (2006) demonstrated the impact of supervision on the development of the therapist/client working alliance, treatment retention rates, client satisfaction, and symptom reduction in the delivery of brief problem solving interventions. A study of nurses' development of psychosocial education skills found increased staff knowledge and client outcomes among those nurses receiving supervision (Bradshaw et al. 2007).

Increased Need for Supervision

A compelling case can be made that the need for supervision has increased over the past several decades due to forces that have reshaped the nature of practice. Most relevant for this discussion is the expanded use of complex interventions, such as ESTs for clients that are far more explicit and prescriptive compared to historical practice based on theory alone (Hoge et al. 2011). Many social workers also now practice in complex systems of care where coordination with other providers is considered essential (Kowinsky et al. 2009) and shared decision-making with clients and their family members is expected (Drake and Deegan 2009). Clients are more complex, with increased prevalence of co-occurring mental and substance use conditions and medical comorbidity (Kavanagh and Connolly 2009). Average caseload size has increased due to financial pressures in service agencies and state agencies, while professionals are practicing with increasing autonomy due to the shift of services from institutions and agencies to the community (Rice et al. 2007).

Trends in the Current Practice of Supervision

While the need for supervision has increased, there is strong evidence that the provision of supervision has declined significantly over the past couple of decades to an ad hoc or as needed practice rather than a routinely scheduled part of weekly work life (Borders 2005; Crespi and Dube 2005). With respect to social workers, Schroffel (1999) cites evidence that 75 % received little or no supervision. Middle management and supervisory levels within organizations have been reduced due to financial pressures and the remaining supervisors struggle to meet their supervisory responsibilities, burdened with their own direct service and caseload responsibilities (Center for Substance Abuse Treatment 2009).

There is a growing empirical and professional literature that has identified the lack of training in supervision as a critical factor leading to increased supervisor strain and turnover, decreased supervisor satisfaction with work, inadequate accountability of supervisees, and an inconsistent or diminished quality of care (Tebes et al. 2011). Workers become supervisors based largely on seniority or skill in providing direct services (Center for Substance Abuse Treatment 2009). Once promoted, they generally receive little training, mentoring or supervision regarding this new role (Kadushin and Harkness 2002).

There is a general consensus in the field that the supervision typically provided is most often administrative in nature, with minimal focus on clinical or quality of care issues. This conclusion was supported by Hoge et al. (2011) who stated that while staff meetings, team meetings, and peer consultation are regularly being used in place of supervision, these are only adjuncts and lack the critical elements of traditional supervisory relationships.

Further complicating this situation is the absence of clearly identified competencies for supervisors, which hinders effective training and evaluation for these roles (Hoge et al. 2011). Most agencies lack basic supervisory standards and policies related to the required frequency, duration and format of supervision for different classes of employees. Even if policies do exist, it is uncommon in agencies to find supervision logs or other mechanisms for ensuring that the standards are being met. There are few incentives for agencies to address these issues since accreditation standards tend to be fairly non-specific about the provision of supervision and it is almost always a non-billable activity (Hoge et al. 2011). All of these concerns argue for the need to implement supervisory models that provide training and organizational structures for supervision in order to ensure positive clinical outcomes for clients and support for professional caregivers.

A Comprehensive Model of Supervision

The above analysis suggests that the first and foremost challenge to providing effective supervision of all services, including ESTs, is to ensure that the organizational context in which these practices are occurring is one in which supervisors are trained for their supervisory roles, are given time and held accountable for delivering supervision, and focus on clinical and quality issues in the supervision they provide. Building on a framework of implementation science (Fixsen et al. 2005), such an organization is one in which there is a focus both on staff development and on organizational change to support the staff in delivering effective care and supervising the provision of that care. Within such a context, then and only then, can effective supervision of treatment truly occur.

As an outgrowth of a federally funded initiative on the transformation of mental health systems of care, the faculty of the Yale School of Medicine launched the Yale Program on Supervision and developed a model for promoting the effective provision of supervision in the community and state agencies that comprise organized systems of care (Tebes et al. 2011). The model, which has now been used in multiple states in the fields of mental health, addictions, child welfare, and corrections, uses an implementation science framework (Fixsen et al. 2005). This means that it involves focused work with agency leadership to develop and implement written standards and policies regarding supervision and to put in place structures that support supervision delivery. Simultaneously, this is complemented by training and consultation with middle managers, supervisors, and supervisees to build skills in providing and receiving supervision and to forge healthy supervisory relationships. Within this context, supervisors teach, guide and encourage frontline staff in the use of basic clinical skills and ESTs and other best practices that organizational leaders have selected and endorsed for use within the service setting. Thus, this comprehensive model differs from traditional, unstructured supervision of general clinical skills and from reliance solely on EST clinical processes without regard to broader organizational structures and change. Highlights of this model are described below.

Organizational Change Strategies

Organizational Commitment

Securing a commitment from organizational leaders is essential if efforts to strengthen supervision are to be successful. Typically, the Yale Program on Supervision issues a request for qualifications (RFQ) that outlines the

organizational consultation and staff training on supervision that is available to agencies, often at no charge if the initiative is funded by a third party such as a state or federal agency or a foundation. The requirements of participation, including demands on the organization, are clearly specified in the RFQ. Agencies compete to participate and, through the act of applying, demonstrate their organizational commitment and agreement to adhere to all requirements. Separate from large initiatives, the leaders of a single agency often identify a need to strengthen supervision and demonstrate their organizational commitment by seeking training and consultation.

Implementation Teams

Participating agencies are each asked to assemble an implementation team, and encouraged to include within it their chief executive officer, clinical director, human resources director, quality improvement director, and training director. Small agencies may lack some of these positions or a single individual may cover multiple roles. Each organization designates an implementation team leader who serves as the link to the consultants and trainers as the initiative unfolds.

Implementation teams from multiple agencies participate in a half-day orientation at the beginning of the change process. This provides them with an overview of the overall initiative, the competencies that will be taught to their staff, potential supervision standards, a template for creating an agency specific supervision plan, and strategies for creating an organizational culture that values and supports supervision.

Supervision Standards

Consultation with over 50 community and state agencies conducted by the senior leaders of the Yale Program on Supervision revealed that very few organizations had clear and specific standards regarding the delivery of supervision in place. Standards about supervision are a set of requirements regarding its provision that establish expectations of supervisors, supervisees, and managers within the agency. The Yale Program on Supervision has distilled a framework for supervision standards from diverse sources that included the following: the professional literature on supervision; supervisory requirements of professional associations regarding students in training; licensure laws that prescribe minimum post-graduate amounts of supervision required for license eligibility; and the standards of organizations that accredit service agencies. Full implementation of the standards is designed to create a *culture of supervision* in which high quality supervision is delivered routinely and supported by the organization as a whole.

Agency leaders are oriented to a set of optimal supervision standards and criteria for measuring whether each standard has been met. The standards are as follows:

- Development of a *written policy* on supervision with input from all levels of the organization, approval by senior leaders, education of all staff covered, and review and update of the policy every 2 years.
- Adoption of an *informed consent* process in which supervisors review with each supervisee the nature of supervision, including its purpose, frequency and duration, content, roles and responsibilities, supervisee rights, evaluation, and limits regarding confidentiality.
- Implementation of a process for *documentation of supervision*, prescribing the minimum types of information to be recorded.
- Specification of the minimum *duration, frequency, and format* of supervision (e.g., individual vs. group) by major job categories.
- Establishment of minimum *qualifications and preparation* for supervisors.
- Crafting of procedures for *assessing supervision quality*.

Implementation Plans

Informed by the generic set of recommended standards, members of the implementation team return to their agencies to build an implementation plan. This involves reviewing current supervision policies and standards, if any, and current supervisory practices. Team members are encouraged to hold focus groups with staff at varied levels in the hierarchy in order to understand perceived challenges in providing effective supervision and to identify the best practices already in use within the agency by creative and resourceful supervisors. The implementation team typically adopts and adapts to its needs an informed consent document and process developed by the Yale Program on Supervision, which promotes discussion about supervision between supervisor and supervisee.

Using a standardized template, and with review and technical assistance from the consultants, the implementation team compares current practice to the recommended standards and drafts an implementation plan around the steps it intends to take to clarify expectations and build a culture of supervision within the organization. Consultation with human resources personnel in this phase is critical, since desired changes may have implications for job descriptions, personnel evaluations, or contractual agreements with employees. After review and approval of the proposed plan by the senior leaders of the agency, the optimal next step involves an agency-wide kick-off event

to launch the roll out of the standards and associated practices.

Supervisor Skill Development

Training and Consultation

While some states have implemented training and credentialing requirements related to supervision (Trivison and Rough 2009), many supervisors have never received basic training in supervision and the majority are not the recipients of continuing education on this professional practice. While relatively new supervisors seem to highly value training on supervision, most experienced supervisors also welcome the opportunity to step back and reflect on their supervisory role and its challenges.

The Yale Program on Supervision uses the principles of evidence-based teaching (Stuart et al. 2004) to build the skills of supervisors. These principles drive the use of highly interactive and experiential techniques centered on problem-based learning in which participants identify current supervisory problems and work as a group to generate hypotheses about the sources of the problems and a range of constructive responses. There is a heavy emphasis on peer-to-peer learning and on consultation to participants as opposed to didactic instruction.

This education is longitudinal and sequenced. It begins with two consecutive full days of learning. This is followed by a 4–6 week interval, during which participants practice their newly acquired skills and reintroduce more structure, consistency, and energy into their supervisory work. Supervisors then reconvene with the consultants as a group for a full day to recount and explore their experience in attempting to strengthen their supervisory approach. Research conducted by Tebes et al. (2011) on an early version of the evolving Yale model found significant increases among participants in their self-rated abilities on the three variables measured: managing supervisory relationships, managing supervisee job performance, and promoting supervisee professional development.

Peer Learning Communities

A highly recommended element of each organization's implementation plan is the creation of peer learning communities in which supervisors, once trained in a common model, meet periodically to discuss supervisory practice. These typically occur 1 hour monthly for a minimum of 6 months as part of an agency-supported effort to help supervisors adopt and sustain newly learned supervisory skills. With an optimal size of 6–8 supervisors, these groups are usually led by a manager within the organization, such as a training or quality improvement director, who does not hold line authority over the supervisors, though the groups can also be peer led. The focus of discussions is usually quite varied, covering general challenges related to being a supervisor, specific problems in a supervisor–supervisee relationship, implementation of newly learned supervisory skills, and sharing of best practices. When implemented effectively, the learning communities are a vehicle for increasing support and reducing the isolation of supervisors, reinforcing optimal supervisory practices and fostering a culture of supervision in the organization.

Leadership Development

Supervisory roles are considered the first form of leadership for most employees. Various strategies are used by the Yale Program on Supervision to promote the development of leadership potential among supervisors. The core strategy involves sessions in which the DISC is administered and interpreted with groups of supervisors, and then discussed in small group breakouts (http://discassessment.org/). The DISC, which stands for dominance, influence, steadiness and conscientiousness, is a tool that assesses the style with which an individual tends to interact with others. The experience of completing the DISC helps supervisors better understand the following: their strengths; patterns of behavior that may hamper effective job performance; the diverse personal styles of those with whom they work; and the ease or difficulty with which individuals with different styles work together. Supervisors explore how to use this information to understand and manage teams comprised of their supervisees.

Individual Coaching

Coaching affords a safe and supportive context in which to explore supervisory challenges, or more personal issues that might relate to job stress, burnout, work/life balance, a problematic supervisee, conflict with a boss, disillusionment with the direction of the agency, lack of confidence in agency leaders, or developmental career issues. Individual coaching sessions, conducted by the consultants who delivered the initial 3 days of training, are typically offered on a voluntary basis with 45-min initial in person sessions and 30-min follow-up telephonic sessions. In these exchanges, the coach and supervisor can explore the complex and rich intersection between the organizational context, the supervision model, and the professional history, personal style, and developmental stage of the supervisor.

Supervisee Skill Development

An implementation science approach to changing professional practice calls for attention to all of the individuals involved in the practice of interest. A common shortcoming in efforts to improve supervision is to work only with supervisors, ignoring the enormous role and influence of supervisees on supervisory interactions. To address this critical workforce group, a half-day workshop is offered to supervisees of agencies focused on improving supervision. The workshop is designed to create a shared understanding across the organization about the elements of the initiative and its goals, one of which is to offer improved support and professional development to supervisees. Practical strategies are taught regarding: developing a working relationship with a supervisor; responding to concerns raised by a supervisor; and getting the most out of individual and group supervision sessions.

The Model of Supervision

The specific model of supervision taught through this initiative draws on best practices identified in the field over decades and captured in the professional literature (the Yale Program on Supervision has identified 17 key texts at: http://supervision.yale.edu/resources/117363_Tools_Supervision_Books.pdf). While most models of supervision focus on the training of graduate students, this model is unique in that it is designed to be highly relevant to organized systems of care and the agencies that comprise them. It is a practical model for publicly funded services that are stressed by high levels of service demand, acutely and severely ill clients with multiple needs, high levels of public visibility and accountability for the services provided, and the complexity of implementing evidenced supported treatments. Many elements of traditional supervision models lack relevance in such challenging contexts.

Engaging Supervisees through Informed Consent

A major premise of this model is that many supervisory relationships go awry because of the failure to develop a shared understanding about the nature of this working relationship *at its inception*. The concept of *informed consent* with clients is a common one in organized systems of healthcare and has been applied to the initial phase of supervision (Ellis et al. 2008). Others have used different terms to describe this process, such as contracting or agreement setting (Shulman 2010). In this model, supervisors are provided with a standardized Informed Consent Agreement and taught to use it as a guide to discussion with supervisees. Optimally this occurs in the initial phase of the supervisory relationships, but can be introduced in ongoing relationships as well. Under the Yale model informed consent addresses the following topics:

- Identifying all supervisors of a staff member and the role or focus of each supervisor. A professional who is working in an agency may have multiple supervisors and their areas of responsibility with respect to a supervisee and the relationship between supervisors can often be unclear and confusing.
- Clarifying the expected frequency, length and format (individual, group) of supervision. Most critical in this discussion is establishing an agreement that supervisions canceled by either the supervisor or supervisee will be rescheduled, which ensures continuity in the supervisory process.
- Establishing the supervisor's qualifications. An open discussion of the supervisor's educational background, work experience, and areas of expertise can address a supervisee's questions about qualifications. It is also an opportunity for a supervisor to clarify that he or she is open to learning from the expertise of the supervisee and that they both may turn to others in the agency for consultation. In this context, the supervisor can, in a collegial way, make clear his or her authority to supervise, which is derived from his or her appointment to this role by agency leadership. Issues of authority often remain unspoken and sew the seeds of future conflict in supervisory relationships.
- Clarifying the purpose of supervision. Making explicit the functions of supervision, which are described below, creates a common sense of purpose for supervisory meetings.
- Outlining the content of supervision. Clear expectations about the types of things to be covered maximizes productive use of the time on issues ranging from high-risk cases, challenging cases for the supervisee, caseload size, productivity, professional development, and schedules.
- Describing the process of supervisee evaluation. Providing job descriptions, competency expectations, and performance appraisal forms at the beginning of the supervisory relationship and inviting ongoing discussions about performance clarifies the inherent evaluative element of the relationship, while inviting a collaborative approach to identifying the supervisee's strengths and relative weaknesses.
- Clarifying the absence of confidentiality. It is critical for supervisors to clarify that they will treat information sensitively, but cannot guarantee confidentiality in the supervisory relationship.
- Informing supervisees of their rights. Individuals being supervised are entitled to respect, dignity, cultural

sensitivity, and the ability to appeal directives or evaluations from their supervisors.

Balancing Four Functions in the Supervisory Process

Once the supervisor and supervisee developed a shared understanding of supervision, the emphasis shifts to the ongoing work phase, which centers in the Yale model on four core supervisory functions: quality of care, administration, professional development and support. These four functions for supervision were identified from a thorough review of published works, though each function has been described in the literature using varied terms (Hoge et al. 2011).

Quality of Care

The quality of care function is principally focused on the oversight of services provided to clients, guiding the service activities of supervisees, managing and reducing risk, and improving overall care by shaping practice patterns (Hoge et al. 2011). Key elements of the training and consultation provided to supervisors on this function center on strategies for the following: being able to articulate the practice or service model; educating supervisees about the model; using treatment plans as a central focus of supervision; shaping supervisee practice by providing direction; using multiple sources of information, including direct observation, to understand what supervisees are actually doing; and using fidelity measures to educate supervisees and gauge their adherence to the practice model.

Administrative

This supervisory function focuses on managing staff activities in order to accomplish all necessary tasks related to both service delivery and the administrative operation of the agency (Shulman 2010). Examples include scheduling, cases assignments, productivity, mandatory training, compliance with regulatory and accreditation standards, performance evaluations, and documentation (Hoge et al. 2011). The training and consultation on this function centers on strategies for time management, maximizing productivity, and the effective use of data as a managerial tool. A key focus involves fostering supervisors' abilities to assert their authority and to assert it constructively when making demands of supervisees.

Support

Jobs in the health and social service sectors are enormously stressful. The service demands are often quite high, the clients being served often have multiple and severe problems, resources are limited, and it is challenging to navigate the service agency and system. There is extensive documentation of staff burnout (Paris and Hoge 2010) and of the impact of exposure to primary and secondary trauma (Van Dernoot Lipsky and Burk 2009).

In this context, the ability of a supervisor to provide support and "to feel and express empathy" is a crucial variable in determining whether supervision will be effective (Shulman 2010, p. 280). The Yale model emphasizes the importance of availability, basic listening and communication skills, and a strong interpersonal relationship between supervisor and supervisee as the foundation of support, as well as the enormous value of peer support within the working environment. Specific training and consultation for supervisors covers support strategies related to stress management, problem-solving, debriefing from critical incidents, recognizing burnout, advocacy within the agency for supervisees, utilizing EAP services, and providing staff support without providing them therapy (Hoge et al. 2011).

Professional Development

The fourth supervisory function involves a focus on the continuous learning and skill development of the supervisee, with an eye to career advancement. Supervisors are taught a process in which learning is continuous and is driven in large part by the supervisee's self-assessment of strengths and learning needs. Skills are developed through the use of a professional development plan, supervision, work-based learning assignments, and continuing education, with recognition and reward for learning, even if non-financial in nature. In this model, performance evaluations are used to document ongoing discussions and collaboration about learning needs between the supervisor and supervisee.

Additional Supervision Techniques

Complementing the training and consultation on the four functions are a range of other techniques and tools for strengthening supervision. These include: the use of semi-structured agendas to organize and focus supervision sessions; methods for efficient and effective group supervision; and a structured approach to analyzing and intervening in problems in a supervisory relationship. Considerable emphasis is placed on self-care skills for supervisors and their modeling of self-care and healthy behavior for supervisees.

Evaluating the Model

As described above, the Yale model was derived from numerous sources of evidence about staff development and organizational change. Ideally, however, the model itself would be the focus of comprehensive evaluation. Initial evidence offered support for the positive impact of the model on supervisors' self-ratings of their competence (Tebes et al. 2011). The next logical step is to examine other sources of data regarding the impact of training on supervisors, including ratings of competence and job evaluations completed by the individuals to whom they report, as well as the ratings of job satisfaction and supervisor competence provided by individuals that they supervise.

At the organizational level, a key process indicator would involve the impact of the interventions on increasing the frequency and consistency with which supervision is delivered. Other variables worth examining include the effect of implementation on measures of timely documentation, worker productivity and staff turnover. The ultimate goal would be to examine the impact of the interventions on client outcomes. However, this would require a sizeable amount of funding to support the study of large sample sizes over extended periods of time in order to detect the predicted effects and to control for the many potential confounding variables. Funding streams for such research do not currently exist and there are a plethora of obstacles to conducting such evaluations in large, constantly changing, publicly funded systems of services.

Supervision of Evidenced Supported Treatments

Many of the evidenced supported treatments models for services to clients, such as those cited in the following paragraphs, exemplify the type of implementation science approach described above, in which the initial training of supervisors and supervisees is complemented by organizational policies, practices, and systems that ensure quality of care, completion of essential administrative tasks, and professional development and support for those providing direct service. The adoption of ESTs within an agency often elevates the quality and quantity of supervision through elements such as: supervisor selection criteria; in depth initial training of supervisors; periodic booster sessions; supervisor certification; detailed manuals that guide supervisory practice; supervisory tools; and expert consultation to supervisors. Below are examples of the comprehensive approach to supervision imbedded in a number of widely disseminated ESTs for clients. This information is organized around the four core supervisory functions.

Quality of Care

Fidelity is the concept that the care delivered adheres to the original design of the treatment model and the specific intervention practices that research has demonstrated to be effective. Supervision of ESTs centers on ensuring each supervisee's fidelity or adherence to the treatment model. Most typically, this is accomplished through the use of tools that prompt supervisees to follow prescribed practice parameters and yield structured feedback to supervisors about adherence.

As an example, multi systemic therapy (MST) (Henggeler et al. 2009) is one of the ESTs that most explicitly and comprehensively addresses effective implementation and ongoing quality assurance through highly structured supervision. In MST, quality of care is associated with the supervisee's adherence to a specified process of clinical conceptualization, ongoing re-evaluation based on outcomes, and to following nine specific principles of intervention. A highly structured weekly case summary document, which is completed by supervisees, provides the supervisor with detailed information about whether services are being delivered according to model parameters. It also aids the supervisor in determining if the supervisee's conceptualization about the referral problem(s) and the interventions needed are consistent with the MST model. With this information the supervisor can focus supervision and promote effective use of the MST model by providing highly specific feedback and guidance to the supervisee. In a parallel process, the supervisor's feedback is monitored by expert MST consultants, reducing supervisor drift away from the practice model.

Multi dimensional family therapy (MDFT) (Liddle 2002) follows a similar process of weekly case summary documentation by the supervisee, which is then reviewed and annotated by the supervisor (and periodically by the expert consultant). Additionally, in MDFT, and other models like brief strategic family therapy (BSFT) (Szapocznik et al. 2003), the supervisor's assessment of supervisee skill is enhanced through the use of session videotaping. Both MDFT and BSFT provide detailed guidelines and training for how supervisors should incorporate tapes into their supervision sessions, addressing topics such as: frequency of observation; cueing of specific sections for collaborative review; and utilizing specific segments to illustrate or reinforce model specific techniques. The guidelines also suggest specific tasks that supervisors can assign to promote the supervisee's use of the feedback.

In other EST models, structured electronic clinical records offer another strategy to enhance supervision of the quality of care. Ongoing service delivery can be monitored and guided through the use of electronic documentation

systems that align to the treatment model. For example, the electronic Q-System of Functional Family Therapy (Sexton 2011) provides specific prompts as supervisees enter their progress notes, which helps ground them in model adherent thinking about the treatment and session planning. The record is a tool of supervision that highlights for supervisees the areas in which they should seek supervisory input and informs supervisors about the areas in which further model-specific training or guidance may be needed. Further, when electronic record systems are tied to data collection about client outcomes and program performance, supervisors can run reports to help them identify topics on which their team, as a whole, may require further training and development.

Administration

Since practice parameters are often well defined in an EST, the supervisor has at his or her disposal a blueprint to define and track performance expectations for supervisees. Frequency of contact, hours of service, completion of required case conceptualizations, and correct use of intervention tools are all readily observable and measurable performance indicators. The availability of adherence monitoring tools can further guide the supervisory focus.

To be successful in their work with supervisees, the supervisors must be champions of the EST approach and believe in the centrality of the model's specific tools for promoting positive client outcomes. In the early stages of learning evidenced supported treatments, supervisees often struggle with the amount of supervisory feedback, the heightened demands for documentation, the use of treatment tools, and the rigorous requirements for case planning. Informed by first hand experience, a supervisor's convictions about the value of the model and the importance of complying with its many administrative requirements can motivate and sustain supervisees through the often difficult transition to evidence informed practice.

Support

The group supervision process promoted by many EST models and the use of learning collaboratives to promote model adherence both offer meaningful support to supervisees, including the opportunity to receive guidance, to learn vicariously from others, and to reduce feelings of isolation. Some ESTs foster supportive supervisory practices by establishing parallels to the clinical process. Two examples include a focus in supervision on strengths driven feedback (e.g., MDFT, MST), and the explicit sharing of clinical accountability by a supervisee and supervisor. In MST, for example, when a particular planned intervention does not have the anticipated impact, potential supervisor variables that might be contributory to the negative outcomes are considered along with potential client, family, community and supervisee variables.

Some ESTs explicitly encourage supervisory attention to self-care of the supervisee. In MDFT, for example, the *Training and Supervision Manual* (Dakof et al. 2012) explicitly instructs supervisors and agency administrators to ensure scheduled time for teams to relax together, provides suggestions for helping clinicians to manage their time and access other supports, and offers a range of practical suggestions for minimizing staff burnout.

Professional Development

An inherent advantage of ESTs for supervisee development is the required initial training and/or certification process for the specific model. Many models include an extended period of instruction, practice and consultative feedback by model experts before a supervisee is certified. Periodic booster sessions are also common.

Several of the models include explicit tools that help to identify areas for supervisor and supervisee development. Both MDFT and BSFT, for example, have supervision evaluation checklists to ensure that supervisors are attending to all of the areas of supervisee development that are associated with program excellence, combining observations from supervision sessions, team meetings and videotape review. MST experts also developed the therapist adherence measure (TAM), an interactive quality assurance tool that elicits independent feedback from client families about their experience of the therapy, specifically in relation to the nine underlying MST treatment principles. Based on this feedback, the supervisor and supervisee work together to develop an individualized therapist development plan (TDP). The TDP is structured similar to a clinical treatment plan, with well-defined, measurable goals and objectives and regular review of progress.

Discussion

Supervision has a long tradition in social work practice and in other professions within health and social services. While there is evidence of its effectiveness, it is also clear that the practice of supervision has been eroding, both in terms of the consistency with which it is provided and its overall quality, often restricted to a focus on administrative issues. There is a compelling need to implement robust supervisory structures in order to foster positive client outcomes and to maintain a healthy and effective workforce.

An implementation science approach provides a framework for restoring the consistency and quality of supervision within service agencies and organized systems

of care. This framework involves the use of evidence-based teaching principles to educate agency leaders, supervisors, and supervisees about optimal practices in supervision. Staff training is complemented by the development of organizational standards that create uniform expectations and supports. When combined, these workforce and organizational interventions create a culture of supervision within an agency and its capacity to deliver supervision effectively.

The supervision of any best practice, but particularly ESTs, requires this type of culture. The most advanced empirically supported treatment models for clients actually serve as exemplars of an approach to supervision that is grounded in implementation science. They highlight some simple and compelling truths about the essential elements of effective supervisory systems, which are as follows: the service or treatment model must be clearly defined for staff; supervisors must be carefully selected, competent in the service model, and mentored in the practice of supervision; supervisees need to be educated about the practice model and continually given feedback and coached by supervisors regarding adherence to the model; supervisors and supervisees need to develop a shared understanding of the purpose and the process of their work together; and leaders of organizations must ensure the availability of the time, the resources, and the supports necessary for supervision to occur.

References

American Psychological Association, Division 12, Society of Clinical Psychology. (2013). *A guide to beneficial psychotherapy*. Retrieved from http://www.apa.org/divisions/div12/cppi.html on 28 Aug 2013.

Bambling, M., King, R., Raue, P., Schweitzer, R., & Lambert, W. (2006). Clinical supervision: Its influence on client-rated working alliance and client symptom reduction in the brief treatment of major depression. *Psychotherapy Research, 16*, 317–331.

Bellamy, J. L., Bledsoe, S. E., & Traube, D. E. (2006). The current state of evidence-based practice in social work: A review of the literature and qualitative analysis of expert interviews. *Journal of Evidence-Based Social Work, 3*(1), 23–48.

Borders, L. D. (2005). Snapshot of clinical supervision in counseling and counselor education: A five-year review. *The Clinical Supervisor, 24*, 69–113.

Bradshaw, T., Butterworth, A., & Mairs, H. (2007). Does structured clinical supervision during psychosocial intervention education enhance outcome for mental health nurses and the service users they work with? *Journal of Psychiatric and Mental Health Nursing, 14*, 4–12.

Center for Substance Abuse Treatment. (2009). *Clinical supervision and professional development of the substance abuse counselor.* Treatment Improvement Protocol (TIP) Series, No 52). DHHS Publication No. (SMA) 09-4435. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Crespi, T. D., & Dube, J. M. B. (2005). Clinical supervision in school psychology: Challenges, considerations, and ethical and legal issues for clinical supervisors. *The Clinical Supervisor, 24*(1–2), 115–135.

Dakof, G., Liddle, H., & Rowe, C. (2012). *MDFT training and supervision manual*. Miami, FL: MDFT International.

Drake, R. E., & Deegan, P. E. (2009). Shared decision making is an ethical imperative. *Psychiatric Services, 60*, 1007.

Ellis, M. V., Siembor, M. J., Swords, B. A., Morere, L., & Blanco, S. (2008). *Prevalence and characteristics of harmful and inadequate clinical supervision.* Unpublished manuscript presented at the 4th annual International Interdisciplinary Clinical Supervision Conference, Buffalo, NY.

Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature.* Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).

Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). *Multisystemic therapy for antisocial behavior in children and aolescents* (2nd ed.). New York: Guilford Press.

Hoge, M. A., Migdole, S., Farkas, M. S., Ponce, A., & Hunnicutt, C. (2011). Supervision in public sector behavioral health: A review. *The Clinical Supervisor, 30*, 183–203.

Kadushin, A., & Harkness, D. (2002). *Supervision in social work* (4th ed.). New York: Columbia University Press.

Kavanagh, D. J., & Connolly, J. M. (2009). Interventions for co-occurring addictive and other mental disorders. *Addictive Behaviors, 34*, 838–845.

Kowinsky, A., Greenhouse, P. K., Zombek, V. L., Rader, S. L., & Reidy, M. E. (2009). Care management redesign: Increasing care manager time with patients and providers while improving metrics. *The Journal of Nursing Administration, 39*, 388–392.

Liddle, H. (2002). *Family therapy for adolescent cannabis users, cannabis youth treatment series, volume 5.* DHHS Pub. No. 02-3660 Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America*. Retrieved from http://govinfo.library.unt.edu/mentalhealthcommission/ on 28 Aug 2013.

Paris, M., & Hoge, M. A. (2010). Burnout in the mental health workforce: A review. *Journal of Behavioral Health Services and Research, 37*, 519–528.

Rice, F., Cullen, P., McKenna, H., Kelly, B., Keeney, S., & Richey, R. (2007). Clinical supervision for mental health nurses in Northern Ireland: Formulating best practice guidelines. *Journal of Psychiatric and Mental Health Nursing, 14*, 516–521.

Schroffel, A. (1999). How does clinical supervision effect job satisfaction? *The Clinical Supervisor, 18*, 91–105.

Sexton, T. L. (2011). *Functional family therapy in clinical practice*. New York: Routledge.

Sholomskas, D., Syracuse-Siewert, G., Rounsaville, B., Ball, S. A., Nuro, K., & Carroll, K. (2005). We don't train in vain: A dissemination trial of three strategies of training clinicians in cognitive-behavioral therapy. *Journal of Consulting and Clinical Psychology, 73*, 106–115.

Shulman, L. (2010). *Interactional supervision* (3rd ed.). Washington, DC: National Association of Social Workers Press.

Spence, S. H., Wilson, J., Kavanagh, D., Strong, J., & Worrall, L. (2001). Clinical supervision in four mental health professions: A review of the evidence. *Behaviour Change, 18*(3), 135–155.

Stuart, G. W., Tondora, J., & Hoge, M. A. (2004). Evidence-based teaching practice: Implications for behavioral health. *Administration and Policy In Mental Health, 32*, 107–130.

Szapocznik, J., Hervis, O., & Schwartz, S. (2003). *Therapy manuals for drug addiction: Brief strategic family therapy for adolescent drug abuse*. Bethesda, MD: National Institute on Drug Abuse.

Tebes, J. K., Matlin, S. L., Migdole, S. J., Farkas, M. S., Money, R. W., Shulman, L., et al. (2011). Providing competency training to clinical supervisors through an interactional supervision approach. *Research on Social Work Practice, 21*, 190–199.

Trivison, K., & Rough, J. (2009). Ohio counselor, social worker, and marriage and family therapist board laws and rules. Retrieved from http://cswmft.ohio.gov/pdfs/4757101809.pdf on 12 Apr 2013.

Van Dernoot Lipsky, L., & Burk, C. (2009). *Trauma stewardship: An everyday guide to caring for self while caring for others*. San Francisco: Berrett-Koehler Publishers Inc.

Author Biographies

Michael A. Hoge, Ph.D. is a Professor and the Director of Clinical Training in Psychology within the Department of Psychiatry at the Yale University School of Medicine. Dr. Hoge is a founding member of The Annapolis Coalition on the Behavioral Health Workforce and currently directs the Yale Program on Supervision.

Scott Migdole, M.S.W. is an Assistant Professor within the Department of Psychiatry at the Yale University School of Medicine. Mr. Migdole is the Chief Operating Officer of Yale Behavioral Health and the Yale Program on Supervision.

Elisabeth Cannata, Ph.D. is the Vice President of Community-Based Family Services and Practice Innovation at Wheeler Clinic. Dr. Cannata has extensive experience in implementation of empirically supported treatments and in partnering with graduate training programs to promote workforce development in evidence supported practice.

David J. Powell, Ph.D. is an Assistant Clinical Professor within the Department of Psychiatry at the Yale University School of Medicine. He is President of the International Center for Health Concerns, Inc. and a noted author and lecturer on supervision.