

Course 4S – Developmental Model of Behavioral Health Supervision

FORWARD from *CEU By Net*: This *Course 4S, 'Developmental Model of Behavioral Health Supervision,'* is sponsored online for Continuing Education Credit by CEU By Net. The study material is excerpted from a three-chapter public domain document entitled 'Clinical Supervision and Professional Development of the Substance Abuse Counselor: Information You Need to Know.'

- References and bibliographical notations are included within the text from NBCC, AAMFT, NASW, and numerous recognized mental health research publications, reflecting the multi-disciplinary nature of the document, with SUD-specific references where applicable.

The publication was originally published by SAMHSA-CSAT (2009 - Rockville Maryland) as 'Treatment Improvement Protocol (TIP) No. 52'; was revised and updated by SAMHSA-CSAT in 2014; and was subsequently indexed and published online in this document's format in 2014 by National Center for Biotechnology Information, U.S. National Library of Medicine, National Institutes of Health (NIH) 8600 Rockville Pike, Bethesda MD, 20894 USA, as 'Part 1, Chapter 1, Clinical Supervision and Professional Development of the Substance Abuse Counselor: Information You Need to Know.'

In the interest of ensuring that current relevant developments in the behavioral health field are reflected in this sponsored Continuing Education document, *CEU By Net* has inserted the July 2020 notification published by SAMHSA pertaining to modification of the 42 CFR, Part 2 Rule. We have also provided information and links to NBCC's revision of its '*Online Counseling*' policy, now reformulated as '*Policy Regarding the Provision of Distance Professional Services.*'

CEU By Net has also updated URL web addresses with current internet locations where possible; eliminated brief references to material found in the other two chapters of the original document which are not part of this course; rearranged the sequencing and formatting of some material, and added applicable clarifying and inclusive wording as needed. Despite such contextual adjustments, this document remains – in its content, structure, philosophy, bibliographical detail, and clinical insight and direction – the published work of SAMHSA, CSAT, its consultants, and its historical theorists.

Per SAMHSA, this course document addresses:

- Central principles of clinical supervision and guidelines for new supervisors, including the functions of a clinical supervisor.
- The developmental stages/levels of counselors and other behavioral health professionals, and the developmental stages/levels of clinical supervisors.
- Information on cultural competence, ethical and legal issues such as direct and vicarious liability, dual relationships and boundary issues, informed consent, confidentiality, and supervisor ethics.
- Information about monitoring clinical performance of supervisees, including the various methods commonly used for observing the work of supervisees,
- the methods and techniques of clinical supervision and administrative supervision, and
- practical issues such as balancing one's clinical and administrative duties, finding the time to do clinical supervision, documentation, and structuring clinical supervision sessions.

1. Introduction to This Course

Clinical supervision is emerging as the crucible in which mental health and SUD professionals acquire knowledge and skills for the behavioral health professions, providing a bridge between the classroom and the clinic. Supervision is necessary to improve client care, develop the professionalism of clinical personnel, and impart and maintain ethical standards in the field. In recent years clinical supervision has become the cornerstone of quality improvement and assurance.

Your role and skill set as a clinical supervisor *are distinct from those of 'counselor' and 'administrator.'* See **Figure 2.** Quality clinical supervision is founded on a positive supervisor–supervisee relationship that promotes client welfare and the professional development of the supervisee. You are a teacher, coach, consultant, mentor, evaluator, and administrator; you provide support, encouragement, and education to staff while addressing an array of psychological, interpersonal, physical, and spiritual issues of clients.

Ultimately, effective clinical supervision ensures that clients are competently served. Supervision ensures that supervisees continue to increase their skills, which in turn increases treatment effectiveness, client retention, and staff satisfaction. The clinical supervisor also *serves as liaison* between administrative and clinical staff.

Supervision . . . *is a profession in its own right*, with its own theories, practices, and standards. The profession requires knowledgeable, competent, and skillful individuals who are appropriately credentialed both as a counselor/clinician/therapist/social worker and as a supervisor. This document focuses primarily on the teaching, coaching, consulting, and clinical mentoring functions of behavioral health supervisors.

Definitions

The central theme of the document is derived from the Integrated or Blended Developmental Stages Models for both Supervisors and their Supervisees, articulated and published by Stoltenberg, McNeill, and Delworth (1998), Figures 3 and 4. Stoltenberg et al provide guidelines and tools for the effective delivery of clinical supervision across three Stages of Development for both the behavioral health Counselor/Supervisee and the Supervisor.

This document also builds on and makes reference to CSAT's Technical Assistance Publication (TAP), *Competencies for Substance Abuse Treatment Clinical Supervisors* (TAP 21-A; [CSAT, 2007](#)) as well as to other publications and theories pertaining to the development of supervision skills in the mental health and addiction treatment professions.

The perspective of this material is informed by the following definitions of supervision:

- **“Supervision is a disciplined, tutorial process *wherein principles are transformed into practical skills, with four overlapping foci: administrative, evaluative, clinical, and supportive*” (Powell & Brodsky, 2004).**
- Supervision is an intervention provided by a senior member of a profession to a more junior member or members.
- **“The relationship is *evaluative*, extends over time, and has the simultaneous purposes of *enhancing the professional functioning* of the more junior person(s); *monitoring the quality of professional services offered to the clients that she, he, or they see*; and *serving as a gatekeeper* of those who are to enter the particular profession” (Bernard & Goodyear, 2004).**

- **Supervision is** “a social influence process that occurs over time, in which the supervisor participates with supervisees to ensure quality of clinical care.”
 - ♦ Effective supervisors observe, mentor, coach, evaluate, inspire, and create an atmosphere that promotes self-motivation, learning, and professional development.
 - ♦ They build teams, create cohesion, resolve conflict, and shape agency culture, while attending to ethical and diversity issues in all aspects of the process.
 - ♦ Such supervision is key to both quality improvement and the successful implementation of consensus- and evidence-based practices” {CSAT, 2007}.

Rationale

For hundreds of years, many professions have relied on more senior colleagues to guide less experienced professionals in their crafts. This is a relatively new development in the substance abuse field, as clinical supervision was historically not acknowledged as a discrete process with its own concepts and approaches. As indicated in the references cited within this publication, the mental health professions have historically required supervision of its professionals for obtaining and retaining licenses.

As a supervisor dedicated to the client, the supervisee, and the organization, the significance of your position is apparent in the following statements:

- Organizations have an obligation to ensure quality care and quality improvement of all personnel.
The first aim of clinical supervision is to ensure quality services and to protect the welfare of clients.
- Supervision is the right of all employees and has a direct impact on workforce development and staff and client retention.
- You oversee the clinical functions of staff and have a *legal and ethical responsibility* to ensure quality care to clients, the professional development and stability of behavioral health providers, and maintenance of program policies and procedures.
- Clinical supervision is how behavioral health providers in the field learn. In concert with classroom education, clinical skills are acquired through practice, observation, feedback, and implementation of the recommendations derived from clinical supervision.

Functions of a Clinical Supervisor

You, the clinical supervisor, wear several important “hats.” You facilitate the integration of supervisee self-awareness, theoretical grounding, and development of clinical knowledge and skills; and you improve functional skills and professional practices. These roles often overlap and are fluid within the context of the supervisory relationship.

Hence, the supervisor is in a unique position as an advocate for the agency, the supervisee, and the client. You are the primary link between administration and front line staff, interpreting and monitoring compliance with agency goals, policies, and procedures and communicating staff and client needs to administrators.

Central to the supervisor's function is the *alliance* between the supervisor and supervisee. [S. Rigazio-DiGilio, PhD. *Training and Supervision in Marriage and Family Therapy: Current Issues and Future Directions*, 1997.]

As shown in **Figure 1** below, your multipleroles as a clinical supervisor in the context of the supervisory relationship include:

- **Teacher:** Assist in the development of counseling knowledge and skills by identifying learning needs, determining supervisee strengths, promoting self-awareness, and transmitting knowledge for practical use and professional growth. Supervisors are teachers, trainers, and professional role models.
- **Consultant:** Bernard and Goodyear (2004) incorporate the supervisory consulting role of case consultation and review, monitoring performance, counseling the supervisee regarding job performance, and assessing supervisees. In this role, supervisors also provide alternative case conceptualizations, oversight of supervisee work to achieve mutually agreed upon goals, and professional gatekeeping for the organization and discipline (e.g., recognizing and addressing supervisee impairment).
- **Coach:** In this supportive role, supervisors provide morale building, assess strengths and needs, suggest varying clinical approaches, model, cheerlead, and prevent burnout. For entry-level individuals, the supportive function is critical.
- **Mentor/Role Model:** The experienced supervisor mentors and teaches the supervisee through role modeling, facilitates the supervisee's overall professional development and sense of professional identity, and trains the next generation of supervisors.

See Figures 1 and 2 below.

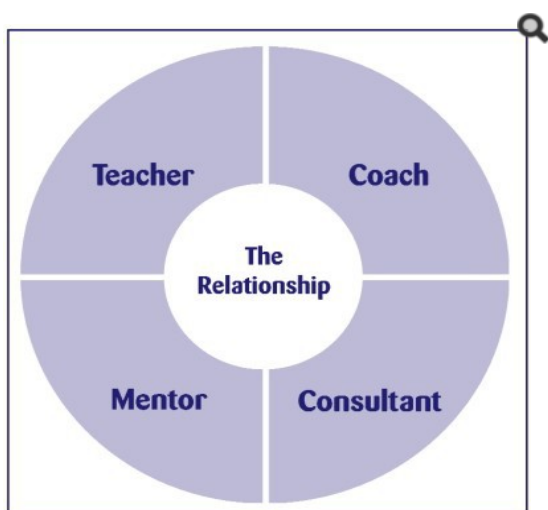


Figure 1

Figure 2

The Difference Between Clinical Supervision of Supervisees, Administrative Supervision, and Provision of Treatment or Counseling

	Clinical Supervision	Administrative Supervision	Counseling
Purpose	<ul style="list-style-type: none"> Improved client care Improved job performance 	<ul style="list-style-type: none"> Ensure compliance with agency and regulatory body's policies and procedures 	<ul style="list-style-type: none"> Personal growth Behavior changes Better self-understanding
Outcome	<ul style="list-style-type: none"> Enhanced proficiency in knowledge, skills, and attitudes essential to effective job performance 	<ul style="list-style-type: none"> Consistent use of approved formats, policies, and procedures 	<ul style="list-style-type: none"> Open-ended, based on client needs
Timeframe	<ul style="list-style-type: none"> Short-term and ongoing 	<ul style="list-style-type: none"> Short-term and ongoing 	<ul style="list-style-type: none"> Based on client needs
Agenda	<ul style="list-style-type: none"> Based on agency mission and counselor needs 	<ul style="list-style-type: none"> Based on agency needs 	<ul style="list-style-type: none"> Based on client needs
Basic Process	<ul style="list-style-type: none"> Teaching/learning specific skills, evaluating job performance, negotiating learning objectives 	<ul style="list-style-type: none"> Clarifying agency expectations, policies and procedures, ensuring compliance 	<ul style="list-style-type: none"> Behavioral, cognitive, and affective process including listening, exploring, teaching

Source: Adapted from Dixon, 2004

2. Central Principles of Clinical Supervision

The Consensus Panel for this publication has identified central principles of clinical supervision. Although the Panel recognizes that clinical supervision can initially be a costly undertaking for many financially strapped programs, the Panel believes that ultimately clinical supervision is a cost-saving process.

Clinical supervision enhances the quality of client care; improves efficiency of supervisees in direct and indirect services; increases workforce satisfaction, professionalization, and retention; and ensures that services provided to the public uphold legal mandates and ethical standards of the profession.

The *central principles* identified by the Consensus Panel are these:

- 1. Clinical supervision is an essential part of all clinical programs.** Clinical supervision is a central organizing activity that integrates the program mission, goals, and treatment philosophy *with clinical theory and evidence-based practices (EBPs)*. The primary reasons for clinical supervision are to (1) ensure quality client care, and (2) ensure that clinical staff continue professional development in a systematic and planned manner. Clinical supervision has historically been the primary means of determining the quality of care provided, but in recent years all healthcare professions have incorporated attention to the *outcomes of treatment*.
- 2. Clinical supervision enhances staff retention and morale.** Staff turnover and workforce development are always a concern in the behavioral health fields. Clinical supervision is a primary means of improving workforce retention and job satisfaction (see, for example, Roche, Todd, & O'Connor, 2007).
- 3. Every clinician, regardless of level of skill and experience, needs and has a right to clinical supervision. In addition, supervisors need and have a right to supervision of their supervision.** Supervision needs to be tailored to the knowledge base, skills, experience, and assignment of each supervisee. All staff need supervision, but the frequency and intensity of the oversight and training will depend on the role, skill level, and competence of the individual. The benefits that come with years of experience are enhanced by quality clinical supervision.
- 4. Clinical supervision needs the full support of agency administrators.** Just as treatment programs want clients to be in an atmosphere of growth and openness to new ideas, all professionals should be in an environment where learning and professional development and opportunities are valued and provided for all staff.
- 5. The supervisory relationship is the crucible in which ethical practice is developed and reinforced.** The supervisor needs to model sound ethical and legal practice in the supervisory relationship. This is where issues of ethical practice arise and can be addressed. This is where ethical practice is translated from a concept to a set of behaviors. Through supervision, clinicians can develop a process of ethical decision making and use this process as they encounter new situations.
- 6. Clinical supervision is a skill in and of itself that has to be developed.** Good behavioral health

professionals tend to be promoted into supervisory positions with the assumption that they have the requisite skills to provide professional clinical supervision. However, clinical supervisors need a different role orientation toward both program and client goals and a knowledge base to complement a new set of skills. Programs need to increase their capacity to develop good supervisors.

7. **Clinical supervision frequently requires balancing administrative and clinical supervision tasks.** Sometimes these roles are complementary and sometimes they conflict. Often the supervisor feels caught between the two roles. Administrators need to support the integration and differentiation of the supervisor's roles, to promote the efficacy of the clinical supervisor.
8. **Culture and other contextual variables influence the supervision process; supervisors need to continually strive for cultural competence.** Supervisors require cultural competence at several levels. Cultural competence involves the supervisee's response to clients, the supervisor's response to supervisees, and the program's response to the cultural needs of the diverse community it serves. Since supervisors are in a position to serve as catalysts for change, they need to develop proficiency in addressing the needs of diverse clients and personnel.
9. **Successful implementation of EBPs requires ongoing supervision.** Supervisors have a role in determining which specific EBPs are relevant for an organization's clients (Lindbloom, Ten Eyck, & Gallon, 2005). Supervisors ensure that EBPs are successfully integrated into ongoing programmatic activities by training, encouraging, and monitoring supervisees. Excellence in clinical supervision should provide greater adherence to the EBP model. Because State funding agencies and commercial insurance plans now often require treatment organizations to adhere to EBPs, supervision becomes even more important.
10. **Supervisors have the responsibility to be gatekeepers for the profession.** Supervisors are responsible for maintaining professional standards, recognizing and addressing impairment, and safeguarding the welfare of clients. More than anyone else in an agency, supervisors can observe supervisee behavior and respond promptly to potential problems, including counseling some individuals out of the field because they are ill-suited to the profession.

The "gatekeeping" function is especially important for supervisors who act as field evaluators for practicum students prior to their entering the profession. Supervisors also fulfill a gatekeeper role in performance evaluation and in providing formal recommendations to training institutions and credentialing bodies.

11. **Clinical supervision should involve direct observation methods.** *Direct observation should be the standard in the field because it is one of the most effective ways of building skills, monitoring supervisee performance, and ensuring quality care.* Supervisors require training in methods of direct observation, and administrators need to provide resources for implementing direct observation. Although small agencies might not have the resources for one-way mirrors or videotaping equipment, other direct observation methods can be employed. [You will read a section dedicated to Methods of Observation in section 6, Study Guide 2.]

Guidelines for New Supervisors

Congratulations on your appointment as a supervisor! By now you might be asking yourself a few questions: What have I done? Isn't there is a major difference between being a COUNSELOR or SOCIAL WORKER or THERAPIST, and being a *SUPERVISOR*? Was this a good career decision?

There are many changes ahead. If you have been promoted from within, you will encounter even more hurdles and issues. First, it is important to face that your life has changed. You might experience the loss of friendship of peers. You might feel that you knew what to do as a treatment provider, but you feel totally lost with your new responsibilities. You might feel less effective in your new role. Supervision can be an emotionally draining experience, as you now have to work with more staff-related interpersonal and human resources issues.

Before your promotion to clinical supervisor, you might have felt confidence in your clinical skills. Now you might feel unprepared and wonder if you need a training course for your new role. If you feel this way, you are right. *Although you are a good therapist or counselor, you do not necessarily possess all the skills needed to be a good supervisor.* Your new role requires a *new body of knowledge and different skills*, along with the ability to use your clinical skills in a different way. Be confident that you will acquire these skills over time and that you made the right decision to accept your new position.

Suggestions for new supervisors:

- *Quickly learn the organization's policies and procedures including human resources procedures* (e.g., hiring and firing, affirmative action requirements, format for conducting meetings, giving feedback, and making evaluations). Seek out this information as soon as possible through the human resources department or other resources within the organization.
- *Ask for a period of 3 months to allow you to learn about your new role.* During this period, do not make any changes in policies and procedures but use this time to find your managerial voice and decision making style.
- *Take time to learn about your supervisees*, their career goals, interests, developmental objectives, and perceived strengths.
- *Work to establish a contractual relationship with supervisees*, with clear goals and methods of supervision.
- *Learn methods to help staff reduce stress, address competing priorities, resolve staff conflict*, and other interpersonal issues in the workplace.
- *Obtain training in supervisory procedures and methods.*
- *Find a mentor*, either internal or external to the organization
- *Shadow a supervisor you respect* who can help you learn the ropes of your new job.
- *Ask often and as many people as possible*, "How am I doing?" and "How can I improve my performance as a clinical supervisor?"
- *Ask for regular, weekly meetings* with your administrator for training and instruction.
- *Seek supervision of your supervision.*

Problems and Resources

As a supervisor, you may encounter a broad array of issues and concerns, ranging from working within a system that does not fully support clinical supervision to working with resistant staff. A comment often heard in supervision training sessions is “My boss should be here to learn what is expected in supervision,” or “This will never work in my agency’s bureaucracy. They only support billable activities.”

The work setting is where you apply the principles and practices of supervision and where organizations are driven by demands, such as financial solvency, profit, census, accreditation, and concerns over litigation. Therefore, you will need to be practical when beginning your new role as a supervisor: determine how you can make this work within your unique work environment.

Working with Staff Who Are Resistant to Supervision

Resistance. Some of your supervisees may have been in the field longer than you have and see no need for supervision. Other individuals, having completed their graduate training, do not believe they need further supervision, especially not from a supervisor who might have less formal academic education than they have. Other resistance might come from ageism, sexism, racism, or classism.

Particular to the field of substance abuse treatment may be the tension between those who believe that recovery from substance abuse is necessary for this counseling work and those who do not believe this to be true.

In addressing resistance, you must be clear regarding what your supervision program entails and must consistently communicate your goals and expectations to staff. To resolve defensiveness and engage your supervisees, you must also honor the resistance and acknowledge their concerns. Abandon trying to push the supervisee too far, too fast. Resistance is an expression of ambivalence about change and not a personality defect of the supervisee. Instead of arguing with or exhorting staff, sympathize with their concerns, saying, “I understand this is difficult. How are we going to resolve these issues?”

When supervisees respond defensively or reject directions from you, try to understand the origins of their defensiveness and to address their resistance. *Self-disclosure* by the supervisor about experiences as a supervisee, when appropriately used, may be helpful in dealing with defensive, anxious, fearful, or resistant staff. Work to establish a healthy, positive supervisory alliance with staff. Because many substance abuse counselors have not been exposed to clinical supervision, you may need to train and orient the staff to the concept and why it is important for your agency.

Things a New Supervisor Should Know

Eight truths a beginning supervisor should commit to memory are listed below:

1. The reason for supervision is to *ensure quality client care*. As stated throughout this TIP, the primary goal of clinical supervision is to protect the welfare of the client and ensure the integrity of clinical services.

2. *Supervision is all about the relationship.* As in counseling, developing the alliance between the supervisee and the supervisor is the key to good supervision.
3. *Culture and ethics influence all supervisory interactions.* Contextual factors, culture, race, and ethnicity all affect the nature of the supervisory relationship. Some models of supervision (e.g., Holloway, 1995) have been built primarily around the role of context and culture in shaping supervision.
4. *Be human and have a sense of humor.* As role models, you need to show that everyone makes mistakes and can admit to and learn from these mistakes.
5. *Rely first on direct observation of your supervisees and give specific feedback.* The best way to determine a supervisee's skills is to observe him or her and to receive input from the clients about their perceptions of the counseling relationship.
6. Have and practice a *model of counseling and of supervision*; have a sense of purpose. Before you can teach a supervisee knowledge and skills, you must first know the philosophical and theoretical foundations on which you, as a supervisor, stand. Counselors need to know what they are going to learn from you, based on your model of counseling and supervision.
7. *Make time to take care of yourself* spiritually, emotionally, mentally, and physically. You are a role model. Supervisees are watching your behavior. Do you "walk the talk" of self-care?
8. You have a unique position as an *advocate for the agency, the supervisee, and the client*. As a supervisor, you have a wonderful opportunity to assist in the skill and professional development of your staff, advocating for the best interests of the supervisee, the client, and your organization.

3. Models of Clinical Supervision

You may never have thought about your model of supervision. However, it is a fundamental premise that you need to work from a defined model of supervision and have a sense of purpose in your oversight role. Four supervisory orientations seem particularly relevant. They include:

- Competency-based Models
- Treatment-based Models
- **Developmental Models.**
- **Integrated Developmental Models.**

Competency-based supervision models (e.g., microtraining, the Discrimination Model [Bernard & Goodyear, 2004], and the Task-Oriented Model [Mead, 1990], focus primarily on the skills and learning needs of the supervisee and on setting goals that are specific, measurable, attainable, realistic, and timely (SMART). They construct and implement strategies to accomplish these goals. The key strategies of competency-based models include applying social learning principles (e.g., modeling role reversal, role playing, and practice), using demonstrations, and using various supervisory functions (teaching, consulting, and counseling).

Treatment-based supervision models train to a particular theoretical approach to counseling, incorporating EBPs into supervision and seeking fidelity and adaptation to the theoretical model. *Motivational interviewing, cognitive– behavioral therapy, and psychodynamic psychotherapy are three examples.* The majority of these models begin with articulating their treatment approach and describing their supervision model, based upon that approach.

Developmental models of supervision, such as *Stoltenberg and Delworth (1987)*, emphasize that *each supervisee goes through different stages of development*, and that movement through these stages is not always linear, i.e., it can be affected by changes in assignment, setting, and population served.

The Integrated or Blended model of supervision (*Stoltenberg, McNeill, and Delworth, 1998*) incorporates and expands upon the Developmental Model above. Blended Developmental Models *address the progressive stages of skills development for both the supervisor and the supervisee.* This model emphasizes and describes how, over time, supervisors as well as supervisees gain competence and comfort with the supervision process, and the behaviors which are characteristic of each stage. **See Figures 3 and 4.**

- This model also focuses upon *affective* issues which arise in the process of supervision, and the mandatory *alliance* which must be formed between the supervisor and the supervisee if supervision is to be effective. Integrated models also emphasize *treatment outcomes* and incorporate EBPs into counseling and supervision.
- *Stoltenberg, McNeill, and Delworth's 1998 Blended Developmental model of supervision is the central theme of this publication, exploring the concept of the supervisor's and the supervisee's progression through stages of competency development.*

Cultural factors. *In all models of supervision*, it is helpful to identify culturally or contextually centered models or approaches and find ways of tailoring the models to specific cultural and diversity factors. Issues to consider are:

- Explicitly addressing the diversity of supervisees (e.g., race, ethnicity, gender, age, sexual orientation) and the specific factors associated with these types of diversity;
- Explicitly exploring supervisees' concerns related to client diversity (e.g., those whose culture, gender, sexual orientation, and other attributes differ from those of the supervisee) and addressing specific factors associated with these types of diversity; and
- Explicitly addressing supervisees' issues related to effectively navigating services in intercultural communities and effectively networking with agencies and institutions.

Refer to additional Cultural discussion on page 16.

It is important for supervisors to identify their model of counseling and supervision and beliefs about change, and to articulate a workable approach to supervision that fits the model of counseling they use.

You may find some of the questions below to be relevant to both supervision and counseling. Answers to these questions influence how you supervise and how the individuals you supervise work.

- What are your beliefs about how people change in both treatment and clinical supervision?
- What factors are important in treatment and clinical supervision?
- What universal principles apply in supervision and counseling and which are unique to clinical supervision?
- What conceptual frameworks of counseling do you use – for instance, *cognitive-behavioral therapy, 12-Step facilitation, psychodynamic, behavioral*)?
- What are the key variables that affect outcomes? (Campbell, 2000)

Qualities of a good model. According to Bernard and Goodyear (2004) and Powell and Brodsky (2004), the qualities of a good model of clinical supervision are:

- *Rooted in the individual, beginning with the supervisor's self, style, and approach to*
- *leadership.* Precise, clear, and consistent.
- Comprehensive, using current *scientific and evidence-based practices (EBPs).*
- Operational and practical, providing specific concepts and practices in *clear, useful, and measurable terms.*
- *Outcome-oriented* to improve supervisee competence; make work manageable; create a sense of mastery and growth for the supervisee; and address the needs of the organization, the supervisor, the supervisee, and the client.

Finally, it is imperative to recognize that, *whatever model you adopt, it needs to be rooted in*

- (1) the learning and developmental needs of the supervisee,
- (2) the specific needs of the clients they serve,
- (3) the goals of the agency in which you work, and
- (4) the ethical and legal boundaries of practice.

These four variables define the context in which effective supervision can take place.

Developmental Stages of Supervisees

Counselors and other behavioral health professionals whom you supervise will be at different stages of professional development. Thus, regardless of the model of supervision you choose, you must take into account the supervisee's level of training, experience, and proficiency. Different supervisory approaches are appropriate for supervisees at different stages of development.

An understanding of the supervised professional's developmental needs is an essential ingredient for any model of supervision. Various paradigms or classifications of developmental stages of clinicians have been developed (Ivey, 1997; Rigazio-DiGilio, 1997; Skolvolt & Ronnestrand, 1992; Todd and Storn, 1997, and others.

The Blended or Integrated Developmental Model (IDM) of Supervision [which is the focus of this course] was created by *Stoltenberg, McNeill, and Delworth, 1998*. See **Figures 3 and 4**.

This SAMHSA-CSAT-NIH document adopted the Integrated Developmental Model (IDM) of Stoltenberg, McNeill, and Delworth (1998) as its central premise in describing the Developmental Stages of Counselors and the Developmental Stages of Supervisors (see figures 2 and 3). This schema uses a three-stage approach for both the supervisee and the supervisor. Each of the three stages of supervisee development have different characteristics, which require supervisory methods which correlate with the supervisee's stage of development. Further application of the IDM to counselors within the substance abuse field may be needed.

The Supervisor must keep in mind several general cautions and principles about supervisee development, including:

- There is a beginning but not an end point for learning clinical skills; be careful of supervisees who think they "know it all."
- Take into account the individual learning styles and personalities of your supervisees and fit the supervisory approach to the developmental stage of each supervisee.
- There is a logical sequence to development, although it is not always predictable or rigid; some supervisees may have been in the field for years but remain at an early stage of professional development, whereas others may progress quickly through the stages.
- Counselors at an advanced developmental level (Level 3) have different learning needs and require different supervisory approaches from those at Level 1; and
- The developmental level of the supervisee may vary for different aspects of overall competence (e.g., Level 2 mastery for individual counseling and Level 1 for couples counseling).

Stoltenberg's 1998 theory of Supervisor Development reflects the 1993 premise of Ronnestad & Skovholt, that the supervisor's approach with a supervisee changes over time, just as the supervisee's competence and needs change over time – initially requiring a highly structured approach to supervision and moving to a more collaborative approach.

Figure 3
Developmental Stages of the Supervisee

Developmental Level	Characteristics	Supervision Development Needs	Techniques
Level 1	<ul style="list-style-type: none"> • Focuses on self • Anxious, uncertain • Preoccupied with performing the right way • Overconfident of skills • Overgeneralizes • Overuses a skill • Gap between conceptualization, goals, and interventions • Ethics underdeveloped 	<ul style="list-style-type: none"> • Provide structure and minimize anxiety • Supportive, address strengths first, then weaknesses • Suggest approaches • Start connecting theory to treatment 	<ul style="list-style-type: none"> • Observation • Skills training • Role playing • Readings • Group supervision • Closely monitor clients
Level 2	<ul style="list-style-type: none"> • Focuses less on self and more on client • Confused, frustrated with complexity of counseling • Overidentifies with client • Challenges authority • Lacks integration with theoretical base • Overburdened • Ethics better understood 	<ul style="list-style-type: none"> • Less structure provided, more autonomy encouraged • Supportive • Periodic suggestion of approaches • Confront discrepancies • Introduce more alternative views • Process comments, highlight countertransference • Affective reactions to client and/or supervisor 	<ul style="list-style-type: none"> • Observation • Role playing • Interpret dynamics • Group supervision • Reading
Level 3	<ul style="list-style-type: none"> • Focuses intently on client • High degree of empathic skill • Objective third person perspective • Integrative thinking and approach • Highly responsible and ethical counselor 	<ul style="list-style-type: none"> • Supervisee directed • Focus on personal-professional integration and career • Supportive • Change agent 	<ul style="list-style-type: none"> • Peer supervision • Group supervision • Reading
Source: Stoltenberg, Delworth, & McNeil, 1998			

Developmental Stages of Supervisors

Just as supervisees go through stages of development, so do supervisors. The developmental model presented in **Figure 4** (The Blended or Integrated Developmental Model (IDM) of supervisors) was created by *Stoltenberg, McNeill, and Delworth, 1998* and provides a framework for the developmental progression of clinical supervisors. It is understood that some individuals who are new to supervision would be at a Level 1 as a supervisor. However, supervisors should be at least at the second or third stage of supervisee development when they are promoted to supervisor. If a newly appointed supervisor is still at Level 1 as a behavioral health provider, he or she will have little to offer to more seasoned supervisees.

Figure 4
Developmental Stages of the Supervisor

Developmental Level	Characteristics	To Increase Supervision Competence
Level 1	<ul style="list-style-type: none"> Is anxious regarding role Is naïve about assuming the role of supervisor Is focused on doing the “right” thing May overly respond as an “expert” Is uncomfortable providing direct feedback 	<ul style="list-style-type: none"> Follow structure and formats Design systems to increase organization of supervision Assign Level I counselors
Level 2	<ul style="list-style-type: none"> Shows confusion and conflict Sees supervision as complex and multidimensional Needs support to maintain motivation Overfocused on counselor’s deficits and perceived resistance May fall back to being a therapist with the counselor 	<ul style="list-style-type: none"> Provide active supervision of the supervision Assign Level 1 counselors
Level 3	<ul style="list-style-type: none"> Is highly motivated Can provide an honest self-appraisal of strengths and weaknesses as supervisor Is comfortable with evaluation process Provides thorough, objective feedback 	<ul style="list-style-type: none"> Comfortable with all levels
Source: Stoltenberg, Delworth, & McNeil, 1998		

More About Culture and Other Contextual Factors in Supervision

Culture is one of the major contextual factors that influence supervisory interactions in all SUD and mental health professions. Other contextual variables include race, ethnicity, age, gender identity, sexual orientation, discipline, academic background, religious and spiritual practices, disability, and recovery versus non-recovery status. These variables occur within the supervisory relationship in the context of the supervisor, supervisee, client, and the setting in which supervision occurs. More care should be taken to:

- Identify the competencies necessary for supervisees to work with diverse individuals and navigate intercultural communities.
- Identify methods for supervisors to assist supervisees in developing these competencies.
- Provide evaluation criteria for supervisors, to determine whether their supervisees have met minimal competency standards for effective and relevant practice.

The competencies listed in SAMHSA's 'TAP 21-A' reflect the importance of culture and other contextual variables in supervision of substance abuse counselors (CSAT, 2007). The Counselor Development domain encourages self-examination of attitudes toward all such variables. The Supervisory Alliance domain promotes attention to diversity variables in the supervisory relationship.

Cultural competence "refers to the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a commitment and is achieved over time" (U.S. Department of Health and Human Services, 2003). Culture shapes belief systems, particularly concerning issues related to mental health and substance abuse, as well as the manifestation of symptoms, relational styles, and coping patterns.

There are three levels of cultural consideration for the supervisory process: 1) the issue of the culture of the *client* being served and 2) the culture of the *treatment provider* in supervision. 3) Beyond that, Holloway (1995) emphasizes the cultural issues of the *agency*, the geographic environment of the *organization*, and many other contextual factors.

- *It is your responsibility to address your supervisees' beliefs, attitudes, and biases about cultural and contextual variables to advance their professional development and promote quality client care.*

Becoming culturally competent and able to integrate other contextual variables into supervision is a complex, long-term process. Cross (1989) has identified several stages on a continuum of becoming culturally competent (see Figure 5, below).

It is your responsibility to help supervisees build on the cultural competence skills they possess as well as to focus on their cultural competence deficits. It is important to initiate discussion of issues of culture, race, gender, sexual orientation, and the like in supervision to model the kinds of discussion you would like supervisees to have with their clients.

- If these issues are not addressed in supervision, supervisees may come to believe that it is inappropriate to discuss them with clients and have no idea how such dialog might proceed. These discussions prevent misunderstandings with supervisees based on cultural or other factors.
- Another benefit from these discussions is that supervisees will eventually achieve some level of comfort in talking about culture, race, ethnicity, and diversity issues.

If you have not done this as a treatment provider, early in your tenure as a supervisor you will want to examine your culturally influenced values, attitudes, experiences, and practices and to consider what effects they have on your dealings with supervisees and clients. Counselors should undergo a similar review as preparation for when they have clients of a culture different from their own. Some questions to keep in mind are:

- What did you think when you saw the supervisee's last name?
- What did you think when the supervisee said his or her culture is X, when yours is Y?
- How did you feel about this difference?
- What did you do in response to this difference?

Constantine (2003) suggests that supervisors can use the following questions with supervisees:

- What demographic variables do you use to identify yourself?
- What worldviews (e.g., values, assumptions, and biases) do you bring to supervision based on your cultural identities?
- What struggles and challenges have you faced working with clients who were from different cultures than your own?

Community resources, such as community leaders, elders, and healers can contribute to your understanding of the culture your organization serves. Finally, supervisors (and supervisees) should participate in multicultural activities, such as community events, discussion groups, religious festivals, and other ceremonies.

- The supervisory relationship includes an inherent power differential, and it is important to pay attention to this disparity, particularly when the supervisee and the supervisor *are from different cultural groups*.
- *A potential for the misuse of that power exists at all times but especially when working with supervisees and clients within multicultural contexts.* When the supervisee is from a minority population and the supervisor is from a majority population, the differential can be exaggerated.

You will want to prevent institutional discrimination from affecting the quality of supervision. The same is true when the supervisee is gay and the supervisor is heterosexual, or the counselor is non-degreed and the supervisor has an advanced degree, or a female supervisee with a male supervisor, and so on. In the reverse

situations, where the supervisor is from the minority group and the supervisee from the majority group, the difference should be discussed as well.

Figure 5
Continuum of Cultural Competence

Cultural Destructiveness
Superiority of dominant culture and inferiority of other cultures; active discrimination
Cultural Incapacity
Separate but equal treatment; passive discrimination
Cultural Blindness
Sees all cultures and people as alike and equal; discrimination by ignoring culture
Cultural Openness (Sensitivity)
Basic understanding and appreciation of importance of sociocultural factors in work with minority populations
Cultural Competence
Capacity to work with more complex issues and cultural nuances
Cultural Proficiency
Highest capacity for work with minority populations; a commitment to excellence and proactive effort
Source: Cross, 1989.

4. Ethical and Legal Issues

You are the organization's *gatekeeper* for ethical and legal issues. First, you are responsible for upholding the highest standards of ethical, legal, and moral practices and for serving as a model of practice to staff. Further, you should be aware of and respond to ethical concerns. Part of your job is to help integrate solutions to everyday legal and ethical issues into clinical practice.

Some of the underlying assumptions of incorporating ethical issues into clinical supervision include:

- Ethical decision making is a continuous, active process.
- Ethical standards are not a cookbook. They tell you what to do, but not always how.
- Each situation is unique. Therefore, it is imperative that all personnel learn how to “think ethically” and how to make sound legal and ethical decisions.
- The most complex ethical issues arise in the context of two ethical behaviors that conflict; for instance, when a supervisee wants to respect the privacy and confidentiality of a client, but it is in the client's best interest for the supervisee to contact someone else about his or her care.
- Therapy is conducted by fallible beings; people make mistakes—hopefully, minor ones.

- Sometimes the answers to ethical and legal questions are elusive. Ask a dozen people, and you will likely get twelve different points of view.
- In general, supervisors adhere to the same standards and ethics as all behavioral health providers with regard to dual relationship and other boundary violations. Supervisors will:
 - Uphold the highest professional standards of the field.
 - Seek professional help (outside the work setting) when personal issues interfere with their clinical and/or supervisory functioning.
 - Conduct themselves in a manner that models and sets an example for agency mission, vision, philosophy, wellness, recovery, and consumer satisfaction.
 - Reinforce zero tolerance for interactions that are not professional, courteous, and compassionate.
 - Treat supervisees, colleagues, peers, and clients with dignity, respect, and honesty.
 - Adhere to the standards and regulations of confidentiality as dictated by the field. This applies to the supervisory as well as the counseling relationship.

Helpful resources on legal and ethical issues for supervisors include Beauchamp and Childress (2001); Falvey (2002); Gutheil and Brodsky (2008); Pope, Sonne, and Greene (2006); and Reamer (2006).

Direct Versus Vicarious Liability

Legal and ethical issues that are critical to clinical supervisors include (1) vicarious liability (or *respondeat superior*) vs. direct liability, (3) dual relationships and boundary concerns, (4) informed consent, (5) confidentiality, and (6) supervisor ethics.

It's a major distinction: *An important distinction needs to be made between direct liability and vicarious liability.* Direct liability of the supervisor might include dereliction of supervisory responsibility, such as “not making a reasonable effort to supervise.” Supervisory vulnerability increases when the supervisee has been assigned too many clients, when there is no direct observation of a supervisee’s clinical work, when staff are inexperienced or poorly trained for assigned tasks, and when a supervisor is not involved or not available to aid the clinical staff.

In vicarious liability, a supervisor can be *held liable for damages* incurred as a result of negligence in the supervision process. *Examples of negligence* include providing inappropriate advice to a supervisee about a client (for instance, discouraging a supervisee from conducting a suicide screen on a depressed client), and failure to listen carefully to a supervisee’s comments about a client. *In legal texts, vicarious liability is referred to as “respondeat superior.”*

- The Latin term ‘respondeat superior,’ which translates as ‘let the master answer,’ refers to a legal doctrine in which an employer or supervisor may be held responsible for the actions of his employees, when the actions are performed in the course of employment. In order for *respondeat superior* to apply, there must be a clear employee-employer relationship established, as the principle does not apply to actions by an independent contractor. [https://legaldictionary.net, 2020]

- The [tort] legal doctrine of *respondeat superior* was established in seventeenth-century England to define the legal liability of an employer for the actions of an employee. The doctrine was adopted in the United States and has been a fixture of agency law. It provides a better chance for an injured party to actually recover damages, because under ‘*respondeat superior*’ the employer is liable for the injuries caused by an employee who is working within the scope of his employment relationship. [<https://legal-dictionary.thefreedictionary.com/respondeat+superior>]

A key question in any legal proceedings against a health care provider is: “Did the supervisor conduct him- or herself in a way that would be reasonable for someone in his position?” or “Did the supervisor make a reasonable effort to supervise?” An example of a generally accepted time standard for a “reasonable effort to supervise” in the behavioral health field might be 1 hour of supervision for every 20–40 hours of clinical services – although this may vary significantly according to the specific discipline or situation. Of course, other variables (such as the quality and content of clinical supervision sessions) also play a role in a reasonable effort to supervise.

Dual Relationships and Boundary Issues

Dual relationships can occur at two levels: between supervisors and supervisees and between supervisees and clients. You have a mandate to help your supervisees recognize and manage *boundary issues*. A dual relationship occurs in supervision when a supervisor has a primary professional role with a supervisee and, at an earlier time, simultaneously or later, engages in another relationship with the supervisee that transcends the professional relationship. You will learn more about countertransference in section

- **Examples of dual relationships in supervision** include providing therapy for a current or former supervisee, developing an emotional relationship with a supervisee or former supervisee, and becoming an Alcoholics Anonymous sponsor for a former supervisee. Obviously, there are varying degrees of harm or potential harm that might occur as a result of dual relationships, and some negative effects of dual relationships might not be apparent until later.

You have the responsibility of weighing with the supervisee the anticipated and unanticipated effects of dual relationships, helping the supervisee’s self-reflective awareness when boundaries become blurred, when he or she is getting close to a dual relationship, or when he or she is crossing the line in the clinical relationship.

Exploring dual relationship issues with supervisees in clinical supervision can raise its own professional dilemmas. For instance, clinical supervision involves unequal status, power, and expertise between a supervisor and supervisee. Being the evaluator of a supervisee’s performance and gatekeeper for training programs or credentialing bodies also might involve a dual relationship.

- **Further, supervision can have therapy-like qualities as you explore countertransferential issues with supervisees, and there is an expectation of professional growth and self-exploration.** What makes a dual relationship unethical in supervision is the abusive use of power by either party, the likelihood that the relationship will impair or injure the supervisor’s or supervisee’s judgment, and the risk of exploitation.
- **The most common basis for legal action against licensees** (20 percent of claims) and the most frequently heard complaint by certification boards against licensees (35 percent) is some form of boundary violation or sexual impropriety (Falvey, 2002b). (See the discussion of transference and countertransference in *Study Guide 2 of this Course 4S*)

Codes of ethics for most professions clearly advise that dual relationships between health care professionals and clients should be avoided. *Dual relationships between supervisees and supervisors are also a concern and are addressed in the substance abuse counselor codes and those of other professions as well.*

- **Problematic dual relationships between supervisees and supervisors** might include *intimate relationships* (sexual and non-sexual) and *therapeutic relationships*, wherein the supervisor becomes the supervisee's therapist.
- **Sexual involvement between the supervisor and supervisee can include sexual attraction, harassment, consensual sexual relationships, or intimate romantic relationships.** Other common boundary issues include asking the supervisee to do favors, providing preferential treatment, socializing outside the work setting, and using emotional abuse to enforce power.

It is imperative that all parties understand what constitutes a dual relationship between supervisor and supervisee and avoid these dual relationships. The specifics of 'dual relationship' prohibitions vary somewhat from State to State and from one behavioral health discipline to another. Sexual relationships between supervisors and supervisees, and between health care providers and clients, occur far more frequently than one might realize (Falvey, 2002b). *In many States, such relationships constitute a legal transgression as well as an ethical violation and may result in loss of license in addition to other legal sanctions.*

- **The decision tree presented in Figure 6** indicates how a supervisor might manage a situation where he or she is concerned about a possible ethical or legal violation by a supervisee.

Informed Consent and Confidentiality

Informed consent and concerns for confidentiality should occur at three levels:

- 1) Client consent to treatment,
- 2) Client consent to supervision of the case, and
- 3) Supervisee consent to supervision (Bernard & Goodyear, 2004).

In addition, there is . . .

- 4) an implied consent and commitment to confidentiality by supervisors
- 5) institutional consent to comply with legal and ethical parameters of supervision. [See also the Code of Ethics of the Association for Counselor Education and Supervision – ACES.]

Basic parameters of Informed Consent include the following:

- *Informed consent* is key to protecting the supervisee and/or supervisor from legal concerns, requiring the *recipient of any service or intervention* to be sufficiently aware of what is to happen during the treatment process.

- The client must be made aware of the potential risks and alternative approaches for treatment, so that the person can make an informed and intelligent decision about participating in that service.
- The *supervisor must inform the supervisee about the process of supervision*, including the feedback and evaluation criteria and other expectations of supervision. The supervision contract should clearly spell out these issues.
- Supervisors must ensure that the supervisee has informed the client about the parameters of counseling and supervision (such as the use of live observation, video- or audiotaping).
- In supervision, regardless of whether there is a written or verbal contract between the supervisor and supervisee, there is an implied contract and duty of care because of the supervisor's *vicarious liability*.
- With Informed Consent and Confidentiality comes a duty not to disclose certain *relational communication which occurs in supervision sessions*.
- Because standards of confidentiality are determined by Federal and State legal and legislative systems, it is prudent for supervisors to consult with an attorney to determine the State codes of confidentiality and clinical privileging.
- *The limits of confidentiality of supervision session content should be stated in all organizational contracts with training institutions and credentialing bodies.*

UPDATED INFORMATION about the *July 2020 changes* in Federal statute '42 CFR, Part 2,' pertaining to confidentiality for persons receiving treatment for SUD:

[CEU By Net has inserted this updated information into the document to reflect the most recent changes in 42 CFR, Part 2 pertaining to Confidentiality of Patient Records of persons receiving treatment for substance use disorders.]

Since 1978, confidentiality in the substance abuse treatment field has been defined by Federal law: 42 CFR, Part 2 and the Health Insurance Portability and Accountability Act (HIPAA). **However, on July 13, 2020**, the Department of Health and Human Services' Substance Abuse and Mental Health Services (SAMHSA) *announced that the agency has revised the Confidentiality of Substance Use Disorder Patient Records regulation, 42 CFR Part 2.*

This shift was ultimately precipitated by the opioid crisis in America, in which thousands have died from overdoses. However, in the last few years, industry stakeholders and lawmakers have also asked for an update to 42 CFR Part 2, which was seen as outdated and burdensome for providers when it comes to sharing the patient records of SUD patients. Other leaders have pressed for an alignment with HIPAA to reduce those challenges.

The announcement by SAMHSA about this change, published online on July 13, 2020 contained the following statement:

"This reform will help make it easier for Americans to discuss substance use disorders with their doctors, seek treatment, and find the road to recovery," said HHS Secretary Alex Azar. "President Trump has made the availability of treatment for Americans with substance use disorders, including opioid use disorder, a priority. Thanks to the valuable input of stakeholders, our final rule will make it easier for Americans to seek and receive treatment while lifting burdens on providers and maintaining important privacy protections."

"The new rule advances the integration of healthcare for individuals with substance use disorders while maintaining critical privacy and confidentiality protections. Under Part 2, a federally assisted substance use disorder program may only disclose patient identifying information with the individual's written consent, as part of a court order, or under a few limited exceptions. Health care providers, with patients' consent, will be able to more easily conduct such activities as quality improvement, claims management, patient safety, training, and program integrity efforts."

"Coordinated care is a vital piece of President Trump's vision for a patient-centric healthcare system, and regulatory reform is a key step toward promoting more coordinated care," said HHS Deputy Secretary Eric Hargan. "As part of our Regulatory Sprint to Coordinated Care, these changes are just the beginning of a comprehensive agenda for reforming regulations that govern the delivery and financing of American healthcare, with the ultimate goal of better care, and better health, at a lower cost."

"The adoption of this rule means Americans will be better able to receive integrated and coordinated care in the treatment of their substance use disorders," said HHS Assistant Secretary for Mental Health and Substance Use Elinore F. McCance-Katz, MD, PhD, the head of SAMHSA. "We are grateful to the individuals and organizations that contributed their input to the rule-making process. This is great news for our nation's families and communities."

"Modernizing 42 CFR Part 2 will strengthen the nation's efforts to reduce opioid misuse and abuse and to support patients and their families confronting substance use disorders," the Assistant Secretary said. "The rule will make it easier for primary care clinicians to treat individuals with substance use disorders."

"We need an all-hands-on-deck approach to treating substance use disorders," said McCance-Katz. "We must do all we can to ensure the greatest access and availability to care for individuals living with substance use disorders. Although well-intentioned, the non-disclosure of critical, lifesaving information the previous rule permitted is itself stigmatizing." – For summative statements about the changes in 42 CFR, Part 2, please go to the SAMHSA-CSAT websites.

Duty-to-Warn: Under duty-to-warn requirements (e.g., child abuse, suicidal or homicidal ideation), supervisors need to be aware of and take action as soon as possible in situations in which confidentiality may need to be waived.

- Organizations should have a policy stating how clinical crises will be handled (Falvey, 2002b). What mechanisms are in place for responding to crises? In what timeframe will a supervisor be notified of a crisis situation? Supervisors must document all discussions with supervisees concerning duty-to-warn and crises. At the onset of supervision, supervisors should ask supervisees if there are any duty-to-warn issues with their clients of which the supervisor should be informed.

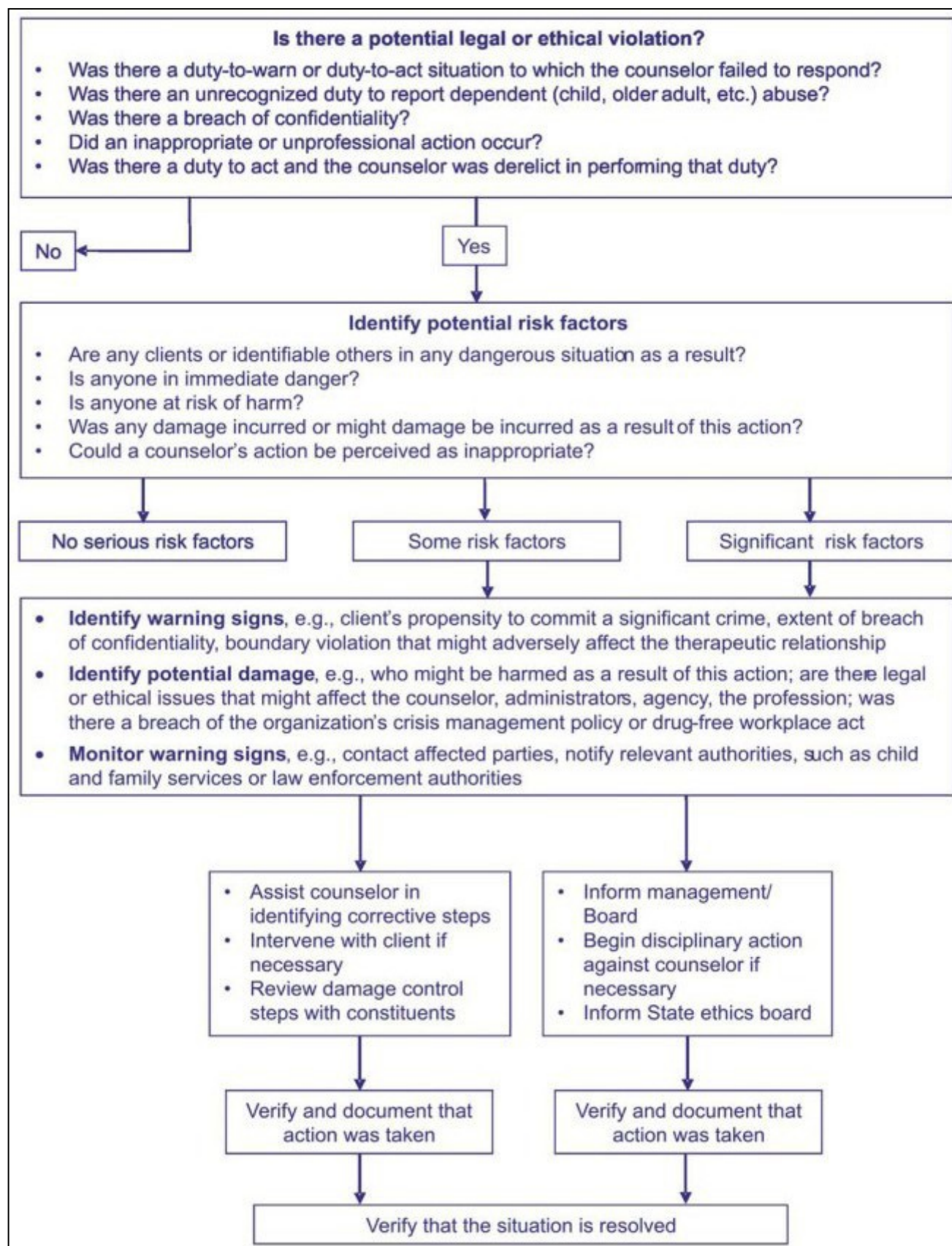
New technology brings new confidentiality concerns. Websites now dispense information about mental health and substance abuse treatment and provide counseling services. With the growth in online counseling and supervision, the following concerns emerge: (a) how to maintain confidentiality of information, (b) how to ensure the competence and qualifications of counselors providing online services, and (c) how to establish reporting requirements and duty to warn, including when services are conducted across State and international boundaries.

- **The National Board for Certified Counselors' (NBCC)** policy regarding the Ethics of Online Counseling was significantly expanded in 2020 to include multiple forms of Online Professional Services, including counseling, supervision, consultation, and education which is conducted as email-based, chat-based, telephone-based, video-based, and computer-based programming. The new policy is entitled *NBCC Policy Regarding the Provision of Distance Professional Services*, which replaces previous NBCC ethics editions.

<https://www.nbcc.org/Assets/Ethics/NBCCPolicyRegardingPracticeofDistanceCounselingBoard.pdf>

See Figure 6 below, 'Deciding How to Address Potential Legal or Ethical Violations.'

Figure 6
Deciding How to Address Potential Legal or Ethical Violations



Note to CEU By Net Participants:

This is the end of Study Guide 1 of sponsored CE Course 4S – The Developmental Model of Clinical Supervision. You can take the quiz for Study Guide 1 now or later. If you want to take it later, you can move on to Study Guide 2.

You will need to pass both quizzes [the Quiz for Study Guide 1 and the Quiz for Study Guide 2] before you can download your certificate.

To access links to the two Quizzes and Study Guides 1 and 2: Return to your account's **My Home Page** and click on the BLUE LINK which is the name of the course – **Course 4S**. You will then see the links to access both of the Study Guides and both of the Quizzes.

Feel free to print the quizzes before you begin studying the course, and mark answers on the paper copy as you move along. When you are ready to take the online quiz, you can transfer your answers to the screen from your paper copy.

If you don't see the name of the course listed on your My Home Page, this means that you have not yet enrolled in the course. In that case, you will need to return to the description of the course in the catalog and click the orange and blue SIGN UP NOW button to the left of the course description. You must be logged in to your account BEFORE you click SIGN UP NOW.

When you have passed a quiz, we will tell you which questions you missed (if any), the correct answers to the questions, and the answers you gave.

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