



# **CLINICAL SUPERVISION: MODELS, ROLES AND RESPONSIBILITIES, ETHICS AND LEGAL ISSUES**

## **3 Continuing Education Credits**

Asynchronous Distance Learning Course

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Then when you know better, do better.*

— Maya Angelou

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## ABOUT THE INSTRUCTOR

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Charlotte Chapman has been in the addictions and mental health counseling field for thirty years. She has practiced as a counselor, supervisor and program director. Charlotte is a licensed professional counselor, a licensed substance abuse treatment provider, a certified masters addictions counselor (MAC) and a certified clinical supervisor (CCS). She is currently the director of counseling services at the University of Virginia's Women's Center where she teaches and supervises graduate counseling students. Charlotte has been providing training in clinical supervision for twenty years. She has served on national and state credentialing boards. Charlotte was a member of the task force that produced TAP21-A: Competencies for Substance Abuse Treatment Clinical Supervisors (SAMHSA, 2007). More information is available at [www.chapmantraining.com](http://www.chapmantraining.com).

# Clinical Supervision in Substance Use Treatment: Current Developments

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The supervision models and ethical frameworks described in this course — the Discrimination Model, the Developmental Model, the IPR Model — remain foundational to clinical supervision practice. What has changed is the context in which supervision occurs: integrated behavioral health settings where substance use counselors work alongside professionals from other disciplines, expanded use of technology in supervision, an evolving workforce that increasingly includes peer specialists and non-traditional providers, and growing emphasis on measurable competency rather than credentialing alone. These shifts do not invalidate the models taught in this course — they demand that supervisors apply them with greater flexibility and contextual awareness than ever before.

A 2025 qualitative study examined supervision experiences across behavioral health disciplines in integrated practice settings, interviewing 20 clinicians working in mental health and substance use treatment. The researchers identified four themes: the value of interprofessional supervision, the emergence of clinical supervision functions within peer supervision spaces, varied individual supervision experiences across practitioners, and the role of organizational culture in shaping supervision quality (Berrett-Abebe et al., 2025). For supervisors trained in the models described in this course, the finding about organizational culture is particularly relevant — the Discrimination Model, Developmental Model, and IPR Model all assume a structured supervisory relationship, but their effectiveness depends on whether the organization supports that structure with protected time, clear role definitions, and administrative commitment. The Berrett-Abebe et al. finding about clinical supervision functions emerging within peer supervision spaces is especially significant for supervisors working in integrated settings. It suggests that when formal clinical supervision is inadequate or unavailable, clinicians seek supervision-like functions wherever they can find them — in peer consultation, team meetings, or informal hallway conversations. While this adaptability demonstrates professional resilience, it also signals a gap that supervisors must address proactively. Peer consultation is valuable, but it cannot substitute for the evaluative, gatekeeping, and developmental functions that trained clinical supervisors provide. For supervisors applying the Discrimination Model, which distinguishes between the teacher, counselor, and consultant roles, this means actively assessing whether their supervisees are receiving appropriate support in each domain — or whether they are cobbling together supervision from fragmented sources that may not cover all three functions.

The workforce expansion described in this course's discussion of supervisor roles now includes non-traditional providers who require adapted supervision approaches. A 2025 study documented the process of training four American Indian community members to deliver a substance use disorder intervention on a reservation, including motivational interviewing training, a two-day curriculum workshop, and weekly supervision meetings during an open trial. The researchers found that "additional training and supervision during the open trial was needed to ensure proper treatment delivery" beyond what initial workshops provided (Skewes et al., 2025). For clinical supervisors, this finding reinforces what the Developmental Model predicts: new practitioners — regardless of their professional background — require intensive, structured supervision that evolves as their competence develops. The Skewes et al. study also illustrates a dimension of supervision that the traditional models sometimes underemphasize: cultural competence flows in both directions. While the clinical supervisor provides treatment fidelity oversight and skill development, community-based providers bring cultural knowledge, relational trust, and contextual understanding that the supervisor may lack. Effective supervision in these settings requires what the Discrimination Model calls the "consultant" role more

than the "teacher" role — approaching the supervisee as a partner whose community expertise informs how the clinical model is adapted for local context, rather than simply ensuring protocol compliance. This has broader implications for any supervisor working with diverse staff: the supervisory relationship must create space for the supervisee's unique knowledge and perspective while maintaining clinical standards. For supervisors navigating this balance, the key is to distinguish between protocol adherence — which is the supervisor's responsibility to monitor — and cultural adaptation — which is the community provider's expertise to inform. Both are necessary for effective treatment delivery, and neither can substitute for the other.

The challenge of measuring whether supervision actually produces competent clinical practice has received direct attention. A 2023 study validated a 12-item scale for measuring motivational interviewing fidelity across 1,089 audio recordings from 238 providers working in 60 community substance use treatment clinics. Community-based providers scored significantly lower on advanced competencies compared to research settings, and the authors concluded that "follow-up coaching by trained supervisors may be needed" to close the gap between training exposure and clinical proficiency (Naar et al., 2023). This finding speaks directly to the supervisor's role described in this course: supervision is not a formality or an administrative requirement. It is the mechanism through which initial training translates into consistent clinical practice — and without it, training alone is insufficient. The Naar et al. data quantifies a problem that supervisors intuitively recognize: clinicians often know what they should do in theory but struggle to execute it consistently in practice. The gap between training-setting proficiency and community-setting proficiency is not a reflection of provider ability — it reflects the difference between controlled learning environments and the complex, under-resourced, high-caseload realities of community treatment. Supervisors who recognize this gap can design their supervision to specifically target the advanced competencies where community providers score lowest, using direct observation, audio review, and structured feedback rather than relying on supervisee self-report, which tends to overestimate proficiency. The validated MI fidelity scale described by Naar et al. also offers supervisors a concrete measurement tool: rather than relying on subjective impressions of supervisee competence, supervisors can use standardized rating instruments to track skill development over time and identify specific areas where coaching is needed. This shift from impression-based to measurement-based supervision represents one of the most important developments in the field since the supervision models in this course were first articulated.

The broader workforce context shapes what supervisors must prepare for. A 2022 analysis of 258 training events reaching 10,143 substance use treatment professionals found that "the demand for training and technical assistance increased during the pandemic, with a prioritization of TA focused on evidence-based practice and health equity" (Scott et al., 2022). A 2023 study evaluating brief training formats — the type most accessible to working counselors — examined whether short-format continuing education produced measurable changes in practice readiness (Cambron et al., 2023). For supervisors, these findings frame a practical reality: the counselors they supervise are receiving training in increasingly diverse formats and modalities, and supervision must bridge the gap between what those training events teach and what clinicians actually do in session. The convergence of findings from all five studies creates a clear mandate for clinical supervisors. Berrett-Abebe et al. (2025) demonstrate that organizational culture determines whether supervision models can function as designed. Skewes et al. (2025) show that new and non-traditional providers need intensive, culturally responsive supervision that goes beyond initial training. Naar et al. (2023) provide evidence that supervision is the mechanism that closes the gap between training and competent practice. And Scott et al. (2022) and Cambron et al. (2023) document a workforce receiving training in formats that are increasingly accessible but that

cannot substitute for the ongoing, relationship-based learning that supervision provides. For practitioners in the supervisory role, the message is that supervision quality — not just supervision availability — determines whether the treatment workforce delivers competent, ethical care. The models taught in this course provide the framework; the current evidence clarifies the conditions under which that framework succeeds.

## Introduction

This course offers a brief review of models of supervision, definitions, roles and responsibilities of supervisors and the opportunity for supervisors to reflect on their own developmental process. Information on ethical and legal issues specific to supervisors is also discussed. Self-inventory, discussion questions and case examples are part of the course content as well as a list of resources for additional reading.

There are many definitions of clinical supervision throughout the literature. Here are a few:

*“An intervention that is provided by a senior member of a profession to a junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person....”*

(Bernard and Goodyear, 2004, p.8)

*“An ongoing educational process in which all persons in the role of supervisor help another person in the role of the supervisee acquire appropriate professional behavior through an examination of the supervisee’s professional activities.”* (Hart, 1982. p.12)

In the substance abuse treatment literature on supervision, David Powell’s definition is probably the most quoted one: *“Clinical supervision is a disciplined, tutorial process where in principles are transformed into practical skills, with four overlapping foci: administrative, evaluative, clinical and supportive.* (Powell, 2004, p. 11)

More recently, the Substance Abuse and Mental Health Services Administration and the Center for Substance Abuse Treatment have published “Competencies for Substance Abuse Treatment Clinical Supervisors, TAP 21-A. In this publication, the authors offer the following definition: *“A social influence process that occurs over time, in which the supervisor participates with supervisees to ensure quality 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.”* (SAMHSA, 2007, p. 3)

And the most recent definition coming from Milne (2009): *“The formal provision, by approved supervisors, of a relationship-based education and training that is work-focused and which manages, supports, develops and evaluates the work of*

*colleague/s. It therefore differs from related activities, such as mentoring and therapy, by incorporating an evaluative component and by being obligatory. The main methods that supervisors use are corrective feedback on the supervisees' performance, teaching, and collaborative goal-setting. The objectives of supervision are 'normative' (e.g. case management and quality control issues), 'restorative' (e.g. encouraging emotional experiencing and processing) and 'formative' (e.g. maintaining and facilitating the supervisees' competence, capability and general effectiveness)." (p. 15-16)* He offers this definition as one that can be researched as there are measurable objectives and therefore moves the supervision field towards a more evidence-based practice. Milne discusses in his book that previous definitions are not supported in empirical literature which is why he has developed a new definition.

We will refer back to some of these definitions and the issues they raise throughout the course. One of the main issues is the obvious complexity of the supervision process and the different tasks, roles and responsibilities someone has who is a supervisor. And then to add to that, some supervisors are also expected to provide counseling services or function as an administrator. One of the goals of this course is to help with breaking down these complexities so that supervisors can hopefully feel less over-whelmed and gain a sense of competency about their work.

The course design that follows is:

- Self-Inventory
- Module 1: Models of Supervision
- Module 2: Roles and Responsibilities
- Module 3: The Developmental Model: Counselors
- Module 4: The Developmental Model: Supervisors
- Module 5: Ethical and Legal Issues
- Resources and References
- Post-Test



## Self-Inventory

This inventory is offered as a way to begin the course by focusing on issues specific to supervision. It also offers an introduction to some of the issues discussed in this course. In addition, supervisors need to have a high level of personal awareness in the supervisory relationship because of issues of power and authority. Please complete and discuss your answers with a trusted colleague or feel free to contact the course instructor.

1. The reasons I became or want to be a clinical supervisor are:  
\_\_\_\_\_
2. The three most important tasks I perform as a supervisor are:  
\_\_\_\_\_
3. I believe I am competent in performing these tasks: Yes \_\_\_\_ No \_\_\_\_ explain your answer: \_\_\_\_\_
4. The type of supervisee I most enjoy working with is:  
\_\_\_\_\_
5. The type of supervisee I least enjoy working with is:  
\_\_\_\_\_
6. The ethical issues I am most concerned about as a supervisor are:  
\_\_\_\_\_
7. The legal issues I am most concerned about as a supervisor are:  
\_\_\_\_\_
8. The type of training and supervision I receive for my supervision is:  
\_\_\_\_\_ and it does \_\_\_\_ or does not \_\_\_\_ meet my needs.
9. If I believed a client was receiving inadequate care, I would take over the case.  
Yes \_\_\_\_ No \_\_\_\_
10. I believe it is okay for me to disclose personal information to my supervisees  
Yes \_\_\_\_ No \_\_\_\_ and the reason I gave this answer is \_\_\_\_\_  
\_\_\_\_\_
11. If I had a sexual attraction to a supervisee, I would \_\_\_\_\_  
\_\_\_\_\_

12. If a supervisee presented me with a really good business partnership idea I would

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## Module One: Models of Supervision

In counselor training most professionals are taught different theories and the approaches that coincide with those theories. For many years, supervision was influenced by these counseling theories. In other words, if you were a client-centered, Rogerian counselor and you moved into a supervisory position, you would most likely practice supervision from a Rogerian theory. In the 1980's, family system theories and solution-focused theories began emerging with a specific type of framework for supervision. From family systems theory the concept of isomorphism was introduced to the supervision literature. This concept describes the parallel process that exists between counselor/client and supervisor/counselor. For example, if a counselor is having difficulty talking about a specific issue with a client, this same issue is being ignored in the supervisory relationship. Another example would be if a supervisor engaged in a boundary crossing with a counselor, this same boundary crossing could occur between the counselor and client, as in touching without permission or inappropriate self-disclosure. From solution-focused theories a more strength-based supervisory process emerged with focus on using the same approach in supervision that a solution-focused counselor would use with a client: eliciting strengths and resources; asking appropriate questions (rather than telling or interpreting for the client); using scales to measure and develop progress; giving positive feedback on even small steps; and adapting to the other's pace.

Since then efforts have been made to balance and integrate counseling theories with teaching and adult-learning theories, and with professional development needs of both the counselor and supervisor in an effort to provide a more encompassing supervision model. In this past decade, the emergence of evidence-based practices has challenged the traditional roles of supervisors and has increased the demand for supervisors to be part of the training and development of staff as these new practices are implemented. In other words, unconditional, positive regard of your staff will not get a new practice implemented! In reading the definitions in the introduction, we can also see how supervision has evolved and how complex it has become.

Even though supervision is a more complex process now, it is still helpful to review some of the early models that were developed so that supervisors have a foundation and a framework for thinking about their approach. We will then discuss in more detail in Module 3 the developmental model to see how a model can be applied in practice.

According to Bernard and Goodyear, there are three types of supervision models:

- Psychotherapy based models

- Developmental models
- Social Role models

As previously discussed, the *psychotherapy based models* are consistent with a counseling or therapy model. Someone using a psychoanalytic model of supervision would believe it is important to explore in the supervisory sessions transference and counter-transference issues with the counselor and client as well as discussing these issues in the supervisory relationship. A person-centered supervision approach would emphasize genuineness, empathy and warmth with the goal being that the counselor would then move toward their own self-actualization and become a better counselor. Cognitive-Behavioral supervision would be more of a goal oriented model with skill analysis and assessment and examining the cognitions of the supervisee along with their level of skills.

Stoltenberg and Delworth are perhaps the best known names in the *developmental models* of supervision. These models propose that counselors move through specific developmental stages with each stage having specific characteristics and developmental tasks. Therefore a supervisor could assess a counselor's level and then use the appropriate supervisory intervention that matches. The foundation of the model suggested by Stoltenberg and Delworth is that supervision should assist counselors in three main areas: autonomy, self and other awareness, and motivation.

There are many noted authors in the *social role theory* of supervision. These models focus on the different roles a clinical supervisor needs to take on in order to be effective. Here is a brief review:

| <b>Author:</b>  | <b>Roles emphasized in their work:</b>                              |
|-----------------|---------------------------------------------------------------------|
| Bernard (1979)  | Teacher, Counselor. Consultant                                      |
| Ekstein (1964)  | Teacher, Therapist, Administrator                                   |
| Williams (1995) | Teacher, Facilitator, Consultant, Evaluator                         |
| Holloway (1995) | Relating, Instructing, Modeling, Supporting, Consulting, Evaluating |
| Carroll (1996)  | Teaching, Counseling, Consulting, Evaluating, Administering         |

In summary, most of these authors all agree on the roles of teacher, counselor and consultant. One of the most well known of these social role authors, Bernard, developed the Discrimination Model (1997). This model goes into

enough detail to help the supervisor determine the need for one role vs. another in specific situations.

In the Discrimination Model, supervision is focused on three areas:

- intervention skills,
- conceptualization skills, and
- personalization skills.

The intervention skills refer to the supervisor's ability to teach a counselor specific techniques and strategies. The conceptualization skills are the abilities the counselor needs in understanding a client and being able to do case analysis. Personalization skills refer to the personal aspects of the counselor's experiences.

So in applying the Discrimination Model to one of these areas, intervention skills, it might look like this:

**Area: Intervention skills**

Supervisor Role: *Teacher*

- Supervisor teaches counselor a specific approach, such as a mindfulness exercise, to use with a client who has anxiety issues

Supervisor Role: *Counselor*

- Supervisee has had extensive training in a specific approach but fails to use it with this client with anxiety issues. Supervisor and supervisee counselor examine what is going on in the session with him/her that limits the use of these skills.

Supervisor Role: *Consultant*

- Supervisee is interested in learning more about behavioral interventions for anxiety disorders. Supervisor provides information via reading assignments or a recommended training session.

Obviously, a social role model requires a supervisor to be flexible in that roles can change from session to session and from each different supervisee. An important quality in a supervisor who follows this model would be the ability to understand the continuous changes in the supervisory relationship and the willingness to respond appropriately.

**Discussion Question:**

Think about the experiences you have had being supervised. What models can you identify in these experiences? Which one did you like the best and why?

As mentioned in the definition section, David Powell developed the most well known supervisory model that is specific to substance abuse counseling in the early 1990's. His model blends elements that are unique to the substance abuse field with the developmental models and with descriptive dimensions of supervision from the model of Bascue and Yalof (1991). Powell's model offers nine dimensions: influential, symbolic, structural, replicative, counselor in treatment, information gathering, jurisdictional, relationship, and strategy. For more in depth information about these dimensions, see resources at the end of this module. To summarize, Powell's model recommends supervisory strategies for counselors at each level of development and addresses issues that are specific in supervising in the substance abuse field, such as, recovery status, para-professionals, use of self-disclosure, and boundaries between personal issues and professional issues.

In addition to offering a theoretical orientation to supervision, some of these models also describe tasks of supervision.

Holloway, one of the *social role* models, defined five tasks for supervisors:

1. Monitoring/evaluating
2. Instructing/advising
3. Modeling
4. Consulting
5. Supporting/sharing

Stoltenberg and Delworth, one of the *developmental* models, describe eight domains of supervision:

1. Intervention skills
2. Assessment techniques
3. Interpersonal assessment
4. Client conceptualization
5. Individual differences
6. Theoretical orientation
7. Treatment goals and plans
8. Professional ethics

**Discussion question:**

Refer back to the self-inventory where you listed the three most important tasks of supervision. Are any of those tasks listed by Holloway or by Stoltenberg and Delworth? Think about your reasons for listing those three tasks. Would you change them now?

Another model, the *Interpersonal Process Recall Model (IPR)* also prescribes specific tasks for the supervisor. This is a supervision model developed by Kagan and Krathwohl (1967) that helps counselors to understand their perceptions and experiences with clients. The goals of IPR are to increase counselor awareness of thoughts and feelings of clients and self, and practice expressing these thoughts and feelings in the here and now without negative consequences, with the goal of deepening the counselor/client relationship. Kagan (1980) believed that counselors “tune out” important client statements, thereby missing important messages from the client. In this model, it’s the supervisor’s responsibility to help counselors become aware of this through review of audio or video tapes of sessions. For more details of how this model works, see references at the end of this Module.

**Case Scenario: Carl**

You are the clinical director for a mental health and substance abuse treatment agency. You provide administrative and clinical supervision to three senior staff, and they provide supervision to the rest of the staff. One of your senior staff, Carl, rarely discloses any personal information to you. He is a licensed clinician with many years of experience and his staff is a close knit group that works well together.

Carl asks to meet with you today and tells you the team is having difficulty with a client. As he is describing this client Carl sounds angry and defensive. He states that the client is obviously “borderline” as she will not do anything staff has suggested. They have tried referring her to another agency but she continues to call here requesting services. Carl has assigned her to three different counselors, and all have had the same result: non-compliance with continued crisis calls of suicidal threats but no attempts. He has referred her to the staff psychiatrist but she does not keep those appointments. Carl asks what you want him to do with this client.

**Questions:**

First what is your reaction as a supervisor?

Using one of the models discussed in Module One, how would you proceed to respond to Carl?

**References for Module One:**

Bascue, L. O. and Yalof, J. A. (1991) *Descriptive dimensions of psychotherapy supervision*. Clinical Supervisor. 9(2), 19-30.

Bernard, J. M. and Goodyear, R. K. (2004). Fundamentals of Clinical Supervision. (3<sup>rd</sup> edition) Boston: Allyn and Bacon.

Bernard, J. M. (1997). *The discrimination model*. In C.E. Watkins, Handbook of Psychotherapy Supervision. New York: Wiley & Sons, 310-327.

Center for Substance Abuse Treatment. *Competencies for Substance Abuse Treatment Clinical Supervisors*. Technical Assistance Publication (TAP) Series 21-A. DHHS Publication No. (SMA) 07-4243. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2007.

Holloway, E.L. (1995). Clinical Supervision: A Systems Approach. Thousand Oaks, CA: Sage

Kagan, N. (1980). Influencing human interaction: Eighteen years with IPR. In A. K. Hess (Ed.), Psychotherapy supervision: Theory, research, and practice (pp. 262-283). New York: Wiley and Sons.

Milne, D. (2009). Evidence-based Clinical Supervision. Wiley-Blackwell: Chichester.

Powell, D.J., and Brodsky, A. (1993). Clinical Supervision in Alcohol and Drug Abuse Counseling. New York: Lexington Books.

Putney, M., Worthington, E Jr., & McCullough, M. (1992) Effects of supervisor and supervisee theoretical orientation and supervisor- supervisee matching on interns' perceptions of supervision. Journal of Counseling Psychology. 39, 258-264.



Stoltenber, C. and Delworth, U. (1987). Supervising Counselors and Therapists. San Francisco: Jossey-Bass.

Watkins, C.E. (1997). Handbook of Psychotherapy Supervision. New York: John Wiley & Sons.

## Module Two: Roles and Responsibilities

In reviewing the various supervision definitions and models, the roles and responsibilities for supervisors are clear in some of them and not so clear in others.

The overall purpose of clinical supervision is to attend to the professional needs of supervisees so that the treatment needs of clients are met. In this regard, clinical supervision is a different role from counseling, case management, training or being an administrator. However, some of the definitions and models include counseling, teaching, etc. in them thus leading to more confusion. In this module we will look at differentiating the role of supervisor from these other roles.

*“Supervision looks like therapy not because the supervisor is doing therapy but because a therapist is doing supervision” (Powell, 1993)*

What is the difference between supervision and counseling? We have already discussed that the main purpose of the supervision session is directed towards the goals of monitoring the supervisee so that he/she can deliver effective treatment to clients. In other words, there is no “client” in the room when a supervisory session is being conducted but rather the client is discussed as a third party. The supervisee should not be treated as a client even though there may be assessment and evaluation tasks that the supervisor performs. The difference is that the supervisee is being assessed on their *professional* strengths and weaknesses and their job performance and not on their *personal* issues or psychological strengths and weaknesses. How much personal issues are discussed in a supervisory session will depend on the supervision model used by the supervisor; but regardless of the model, personal issues of the supervisee should only be discussed in terms of their relevance to the supervisee’s job performance or client relationship.

For example, our case discussion with Carl in Module One stated that Carl seemed angry and defensive. This would be something appropriate to discuss with him as it could be interfering with his handling of this client. It could also be that he was angry because he just got a speeding ticket on his way to work. And that would have no bearing on the client nor need to be discussed further by the supervisor (unless he had been in an agency car!)

In addition, supervision has its own knowledge base and set of skills that are different from what is required of a counselor. In TAP 21A, discussed previously, the following are recommended areas of knowledge for supervisors:

- Understand theories, roles and modalities of clinical supervision
- Leadership
- Understand the supervisory alliance
- Critical thinking
- Organizational management and administration (p. 13)

These are clearly different areas of knowledge than that expected of counselors.

There may also be confusion about counseling vs. supervision vs. case management. In some agencies, case management is blended into everyone's job; in others, there are staff hired who perform only case management. Supervisors may be confused between supervising a case manager vs. supervising a counselor. Case management can be defined as a collaborative process that assesses, plans, implements, coordinates and monitors the options and services required to meet a client's needs. It is characterized by advocacy, communication and resource management. Counseling is a structured, collaborative process that involves assessment of the client's mental and emotional health, diagnosis, and techniques that facilitate the improvement of the client's mental and emotional health. It is based on a theory of human growth and development, and the techniques are derived from a theory based on a belief about how people change. Counseling and case management can certainly overlap; however, there is a specific knowledge base and core set of competencies for most counseling professionals, especially if credentialed, that differs from a case management job.

There may also be confusion about clinical supervision and administrative supervision as many supervisors are asked to blend administrative responsibilities in their jobs. A clinical supervision session focuses on the professional development of a supervisee and improving his/her clinical skills. An administrative supervision session would focus more on the procedural aspects of the supervisee's job, employee status and agency requirements. For example, in a clinical supervision session, the supervisor would typically ask about the diagnosis, treatment plan or progress made of specific clients. In an administrative session, the supervisor would discuss that the billing information had not been completed on a client or discuss an agency policy that the supervisee had violated. We can see how a supervisor who has both of these roles needs to be very careful about limiting how much personal information a

supervisee discusses. The counselor who has disclosed personal information in a clinical supervision session and is then reprimanded by this same supervisor in their next session for a violation of agency policy, would understandably have conflicting feelings about their ongoing supervisory relationship.

In summary, the Association for Counselor Education and Supervision has developed a code of ethics for supervisors. Section 2: Supervisory Roles states:

*“Inherent and integral to the role of supervisors are responsibilities for:*

- A. monitoring client welfare;*
- B. encouraging compliance with relevant legal, ethical, and professional standards for clinical practice;*
- C. monitoring clinical performance and professional development of supervisees; and*
- D. evaluating and certifying current performance and potential of supervisees for academic, screening, selection, placement, employment and credentialing purposes.” (1993)*

Further in this section, the code states: *“Supervisors who have multiple roles with supervisees should minimize potential conflicts. Where possible, the roles should be divided among several supervisors. Where this is not possible, careful explanation should be conveyed to the supervisees as to the expectations and responsibilities associated with each supervisory role.” (2.09)*

We will discuss ethical issues in more detail in Module Five.

Just as in the counseling relationship, when there are potential role conflicts (group counselor vs. individual counselor), a written informed consent process is needed for supervisors with their supervisees. Fall and Sutton (2004) suggest the following guidelines for a good informed consent for clinical supervision:

- A. Define the purpose of the supervision
- B. Where, when and for how long the supervision will take place
- C. Method and type of evaluation of supervisee
- D. Duties and responsibilities of supervisee and supervisor
- E. Documentation responsibilities of supervisee and supervisor
- F. Supervisors scope of practice
- G. Supervision model used by supervisor
- H. Confidentiality
- I. Ethical and legal guidelines (For example, supervisee is to notify you immediately if a client is suicidal or a threat to others)

- J. Process for addressing supervisee complaints
- K. Emergency procedures (what to do if you cannot be reached in a crisis situation)
- L. How supervision will be delivered (weekly individual meetings, audio tapes, etc)
- M. Financial arrangements if appropriate

Here is an example of an informed consent for supervision form from McCarthy et al (1995). The content has been edited and just a few examples of wording used here because of the length of the document. There are seven sections: purpose, professional disclosure, practical issues, supervision process, administrative tasks and evaluation, legal/ethical issues and statement of agreement.

### **Informed Consent for Supervision Form**

#### **Purpose**

“The purpose of this form is to acquaint you with your supervisor, to describe the supervision process, to provide structure to your supervision experience, to give you the opportunity to ask questions you may have and to ensure a common understanding about the supervision process.

#### **Professional Disclosure**

(This paragraph states the education, training and credentials of the supervisor and describes the theoretical orientation.)

“My theoretical orientation for counseling and supervision is an integration of cognitive-behavioral, humanistic, and psychodynamic theories. Throughout this supervision experience, I will take on different roles at different times – teacher, consultant, counselor, and evaluator.”

#### **Practical Issues**

(This paragraph discusses office hours, meeting times, payment)

#### **Supervision Process**

Examples from this paragraph: “You will be expected to be an active participant in the supervision process, to arrive on time, to be prepared for each session, and to complete all required work in a timely manner.....Possible risks include

discomfort arising from challenges to your counseling knowledge, abilities and/or skills.”

### **Administrative Tasks and Evaluation**

Examples from this paragraph: “Evaluation criteria include oral and written case reports, four audio or videotapes of counseling sessions, and the degree to which you accomplish the goal set forth at the beginning of this supervision experience”.

### **Legal/Ethical Issues**

Examples from this paragraph: “Supervision is not intended to provide you with personal counseling or therapy. If personal issues or concerns arise, I urge you to seek counseling. The content of our sessions and evaluation are confidential, except what I share with my supervisor.”

### **Statement of Agreement**

This consists of signatures and date.

In addition to the informed consent of the supervisee there are two other informed consents for a supervisor to monitor; the client’s consent to receive counseling and the client’s consent to be a part of the counselor’s supervision. The informed consent that the counselor discusses with clients should include the information about the supervisory relationship and any recording or live supervision that will be expected. Clients can refuse one consent, that of the supervision, and still consent to receive counseling. Supervisors need to be prepared for how to respond when this occurs.

Informed consent is one of the key responsibilities of a supervisor that helps define the important aspects of the supervisory relationship. It also helps with ethical issues which will be discussed in Module Five. Other supervisory responsibilities include ongoing evaluation of supervisees, ongoing evaluation of client progress, continuous development of staff including self-care issues, monitoring ethical and legal practices, and administrative issues as relevant to their job.

## Discussion Questions:

It is important to begin to integrate all of the information we have covered into your own supervisory practice. Here are some suggested questions to help with application of this material.

1. Write your own definition of supervision that is meaningful to you and your current practice. The definition should include your roles and responsibilities.
2. Decide which model of supervision will be your preferred practice. Write down some key issues in this model that will be important to implement with your staff.
3. Write out an informed consent document that can be used with your current supervisory job in the setting you are in.

## References for Module Two

ACES Code of Ethics. (1993) Association for Counselor Education and Supervision.

Center for Substance Abuse Treatment. *Competencies for Substance Abuse Treatment Clinical Supervisors*. Technical Assistance Publication (TAP) Series 21-A. DHHS Publication No. (SMA) 07-4243. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2007.

Fall, M. and Sutton, J. M. (2003) Clinical Supervision: A Handbook for Practitioners. Boston, MA: Allyn and Bacon.

McCarthy, P., Snugden, S., Koker, M., Lamendola, F., Maurer, S., and Renninger, S. (1995) A practical guide to informed consent in clinical supervision. Counselor Education and Supervision, 35, 130-138.

Powell, D.J., and Brodsky, A. (1993). Clinical Supervision in Alcohol and Drug Abuse Counseling. New York: Lexington Books.

## Module Three: Counselor Development

As discussed in Module One, Developmental Theory is one of the models of supervision. It is part of the blended-model developed by Powell (1993) for use by clinical supervisors in the substance-abuse treatment field. We will discuss it in detail in this module and then apply it to supervisor development in the next module.

Counselor development is a complex process that involves supporting counselor self-efficacy over a period of time. Three aspects of each level of development are self and other awareness, motivation and autonomy. Self and other awareness focuses on the cognitive and affective components of the counselor and the client. For example, fears, anxieties, anger, discomfort and how these thoughts and feelings impact clinical work.

Motivation focuses on the understanding of the role of the counselor and the process of counseling, helping the counselor identify strengths and weaknesses and reasons for being a counselor. Autonomy deals with dependence on others, such as authority figures, and the ability to make independent decisions and develop self-confidence as a counselor.

The following is a description of characteristics common to each level of development.

### **Level One**

*“Doesn’t know what he/she doesn’t know”*

This counselor is usually a beginning counselor or someone entering a new field of counseling, for example, a substance abuse counselor who is now learning to work with mental health issues. S/he is typically looking for the “right” answers and can employ a type of cookbook approach to his work. They may lack confidence and worry about their evaluations but also have a high level of enthusiasm and desire to do a good job. Here is a list of some of the characteristics of this level:

- High motivation
- High levels of anxiety
- Focused on gaining skills
- Dependent on supervisor and will copy supervisor



- Needs structure
- Self-awareness is limited: projects own experiences onto clients
- Focuses more on self than clients
- Unaware of strengths and weaknesses
- May have been taught one counseling theory/approach and clings to that
- No clear understanding of ethical practice: may know the laws and codes but no experience with application

Some statements a level one counselor may make:

“I don’t want to hurt the client’s feelings so I couldn’t end the session on time”

“I had to respond to her question and give her an answer right then”

“I told him the same thing had happened to me, and I am sure he will be fine”

### **Discussion question:**

1. List what some of the supervision issues would be for you with a level one counselor.
2. What are some of the things you would like about supervising a level one counselor?

## **Level Two**

*“Knows more than you”*

A level two counselor has some experience and wants to begin to assert their independence and show initiative. This counselor is still struggling with the identity of being a counselor but without the level of anxiety of a counselor in the first stage. They still need supervision because of issues such as over-identifying with clients, burn-out, or pushing themselves to do something beyond their level of competency. Here are some characteristics of a Level two counselor:

- Motivation fluctuates; can decrease with more difficult clients
- Less anxiety but still confusion about being a counselor
- Dependency-autonomy conflict with supervisor
- Less inclined to ask for advice from supervisor
- Can be assertive with own agenda
- Focuses more on clients than self
- More understanding of clients’ worldview
- Open to learning more approaches

- Needs help balancing between self and client needs: can easily burn-out
- Ethical decision making practice has started: complex situations will still need supervisory help

Some statements a level two counselor may make:

“This is not what I planned on doing when I became a counselor”

“What you told me to do last session with this client didn’t work, so I tried something else”

“I have to come in on Saturdays because this client cannot find reliable child care any other time, and I know what that’s like as a parent”

### **Discussion question:**

1. List what some of the issues would be for you in supervising a Level Two counselor?
2. What are some of the positives about supervising this level counselor?

### **Level Three**

*“Knows he/she doesn’t know everything and that’s okay”*

This is an experienced counselor who has developed a range of skills and has accepted their professional identity. They are able to accept frustrations of their work as well as discuss successes; in other words, they know their strengths and their limits and have a level of confidence. If they move into another clinical area where they have not been trained, they may struggle with level one or two issues again.

- Stable motivation
- Has assumed professional identity as counselor; diminished anxiety
- Knows when to seek supervision and is comfortable in the supervisory relationship
- Acceptance of self; nothing to “prove”
- High empathy and understanding of clients
- Better balance with self-care and client needs
- Integration of ethical practice with clinical practice

Some statements a level three counselor may make:

“When the client mentioned suicide I asked her what had been going on prior to that to bring that up for her. She expressed relief at the end of the session that I

didn't jump to the phone and call the crisis people to come evaluate her for hospitalization"

"I advised the client that sexual addiction is not an area I am trained in and suggested some other resources for him. We are going to continue to work on his parenting issues here"

"What are your ideas about how I handled that?"

### **Discussion question:**

1. List some of the issues for you in supervising a Level Three counselor.
2. What would be the positive aspects of supervising this level counselor?

### **Level Four**

*"Knows a lot, including own limits"*

Level four counselors are ready for independent practice. They have a realistic enthusiasm (no unrealistic expectations) for their work and a strong sense of professional identity. They may also be supervisors, consultants, or trainers.

- Self-motivating
- Skilled interpersonally and cognitively
- Collaborative relationship with supervisor
- Good self-care
- Can resolve complex ethical situations but knows not to do that alone

Some statements a level four counselor may make:

"I realized I needed to learn more about the medications this client was discussing"

"I re-scheduled my late evening clients so that I could attend a dinner party for my colleague who is retiring"

"I need to talk about my anger at this client who is having an affair"

### **Discussion question:**

1. What would be the pros and cons of supervising this level counselor?

We have taken time to discuss the Developmental Model as it is a good framework for understanding counselor development. By using this model to

assess the level of a counselor, a supervisor then has a clear direction for their supervisory interventions.

Here are some suggestions for supervision issues for each level. Compare these to the answers you gave to the discussion questions.

When supervising a Level One counselor:

- increase counselor's awareness of numerous approaches to helping clients
- decrease counselor's anxiety so they can learn
- find ways to promote their autonomy that does not compromise client welfare
- teach them practical, helpful techniques with use of role plays and demonstrations
- Increase their awareness of their strengths; lead any feedback session with what they did well in a particular situation
- **do not take control of their cases**; teach them to be a better counselor rather than abdicating your supervisory role to become the counselor
- talk them through ethical situations; don't solve it for them unless it is a crisis type of situation; then be sure to go back and talk through it

When supervising a Level Two counselor:

- be aware of greater need for autonomy and avoid power struggles
- be prepared for challenges to your supervision; use that as a teaching moment to explain theory or rationale behind clinical suggestions
- be aware of transference issues especially around power and competency
- provide more challenging clients, again, without compromising client welfare
- monitor self-care issues to help prevent burn-out
- as counselor's personal issues emerge, have clear guidelines for addressing these that fit with your supervision model
- be open to counselor questioning whether he/she is in the right field; support career exploration
- encourage independence in ethical decisions but continue to talk through complex ethical situations
- Don't Stop Teaching!

When Supervising a Level Three counselor:

- Flexibility in responding to a wider range of clinical and professional issues
- Self-disclosure by supervisor may be helpful at this level
- Be prepared for counselor to perhaps be more skillful in some areas than supervisor ; letting go of own ego may be needed
- Continue to stimulate and challenge; don't abandon the supervisory role
- Ethical decision making will be more collaborative and there may be healthy disagreement

When Supervising a Level Four counselor:

- Take role as more of a consultant
- Share experiences, staff own cases if appropriate; more mutuality
- Continue to challenge with new goals, new learning; encourage counselor to take on new roles like training or writing to share expertise
- Ethical issues may be more about personal reactions to clients; counter-transference discussions.

### **Case Scenario:**

You are a clinical supervisor for a mental health public program. The agency is trying to move towards providing better services for clients with co-occurring issues. In the process, the clinical supervisor for substance abuse services leaves and her staff is assigned to you for supervision. All of your credentials are in mental health services.

When you meet with one of the counselors who is being transferred to you, he says:

“What do you know about substance abuse treatment? I have been running 12 step recovery groups for three years here and getting good results. Are you going to tell me I have to let mentally ill people in my groups?”

Discussion questions:

1. What level of counselor would you hypothesize he is?
2. What would be your response?
3. What would be your supervision plan for him?

### **References for Module Three**

Powell, D.J., and Brodsky, A. (1993). Clinical Supervision in Alcohol and Drug Abuse Counseling. New York: Lexington Books.

Skovholt, T.M. and Ronnestad, M.H. (1992) The Evolving Professional Self: Stages and Themes in Therapist and Counselor Development. New York: Wiley and Sons.

Stoltenberg, C. and Delworth, U. (1987). Supervising Counselors and Therapists. San Francisco: Jossey-Bass.

## Module Four: Supervisor Development

*“Taking on the role of supervisor demands that we act on our ethical responsibility to oversee and promote our ongoing development”.* (Heid, p. 151)

Supervisors are often so focused on the needs of their counselors, clients, and agency that their own professional development needs are ignored. Just as counselors have developmental stages, supervisors experience developmental stages and issues at each stage. This is again a helpful way to look at the supervisory relationship in that it provides a framework for assessing where a supervisor may be and where a counselor may be. It could be that some stages of development of a supervisor are better matches for the supervisory needs of certain stages of a counselor's development. We will discuss that further in this module.

Regardless of training and years of experience, these are suggested as areas all supervisors need to address throughout their professional development:

- Sense of professional identity as a supervisor vs. identity as a counselor, trainer, administrator
- Confidence as a supervisor
- Degrees of autonomy and dependence
- Use of power and authority with supervisees
- Structure, flexibility and varieties of supervisory interventions
- Focus on needs of supervisees and self
- Degree of personal investment in supervisees and clients success
- Use of the supervisory relationship in the process of supervision
- Degree of awareness of impact of self on the supervisory relationship/process
- Containment of personal issues, biases and awareness of counter-transference reactions
- Cultural, gender and age related factors in the supervisory relationship
- Ethical and legal issues specific to supervision

One of the main issues identified throughout the literature on supervision is the shift that is required when someone is moving from the counselor role to the supervisory role. Some of the problems that can occur in this transition are described by Borders (1992):

- *Supervisors who think like clinicians and see supervisees as surrogates.* In the previous model in listing supervisory strategies for a level one counselor, it was noted that a supervisor should not take over the case for the counselor. This is a common mistake that beginning supervisors can make, as if the client is on their case load, rather than on the counselor's case load. In addition, these beginning supervisors make detailed notes about the client when they review tapes, generate numerous hypotheses about dynamics, and devise plans for working with client. They may lecture the counselor on what should have been done or on how they would have done it. The supervisor may fail to hear anything that the supervisee has to say.
- *Supervisors who focus on the supervisee as a client.* These supervisors are focused primarily on the supervisees' personal issues and attribute any problems in clinical work as related to these issues. This focus obviously prevents adequate assessment of the counselor's knowledge and skills.
- *Supervisors who think of supervisees as learners and themselves as educators.* This again could be a beginning supervisor who is comfortable in the role as teacher and only focuses on that in supervision. As discussed in previous modules, good supervision involves many different types of roles.

Watkins (1997) suggests some other type of problems that can occur with supervision:

- "The Mr. Rogers Supervisor ": This supervisor is warm, patient, kind, and good-natured, but does not provide substantive critical feedback or education. Obviously the problem with this supervisor is that his/her supervisees will not have accurate feedback about their skills as counselors. Although positive feedback and strength based approaches are helpful in supervision, using that to the exclusion of other responsibilities, such as evaluation and corrective action, is detrimental to the supervisory relationship.
- "Attila the Hun Supervisor": This supervisor believes there is only one way to do things, which is "my way". He/she becomes upset if the supervisee does not conform. In looking at the levels of counselor development this would obviously be a major conflict with a level two counselor and not meet the needs of counselors at other levels.
- "The "How do you feel?" Supervisor ": This supervisor focuses the supervision on personal feelings of the supervisee about the client. Again, some discussion of this can be helpful in the development of a counselor but using only this focus is detrimental in that the needs of the client are not discussed along with other important issues.



Various authors have identified different stages of development for supervisors similar to the stages of counselor development. (Watkins, 1990 and 1993; Stoltenberg and Delworth, 1987) This is a normal process that anyone would move through in their development as a supervisor. In addition, a supervisor could move back and forth in these levels. For example in our Case Scenario in Module Three, a level three supervisor in mental health services is now having to supervise out of her area of competency. This could easily cause a move to level one issues of dependency needs with her own supervisor, identity confusion, and anxiety.

#### Level One Supervisor

- Highly motivated
- Dependent on own supervisor: high anxiety
- Self-focused (am I doing this right?)
- Identity confusion in transitioning from counselor: if promoted from a peer group of counselors, this can add to the transition problem
- Struggles with power issues and the move to middle-management (especially in agencies where there is an “us against them” mentality of counseling staff vs. management staff)
- Limited skills in applying ethical principles to the supervisory relationship: may only think about client and not his/her ethical obligations to the supervisee as well. For example, a supervisee reports that a client has made suicidal statements. The supervisor steps in and does a pre-screening to commit the client rather than advise the counselor on how to manage this.

#### Level Two Supervisor

- Less anxiety and more clarity about role as a supervisor
- Continues to struggle with authority issues. For example, management makes a decision that is problematic for counseling staff and the supervisor sides with the counseling staff.
- Independent behaviors but still checking in with own supervisor
- May question decision to become a supervisor
- Aware of need to include supervisee welfare in ethical decision making process

#### Level Three Supervisor

- Balances awareness of self and supervisee
- Acceptance of authority and role as middle-management

- Functions autonomously
- Has developed clear supervision model
- Accepts professional identity as a supervisor
- Shows consistency in supervisory behavior (doesn't revert to counselor role)
- Realistic appraisal of own skills and limitations
- Integration of ethical practice with supervisory role

#### Level Four Supervisor

- Integrations of identity, knowledge and skills
- Fulfills requirements for supervisory credentials
- Sense of mastery as a supervisor
- Ready to supervise other supervisors

#### **Discussion questions:**

1. Identify which level supervisor you are. Write out a professional development plan based on your assessment.
2. You are a level one supervisor supervising a level three counselor. Identify two areas of concern that could occur for you.
3. You are a level two supervisor supervising a level one counselor. Identify two areas of concern that could occur for you.

#### **References for Module Four**

Borders, L.D. (1992). Learning to think like a supervisor. Clinical Supervisor, 10, 135-148.

Stoltenberd, C.D., McNeill, B., and Delworth, U. (1998). IDM supervision: An integrated developmental model for supervising counselors and therapists. San Francisco: Jossey-Bass.

Watkins, C.E., Jr. (Ed.). (1997). *Handbook of psychotherapy supervision*. New York: Wiley

## Module Five: Ethical and Legal Issues

There are several sources for guidelines regarding ethical behavior for supervisors. If a supervisor holds a specific credential, there may be ethical guidelines with the regulations governing that credential which address supervisory behaviors. As previously noted the Association for Counseling Educators and Supervisors offers a code of ethics for members. Resources for learning about specific credentials for supervision are located at the end of this module.

### **Discussion Questions:** Is This Ethical?

1. A supervisor gives a counselor extra personal leave time, which requires cancelling a group for clients two weeks in a row as no other staff is available to run the group.
2. A supervisor requires all counselors to be in their own counseling for the first six months of employment.
3. A supervisor goes to lunch every Friday with two of her staff without inviting any other staff to join them.

Many authors in the field of ethics suggest that an ethical decision making process is essential for good practice rather than just relying on a code of ethics. Ethical practice is a way of being and not just knowledge of a code. In addition to practicing an ethical decision making process, supervisors need to be able to teach it to staff. In this process they need to be able to apply ethical principles to the supervisory relationship in addition to the client/counselor relationship. These principles are:

- Autonomy: supporting self-efficacy and not creating dependence
- Beneficence: contributing to the well-being of others: “doing good”
- Competence: having the knowledge, skills and abilities to do what we say we can do
- Justice: fairness in dealing with everyone; adhering to standards of practice
- Discretion: protecting the privacy of clients
- Nonmaleficence: Causing no harm

### *Autonomy*

A supervisor who is using the developmental model for supervision would need to adjust the application of this ethical principle depending on the needs of the

supervisee. A beginning counselor will have more dependency needs than an experienced counselor. It could even be considered unethical to give a beginning counselor too much autonomy in that it could compromise client and supervisee welfare. At the same time, to keep a supervisee dependent on a supervisor and not facilitate their independent thinking, would be considered unethical. A supervisor's responsibility is to facilitate professional growth of the supervisee and to help that counselor develop their own identity; not continue to be a clone of the supervisor. One way to begin to promote autonomy of beginning counselors is to ask questions in the supervisory session rather than to lecture or give answers. When a counselor asks about a clinical situation, the supervisor can ask the counselor to think it through first before giving their own response.

Even without the developmental model, a supervisor will need to have a good assessment of their counselor to determine how to support self-efficacy. The type of supervision as well as the clinical setting will also impact autonomy. Supervisors who have access to audio and video recordings of all sessions may feel more comfortable allowing for counselor autonomy vs. supervisors who are providing supervision offsite with no live tools to know what is happening in the sessions.

### *Beneficence*

What does it mean to “do good” as a supervisor? The welfare of the clients must be primary and at the same time, the supervisor is responsible for the welfare of supervisees. Examples of possible ethical dilemmas of beneficence are:

- Leaving clients on a waiting list because staff already have too high of a case load
- Assigning a difficult client to a beginning counselor so that the counselor can learn how to work with this population
- Giving a counselor extra leave time to take care of personal issues which means cancelling groups sessions as no other staff are available to run the group

Some supervisors may step in and provide clinical coverage themselves in order to resolve some of these dilemmas, for example, running the group. Others might push the counselors to the point of burn-out and deny personal leave rather than have clients wait for services. The ACES Code of Ethics offers the following guidelines:

*“Supervisors should use the following prioritized sequence in resolving conflicts among the needs of the client, the needs of the supervisee, and the needs of the*

*program or agency. Insofar as the client must be protected, it should be understood that client welfare is usually subsumed in federal and state laws such that these statutes should be the first point of reference. Where laws and ethical standards are not present or are unclear, the good judgment of the supervisor should be guided by the following lists:*

- a. Relevant legal and ethical standards ( i.e. duty to warn)*
- b. Client welfare*
- c. Supervisee welfare*
- d. Supervisor welfare*
- e. Program and/or agency and administrative needs” (Section 3.20)*

One of the ways to help with beneficence is to have a good supervisory informed consent or a contract for supervision. This could outline expectations, how requests for personal leave are handled, etc, etc. An example of an informed consent was discussed in a previous module. It is strongly recommended that supervisors use a written informed consent to promote good ethical practice.

### *Competence*

As we have previously discussed, supervision requires a specific set of knowledge, skills and abilities. A competent counselor is not necessarily qualified to be a supervisor but often in agencies, a competent counselor is promoted to the position without adequate training and preparation. Every professional cannot be competent in all the tasks they may be required to perform as professional development takes time.

The ethical responsibility is to make every effort to pursue the training and supervision that is needed to provide supervision for staff. If there are areas of deficiencies, other resources should be located so that staff welfare and client welfare are not compromised while the supervisor is developing his/her proficiencies. For example, in our case scenario of the mental health supervisor taking over a substance abuse staff, someone else within the agency who is proficient in substance abuse treatment could provide consultation for the staff while this supervisor learns what is needed.

One of the issues in the developmental model of supervisors is that it is hard for a beginning supervisor to admit they do not know something because of the developmental need to establish credibility in this new role. Beginning supervisors need to especially be aware of the ethical responsibility of

competence and to allow other professionals to assist them as they move into this supervisory role. It is unrealistic to expect that a beginning supervisor would know all that is needed just like one would not expect a beginning counselor to know everything about treating clients.

The ACES Code of Ethics states:

*“Supervisors should have had training in supervision prior to initiating their role as supervisors” (2.01)*

*“Supervisors should pursue professional and personal continuing education activities such as advanced courses, seminars, and professional conferences on a regular and ongoing basis. These activities should include both counseling and supervision topics and skills”. (2.02)*

This code speaks to the ethical responsibility for supervisors to continue their education. In some situations where there are minimal training funds, supervisors may decide to use the funds for staff training rather than their own. This is not good practice, and supervisors need to also budget for their own learning needs. Ongoing supervision of supervision is also recommended to help maintain good practice and facilitate professional development of the supervisor.

Bernard and Goodyear state:” *...because of the tremendous influence that supervisors have on future practitioners, it is frightening to consider the supervisor who is not actively engaged in continuing education” (1992, p. 143.)*

Supervisors also have to monitor the competence of counselors. There are numerous evaluation tools available for supervisors, however, most authors in this field agree that live supervision is the most effective for knowing exactly what occurs in a counselor/client session. Evaluation requires objectivity so it is important that supervisors remain as objective as possible about staff in order to be effective at evaluating their abilities. Objectivity is part of the ethical obligation of a competent supervisor.

An aspect of competence that can cause anxiety for supervisors is impairment. In addition to knowledge and skills, counselors also have to be personally stable in order to be effective with clients. There are a lot of gray areas and disagreement about what constitutes personal stability. It is advisable that supervisors work with their human resources staff to have a description of impairment that is suitable for their agency, and procedures for how staff is to be assessed so that

there is consistency. If at all possible, a third party would be best for assessing impairment so that the supervisor is not in that dual role. Employee assistance programs are helpful in providing objective evaluations and recommendations. They can also help with back to work guidelines for any impaired staff that have to take a leave of absence. Impairment is an area that a supervisor should not try to address on their own as there are numerous ethical as well as legal issues involved. Again, this is information that should be covered in an informed consent.

### *Justice*

Supervisors can have counter-transference reactions to staff just as counselors have reactions to clients. In the self-inventory, questions were asked about staff you enjoy supervising and those you do not. It is normal to have reactions to different people and their behaviors. However, a supervisor needs to maintain a high level of personal awareness about these reactions so that all staff is treated equally and fairly.

Supervisors also need training in cultural issues in supervision, and to have a good awareness of the issues of power and authority that can be viewed differently by different cultures. Some even suggest that supervisors' ethical responsibility is to actively recruit staff from minority cultures especially if that is the client population being served. If a supervisor notices a pattern of treating some staff differently than others, consultation is advised for help with identifying these issues and correcting them.

### *Discretion*

This is the principle that the supervisor upholds in protecting privacy and confidentiality of clients. Some supervisors also apply this principle to discussions in supervision sessions; however, if the supervisor also has an administrative role, there may be times when information shared in supervision sessions has to be discussed with others in the agency. Supervisees are not clients and they are not protected under codes of ethics or in the privilege communication statutes. Supervisors should clarify in their informed consent with staff what information will be kept private and what information will not.

### *Nonmaleficence*

Supervisors should do no harm to their staff. This seems obvious yet there have been a number of studies citing dual and sexual relationships with supervisors and counselors (Bernard and Goodyear, 1998). As noted in the literature on dual relationships with clients, boundary violations often occur on a continuum. When adults work closely together, it is normal that feelings and reactions will occur. Touching a supervisee or types of personal disclosure can be the beginning of the continuum that can then lead to sexual behaviors.

It is unethical for supervisors to put their sexual needs first. The power differential in the supervisory relationship sets the stage for exploitation; and for the supervisee, no matter how the relationship ends, to feel victimized in some way. So it is important for supervisors to monitor their own personal reactions to staff as well as their practices of physical touching and self-disclosure. Social invitations that are extended to one staff member and not others is also a step on that boundary violation continuum. Giving gifts to one staff member and not others would be a concern as well. Business relationships can also be problematic as a dual relationship. For example, a supervisor and her counselor go into business as trainers together and something goes wrong with the business. They now have to resolve this in order to be able to continue a positive supervisory relationship.

In conclusion, ethical management of the supervisory relationship requires the supervisor to seek consultation because it is hard to be objective about a relationship that you are part of and to monitor the reactions and behaviors of yourself. Dual relationships should be discouraged because of the issues related to objectivity, isomorphism, and exploitation. Proper boundaries should be discussed in the informed consent process and clarified throughout the supervisory relationship. Supervisor self-disclosure can be used as a teaching tool when appropriate for the developmental needs of the supervisee. It can also easily lead to boundary violations so must be closely monitored. The same guidelines that are recommended for counselor self-disclosure with clients should be utilized for supervisor self-disclosure: monitor the impact of the disclosure (is it helpful?), the frequency (happening too often?), the timing (too early in the relationship?), and the content (too much?). By following these guidelines, the supervisor is also providing good role modeling for the counselor/client relationship in boundary management.



A good ethical decision making process that can be applied with all staff is also essential in guaranteeing that there is no favoritism or discrimination with staff. And part of the supervisor's ethical decision making model should include knowledge of legal issues.

### *Legal Issues for Supervisors*

Liability issues are a primary legal concern for supervisors. Harrar and VandeCreek (1990) identify two areas of concern that have been established by courts: actions of others and self actions.

In order for a supervisor to be liable for the actions of another person, there are three conditions that must exist:

1. supervisee must voluntarily agree to work under the direction of the supervisor
2. supervisee must have acted within the defined scope of tasks
3. supervisee must have the power to control and direct the supervisee's work

The legal question is who has the administrative control regarding client care.

The situations where supervisors are liable for their own actions are:

1. Neglect in the supervision of a supervisee and a client is harmed
2. Give inappropriate advise to a supervisee, the supervisee follows this advise, and a client is harmed
3. Assign a task to a supervisee that he/she is not adequately trained to perform

*"If at any time the supervisor believes that a client is not receiving adequate care, they must act to protect the client. The protection holds true not only for the decisions in the course of treatment but for termination or referral as well" (Harrar and VandeCreek, p. 40)*

This again speaks to the balancing act a supervisor needs to be able to perform between client welfare and supervisee welfare in order to practice within legal guidelines. As we discussed under counselor development as well as the ethical principles of autonomy and beneficence, the supervisor's role of teacher is

important. If the supervisor steps in and provides care in situations where there is inadequate care, this will impact the counselor's development and the supervisory relationship. However, it is clear that the court system values the welfare of the client above all else so that is why liability issues need to be a part of the ethical decision making process.

Obviously other legal issues that need to be considered in this process are duty to warn laws, duty to protect and duty to report. There may be legal issues with regard to the agency or practice of the supervisor. The Americans with Disabilities Act is something supervisors should be knowledgeable about especially in dealing with staff with impairment or disability issues. Other legal concerns will arise if a supervisor has administrative/personnel responsibilities such as hiring guidelines, grant requirements, etc.

#### Resources for Module Five

ACES Code of Ethics. (1993) Association for Counselor Education and Supervision.

Bernard, J. M. and Goodyear, R. K. (2004). Fundamentals of Clinical Supervision. (3<sup>rd</sup> edition) Boston: Allyn and Bacon.

Disney, M.J. and Stephens, A.M. (1994) Legal issues in clinical supervision. Alexandria, VA: American Counseling Association.

Harrar, W.R. and VandeCreek, L. (1990) Ethical and legal aspects of clinical supervision. Professional Psychology: Research and Practice, 21, 1, p. 37-41.

#### Certifications for supervisors

##### *Approved Clinical Supervisor*

National Board for Certified Counselors  
3 Terrace Way  
Greensboro, NC 27403  
[www.cce-global.org/acs.htm](http://www.cce-global.org/acs.htm)

##### *Approved Supervisor Designation*

American Association for Marriage and Family Therapy  
112 South Alfred Street

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## Discussion of Scenarios

Now we will integrate the material in all of the modules and discuss some of the scenarios in the course.

### **Discussion for Case Scenario Module One: Carl**

1. What is your reaction as a supervisor? Well, there could be lots of reactions. One could be that you are surprised that Carl is asking you for help. One is that you feel annoyed because you count on him to figure these things out with his team and you don't have the time to deal with this. You could feel good that he is asking for your help. You might feel concerned about how the client is being treated given Carl's attitude and the fact that the client has had three different counselors.
2. In addition to thinking about what model would work best with this scenario we also need to know what type of supervisory relationship you and Carl have. Since he is not one who discloses much, it would be ill advised to begin with asking him about his feelings so the Interpersonal Recall Model may not be a good choice here. However, if you have a solid supervisory relationship you might start by reflecting on the fact that it is unusual for him to seem so frustrated with a client and to ask for your help and then ask him what he thinks is going on? He is clearly a level three or four supervisor so supporting his autonomy in this scenario is important. Legally you may feel the need to ask to see the client's chart and to observe the next session when the client is at the agency. It would be best to try to do this in a collegial manner.

### **Discussion for Case Scenario Module Three**

1. What level of counselor? It sounds like a Level Two counselor in that he has been providing group for three years in an approach that he thinks is getting good results, so he has some level of competency. His challenging of a new supervisor also fits with Level Two characteristics.
2. What would be your response? Since you do not have a relationship yet with this counselor you want to be careful in that your response will set the tone for the relationship. If you are going

to use a developmental model you could respond by asking him to tell you more about his groups, ask about what he has been doing that is working well, and what are his concerns about having mentally ill clients attend. This would support the independence issues of a Level two counselor. Then you would give him your response, first by reflecting back what he is doing well and how you think mentally ill clients could benefit from that but also being open to the fact that they may not. A contract could be to give it a trial period with both of you monitoring and assessing how the groups are working with this new combination of clients. To get a level two counselor invested in the solution to the problem that they raise is usually an effective strategy.

3. A supervision plan could consist of lots of things. One would be to ask him what has worked well previously in his supervision experiences and also give him a chance to debrief the loss of the previous supervisor – it may have been a positive relationship or not – so that would be important information to have before you proceed with a plan. Then something to include increasing his knowledge and comfort level with co-occurring clients. You could offer to sit in on some groups so that you can learn about the SA treatment part or do live supervision if a one way mirror is available. Also ask him what he is interested in learning at this point in his development. Maybe he has good group skills but would like to develop more individual counseling skills. You would also want to take time to talk with him about your style of supervision and how the plan will unfold. Some counselors have never had a supervisor who provides informed consent or a plan so be prepared for some reaction to that – again, positive or negative.

### **Discussion of scenarios in Module Five: Is This Ethical?**

1. The canceling of a group could possibly be a violation of client welfare especially if clients are mandated to attend, and this could impact their probation, so the supervisor would be acting unethically in terms of clients. In addition, granting one counselor extra personal leave could backfire as other staff will then ask for and should be given the same treatment under the principle of justice. A supervisor in this situation should have a written policy about how extra personal leave is granted and in what situations, for example, a mental health issue that is documented by a therapist or

psychiatrist. If clients are also receiving individual counseling during the two week period, then their welfare issues are taken care of. If not, the supervisor needs to facilitate the group; or if not competent to do so, hire someone to do so. To not grant the personal leave would compromise the counselor's welfare which in turn impacts clients.

2. The fact that this is required of all counselors is good in that it upholds the principle of justice; however if this was not stated as a condition of employment before counselors were hired, then it is questionable practice. The supervisor would need to justify why this is a requirement for employment. To *suggest* it to everyone would be a better approach.
3. This supervisor may be using the lunches to provide some type of a supervision group; and if so, then this needs to be communicated to the rest of her staff. If it is not work related, then she is risking boundary crossings by constantly socializing with supervisees; and she is in violation of the principle of justice in not treating all staff the same.

# REFERENCES

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- Berrett-Abebe, J., Novella, J., Pagnotta, M., & Eaves, T. (2025). The state of interprofessional supervision in practice: A qualitative analysis. *Social Work*, 70(3), 247-254. <https://doi.org/10.1093/sw/swaf018>
- Cambron, C., Castillo, J. T., & Frost, C. J. (2023). Effectiveness of brief in-person and virtual substance use disorder counselor trainings, 2019-2021. *Public Health Reports*, 138(1\_suppl), 56S-62S. <https://doi.org/10.1177/00333549221123585>
- Naar, S., Chapman, J. E., & Aarons, G. A. (2023). Efficient and effective measurement of provider competence in community-based substance use treatment settings: Performance of the Motivational Interviewing Coach Rating Scale (MI-CRS). *Journal of Substance Use and Addiction Treatment*, 150, 209027. <https://doi.org/10.1016/j.josat.2023.209027>
- Scott, K., Salas, M. D. H., Bayles, D., Sanchez, R., Martin, R. A., & Becker, S. J. (2022). Substance use workforce training needs during intersecting epidemics. *BMC Public Health*, 22(1), 1063. <https://doi.org/10.1186/s12889-022-13500-6>
- Skewes, M. C., Gonzalez, V. M., & Stix, A. (2025). Training community members to deliver an intervention for substance use disorder: Overcoming implementation barriers in American Indian communities. *Journal of Substance Use and Addiction Treatment*, 168, 209541. <https://doi.org/10.1016/j.josat.2024.209541>

## **Appendix A: Post Test and Evaluation *Clinical Supervision: Models, Roles and Responsibilities, Ethics and Legal Issues***

**Directions:** To receive credits for this course, you are required to take a post test and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CEU Matrix – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions. Then, submit your test online for processing. This can be done in the following manner:

*Submit your test via the Internet.* All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions found at the end of this appendix. Then, return to your browser and go to the Student Center located at:

<http://www.ceumatrix.com/studentcenter>

Once there, log in as a Returning Customer using your Email Address and Password. Go to 'My Courses' then to the subject course. Then click on 'View Lesson Quiz' and you will be presented with the electronic exam.

**NOTE: THE EXAM QUESTIONS AND /OR ANSWERS MAY BE IN A DIFFERENT ORDER IN THE ONLINE EXAM**

To take the exam, simply select from the choices of "a" through "e" for each multiple choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded and you will receive your results immediately. If your score is 80% or greater, you will receive a link to the course evaluation. You will also receive a link to the Certificate of Completion. This is the final step in the process, and you may save and / or print your Certificate of Completion.

If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.



**Answer the following questions by selecting the most appropriate response.**

1. According to Milne, the objectives of supervision which can be measured are:
  - a. mentoring, teaching, counseling
  - b. normative, restorative, formative
  - c. evaluative, supportive, educational
  - d. team building, case consultation, teaching
2. There are three types of supervision models which are:
  - a. evaluative, supportive, educational
  - b. rogerian, developmental, solution-focused
  - c. systems theory, psychotherapy based, developmental
  - d. psychotherapy based, developmental, social role
3. A supervisor who discusses transference issues with a supervisee is most likely using which model of supervision:
  - a. psychotherapy
  - b. developmental
  - c. systems theory
  - d. rogerian
4. The developmental model of supervision states that:
  - a. counselors move through stages with various tasks
  - b. supervisors determine which role they should be in based on their developmental level
  - c. supervisors should emphasize genuineness, empathy and warmth
  - d. supervisors should discuss transference issues in the supervisory relationship
5. One of the most well known of the Social Role Models is:
  - a. Interpersonal Recall
  - b. Discrimination Model
  - c. Psychoanalytic Model
  - d. Teacher, Therapist, Administrator

6. One of the social role models developed by Holloway defined five tasks. Which of the following is **not** one of those tasks:
- a. monitoring/evaluating
  - b. instructing/advising
  - c. ethical decision making
  - d. consulting
7. The goals of the Interpersonal Recall Model are:
- a. to increase counselor's awareness of thoughts and feelings
  - b. to facilitate counselor's professional development through stages
  - c. to teach counselors intervention skills through practicing in the moment
  - d. to assist counselors with autonomy and motivation
8. One of the differences between clinical supervision and counseling is:
- a. counseling requires ethical decision making
  - b. supervision focuses on the professional strengths and weaknesses of the supervisee and not personal issues as in counseling
  - c. counseling requires more documentation
  - d. supervision focuses on developmental issues
9. Personal issues of the supervisee should be discussed in supervision when:
- a. the supervisee brings them up
  - b. the supervisor is using a psychoanalytic approach
  - c. it is clear the issues are relevant to the job performance of the supervisee
  - d. the supervisee is going to be put on probation
10. According to TAP 21A there are five recommended areas of knowledge for supervisors. Which of the following is **not** one of these areas:
- a. leadership
  - b. critical thinking
  - c. adult learning models
  - d. understand the supervisory alliance

11. According to ACES Code of Ethics, a supervisor who has multiple roles should:
- a. minimize potential conflicts by discussing with the supervisee expectations and responsibilities of each role
  - b. have a written informed consent for each of the roles
  - c. have consultation for each of the roles
  - d. have his/her supervisor take over some of the roles
12. A supervisor has three areas of informed consent to monitor. They are:
- a. the agency's consent for treatment, a counselor's consent for supervision, the supervisor's consent to supervise
  - b. the client's consent to treatment, the client's consent to the supervision process, the counselor's consent to supervision
  - c. the client's consent to treatment, the agency's consent, the supervisor's consent to supervise
  - d. none of the above
13. Three aspects of counselor development according to the Developmental Model are:
- a. self and other awareness, motivation and autonomy
  - b. anxieties, issues of authority, self-confidence
  - c. authority issues, motivation issues, self-confidence
  - d. dependency issues, self-awareness, and autonomy
14. A level one counselor will have which of the following characteristics:
- a. dependency-autonomy conflict with supervisor
  - b. integrated ethical decision making process
  - c. high motivation and high anxiety
  - d. high empathy and understanding of clients
15. A level two counselor will have which of the following characteristics:
- a. dependency-autonomy conflict with supervisor
  - b. no clear understanding of ethical practice
  - c. high motivation and high anxiety
  - d. high empathy and understanding of clients

16. Which level of counselor will have a more collegial relationship with his/her supervisor?
- Level one
  - Level two
  - Level three
  - Level four
17. A level three counselor might make which one of the following statements to his/her supervisor?
- "I am not sure I want to be in the counseling field"
  - "I think CBT is the only way to treat this client"
  - "I would like to talk with you about the ethical issues in this case"
  - "I don't know what to say to this client"
18. All of the following are true about Level Four counselors except:
- self-motivating
  - good self-care
  - because of length of time in the field they will burn-out
  - can resolve complex ethical situations
19. When supervising a Level One counselor it is suggested that a supervisor:
- take over cases that are not going well
  - increase awareness of counselor's strengths
  - let them solve ethical situations on their own so they can learn
  - assign difficult clients so they will feel challenged
20. When supervising a Level Three counselor it is suggested that a supervisor:
- be prepared for challenges to your supervision
  - increase awareness of counselor's strengths
  - have a clear plan for prevention of burn-out
  - be flexible in responding to a wider range of clinical and professional issues

21. Some of the problems that can occur when moving into a supervisory role as identified by Borders are:
- a. supervisors who act as if they are the counselor
  - b. supervisors who socialize with staff
  - c. supervisors who do not know legal issues pertaining to liability
  - d. supervisors who violate their supervisee's confidentiality
22. Watkins also identifies some problems with moving into a supervisory role. "Attila the Hun Supervisor" is someone who:
- a. only talks with supervisor about his/her feelings about clients
  - b. uses one approach with all supervisees
  - c. expects supervisees to conform to his/her way of doing clinical work
  - d. follows ethics codes literally without any decision making
23. Which of the following is **not** a characteristic of a Level One supervisor:
- a. highly motivated
  - b. functions autonomously
  - c. limited skills in applying ethical principles to the supervisory relationship
  - d. struggles with power issues
24. Which of the following is **not** a characteristic of a Level Two supervisor:
- a. less anxiety and more clarity in supervisor role
  - b. ready to supervise other supervisors
  - c. may question decision to become a supervisor
  - d. continues to struggle with authority issues
25. A supervisor who has obtained additional knowledge and skills before moving from the counselor role to supervisor is practicing which ethical principle:
- a. Autonomy
  - b. Beneficence
  - c. competence
  - d. discretion

26. A supervisor tells staff that he/she will not discuss anything that they disclose in their clinical supervision sessions with anyone else. This is upholding the ethical principle of:
- autonomy
  - beneficence
  - competence
  - discretion
27. A supervisory relationship that moves into a business relationship is an example of:
- transference and counter-transference
  - isomorphism
  - developmental model of supervision
  - dual relationship
28. The following would be an example of a boundary violation in a supervisory relationship:
- half of the supervision session is spent on the supervisor discussing his/her personal issues
  - the supervision session takes place outside of the office setting
  - the supervisor discusses his/her own client cases with a supervisee
  - the supervisor provides a training session for staff that is mandatory to attend
29. Dual relationships are unethical in the supervisory relationship because:
- it causes lack of objectivity for the supervisor
  - it can lead to exploitation
  - there is an imbalance of power
  - all of the above
30. In order for a supervisor to be held liable for the actions of other what needs to happen:
- supervisor must have a supervisory credential
  - supervisor and supervisee must be employed by the same agency
  - supervisee must have acted within the defined scope of tasks
  - supervisor did not have regular meetings with the supervisee