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

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ABOUT THE INSTRUCTOR

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.

Clinical Supervision in Substance Use Treatment: Current Developments

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

_____

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:

Author:	**Roles emphasized in their work**:
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, Administrating

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 of 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:

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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 recommend 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 clients' 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

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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 advise 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?

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