Clinical Supervision for Mental Health Professionals in Florida

HOW TO RECEIVE CREDIT

- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Answer Sheet to NetCE by mail or fax, or complete online at www.NetCE.com. Your postmark or facsimile date will be used as your completion date.
- Receive your Certificate(s) of Completion by mail, fax, or email.

Faculty
Lauren E. Evans, MSW, received her Master's degree in Social Work from California State University, Sacramento, in 2008. Her focus was on political and community social work. She has also been a Registered International Instructor of Therapeutic Horseback Riding through the Professional Association of Therapeutic Horsemanship International (PATH Intl.) since 2006. She currently works as a mental health practitioner with the homeless population.

Faculty Disclosure
Contributing faculty, Lauren E. Evans, MSW, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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Division Planner/Director Disclosure
The division planner and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience
This course is designed for professional clinicians in Florida, including counselors, social workers, therapists, and pastoral counselors, who supervise others, clinically and/or administratively.

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This course is considered self-study by the New York State Board of Marriage and Family Therapy.

Designations of Credit

Social workers completing this intermediate-to-advanced course receive 4 Clinical continuing education credits.

NetCE designates this continuing education activity for 1.5 NBCC clock hours.

Individual State Behavioral Health Approvals

In addition to states that accept ASWB, NetCE is approved as a provider of continuing education by the following state boards: Alabama State Board of Social Work Examiners, Provider #0515; Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health, Provider #50-2405; Illinois Division of Professional Regulation for Social Workers, License #159.001094; Illinois Division of Professional Regulation for Licensed Professional and Clinical Counselors, License #197.000185; Illinois Division of Professional Regulation for Marriage and Family Therapists, License #168.000190.

Special Approvals

This course meets the Florida requirement for 4 hours of qualified supervisor training education.

About the Sponsor

The purpose of NetCE is to provide challenging curricula to assist healthcare professionals to raise their levels of expertise while fulfilling their continuing education requirements, thereby improving the quality of healthcare.

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Course Objective

The purpose of this course is to help supervisors or potential supervisors in the human services or helping professions to more effectively work with those they are entrusted to supervise.

Learning Objectives

Upon completion of this course, you should be able to:

1. Outline ethical issues that may arise in the supervisory process.
2. Describe legal issues to consider when providing supervision.
3. Discuss regulatory issues pertinent to clinical supervisors in Florida.
4. Analyze Florida laws that govern clinical supervision in the mental health professions.
5. Evaluate effective clinical supervision models.
6. Identify responsibilities and potential challenges in the supervisory relationship, including documentation of supervisory sessions, teletherapy, and cultural considerations.
7. Discuss the business aspects of supervision.

INTRODUCTION

Supervision plays an important part in the ongoing development of mental health professionals, including keeping updated in best practices and knowledge [1; 2; 3]. Its importance can be observed in research showing that practitioners often fail to use best practice techniques emphasized during their initial training. For example, in one study, mental health practitioners who had completed intensive training in evidence-based, cognitive-behavioral family intervention discontinued use of the tools within six months to three years after completion of the program. One of the most common reasons given was the fact that clinical supervision was difficult to find [3].

This course will discuss the ethical, legal, and regulatory issues regarding both traditional supervision and the use of technology in supervision. Specific Florida law pertaining to clinical supervision will be outlined, as will the challenges related to clinical supervision. This course will also review the literature regarding clinical supervision styles and their effectiveness, including supervision styles that have been most popular with supervisees.

ETHICAL ISSUES

SUPERVISOR QUALIFICATIONS

Individuals who wish to supervise interns and other practitioners must work within the limits of their competence and practiced techniques. Supervisors should be qualified to hold the position, either by demonstrating the ability to supervise or by receiving training [1]. The National Association of Social Workers (NASW), the American Psychology Association (APA), the American Association for Marriage and Family Therapy (AAMFT), the American Counseling Association (ACA), and the National Board for Certified Counselors (NBCC) all include standards in their respective code of ethics that require mental health professionals to work within their limits of knowledge [14; 15; 16; 17; 23]. While this is most clear in work with clients, it also pertains to work with other practitioners or interns as a supervisor. When using technology in their work and for supervisory purposes, mental health professionals should have the required knowledge and tools to use the technology safely and competently. When an individual uses new techniques, tools, or plans to provide services, he or she should seek additional education or supervision from a more experienced practitioner [14; 15; 16; 17; 23].

According to the APA's Code of Ethics, psychologists who require professional knowledge related to age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status in order to effectively provide services should seek training, consultation, or supervision, or they must make a referral to a psychologist who has the required knowledge or experience [15].

DUTIES AND RESPONSIBILITIES OF SUPERVISORS

Mental health practitioners who accept the role of supervisor also accept the responsibility of helping to further the professional development of their supervisees. This includes providing supervisees with opportunities for learning, giving evaluations promptly, and providing constructive feedback during sessions. Lack of timely feedback is reported to be one of the main ethical complaints against supervisors [1]. Supervisees who are not performing at an acceptable level should first be given a plan for improvement. If a poor evaluation is given, it should not come as a surprise to the supervisee; rather, it should be the result of not meeting the terms of a previously discussed plan [1].

It is important that supervisors have basic information about the supervisee's clients in order to make and monitor treatment plans. Supervisors should be available for emergencies regarding clients and for client interventions, if needed. Keeping in mind the fact that the well-being of the client is ultimately the responsibility of the supervisor, supervisors should not supervise more interns than they can responsibly manage [1].

DUAL RELATIONSHIPS

A supervisor holds a position of trust and is expected to always consider the well-being of his or her supervisee. Because of the power dynamics that exist between supervisor and supervisee, entering into dual relationships with supervisees is discouraged, as this could affect the supervisory relationship, as well as the supervisor's professional judgement [1; 2; 19; 23]. Examples of dual relationships include when a supervisor is also a friend, family member, therapist, business partner, or romantic partner, or enters a sexual relationship with his or her supervisee.

The risk of establishing a dual relationship of supervisor and therapist is increased because many strategies used in supervision are derived from strategies used in therapy [2]. Teaching supervisees how to use such strategies in clinical sessions and working through personal issues can result in a blurring of boundaries. Studies show that supervision is less effective for the supervisee when the supervisor takes on a therapist role rather than using deliberate instruction of new skills. One of the most significant grievances that supervisees have about supervisors is regarding the dual relationship of supervisor and therapist [2; 19].

Supervisors should never enter sexual or romantic relationships of any kind with students, interns, or supervisees. This includes verbal, written, electronic, or physical contact [14]. Further, no person should agree to supervise a person with whom they have had a romantic or sexual relationship. Students not only include those under direct supervision but also any intern in a clinician's department, agency, or center or any student who the individual may have need to evaluate in the future [15].

INFORMED CONSENT

Supervisors have the responsibility to ensure that clients are informed when students, interns, or individuals in trainings are providing client services [1; 14; 15; 17]. Clients have the right to choose a more experienced practitioner if they do not feel comfortable receiving services from an individual in training [1]. Failure to inform a client could result in legal action against the supervisor or supervisee [1].

Clients should give their informed consent to supervision of their case, as the supervisee will share certain details of the client sessions with his or her supervisor. While the supervisee has the responsibility to maintain client confidentiality, there are some limits to confidentiality because of possible vicarious liability to the supervisor [19]. This will be discussed later in this course.

MARKETING AND PAYMENT ISSUES

There are specific payment and advertisement issues faced by supervisors and supervisees. First, supervisees are not allowed to advertise their services. Payments for services must be made directly to the supervisor or the agency at which the supervisee is working. Any business cards with the supervisee's name should make their status as an intern, trainee, or student clear. It should not appear that an uncredentialed individual provides services independently [1].

LEGAL ISSUES

DIRECT AND VICARIOUS LIABILITY

Supervisors may be exposed to charges of direct liability if their action or inaction is found to have caused injury to a client. For example, direct liability can occur when supervisors are negligent in their duties and do not properly plan and supervise client outcomes. Also, as supervisors are required to have sufficient knowledge of clients, direct liability can occur if the supervisor gives inaccurate or inappropriate advice, which is then used in therapy to the detriment of the client. This is also true if the supervisor did not fully understand the supervisee's description of the client's needs because they failed to listen carefully. Similarly, direct liability can occur if the supervisor gives tasks to the supervisee that are inappropriate for his or her level of skill. Supervisors should have good knowledge of the abilities of their supervisees and should not assign tasks outside of supervisees' training and ability [1; 19; 23].

Because of their position, supervisors are responsible for the actions of their employees or supervisees. If a client suffers harm or injury because of the actions of a supervisee performing regular work duties, supervisors may be held responsible for those injuries. An individual in training cannot assume final responsibility for a client; a credentialed professional must carry decision-making roles and responsibilities [1].

CONFIDENTIALITY AND DUTY TO PROTECT

As a result of the case of Tarasoff v. Regents of the University of California of 1976, in which it was found that a psychologist should have done more to prevent a murder committed by his client, it was established that mental health professionals are required to warn and protect when a client appears to be a danger to others. Even though their training may not be complete, interns, students, and trainees still have the responsibility to provide the same standard of care as a licensed mental health professional. This includes the possibility of needing to violate client confidentiality in order to protect others from harm. A supervisor must intervene to protect a client from harm when the supervisee is deemed to be incompetent [23]. Supervisors and their supervisees can be held responsible for harm done to a person that could have been prevented by reporting [1].

Supervisors and agencies should have policies in place to guide supervisees in situations in which they are required to issue a warning, as supervisors can also be held responsible for actions taken by clients because a trainee failed to warn and protect [1].

STANDARD OF CARE

As mentioned, clients deserve the same standard of care regardless of whether they receive service from a licensed practitioner or from interns, students, or trainees. Supervisors who believe that clients are not receiving adequate care are required to act to protect the client. This includes thoroughly investigating complaints that clients may make about supervisees [1].

REGULATORY ISSUES

In the State of Florida, there are several requirements one must meet in order to become a qualified supervisor, according to the Florida Board of Clinical Social Work, Marriage & Family Therapy, and Mental Health Counseling. Individuals wishing to be qualified supervisors must have taken a graduate-level academic course in supervision and a continuing education course in supervisory training that meets the requirements of rule 64B4-6.0025 (which regulates continuing education hours). Candidates must also be an AAMFT-approved supervisor or have taken a post-graduate training course for field instructors in clinical social work (for Qualified Supervisors for Clinical Social Work and Mental Health Counselor Interns) [5]. In addition, Qualified Supervisors for Clinical Social Work must have at least four years of clinical social work experience, two of which can be earned during a post-Master's clinical internship. Qualified Supervisors for Marriage and Family Therapy Interns and Mental Health Counselor Interns must have five years of clinical experience, two of which may be earned during a post-Master's clinical internship [18].

Candidates who are not licensed clinical social workers must provide a copy of their Master's level transcript indicating completion of a minimum of 9 semester or 12 quarter hours of graduate level coursework from a Council on Social Work Education-accredited school of social work in order to supervise registered clinical social work interns. The coursework must relate to at least three of the following areas of content [18]:

- Human behavior and social environment I and/or II
- Social work practice theories
- Models of social work practice
- Advanced social work practice
- Ethical issues in contemporary social work practice

Individuals who are not licensed marriage and family therapists may supervise registered marriage and family therapy interns, but will need to provide a copy of a Master's level transcript indicating completion of a minimum six semester or eight quarter hours of graduate coursework in marriage and family systemic theories and techniques from an accredited university [18].

In order for an individual who is not a licensed mental health counselor to supervise registered mental health counselor interns, one will be required to provide a copy of his or her Master's level transcript indicating completion of three semester- or four quarter-hour graduate level courses in at least three of the following content areas [18]:

- Counseling theories
- Counseling practice
- Assessment
- Career counseling
- Substance abuse
- Legal, ethical, and professional standards

These credits must be attained from a clinical counseling program in an institution fully accredited by an accrediting body recognized by the Council for Higher Education Accreditation and/or the U.S. Department of Education. Coursework from an accredited school of social work does not meet this requirement [18].

In order to apply to become a qualified supervisor of registered interns, one must complete the Qualified Supervisor Affirmation Statement and fax or e-mail the completed form and supervisory training documentation to the Board. If one wishes to supervise a registered intern of another profession, he or she must also complete the education verification form on the affirmation statement. The Board will then indicate if an individual meets the requirements of a qualified supervisor. An individual should wait for correspondence from the Board before beginning supervision with any registered interns [18].

FLORIDA LAW PERTAINING TO INTERNS AND SUPERVISORS

CS/HB 373: MENTAL HEALTH COUNSELING INTERNS

In 2016, CS/HB 373 Mental Health Counseling Interns was signed into law by the Governor of Florida. The law sets new requirements for mental health interns, including in the fields of social work, marriage and family therapy, and mental health counseling. Individuals who do not meet the postgraduate or post-Master's level experience requirements must register as an intern in the field for which he or she is seeking licensure. Individuals must complete the application form and pay an application fee, which should not exceed $200 [4].

In addition to meeting certain education requirements, applicants must present a plan for supervision, including identifying a qualified supervisor and remaining under supervision for the entirety of his or her internship. Hours worked before registering as an intern do not count toward the internship requirement. Intern registration is valid for five years. CS/HB 373 also requires that a licensed mental health professional be on the premises when clinical services are provided by a registered intern in a private practice setting [4].

DEPARTMENT OF HEALTH RULE 64B4-2.002

Rule 64B4-2.002 defines the role of supervisor in the fields of clinical social work, marriage and family therapy, and mental health counseling. The rule defines supervision as [5]:

> ...the relationship between the qualified supervisor and intern that promotes the development of responsibility, skills, knowledge, attitudes, and adherence to ethical, legal and regulatory standards in the practice of clinical social work, marriage and family therapy, and mental health

counseling. Supervision is contact between an intern and a supervisor during which the intern apprises the supervisor of the diagnosis and treatment of each client, client cases are discussed, the supervisor provides the intern with oversight and guidance in diagnosing, treating and dealing with clients, and the supervisor evaluates the intern's performance.

Rule 64B4-2.002 states that interns will be credited for the time of supervision if the intern received at least 100 hours of supervision in no less than 100 weeks, provided at least 1,500 hours of face-to-face psychotherapy with clients, and received at least one hour of supervision every two weeks [5].

Supervision should be focused on data from the intern's face-to-face psychotherapy with clients, for example, from written clinical materials, direct observation, or video and audio recordings. Supervisors and interns may use face-to-face electronic methods for supervisory sessions but not telephone-only communication. At least 50% of all sessions must be in-person meetings. Before using any online or electronic method, the supervisor and intern must have at least one in-person meeting. Both the supervisor and intern are responsible for maintaining client confidentiality during supervision [5].

Interns may receive group supervision; however, each hour of group supervision must alternate with an hour of individual supervision. Group supervision must be conducted with all participants present in-person. Individual supervision is defined as one qualified supervisor supervising no more than two interns, and group supervision is defined as one qualified supervisor supervising more than two and up to a maximum of six interns per group [5].

EFFECTIVE SUPERVISION MODELS

The Substance Abuse and Mental Health Services Administration (SAMHSA)'s Treatment Improvement Protocol (TIP) series outlines several effective supervision models, including [19]:

- Competency-based models (e.g., microtraining, the Discrimination Model, and the Task-Oriented Model) focus primarily on the skills and learning needs of the supervisee and on setting goals that are specific, measurable, attainable, realistic, and timely (SMART). They construct and implement strategies to accomplish these goals. The key strategies of competency-based models include applying social learning principles (e.g., modeling role reversal, role playing, and practice), using demonstrations, and using various supervisory functions (teaching, consulting, and counseling).
- Treatment-based supervision models train to a particular theoretical approach to counseling, incorporating evidence-based practice into supervision and seeking fidelity to and adaptation of the theoretical model. Motivational interviewing, cognitive-behavioral therapy, and psychodynamic psychotherapy are three examples. These models emphasize the counselor's strengths, seek to demonstrate the supervisee's understanding of the theory and model taught, and incorporate the approaches and techniques of the model. The majority of these models begin with articulating their treatment approach and describing their supervision model based upon that approach.
- Developmental models understand that each counselor goes through different stages of development and recognize that movement through these stages is not always linear and can be affected by changes in assignment, setting, and population served.

- Integrated models, including the Blended Model, begin with the style of leadership and articulate a model of treatment, incorporate descriptive dimensions of supervision, and address contextual and developmental dimensions in supervision. They address both skill and competency development and affective issues, based on the unique needs of the supervisee and supervisor. Finally, integrated models seek to incorporate evidence-based practices into counseling and supervision.

While clinical supervision is widely accepted as beneficial, there is a limited number of empirical studies available proving its effectiveness [2; 3]. One of the reasons may be because of the complexity of supervision, including the many settings in which it may take place, different methods for providing supervision, and various definitions of supervision. This has caused design errors in research that attempts to study the effectiveness of supervision [2; 3].

Studies observing the effect of supervision on supervisee competence indicate that directional and instructional methods of supervision have the strongest positive impact. For example, Talen and Schindler found that goal-directed supervision plans help supervisees improve in diagnosis and treatment planning; however, their study did not include a control group to compare progress, and the results of the study were based on interns' reports of their own progress [2; 6]. Another small study used independent raters to review random videos of clinical sessions and found that when trainers asked more specific questions and intervened more often, therapists improved their skills [2; 7].

The ultimate goal in supervision is to improve client outcomes and care by ensuring that best practice is being used in clinical settings [2]. In one study, supervisor helpfulness was related to more positive client outcomes [2; 8]. Another study also found that client outcomes improved when direct instructional methods of supervision were used [2; 9]. Both of these studies were based on supervisor ratings of client outcome, not clients' perceptions of improvement [2]. In another study, clients were more likely to attend therapy sessions when therapists received more supervision. However, the same study found that there was no relationship between client outcome and the amount of supervision received by the therapist [2; 10].

Unfortunately, very few supervisors receive formal training in supervision skills. In one study, supervisors were trained in a one-day workshop, followed by supervision sessions for three hours per month for five months. The training emphasized a structured model of supervision and included models of supervision, relationship dynamics, methods and strategies to use in supervision, and role playing. After completing the training, supervisors reported feeling more credible and authentic in their role, making more use of supervision tools and role-plays, and being more able to manage difficult situations [2; 11]. Barrow and Domingo also found that supervisors who were trained were more willing to allow their supervisees to have more control in the supervision process [2; 12].

Three essential roles of supervision have been identified. First, supervision serves to provide practitioners with knowledge, tools, and new attitudes to be used with clients. Second, supervision provides guidance in terms of the organizational or administrative aspects of the agency where therapy is taking place. This may include assignment of new clients, planning, and performance evaluation. It may be common for administrative duties to take over supervision time, limiting the essential time to discuss the clinical setting. This is a situation about which many supervisees complain, as they feel it does not help improve practice, and it is important to balance both aspects of supervision. Finally, supervision provides personal support to practitioners, helping to boost motivation and morale while combating burnout and/or other mental health issues related to job stress [2; 3].

APPROACHES TO SUPERVISION	
Approach	**Description**
Authoritative Approaches	
Informative behavior	The supervisor gives knowledge and information to the supervisee.
Prescriptive behavior	The supervisor gives advice and instructions to the supervisee.
Confrontative behavior	The supervisor challenges the beliefs of the supervisee and gives direct feedback about their performance.
Facilitative Approaches	
Cathartic behavior	The supervisor allows the supervisee to vent emotions and release tensions.
Catalytic behavior	The supervisor asks the supervisee to reflect on her/his performance and to be self-directive.
Supportive behavior	The supervisor helps to validate the value and worth of the supervisee.
Source: [2; 13]	*Table 1*

The choice of supervision model should be guided by the supervisee, particularly how he or she best learns and receives feedback, and by the setting in which provision of services is taking place. Supervisees may benefit from different models of supervision in different stages of their professional development, but supervisors often maintain the same approach to supervision regardless of the needs of supervisees or the setting [2]. Objective observation of supervisors who report modifying supervision style to match supervisees indicates that supervisors are less accommodating than they believe they are [2]. Because supervisors have been found to be inaccurate when describing their own behaviors and styles in supervision, the validity of studies that use the supervisor's opinions to rate the effectiveness of supervision styles has sometimes been brought into question [2].

Two main supervision styles have been identified: authoritative and facilitative. Various teaching styles may be organized into these two categories (***Table 1***) [2; 13].

In one literature review, inexperienced practitioners were found to benefit more from directive styles of supervision. They also preferred supervisors who offered clear answers and more opportunities for practice. Inexperienced practitioners also preferred supervisors who were enthusiastic, showed interest in the supervisee, were dynamic and energetic, and who gave the practitioners a good model of a clinician [2]. Experienced practitioners preferred the same type of clear direction when learning new skills or when working with clients who presented more severe problems [3]. Regardless of the level of experience of the practitioner, a supportive supervisory relationship was deemed to be important to supervisees [2].

Across mental health fields, supervisees have identified qualities and actions that are preferred and non-preferred during supervision. *The following lists are reprinted with permission from Spence S, Wilson J, Kavanagh D, Strong J, Worrall, L. Clinical supervision in four mental health professions: a review of the evidence. Behav Change. 2001;18(3):135-155 [2].*

Preferred Behaviors

- Creating a climate and relationship that is nurturing, supportive, interactive, welcoming, and safe enough for open disclosure of information by both parties
- Being respectful and empathic, validating, demonstrating concern for supervisee welfare, and showing an interest in and listening to supervisee's input and issues
- Facilitating the processing of emotional material, the gaining of insight and creativity, and creating a "space for thinking"
- Demonstrating an interest in, and valuing of, supervision
- Showing enthusiasm, dynamism, and energy
- Being available, punctual, and accessible for supervision and advice on crisis management
- Encouraging the supervisee to take increasing responsibility for their professional practice and professional development
- Empowering supervisee, by affirming rights and strengths and establishing a process of informed decision making
- Encouraging supervisee to take an active, rather than passive, role in supervision sessions
- Being flexible, adapting style of supervision to the specific needs of the supervisee and the type of casework, and allowing increased autonomy and self-direction with increased experience of supervisee
- Addressing process issues within supervisory relationship, seeking feedback, and regularly evaluating own performance as a supervisor
- Adhering to boundaries and avoiding dual-relationship issues
- Identifying, in association with the supervisee, the core skills, knowledge, attitudes, and competencies required for professional practice
- Identifying, with the supervisee, the supervisee's strengths and weaknesses relating to core skills, knowledge, attitudes, and competencies, and developing goals for improvement
- Focusing on specific, concrete examples of supervisee's clinical activities
- Clearly describing specific skills to be learned and demonstrating their use
- Providing constructive, nonjudgmental feedback (verbal and written) in a clear but sensitive manner, with specific, concrete suggestions for improvement
- Providing a competent model as a clinician, and demonstrating and communicating high levels of clinical skills, knowledge, and ethical practice
- Using a range of instructional methods, including information giving, providing guidance, modeling, audiovisual demonstration, observation of supervisee practice (direct, taped, case-descriptions, reports), and providing opportunities for practice and problem solving
- Negotiating a clear contract prior to the onset of supervision, and specifying boundaries, tasks, roles, and responsibilities of supervisor and supervisee in supervision
- Negotiating format, goals, methods, frequency, duration, content, and type of supervision, roles/responsibilities, and accountability of both parties
- Negotiation methods of record keeping, methods and timing of evaluation and feedback, review dates, nature and timing of reporting (if any) to external authorities, professional indemnity issues, legal reporting requirements, and duration of supervision commitment
- Setting an agenda for the supervision session, in consultation with the supervisee, and linking content to the supervision contract

Non-Preferred Behaviors

- Allowing administrative issues to dominate sessions, leaving insufficient time for clinical supervision
- Telling rather than suggesting or exploring, or dominating the sessions
- Providing guidance or feedback in a vague, unclear manner
- Avoiding contentious or challenging issues
- Having a laissez-faire approach, lacking direction and guidance, failing to provide feedback and targets for change, and providing inadequate structure to sessions
- Creating a hierarchical rather than collegial atmosphere
- Becoming competitive with the supervisee
- Setting unrealistic or unclear goals and expectations or failing to specify goals
- Insisting that supervisee works in exactly the same manner as supervisor, being overly restrictive with respect to methods, or failing to permit sufficient autonomy
- Being overly critical and failing to point out strengths, achievements, and improvements
- Being too busy and/or cancelling supervision sessions or being unavailable to give advice for managing crises
- Being arrogant, self-interested, egocentric, or defensive
- Being vague, distracted, inattentive, preoccupied, disinterested, unempathic, or insensitive to supervisees' concerns
- Having inadequate professional knowledge or skills (or failing to demonstrate or communicate adequate clinical competence)
- Unethical supervisory behavior, including breach of client/supervisee confidentiality, sexual harassment, and formation of dual relationships
- Becoming the therapist in relation to personal issues

RESPONSIBILITIES IN THE SUPERVISORY RELATIONSHIP

RESPONSIBILITIES OF SUPERVISORS

Clinical supervisors have several roles in their work with interns. The SAMHSA describes clinical supervision as having four functions: teacher, consultant, coach, and mentor/role model [19]. Supervisors serve as teachers by helping interns to develop knowledge and skills. Supervisors teach, train, and serve as professional role models for their supervisee. As consultants, supervisors have the responsibilities of case consultation, performance monitoring, giving feedback about job performance, and assessment. The supervisor also assumes the role of coach by providing moral support, assessing supervisee's needs and strengths, suggesting clinical approaches, and providing role plays for modeling, encouraging, and preventing burnout. As a mentor/role model, a supervisor teaches through modeling and helps to facilitate his or her supervisee's professional identity [19].

The role of a supervisor is of utmost importance in the development of the supervisee's ethical practice. He or she can also be considered a gatekeeper to the profession and must maintain professional standards while also being sure that clients are receiving the best care. Because of the importance of this role, new supervisors may find it beneficial to find a mentor. A talented clinician does not always take to his or her new role as supervisor easily [19]. The SAMHSA TIP series provides helpful reminders for supervisors [19]:

- The reason for supervision is to ensure quality client care. The primary goal of clinical supervision is to protect the welfare of the client and ensure the integrity of clinical services.
- Supervision is all about the relationship. As in counseling, developing the alliance between the counselor and the supervisor is the key to good supervision.

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

RESPONSIBILITIES OF THE INTERN/SUPERVISEE

Internship has been referred to as the professional adolescence of the mental health professions [20]. As a period of growth and new experiences, common stressors include adjusting to a new organization or program and developing relationships with new colleagues/staff in charge of training. In addition, interns are gaining new skills to work with clients and/or groups, assessing personal strengths and weaknesses, evaluating their competence with clients, and planning for a professional career after the internship has ended.

It is important for the supervisee or intern to maintain an open mind in order to learn from experiences during his or her internship. An internship gives a practitioner the opportunity to practice new skills. Interns should take advantage of the expertise, not only of his or her supervisor, but of all mental health professionals he or she may encounter at the organization. If an intern feels that he or she is not being sufficiently challenged by a supervisor or if he or she is having difficulty at the placement, he or she should be vocal and ask for help or for more challenging opportunities [21].

DOCUMENTATION OF SUPERVISORY SESSIONS

Both the supervisor and the supervisee have the responsibility to properly document supervisory sessions, as well as to provide the necessary documentation required by administrative and human resources (HR) personnel, including emergency contact information and profiles for each supervisee, a supervisory logging sheet, supervision notes, and case reviews [19]. Supervisors are also responsible for informal and formal evaluations of their supervisees [19].

While some documentation is available for HR to access, supervision notes, especially notes related to work with clients, should be held separately and kept confidential to protect the identity of the supervisee and client. Supervisory notes may include a summary of the topics that were discussed during supervision, comments about the strengths and weaknesses of the supervisee, actions to be taken by either the supervisor or supervisee before the next session, and other comments that any party may wish to note. The purpose of supervision notes should be to help the supervisee to improve clinical skills and to ensure quality in patient care. Wording should be specific regarding plans for follow-up about particular clients while also maintaining client confidentiality [19]. It is the responsibility of the supervisor to provide supervisees with documentation of supervised sessions within a reasonable time [22].

Upon the completion of supervisory hours (or termination of the supervisory relationship) as required by the Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling, qualified supervisors must complete the Verification of Clinical Experience form, available at https://floridasmentalhealthprofessions.gov/forms/clinical-exp-verification.pdf.

ELECTRONIC DELIVERY SYSTEMS FOR SUPERVISION

Technologies that allow for the electronic delivery of clinical supervision have multiplied and evolved over time [28]. There are several advantages to electronic supervision, including the fact that students/interns in rural areas have more options in terms of selecting a supervisor. There are also fewer costs related to travel and greater ease and flexibility in scheduling supervisory meetings, as well as more practical methods in documenting supervision [28].

There are several platforms available for teleconferencing, including programs such as Zoom, Skype, Google Meet, and FaceTime, which are free to use and familiar to most people. Less widely known applications include VSee, Via3, and Webex. It is important to note that not all programs offer the same amount of security [27; 28; 29; 30]. For example, while FaceTime is Health Insurance Portability and Accountability Act (HIPAA) compliant, Skype is not. Email, text, and messaging can also be useful tools in supervision, although it is important to consider factors that may affect confidentiality, some of which will be discussed later in this course [28].

ETHICAL, LEGAL, AND REGULATORY ISSUES OF TELETHERAPY

Florida Department of Health Rule 64B4-2.002 states that supervisory meetings may be held using video conferencing, so long as the first meeting between supervisor and supervisee occurs in person and that in-person meetings make up at least 50% of all total meetings [5]. Also, using the telephone without video is not to be counted toward supervision hours.

One ethical concern regarding the use of technology in supervision is the fact that phones, computers, and electronic devices are designed to share information, sometimes automatically without the knowledge of the user. For example, photos or videos may be automatically shared from a smart phone at work to a tablet at home. Devices may also automatically share the user's location, documents, emails, and contacts, creating possible breaches in confidentiality of both the supervisee and the client [28].

Similarly, electronic devices are often constantly on, in some cases with listening devices that can respond to requested information, play music, control other smart devices, and record what they hear.

This is a stark change from electronic devices of the past (e.g., tape recorders or video recorders), which were turned on manually and only when the user required them. The fact that some devices or apps may perpetually be "on" in the background is an ethical concern when considering the confidentiality of supervisees and clients [28].

Many devices are programmed to update automatically, which may affect the competency with which the user may operate the app, as system updates may change the location of commands or information. Downloading apps or programs often requires that the user accept the terms of use, which can contain permissions to automatically share information to third party apps or companies [28].

Another ethical concern in terms of confidentiality of supervisees and clients is the use of cloud storage to save documents, photos, and general information. While cloud storage is more efficient, both in terms of space and cost, it poses a risk to confidentiality because companies rent cloud storage from third parties, in some cases internationally, and data may be stored in more than one place. This makes it more difficult for users to ensure that their confidential files are kept safe [28].

The general recommendation to supervisors using electronic devices in supervision is to avoid using cloud storage with client or supervisee information. If cloud storage must be used, supervisors should encrypt documents, use strong passwords, and use cloud storage that is HIPAA compliant. Use of cloud storage should be disclosed to clients and supervisees [28]. HIPAA-aligned cloud storage websites include [28]:

- https://mydocsonline.com
- https://www.braveriver.com
- https://www.box.com
- https://www.boxcryptor.com
- https://www.carbonite.com
- https://www.dashsdk.com

CHALLENGES IN SUPERVISION

Supervisors may be asked to internally supervise current colleagues or may externally supervise interns from other organizations. Both cases offer special challenges. Supervising current colleagues can be difficult when professional relationships, and in some cases personal relationships, change. Because of the proximity, both supervisor and supervisee may take for granted the ease of supervisory meetings and therefore take such meetings less seriously. On the other hand, external supervision of an intern can lead to conflicts between the organizational standards and the advice of the supervisor. Initially, an external supervisor may not be as familiar with the work of a supervisee [24].

Another challenge in supervision is balancing clinical and administrative duties, and the time commitment is often a first barrier for busy professionals. Supervisors who are responsible for supervising clinical sessions of their supervisees while also scheduling, hiring, and delegating tasks may find it challenging to juggle such a heavy load. It is important for supervisors to find time to fulfill both roles and remember which role they are taking on at any specific time [19]. Supervisors who are also practitioners with their own clients will need to find time to supervise while also keeping up with client sessions and documentation. As mentioned, supervisors should not take on more supervisees than can be effectively handled [19].

In some cases, professionals may resent being supervised, which can present in a variety of ways. Older professionals who have been working in human services in some capacity for many years but are moving into a new area of service are likely to feel some level of resentment. This resentment can be more significant if they are being supervised by younger professionals (contingent, of course, upon personal variables). Professionals are more likely to experience resentment or be resistant to supervision if they feel they know more about therapy/counseling, obtained through life experiences, compared with a supervisor who has less real-world experience. Excellent

students may be prone to entering an internship or work feeling that they know it all and could be sensitive to correction. Inferiority fears can also be a major reason for resisting supervision and the corrective feedback that comes with it. Supervisors may even find that the agency or organization itself is resistant to clinical supervision [19].

CULTURAL ISSUES WITHIN THE SUPERVISORY RELATIONSHIP

Most supervisory relationships have aspects of a power dynamic between the supervisor and the supervisee. Issues of race, gender, sexuality, age, ability, and/or social class may further affect the already existing power dynamic [2]. Research indicates that when supervisor and supervisee are matched by background, supervision can be more beneficial, although more research is needed [2]. There is a general agreement that supervisors should be aware of systemic and social power dynamics that may arise in supervision as well as the need for culturally sensitive supervision [2].

A culturally competent supervisor is actively engaged in the process of becoming aware of his or her assumptions about human behavior, values, biases, preconceived notions, and personal limitations [25]. This is an ongoing process of self-discovery that requires a willingness to address any issues that may arise. For example, because the concept of boundaries varies across cultures, therapeutic elements related to boundaries should be modified to adapt to this variance (within ethical and legal boundaries) [25].

The expectation of confidentiality varies, and in many cultures, confidentiality is neither expected nor therapeutic [26]. As such, supervisors should resist assuming that confidentiality is implicitly restricted to the supervisor and supervisee. Being culturally competent requires vigilance and an understanding that referral to another supervisor might be necessary in some circumstances (e.g., when working with a supervisee is beyond the supervisor's boundaries of competence) [25].

A culturally competent supervisor actively attempts to understand the worldview of a culturally different supervisee by employing empathy and avoiding negative judgments [25]. This involves becoming familiar with the culture, subculture, and political history of the supervisee when these differ from those of the supervisor. Seeking continuing education yields valuable rewards and is useful in avoiding the common therapeutic blunder of overgeneralization [26]. For example, knowing a supervisee's ethnicity, political affiliation in their country of origin, religious beliefs, and expectations of gender roles contributes to the supervisor's ability to create a more precise framework from which supervision can be applied. Supervisees usually recognize and appreciate supervisors' attempts to learn about their culture, which can enhance the supervisory alliance [26]. It is also important to recognize that the supervisee is part of a larger cultural system that may include family members, societal elders, or others of significance. These others can impact the supervisee's therapy, with positive or negative outcomes, depending on whether they are enlisted as allies or alienated [26].

A culturally competent supervisor also actively develops and practices appropriate, relevant, and sensitive intervention strategies and skills when working with culturally different supervisees. In order to keep abreast of new interventions and strategies, the supervisor may acquire additional education, training, and supervised experience [25].

Common issues in the supervisory relationship (e.g., gifts, touch, eye contact, medication compliance, choice of vocabulary) are all influenced by culture. Rather than adhering to a rigid theoretical approach when dealing with these issues, it is best to seek out their cultural meaning on a case-by-case basis. Enlist the expertise of a cultural informant, if one is available. This person is generally from the same culture as the supervisee, is not an active participant in the therapy, and functions as a consultant to the professional by interpreting or identifying culture-specific issues. The Department of Health and Human Services offers trainings in cultural competence. A list of these courses is available online at https://thinkculturalhealth.hhs.gov/education/behavioral-health.

BUSINESS ASPECTS OF SUPERVISION

When a clinical supervisor is not available as part of employment, interns may be required to arrange to hire a supervisor on their own. Practitioners who choose to be clinical supervisors typically bill supervisees for the supervisory hour, usually charging the same fee they would charge for a clinical session with a client. This fee reflects the use of the supervisor's time and expertise. First, and perhaps most importantly, supervisors are responsible for all clients seen by a supervisee. As mentioned, supervisors can be held liable for harm to clients because of the actions or inactions of the supervisee. In addition, the supervisor must be available to help the supervisee and/or client in emergency situations or in order to ensure the best possible care of a client. Supervisors are also responsible for completing continuing education hours in order to become and remain a supervisor. Being a supervisor is an important responsibility, takes time and preparation, and can potentially have legal consequences for the supervisor.

CONCLUSION

While there are some challenges, being a clinical supervisor is an important position, with many rewards and responsibilities associated with helping to prepare the next generation of mental health professionals. There are several approaches that can be used in supervision, although it is important that the supervisor take into account the needs and learning styles of his or her supervisees. Forming a supportive relationship with one's supervisees and assisting them to acquire new tools and strategies when working with clients helps to achieve the ultimate goal of supervision: ensuring that clients have access to excellent care.

APPENDIX: FLORIDA ADMINISTRATIVE CODE

The Florida Administrative Code defines the appropriate practice of supervision and the requirements for qualified supervisors in the state. The following excerpts from the Administrative Code should be considered by all supervisors practicing in the state.

64B4-2.002 Definition of "Supervision" for Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling.

Supervision is the relationship between the qualified supervisor and intern that promotes the development of responsibility, skills, knowledge, attitudes and adherence to ethical, legal and regulatory standards in the practice of clinical social work, marriage and family therapy and mental health counseling. Supervision is contact between an intern and a supervisor during which the intern apprises the supervisor of the diagnosis and treatment of each client, client cases are discussed, the supervisor provides the intern with oversight and guidance in diagnosing, treating and dealing with clients, and the supervisor evaluates the intern's performance.

(1) An intern shall be credited for the time of supervision required by Section 491.005, F.S., if the intern:
   (a) Received at least 100 hours of supervision in no less than 100 weeks; and,
   (b) Provided at least 1,500 hours of face-to-face psychotherapy with clients; and,
   (c) Received at least 1 hour of supervision every two weeks.

(2) The supervision shall focus on the raw data from the intern's face-to-face psychotherapy with clients. The intern shall make the raw data directly available to the supervisor through such means as written clinical materials, direct observation and video and audio recordings. Supervision is a process distinguishable from personal psychotherapy or didactic instruction.

(3) The supervisor and intern may utilize face-to-face electronic methods to conduct the supervisory sessions; however, the supervisor and intern must have in-person face-to-face contact for at least 50% of all of the interactions required in subsection (1), above. Prior to utilizing any online or interactive methods for supervision, the supervisor and the intern shall have at least one in-person face-to-face meeting. The supervisor and the intern are responsible for maintaining the confidentiality of the clients during both in-person and online or interactive supervisory sessions.

(4) If an intern obtains group supervision, each hour of group supervision must alternate with an hour of individual supervision. Group supervision must be conducted with all participants present in-person. For the purpose of this section, individual supervision is defined as one qualified supervisor supervising no more than two (2) interns and group supervision is defined as one qualified supervisor supervising more than 2 but a maximum of 6 interns in the group.

(5) A qualified supervisor shall supervise no more than 25 registered interns simultaneously.

(6) "Face-to-face psychotherapy" for clinical social workers, marriage and family therapists, and mental health counselors registered pursuant to Section 491.0045, F.S., includes face-to-face by electronic methods so long as the registered intern establishes and adheres to the following:
   (a) The registered intern has a written telehealth protocol and safety plan in place with their current qualified supervisor which includes the provision that the qualified supervisor must be readily available during the electronic therapy session; and

(b) The registered intern and their qualified supervisor have determined, through their professional judgements, that providing face-to-face psychotherapy by electronic methods is not detrimental to the patient is necessary to protect the health, safety, or welfare of the patient, the registered intern, or both, and does not violate any existing statutes or regulations.

(7) Notwithstanding subsections (3) and (4) above a qualified supervisor may utilize face-to-face electronic methods, including telephone only communication, to conduct all supervisory sessions for internship hours if the qualified supervisor determines, through their professional judgment, that such methods are not detrimental to the registered intern's patients and are necessary to protect the health, safety, or welfare of the qualified supervisor, the registered intern, or both. Any clinical hours obtained via face-to-face psychotherapy by electronic means shall be considered clinical hours for the purpose of meeting internship requirements.

(8) No later than 90 days prior to June 30, 2026, the Board shall review and amend, modify, or repeal subsections (6) and (7) above if it determines that same creates barriers to entry for private business competition, is duplicative, outdated, obsolete, overly burdensome, imposes excessive costs, or otherwise negatively impacts the quality of psychotherapy received by Florida citizens.

64B4-2.0025 Definition of "Qualified Supervisor."

(1) A "qualified supervisor" for clinical social work as specified in Section 491.005(1)(c), F.S., means a licensed clinical social worker or the equivalent who meets the qualifications specified in Rule 64B4-11.007, F.A.C.

(2) A "qualified supervisor" for marriage and family therapy as specified in Section 491.005(3)(c), F.S., means a licensed marriage and family therapist with at least five of experience or the equivalent who meets the qualifications specified in Rule 64B4-21.007, F.A.C.

(3) A "qualified supervisor" for mental health counseling as specified in Section 491.005(4)(c), F.S., means a licensed mental health counselor or the equivalent who meets the qualifications specified in Rule 64B4-31.007, F.A.C.

64B4-2.003 Conflict of Interest in Supervision.

Supervision provided by the applicant's therapist, parents, spouse, former spouses, siblings, children, employees, or anyone sharing the same household, or any romantic, domestic or familial relationship shall not be acceptable toward fulfillment of licensure requirements. For the purposes of this section, a supervisor shall not be considered an employee of the applicant if the only compensation received by the supervisor consists of payment for actual supervisory hours.

64B4-6.0025 Approved Continuing Education Course for Supervisory Training.

The continuing education course required to meet the qualifications for a qualified supervisor pursuant to Section 491.005, F.S., and subparagraph 64B4-11.007(3)(b)2., paragraph 64B4-21.007(3)(b), and subparagraph 64B4-31.007(2)(b)2., F.A.C., must be offered by a Board approved provider of continuing education and consist of the following:

(1) It must meet all the requirements of subparagraphs 64B4-6.004(2)(a)1.-5., F.A.C.;

(2) It must be 12 clock hours of didactic and interactional instruction which must be provided live and delivered in a manner and in such a way that monitors attendance, minimizes distractions, and allows for real-time interaction between the instructor and the attendee; and,

(3) Must contain content that satisfies the following learning objectives. The participant will:

(a) Become familiar with the major models of supervision for clinical social work, marriage and family therapy or mental health counseling;

(b) Gain skills to develop a personal model of supervision, drawn from existing models of supervision and from preferred styles of therapy;

(c) Understand the co-evolving dynamics of therapist-client and supervisor-therapist-client relationships;

(d) Explore distinctive issues that arise in supervision;

(e) Address the contextual variables in practice such as culture, gender, ethnicity, power and economics;

(f) Become familiar with the ethical, legal and regulatory issues of supervision;

(g) Review the Florida laws and the board rules governing interns and supervision; and,

(h) Understand the role of evaluation in supervision.

(4) Every third biennium, a qualified supervisor shall obtain 4 hours of supervisory training continuing education.

(a) These hours shall count toward satisfaction of the continuing education hours required for license renewal for the biennium in which the hours are taken.

(b) The course will:

1. Review changes to Florida laws and rules relating to Interns and Supervisors,
2. Discuss various electronic delivery systems for supervision and methods for ensuring confidentiality,
3. Discuss ethical, legal and regulatory issues of supervision, including documentation of the supervisory sessions,
4. Review research of effective supervision models,
5. Review challenges in supervision,
6. Address how cultural issues can affect the supervisory relationship,
7. Discuss accountability of both the supervisor and the intern in the supervisory relationship,
8. Discuss the business aspects of supervision,
9. Discuss the ethical, legal, and regulatory issues of teletherapy.

64B4-11.007 Definition of "Licensed Clinical Social Worker, or the Equivalent, Who Is a Qualified Supervisor."

(1) "Licensed clinical social worker, or the equivalent, who is a qualified supervisor," as used in Section 491.005(1)(c), F.S., is defined as an individual who, during the period for which the applicant claims supervised clinical experience, meets one of the following:

(a) Holds an active license as a clinical social worker in the State of Florida;

(b) Is licensed or certified as a social worker in a jurisdiction other than Florida in which the supervision took place, or resides in a jurisdiction other than Florida in which licensure was not required, provided that he or she meets the education and experience requirements for licensure as a clinical social worker under Section 491.005(1), F.S., or

(c) Is licensed as a marriage and family therapist, or mental health counselor in Florida or in the state in which the supervision took place and can demonstrate nine semester or twelve quarter hours of course work in social work theories and techniques. The concerned hours shall be chosen from an accredited graduate school of social work and relate to three (3) of the following six areas of content: human behavior and social environment I and/or II, social work practice theories, models of the social work practice, advanced social work practice, or ethical issues in contemporary social work practice.

(2) This rule applies to all supervisors providing clinical supervision to interns and trainees.

(3) A qualified supervisor who provides supervision in Florida for interns and trainees must meet equivalency standards of subsection (1); and,

(a) Have completed four (4) years of clinical social work experience, two (2) years of which can be earned during a post-masters clinical internship with the remaining two (2) years of experience earned post-licensure; and,

(b) Have completed, subsequent to licensure as a clinical social worker, training in supervision in one of the following:

1. A graduate level academic course in supervision which meets the requirements of Rule 64B4-6.0025, F.A.C., or
2. A continuing education course in supervisory training which meets the requirements of Rule 64B4-6.0025, F.A.C., or
3. A post-graduate training course for field instructors in clinical social work, or
4. Has been designated an Approved Supervisor by the AAMFT.

64B4-21.007 Definition of "a Licensed Marriage and Family Therapist with at Least Five Years Experience or the Equivalent, Who Is a Qualified Supervisor."

(1) "A licensed marriage and family therapist, who is a qualified supervisor," as used in Section 491.005(3)(c), F.S., is defined as an individual who, during the period for which the applicant claims supervision meets one of the following:

(a) Holds an active license as a marriage and family therapist in the state of Florida;

(b) Is licensed or certified as a marriage and family therapist in another state, or resides in a state in which licensure for marriage and family therapy is not required, and can document a minimum of six (6) semester or eight (8) quarter hours of graduate coursework in marriage and family systemic theories and techniques, and five (5) years of clinical experience as a marriage and family therapist, or

(c) Is designated an Approved Supervisor by the American Association for Marriage and Family Therapy;

(d) Is licensed as a clinical social worker or mental health counselor in Florida, or in the state in which the supervision took place, and can document a minimum of six (6) semester or eight (8) quarter hours of graduate coursework in marriage and family systemic theories and techniques, and five (5) years of clinical experience in marriage and family therapy, two (2) years of which can be earned during a post-masters clinical internship.

(2) This rule applies to all supervisors providing clinical supervision to interns and trainees.

(3) A qualified supervisor who provides supervision in Florida for interns and trainees must meet equivalency standards of paragraph (1)(a), (b), (c) or (d) and have:

(a) Completed five (5) years of clinical experience, two (2) years of which can be earned during a post-masters clinical internship with the remaining three (3) years of experience earned post-licensure; and,

(b) Completed, subsequent to licensure as a marriage and family therapist, training in supervision in one of the following:

1. A graduate level academic course in supervision which meets the requirements of Rule 64B4-6.0025, F.A.C., or
2. A continuing education course in supervisory training which meets the requirements of Rule 64B4-6.0025, F.A.C., or
3. Is designated an Approved Supervisor by the AAMFT.

64B4-31.007 Definition of a "Licensed Mental Health Counselor or the Equivalent, Who Is a Qualified Supervisor."

(1) A "licensed mental health counselor, or the equivalent, who is a qualified supervisor," as used in Section 491.005(4)(c), F.S., is defined as an individual who, during the period for which the applicant claims supervision, meets one of the following:

(a) Holds an active license as a mental health counselor in the state of Florida;

(b) Is licensed or certified as a mental health counselor in another state, or resides in another state where licensure is not required, provided that he or she meets the education and experience requirements for licensure as a mental health counselor under Section 491.005(4), F.S.;

(c) Is licensed as a clinical social worker or marriage and family therapist in Florida or in the state in which the supervision took place and can demonstrate a three semester or four quarter hour graduate level course in three of the following six content areas: counseling theories, counseling practice, assessment, career counseling, substance abuse, or legal, ethical, and professional standards from a clinical counseling program in an institution fully accredited by an accrediting body recognized by the Council for Higher Education Accreditation and/or the U.S. Department of Education;

(d) Is licensed as a psychologist in Florida or in the state where the supervision took place and completed a minimum of three years of experience providing psychotherapy, consisting of a minimum of 750 hours of direct client contact per year;

(2) Qualified supervisors who provide supervision in Florida for interns and trainees must meet the equivalency standards of subsection (1), and have:

(a) Completed five (5) years of clinical experience, two (2) years of which can be earned during a post-masters clinical internship with the remaining three (3) years of experience earned post-licensure; and,

(b) Completed, subsequent to licensure as a mental health counselor, training in supervision in one of the following:

1. A graduate level academic course in supervision which meets the requirements of Rule 64B4-6.0025, F.A.C., or
2. A continuing education course in supervisory training which meets the requirements of Rule 64B4-6.0025, F.A.C., or
3. A post-graduate training course for field instructors in clinical social work, or
4. Is designated an Approved Clinical Supervisor (ACS) by The Center for Credentialing and Education, Inc. (CCE), or
5. Is designated an Approved Supervisor by the AAMFT.

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