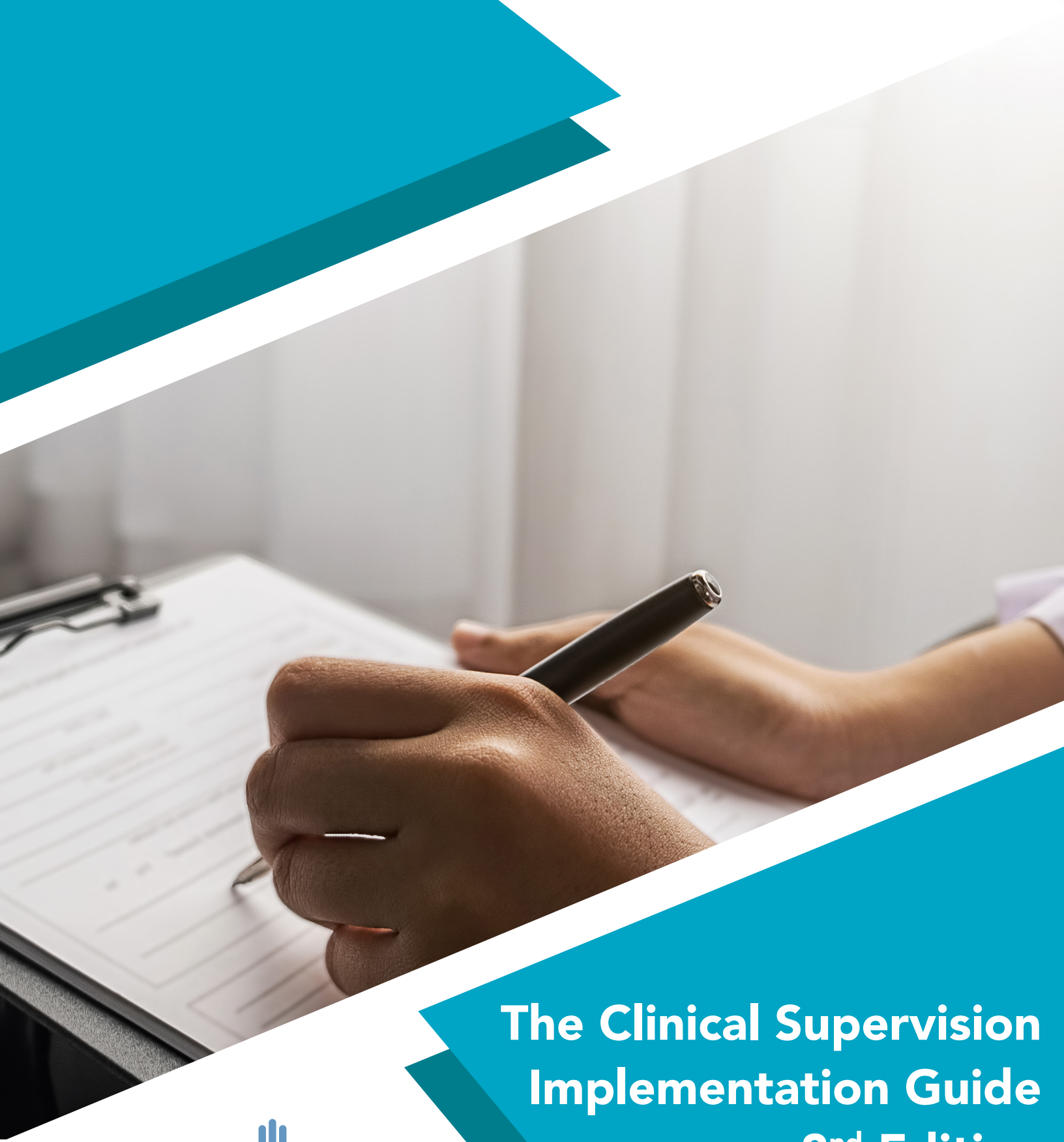

The Clinical Supervision Implementation Guide 2nd Edition

2025

HEALTH CARE AUTHORITY

Clinical Supervision Implementation Guide 2nd Edition
Table of Contents

Section 1: 2024 Clinical Supervision Implementation Guide Introduction

The first edition of this guide was written in 2018, with the goal of offering a practical guide for clinical supervisors to support their local clinical practice. The materials in it, gleaned from local practice and national research, were compiled with the goal of improving information sharing and outcomes for clinical supervision around the state of New Mexico. This guide has been successfully disseminated across the state with positive feedback about the information and resources it contained.

Much has changed in the world and the clinical landscape since 2018. We saw the need for a second edition of the guide to address changing rules and best practices in telehealth and tele-supervision and increased adoption of integrated health. Additionally, we saw areas that needed more attention, such as cultural humility and multicultural practice; interdisciplinary practice, including greater inclusion of certified and credentialed professionals; documentation in both supervision and in practice; and best ethical practices.

The first five sections of this Guide – *The Clinical Supervision Experience, Types and Formats of Supervision, An Introduction to Certified and Credentialed Professionals, Clinical Supervision in New Mexico, and Clinical Supervision Models* – introduce foundational components of clinical supervision and ways it is delivered, as well as an overview of provider types in New Mexico and their licenses or credentials. This is followed by *Ethics in Supervision* and *Clinical Supervision and High-Quality Practice*, which are focused on the more complex question of how to do clinical supervision well. *Clinical Supervision and Clinical Writing and Clinical Supervision Documentation* cover the related skills of having an adequate record of both the services provided to clients and the supervisory sessions. *Clinical Supervision and Integrated Healthcare* covers the growing practice of whole-person care in a single setting, and also contains practical recommendations on supporting supervisees to consider client physical health in any setting. The final section, *Quick Links*, gives a quick reference to links used throughout the guide in order for the reader to have easy access.

The following team worked together on writing this 2nd Edition to the NM Clinical Supervision Implementation Guide. This interdisciplinary group from around the state worked hard to reflect the variety of practice conditions and needs within New Mexico.

Name	Organization	Email
Lisa Morad-McCoy, LCSW	UNM Division of Community Behavioral Health, Albuquerque	lmmccoy@salud.unm.edu
Jen Panhorst, LCSW	UNM Division of Community Behavioral Health, Albuquerque	jpanhorst@salud.unm.edu
Denise Moore, LPCC	Tierra Nueva Counseling Center, Santa Fe	denisemoore@swc.edu
Sonya Briones, LPCC	All Faiths, Albuquerque	sbrionesparks@allfaiths.org
Brenda Quiñones-Cortés, LCSW	El Puente de Encuentros, Albuquerque	elpuentedeencuentros@gmail.com
Marie Weil, PsyD, ABPP	Independent practice, Silver City	mariecweil@gmail.com
Betty Downes, PhD	New Mexico Behavioral Health Services Division, Santa Fe	betty.downes@hca.nm.gov
Lacy Keith, LPCC	Mental Health Resources, Inc., Clovis	lkeith@mhrnewmexico.com
John Birkey	Mental Health Resources, Inc., Clovis	jbirkey@mhrnewmexico.com
Autumn Drags Wolf, LCSW	Nizhoni Counseling, LLC, Albuquerque	adragswolf@nizhonicounseling.org

The writers of this 2nd Edition could not have done this without the hard work of the 1st Edition authors. Thank you to:

Marie C. Weil, PsyD, ABPP
Bobby Heard, LCSW, LADAC
Donna Lucero, LPCC
Juliet Kinkade-Black, LMFT
Lourdes Torres
Joseph Carlson, LPCC
Catherine Sims, LCSW
Kate Gibbons, LCSW, LISW
Tiffany Wynn, LPCC
Jennifer Swanberg, M.ED, MAC, LPCC
Betty Downes, PhD
Kristin Jones, LCSW
Molly Faulkner, PhD, APRN, LCSW
Jen Panhorst, LCSW

Section 2: The Clinical Supervision Experience

Both supervisor and supervisee benefit from understanding their roles and the professional responsibilities that each person has in order to uphold the expectations that come along with such an important relationship. This section will address specific rights and responsibilities of supervisor and supervisee; transference and countertransference in the supervisory relationship; the concept of parallel process in the supervisory relationship; and cross-cultural supervision considerations, including supervising multilingual supervisees.

Supervision is an integral part of professional practice, education, and training in behavioral health. The supervisor and supervisee collaborate to develop the supervisee's skills in evidence-based and effective practices as well as to protect the welfare of clients in care. The provider organization of both the supervisor and supervisee benefit from having formal agreements (or contracts), expectations, and policies related to the supervisory relationship. Modifications may be necessary in the event that an organization is unable to provide an onsite supervisor from within the organization. In these situations, organizations benefit from having specific policies around employees receiving external supervision.

An external supervision contract can be used to clarify expectations of the organization, the supervisor, and the supervisee. It is also imperative for organizations, supervisors and supervisees to know state licensing board regulations, policies, and documentation, as these differ according to the specific behavioral health license or certification. For example, many boards have specific requirements for becoming an eligible supervisor. In interdisciplinary supervision, an increasingly common practice, supervisors oversee providers from a variety of disciplines, different from their own, for example a social worker supervising a mental health counselor. Supervisors working in this capacity should be knowledgeable about credentialing, number of hours of interdisciplinary supervision allowed by that particular board, as well as clinical processes and ethical standards that are specific to the role of their supervisee. See **Section 5** of this guide for more details on licensure and to ensure you meet criteria for providing supervision to the various licenses and credentials relevant in your setting.

In *cross-cultural supervision*, the supervision dyad takes place between a supervisor and supervisee from different ethnic and cultural backgrounds. In effective cross-cultural supervision, supervisors develop specialized knowledge about the cultural background of supervisees as it relates to clinical practice and engage in ongoing self-reflection about their own culture and potential biases. Supervisors should obtain information from the supervisee or others who are knowledgeable about that culture in order to expand their learning. Supervisors should also use a similar research and learning process to understand the culture of the clients whom supervisees are serving.

Cross-cultural supervision should not only include an understanding of the client's culture. The supervisor also must model an ongoing understanding, analysis, and overall curiosity about the community that their agency serves. Investing and engaging in the community is crucial for the agency and its providers to build trust. This process is crucial for creating a sustainable practice particularly in communities of color. Supervisors can help supervisees learn that there is seldom a separation between individual and community.

Supervisors are responsible for sharing with the supervisee best practices regarding clinical approaches, techniques, and the overall role that culture plays in the treatment process for clients. Supervisors create a safe environment for supervisees to reflect upon their cultural experiences in the supervisory relationship. Supervisees benefit from this approach by learning how to navigate cultural practices, communication, and their self-reflection on biases.

Best Practice Guidelines

Discipline-specific best practice guidelines related to supervision promote high standards to guide clinicians and mental health providers. Please consult each of these as relevant:

- American Psychological Association Guidelines for Clinical Supervision in Health Service Psychology: https://www.apa.org/about/policy/guidelines-supervision.pdf
- Association for Counselor Education and Supervision of the American Counseling Association Best Practices in Clinical Supervision: https://acesonline.net/wp-content/uploads/2018/11/ACES-Best-Practices-in-Clinical-Supervision-2011.pdf
- National Association of Social Workers Best Practice Standards in Social Work Supervision: https://www.socialworkers.org/LinkClick.aspx?fileticket=GBrLbl4BuwI%3d&portalid=0
- Substance Abuse and Mental Health Services Administration's Quick Guide on Clinical Supervision and Professional Development of the Substance Abuse Counselor: https://store.samhsa.gov/sites/default/files/sma13-4770.pdf

The Clinical Supervision Relationship

Both supervisor and supervisee benefit from understanding their roles and professional responsibilities within the supervisory relationship. Each person has a responsibility to understand the expectations that come along with the clinical supervision journey. Below is an overview of this topic; more resources are available in the best practice guidelines linked above.

The supervisor is responsible for creating a collaborative supervisory relationship, where supervisees can grow in their skills and competence. Supervisors should approach the supervisory relationship in a receptive, professional, and culturally humble manner, which will in turn create a sense of trust. It is helpful to address power differentials inherent in the supervisory relationship early on, as well as differences in values, beliefs, and cultural concepts.

A *rupture* is defined as a conflict and or strain in the therapeutic alliance between the supervisor and supervisee. When unaddressed by the supervisor, ruptures can lead to withdrawal from the supervisory relationship, which impacts client care. Supervisors should expand on what ruptures are and give permission to supervisees at the onset of the supervisory relationship to be open about their experiences, setting a foundation for later conversations as they occur. Whenever a supervisor becomes aware of a rupture, they should seek to address it, clarify any misunderstandings, and validate the supervisees experience. By extension, the supervisors are modeling how supervisees navigate rupture and repair with their clients.

Approaches to Transference and Countertransference in the Supervisory Relationship

Supervisors must be mindful of transference, countertransference and the parallel process in the supervisory relationship, as this serves to benefit the client and supervisee. *Transference* occurs when a client unconsciously transfers or projects their feelings from another person in their life onto their provider. Conversely, *countertransference* (CT) occurs when the unconscious needs, feelings and wishes of a provider are projected onto the client. In a *parallel process*, the supervisor takes on the role of the therapist and the therapist enacts the client's concerns or experience as a way to process any countertransference or transference that occurs in the session. This approach helps the supervisee use transference and countertransference to identify new ways to support the client, especially when movement forward seems to have "stalled." The supervisee projects the client's thoughts and behaviors back to the supervisor, while the supervisor responds as the supervisee would in the form of a countertransference response. When the supervisee takes on the client's role, they may gain increased empathy or insight into the client's behavior or the situation, in the hopes of leading to more effective treatment. By extension, the supervisor may experience increased empathy for the supervisee as they encounter challenging situations and diagnoses. Depending on the nature of the therapeutic dynamic occurring, conscious exploration of the parallel process may be required in order for the supervisee to find resolution; otherwise, the lack of movement in the situation could be perpetuated in the supervisory dynamic, which could go as far as creating a rupture.

Transference and countertransference on the whole should be explored in the supervisory relationship, either through a parallel process or other techniques. The supervisor is responsible for shaping a supportive space that allows for the supervisee's meaningful self-reflection.

In addition, supervisors should discuss with the supervisee how their own identity can show up in the therapeutic relationship and how to manage their countertransference responses. Supervisees can reflect on how their client's transference onto them can impact the therapeutic process. Supervisors are responsible for supporting their supervisee on how to manage their countertransference responses, including:

- Normalizing and destigmatizing the occurrence of transference and CT in the therapeutic relationship.

- Assuring the supervisee that the goal is not to eliminate CT but to understand it and its meaning.
- Identifying how the supervisee's identity and culture interacts with the client's and providing support for unconscious bias or issues related to CT.
- Providing resources about different cultural practices and tracking around stereotyping and biases.
- Asking supervisees to reflect on their somatic responses during the therapy session to increase insight.

Normalizing and addressing transference and countertransference responses for supervisees in session can be useful in guiding the work and provides a learning opportunity especially for newer clinicians and credentialed professionals. By providing a space to explore this dynamic, supervisors support ongoing learning and quality client care.

The Rights and Responsibilities of Supervisor and Supervisee

In order to promote a healthy and collaborative supervisory relationship, both the supervisor and supervisee benefit from having clear rights and responsibilities. Both parties share responsibility for clarifying expectations of supervision and the limits of confidentiality. Ongoing assessment is crucial in the supervisory relationship to check for and repair ruptures, as well as review the goals and progress of the supervisee. This assessment is in the best interest of clients' well-being and the professional development of the supervisee and should come from a strengths-based approach. It is critical that supervisees attend clinical supervision regularly. Supervisees should be engaged in supervision and prepared to staff cases or address administrative tasks, as well as remain open to feedback from their supervisor. Supervisees benefit most from supervision by being willing to engage in self-reflection. Supervision is not therapy, and this distinction should be made clear to the supervisee.

Supervisees are responsible for the best interests of the client and the agency/practice, while working in accordance with their individual licensing board expectations and ethical standards. Providers learn about the ethics of the field and strive towards developing professionalism and high-quality practice. For more details on these concepts, see **Section 7** regarding ethics and **Section 8** regarding high-quality practice.

Meanwhile, supervisors must make explicit that their responsibility is not only to the supervisee, but also the agency/practice, the clients, and the community at large. Supervisors are a "gatekeeper" to the profession to ensure clients receive the best care possible from supervisees. Supervisors are responsible for developing competency in the areas that they are supervising, such as specific psychotherapy approaches or diversity dimensions of the clients and community in which they and the supervisee practice.

Supervisors support the supervisee with professional and skill development, as well as with upholding ethical standards and avoiding dual relationships. *Dual relationships* are relationships outside of the professional setting with supervisees and can cause conflict and issues if boundaries are not maintained. While avoiding dual relationships may be easier in larger communities, this may not be possible in rural communities with limited providers. However, even when the supervisor and supervisee know each other personally, the supervisor still has a responsibility to create an emotionally safe environment where personal and professional are separated, and the supervisee can bring forward concerns about the duality of the personal-professional relationship. The supervisor and supervisee also need to provide each other assurances of the privacy of the supervision; while this is always important in any supervisory relationship, this is particularly relevant when practicing in a setting where the supervisor, supervisee, and/or clients may know each other's family and friends.

Additionally, supervisors provide guidance and support with clinical documentation. Supervisors support the supervisee with assessment, safety planning, case formulation, treatment planning, selecting appropriate interventions and learning new techniques. See **Section 9** in this guide for more on clinical documentation and writing.

Supervisors also assist supervisees with developing a clinical therapeutic relationship with their clients. This includes how to navigate countertransference, cultural factors, the termination process and the supervisees' scope of practice.

Lastly, supervisors are responsible for making explicit their roles as administrators in the agency, should they have such a role. Supervisors offering administrative support may review documentation, coach the supervisee in regard to performance issues, and provide constructive and timely feedback on their work. Administrative supervision may put the supervisor in the role of acting as a liaison among the supervisee and Human Resources, as well as in meditation with other staff. Supervisors have an ethical responsibility to ensure a balance between clinical and administrative supervision demands and that one is not overshadowing the other when meeting with supervisees.

Supervising Multilingual Supervisees

New Mexico ranks third in the United States for proportion of multilingual residents, with nearly a third of residents speaking another language in addition to or other than English. The most commonly spoken languages are Spanish and Diné. However, there are many others, such as a variety of Indigenous languages, like Keres, Zuni, Tewa, and Apache; American Sign Language; and over 40 different languages in Albuquerque's International District, including Vietnamese and Pashto. However, finding services in languages other than English can be difficult because there are too few providers who are multilingual (Guilman 2015, Weber 2019). Because of this, clients can spend a significant time on wait lists and experience worsening symptoms and present with higher acuity when they begin receiving services. Because bilingual supervisees often have higher caseloads due to limited services, as well as being asked to interpret colleagues' sessions or translate documents

without a caseload or pay differential, burnout rates are higher than average for Spanish-English bilingual providers (Verdinelli and Biever, 2009).

Supervisors should focus on the following best practices with supervisees who are providing services in languages other than English:

- *Whenever possible, have supervision conducted in the same language in which the supervisee is providing services (Consoli and Flores, 2020).* This can increase the continuity of care and ensuring that nothing is "lost in translation," which can happen when supervisees must describe the session in a different language. When this is not possible, then supervisors should *support their supervisees in finding external same-language professional Mentorship* so they have opportunities to have professional discussions in the language in which they are providing services. Additionally, supervisors who are monolingual should make attempts to learn some words and terms in the language in which their supervisee is practicing.
- *Support supervisees with accessing professional training in the language in which they provide services.* Just because an individual is fluent in a language does not mean that they are familiar with technical terminology specific to behavioral health. Because providers are doing their case notes in English, this can lead to difficulties with formulation and interpretation (see more on bilingual documentation in **Section 9**). Additionally, similar to getting same-language supervision or mentorship, same-language ongoing training like Continuing Education gives supervisees another forum to enhance their skills in the language in which they practice.

  Examples for Spanish language training in New Mexico include:
  - National Latino Behavioral Health Association: https://nlbha.org/
  - New Mexico Highlands University's Bilingual/Bicultural MSW program: https://www.nmhu.edu/landing-masters-of-social-work/
  - University of New Mexico's Rural Psychiatry annual spring conference that is solely in Spanish: https://app.smartsheet.com/b/publish?EQBCT=67cc80bd03594061b64b48a52121b3ff

- *Advocate for supervisees to have equitable caseloads.* While it can be difficult to limit caseloads when there is high demand, research shows a correlation between burnout and caseload size (Quinn et al., 2019). Because supervisees are frequently not in control of how many clients they are asked to see, it is the supervisor's responsibility to evaluate how much bilingual supervisees are being asked to do compared to others in the organization and ensure that the bilingual supervisees are not being asked to do a disproportionate amount of work, particularly if this is unpaid.
- *Invest in interpreters and contractors rather than using bilingual providers (or other employees who are not interpreters).* Interpreting is a specific set of skills that require training and is not the same as being bilingual. Having bilingual providers interpreting for their colleagues or translating handouts and signage for the agency pulls them away from their own clients and increases burnout, as this is outside of their scope of work and likely not what they hoped to do with their behavioral health license or credential. Mexico specifically for behavioral health sessions. For example, please see the National Latino Behavioral Health Association's Behavioral Health Interpreter training: https://nlbha.org/projects/behavioral-health-interpreter-training-bhit/

It is the supervisor's responsibility to ensure that the professional language needs of their supervisees are being met. This should help retain bilingual providers and improve the overall quality of services being provided to the community.

Summary

The complexity of true clinical supervision requires both supervisors and supervisees to engage in training, self-reflection, and open dialogue to ensure everyone is familiar with their roles, responsibilities, and rights. These can vary depending on the communities and clients served by the agency. Now that we have established what clinical supervision is, we will explore in the next section delivery methods and configurations for supervision.

Section 2 References and Resources

[Child-Parent Psychotherapy]. (2022, January 20). Countertransference in the Treatment of Maltreated Children [Video]. Youtube.com. https://www.youtube.com/watch?v=q0BfqCX6DZ0

Consoli, A. J., & Flores, I. (2020). The teaching and training of bilingual (English/Spanish) mental health professionals in the United States. In G. J. Rich, A. Padilla López, L. Ebersöhn, J. Taylor, & S. Morrissey (Eds.), *Teaching psychology around the world* (pp. 441–454). Cambridge Scholars Publishing.

Cross-Cultural Supervision: Racial/Ethnic Minority Supervisees' Perspectives. (n.d.). Retrieved from https://egrove.olemiss.edu/cgi/viewcontent.cgi?article=1036&context=jcrp

Falender, C. A., Grus, C., McCutcheon, S., Goodyear, R. K., Ellis, M. V., Doll, B.,...Kaslow, N. J. (2016). Guidelines for clinical supervision in health service psychology: Evidence and implementation strategies. Psychotherapy Bulletin. Retrieved from: https://societyforpsychotherapy.org/guidelines-clinical-supervision-health-service-psychology/

Falender, C. A., Shafranske, E. P., & Falicov, C. J. (Eds.). (2014). *Multiculturalism and diversity in clinical supervision: A competency-based approach*. American Psychological Association. https://doi.org/10.1037/14370-000

Guilman, S. R. (2015). Beyond interpretation: The need for English-Spanish bilingual psychotherapists in counseling centers. James Madison Undergraduate Research Journal, 2(1), 26-30. Retrieved from http://commons.lib.jmu.edu/jmurj/vol2/iss1/5

Hall, J. C. (2018). Black women talk about stereotypical transference enactments in cross-cultural supervision. Journal of Human Behavior in the Social Environment, 28(8), 1019–1032. https://doi.org/10.1080/10911359.2018.1489930

How unintentional but insidious bias can be the most harmful https://www.youtube.com/watch?v=mgvjnxr6OCE
Jang, H., Bang, N. M., Byrd, J., & Smith, C. (2020). Cross-cultural supervision: Racial/ethnic minority supervisees' perspectives. Journal of Counseling Research and Practice, 5(2), 1–19. https://doi.org/10.56702/uckx8598/jcrp0502.2

Quinn, A., Ji, P., & Nackerud, L. (2019). Predictors of secondary traumatic stress among social workers: Supervision, income, and caseload size. *Journal of Social Work*, 19(4), 504–528. https://doi.org/10.1177/1468017318762450

Sandeen, E., Moore, K. M., & Swanda, R. M. (2018). Reflective local practice: A pragmatic framework for improving culturally competent practice in psychology. *Professional Psychology: Research and Practice, 49(2), 142–150.* https://doi.org/10.1037/pro0000183

Shafranske, & C. J. Falicov (Eds.), *Multiculturalism and diversity in clinical supervision: A competency-based approach* (pp. 29–58). American Psychological Association. https://doi.org/10.1037/14370-002

The Clinical Supervision Relationship: https://files.santaclaracounty.gov/migrated/The%20Clinical%20Supervision%20Relationship.pdf

Vandament, M. L., Duan, C., & Li, S. (2022). Relationships among supervisee perceived supervisor cultural humility, working alliance, and supervisee self-efficacy among white supervisor and supervisee of color dyads. *Training and Education in Professional Psychology*, 16(3), 244–252. https://doi.org/10.1037/tep0000370

Verdinelli, S., & Biever, J. L. (2009). Experiences of Spanish/English bilingual supervisees. *Psychotherapy: Theory, Research, Practice, Training*, 46(2), 158–170. https://doi.org/10.1037/a0016024

U.S. Department of Health and Human Services Office of Minority Health. (n.d.). *Culturally and Linguistically Appropriate Services (CLAS) Behavioral Health Implementation Guide.* Retrieved August 16, 2024, from https://minorityhealth.hhs.gov/clas-behavioral-health-implementation-guide

Weber, J. (2019, July 17). Habla Español? Hispanics face growing mental health care crisis. USA Today. https://www.usatoday.com/story/news/2019/07/17/lack-of-spanish-speaking-therapists/1422002001/

Section 3: Types and formats of supervision

The two general formats of clinical supervision are individual supervision and group supervision. Within these categories, there are a variety of ways to carry out clinical supervision sessions, depending on the needs of the supervisor and the supervisee. Considerations for determining the best method to use include supervisee developmental stage (see **Section 6**), geographical proximity of the supervisor and supervisee, theoretical approaches of the agency, and supervisor workload. Research has shown that all types and formats of supervision can be beneficial as long as the supervisory relationship contains basic elements like trust; see **Section 8** for more on this and other elements of high-quality practice.

Please see **Section 5** on licensing rules regarding who can provide supervision (including interdisciplinary supervision, defined on **page 14**) and regulations on matters like the size of group supervision.

Individual Clinical Supervision

This involves one supervisee and one supervisor in face-to-face supervision. Individual supervision can be done in person or through tele-supervision (defined on **page 14**). Individual supervision allows the supervisor and the supervisee to get to know each other well professionally and allows for more personalized supervision. Developing a supportive professional relationship in individual clinical supervision is often key for the supervisee's growth and is an integral part of high-quality behavioral health practice.

Group Clinical Supervision

This consists of two or more supervisees in face-to-face supervision with one supervisor. Group supervision can be done in person or through tele-supervision (defined on **page 14**). There are several benefits of group supervision. The supervisee is exposed to other behavioral health professionals' points of view, practice methods, and possibly a variety of populations. Hearing about other professionals' challenges can also decrease anxiety for new professionals concerned with being viewed through a deficit lens. Group supervision can also increase the supervisor's capacity because they are able to supervise multiple people in one hour, although this should not be the only motive for conducting group supervision and needs to be done in compliance with rules and regulations about group size when applicable. Additionally, the supervisor has greater responsibilities during group supervision to monitor the entire group dynamic and moderate discussions when clinical disagreements arise.

In-person clinical supervision:

The supervisor and the supervisee are face-to-face in the same physical setting. Elements of in-person supervision could include:

- Increased likelihood of shared familiarity with the community the supervisee works in and with
- Greater visual cues regarding the environment and body language for both the supervisor and supervisee
- Greater potential for demonstration of particular therapeutic techniques that have physical elements, such as play therapy or Gestalt's empty chair

Tele-supervision:

The supervisor and supervisee are face-to face supervision with use of a HIPAA-compliant tele-conferencing software. It is essential that this technology has been adequately reviewed for HIPAA-compliance and includes end-to-end encryption. Tele-supervision can be done individually or in group. Telephone can also be used when connectivity via tele-conferencing software is not possible, although should be limited. Tele-supervision offers many advantages, including:

- Improved accessibility in rural and frontier areas where licensed supervisors may not be available.
- Increased flexibility for supervisors and supervisees because a commute to a separate location is not needed.
- Ability to model therapeutic techniques used in teletherapy, such as completing a worksheet or application on a shared screen, use of emojis and camera angles, or playing a game.

Some unique considerations for tele-supervision include ensuring that all parties hold the appropriate license for practice in that jurisdiction (ex. a supervisee licensed in New Mexico and seeing clients in New Mexico can only be supervised by a supervisor who is also licensed in New Mexico), as well shared responsibility for ensuring that the physical environment that they are participating from is sufficiently private.

Interdisciplinary supervision (IDS):

The supervisee receives clinical supervision from a supervisor with a different behavioral health license. For example, a social worker who receives IDS could receive this from a licensed clinical psychologist, psychiatrist or licensed professional clinical counselor (LPCC). This can be done in-person or via tele-supervision, either individually or in a group. Some benefits of IDS include:

- Providing a different perspective around assessment and treatment for both the supervisor and supervisee.
- Increasing access to clinical supervision in rural communities where there may be few options for same-discipline supervision.

- Potential for modeling and practicing multi-disciplinary communication and collaboration that is frequently needed in agency settings, including integrated health.

Supervisors who have supervisees of another discipline need to be responsible for being familiar with and/or seeking out the rules and regulations of that profession, including regarding supervision towards higher licensure. An overview of these supervisory rules is provided in **Section 5**. While supervisees need to be responsible for familiarity with these rules as well, the supervisor must recognize the potential for unintentionally misguiding a supervisee because of their senior role, which can lead to ruptures, delays in professional advancement, and/or turnover.

Summary

There are multiple methods and configurations that supervisors can use to meet their supervisees' needs for supervision. None of these are "better" or "worse," but rather have pros and cons.

Before we move into licensing and regulation for all professions, we will spend time covering the newest providers to the field, Certified and Credentialed Professionals. This will add context to references to recommendations made elsewhere in the Guide specific to these professionals.

Section 3 References

State Records Center & Archives. (2024, April 3). *Chapter 63 – Social Workers - State Records Center & Archives*. State Records Center & Archives - Official Web Site of the New Mexico State Records Center and Archives (SRCA). https://www.srca.nm.gov/nmac-home/nmac-titles/title-16-occupational-and-professional-licensing/chapter-63-social-workers/

Supervision. (n.d.). https://naswnm.socialworkers.org/Professional-Development/Supervision *Credentials and certifications*. https://www.socialworkers.org/Careers/CredentialsCertifications

Wood, J. Miller, T. & Hargrove, D. (2005). Clinical supervision in rural settings: a telehealth model. Professional Psychology: Research and Practice, 36 (2), 173179. DOI: 10.1037/0735-7028.36.2.17

Section 4: An Introduction to Certified and Credentialed Professionals

Certified and credentialed professionals (C&CPs) provide non-clinical, strengths-based support to individuals seeking services. The role of a C&CP is to partner with licensed clinicians to provide on-going support for individuals struggling with substance use disorder, mental illness, and co-occurring disorders. The purpose of most C&CPs is to walk alongside clients in their recovery journey. C&CPs can engage in a wide range of activities, including advocacy, linkage to resources, non-clinical support group facilitation, skill building, mentoring, goal setting, and more. Common certifications for C&CPs include but are not limited to:

- Community Health Worker(CHW)
- Prevention Specialist Intern (CPS-I)
- Prevention Specialist (CPS)
- Senior Prevention Specialist (S-CPS)

Some C&CPs have *lived experience* with mental illness, substance use disorder, or both. C&CPs who have lived experience are commonly referred to as "peers." Peers or certified peer support workers (CPSW) may be referred to by different names depending on where they practice. Common certifications for C&CPs with lived experience include but are not limited to:

- Peer Support Worker
- Peer Family Support Worker
- certified peer specialists
- peer recovery coaches
- peer advocates
- peer recovery support specialists

For more information about what behavioral health certifications are available, see **Section 5**.

Community Support Workers (CSWs):

CSW's are hired to provide Comprehensive Community Support Services (CCSS) through a behavioral health agency. CSW's can be an integral part of a behavioral health team. ***However, CSW's are not certified or credentialed like the titles listed above.***

CSW's must be 18 years old, they must have a high-school diploma, GED, or equivalent. They must also get a CCSS training certificate by attending a 20-hour training, given by the University of New Mexico Health Sciences Center, Division of Behavioral Health. CSW's must maintain their eligibility to provide CCSS by taking 20 hours of relevant education credits per year.

Please note that for the purposes of this Clinical Supervision Implementation Guide, many of the supervision principles that we discuss for C&CP's will apply to CSW's as well. For more information about Community Support Workers (CSW) and Comprehensive Community Support Services (CCSS) please see the links below.

Learn more about CCSS and Community Support Workers here:
https://nmrecovery.org/ccss-2
Learn more about CCSS training here:
https://nmrecovery.org/ccss-2

Because C&CPs and are the newest types of providers to behavioral health, some providers are not familiar with them. Therefore, the remainder of this section covers C&CPs scope of practice so supervisors can be aware of what they can and cannot ask a C&CP to do, as well as special considerations for supervising C&CPs.

Certified and Credentialed Professionals' Scope of Practice (Please see table below for an illustration of C&CP's scope of Practice)

The table below shows some of the duties that C&CPs are qualified to perform. **Please note**, in the table below, Licensed Alcohol and Drug Abuse Counselors (LADACs) are listed. *LADACs are licensed behavioral health professionals*. They receive their license from the New Mexico counseling and therapy board. Depending on the C&CP's scope of work, LADACs can be an excellent source of supervision for C&CPs who work with individuals with an SUD diagnosis.

Please note that the table below is not an inclusive list of all C&CP's scopes of work. For example, It's important to highlight that Certified Peer Support Workers (CPSW's) can also provide education and support around substance abuse harm reduction. Some CPSWs are employed in medically Assisted Treatment (MAT) clinics and have received *Narcan* training. Naloxone, also known as *Narcan*, is a medication used to reverse opioid overdoses.

Typical Areas and Scope of Work for Certified and Credentialed Professionals

Source: Wilger, S. (n.d.). *Medicaid Reimbursement and Unlicensed Behavioral Health Professionals* [Slide show; Power Point].

PREVENTION						HARM REDUCTION		TREATMENT							RECOVERY		
Advocacy & Policy	Environmental Strategies/ Prevention Programming	Community Assessment & Program Evaluation	Community Organizing, Coalition, Outreach	Universal Education/ Media Campaigns	Linkage to Resources & Navigation	Needle Exchange Narcan & Other Services	Education & Information	Screening	Discharge & Transition Planning	Crisis Intervention	Care Plan	Care Coord	Assessment & Diagnosis	Counseling	Indy & Family Recovery Support	Recovery Groups	Recovery Coaching
CPI	CPI	CPI	CPI	CPI	CPI	CPI	CPI										
CPS	CPS	CPS	CPS	CPS	CPS	CPS	CPS										
SCPS	SCPS	SCPS	SCPS	SCPS	SCPS	SCPS	SCPS										
CHW	CHW	CHW	CHW	CHW	CHW			CHW	CHW	CHW	CHW	CHW					
					CPSW			CPSW	CPSW		CPSW	CPSW			CPSW	CPSW	CPSW
					CFPSW					CFPSW	CFPSW	CFPSW			CFPSW	CFPSW	CFPSW
					CSW			CSW	CSW	CSW	CSW	CSW			CSW		
					CWF			CWF	CWF	CWF	CWF	CWF					
					WS			WS	WS	WS	WS	WS					
					LSAA*	LSAA*	LSAA*	LSAA*	LSAA*	LSAA*	LSAA*	LSAA*	LSAA*	LSAA*	LSAA*	LSAA*	
					LADAC	LADAC	LADAC	LADAC	LADAC	LADAC	LADAC	LADAC	LADAC	LADAC	LADAC	LADAC	

*Can provide services under the guidance of a supervisor (an LPCC, LFMT, LPAT, or LADAC)

Certified and Credentialed Professionals and the Supervisory Relationship

Much like supervision of licensed behavioral health professionals, C&CPs need regular and consistent supervision by a licensed clinician of any type. There are certifications for C&CPs who wish to become supervisors within their certification level.

Supervisors play a key role in the successful integration of C&CPs in the workplace. Providing supervision promotes good ethical practices, including supporting C&CPs to only provide services within their scope of work.

Supervisors of C&CPs should strive to provide an environment where C&CPs are empowered to understand their strengths and learn from their mistakes. Supervisors of C&CPs can use supervision time to help C&CPs identify areas where they may need more training and areas where professional and personal growth have occurred. With most supervisory relationships, supervision is the perfect time to help reframe unexpected client outcomes as opportunities for professional development.

Supervision of C&CPs should include supportive, administrative, and educational components depending on the C&CPs needs. Supportive supervision typically focuses on the C&CPs morale and over-all job satisfaction. Supportive supervision can help C&CP learn about boundaries related to self- care so that compassion fatigue and burn out can be prevented or noticed and addressed quickly.

The supervisor can also use the supervision hour to give the C&CP constructive feedback on their work, while providing validation and encouragement. Much like supervision of licensed professionals, C&CPs need a safe space to discuss their personal reactions to client issues and examine areas of bias with a supervisor they trust.

Administrative supervision gives C&CPs clarity about agency policies and procedures. It often involves talking about the C&CPs performance, quality of work, and time management. Administrative supervision is important to make sure that C&CPs are working within their scope of practice and keeping up with documentation and record keeping.

Educational supervision of C&CPs can include mentoring and shadowing—in a sense, watching supervisors do their work. It's important to provide space and time for formal training as well. Supervision time can be used to reflect on what training the C&CP may benefit from and how they learn most efficiently. A combination of supportive, administrative, and educational supervision can strengthen the C&CPs career development as well as the C&CPs ability to do this difficult work in a sustainable way.

Supporting Peer Support Workers Around Self-Disclosure

Self-disclosure with clients done with intentionality is part of the CPSW's scope of work. Self-disclosure can be used as a vehicle to build rapport and instill a sense of hope for many people in recovery. It can serve as a communication strategy to enhance behavioral change. Peer support, and particularly appropriate self-disclosure, is increasingly accepted as an intervention in many behavioral health settings and has been shown to decrease symptoms and increase treatment engagement.

The supervisor's role in CPSW self-disclosure can be to model and teach appropriate boundaries around using their recovery story as an intervention. For example, a CPSW can be encouraged to ask themselves, "what is the purpose of this disclosure? Will it benefit the client?" This also requires the supervisor addressing the CPSW's level of insight and self-awareness around what topics they may feel are too sensitive, private, or difficult to discuss. Despite self-disclosure being part of their scope, CPSWs should not feel this obligates them to share all parts of their personal life or lived experience.

Helping CPSWs develop insight around self-disclosure can help them create healthy boundaries around this practice and supports burnout prevention.

For more information about CPSW's and recovery from a nation wide perspective. Please see the following link from The Substance Abuse and Mental Health Administration (SAMHSA)

https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers

Summary

Certified and Credentialed Providers are a group of newer provider types with whom all providers should be familiar. Supervisors of C&CPs should pay particular attention to topics like understanding the supervisory relationship, scope of practice, and self-disclosure in order to meet the professional development needs of these providers and support career sustainability.

In the next section, we will cover the rules and regulations for licensing boards relevant to the material we have covered so far in **Sections 2**, **3**, and **4**.

Section 4 references

National Association of Peer Supporters (2019). National Practice Guidelines for Peer Specialists and Supervisors. Washington, DC: N.A.P.S.

New Mexico Credentialing Board of Behavioral Health Professionals. (n.d.) https://nmcbbhp.org/
New Mexico Recovery Project. (n.d.). https://nmrecovery.org/opre-pre-application

Paquette, K.L.; Pannella Winn, L.A.; Wilkey, C.M.; Ferreira, K.N.; Donegan, L.R.W. (2019). A framework for integrating young peers in recovery into adolescent substance use prevention and early intervention. *Addictive Behaviors*, 19.

Repper, J., and Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health*, 20(4), 392-411.

Truong, C.; Gallo, J; Roter, D.; & Joo, J. (2019). The role of self-disclosure by peer mentors: Using personal narratives in depression care. *Patient Education and Counseling*, 102(7), 1273-1279.

Section 5: Clinical Supervision in New Mexico

Requirements for who can supervise and how supervision occurs can vary considerably not just by profession, but also by state. The following section covers 1) licensing and credentialing in New Mexico and requirements for advanced licensure; 2) becoming an approved supervisor with the New Mexico professional boards.

State Licensing and Credentialing Boards

Licenses and credentials serve an important public safety function to the behavioral health field. It is important for supervisors to model good habits with licensure to their supervisees, including displaying their license, renewing their license on time, and keeping up with continuing education required by the State's Regulation and Licensing Department (RLD). This practice is in alignment with ethical standards across the disciplines discussed in this section.

Many behavioral health professionals in New Mexico have independent licensure that can be gained through a combination of practice experience and supervision. While each individual is responsible for their own supervision process; it is good practice for the supervisor(as the senior clinician) to consult with the licensing boards and know the supervision standards for their various supervisees, as discussed in **Section 3**.

The following is a listing of the behavioral health licensing and credentialing boards in the state, organized by the state entity they fall under. Each listing includes a brief overview of the supervision rules specific to these boards and organizations, as well as where to find more details. This information is current as of the publication of this Clinical Supervision Implementation Guide.

Please refer to the New Mexico Health Care Authority Behavioral Health Policy and Billing Manual for any certified and credentialed provider types not listed here, such as Community Support Workers (CSW) and Behavioral Management Specialists (BMS).

New Mexico Children Youth and Families Behavioral Health Services (housed within New Mexico State University's Center of Innovation): https://centerofinnovationnm.org/

Non-independent certification type(s)	Independent certification type(s)	Requirements to earn certification	Interdisciplinary sup allowed	Group allowed	Telesup allowed
Certified Family Peer Support Worker (CFPSW)	n/a	*40 hrs supervised work in order to get certification *No independent license; all work requires supervision	Yes, any type of BH provider	Yes	Yes
Certified Wraparound Facilitator (CWF)	n/a	*18 months of training, coaching, and observation *No independent license; however can mentor and train others after 18 months	Yes, any type of BH provider	Yes	Yes
Certified Youth Peer Support Worker (CYPSW)	n/a	*40 hrs supervised work in order to get certification *No independent license; all work requires supervision	Yes, any type of BH provider	Yes	Yes

New Mexico Credentialing Board for Behavioral Health Professionals: https://nmcbbhp.org/

Non-independent certification type(s)	Independent certification type(s)	Requirements to earn certification	Interdisciplinary sup allowed	Group allowed	Telesup allowed
People working towards a Certified Alcohol and Drug Counselor license likely to hold an Licensed Substance Abuse Associate (LSAA) (see Counseling and Therapy Practice Board section in this Guide pgs. 25-26)	Certified Alcohol and Drug Counselor (CADC)	*300 hours of supervision in 3 years *2000-6000 hours of supervised alcohol and drug counseling specific work *Work experience requirements decrease w/ more formal education	Yes, but with appropriate experience with alcohol and drug counseling	Yes	Yes
Certified Prevention Specialist (CPS)	Senior Certified Prevention Specialist (SCPS)	*10000 hours of prevention experience in 5 years (2000 have to be done as a Certified Prevention Intern (CPI) before getting CPS) *144 supervision hours *Within the total supervision hours, a minimum of 10 hrs on each of the 6 International Certification and & Reciprocity Consortium (IC&RC) prevention domains	Yes, but with appropriate experience in prevention work	Yes	Yes
Certified Clinical Supervisor applicants must hold a substance treatment related certification or license already	Certified Clinical Supervisor (CS)	*200 hours of supervision in 5 years *6000-10000 hours of alcohol and drug counseling specific work, with 4000 being in alcohol and drug counseling supervisor work *Work experience requirements decrease w/ more formal education	Yes, but with appropriate experience with alcohol and drug counseling	Yes	Yes

New Mexico Office of Peer Recovery and Engagement:
https://yes.nm.gov/nmhr/s/office-of-peer-recovery-and-engagement?language=en_US

Non-independent certification type(s)	Independent certification type(s)	Requirements to earn certification	Interdisciplinary sup allowed	Group allowed	Telesup allowed
Certified Family Peer Support Worker (CFPSW)	n/a	*40 hrs supervised work in order to get certification *No independent license; all work requires supervision	Yes, any type of BH provider	Yes	Yes

New Mexico Regulation and Licensing Division Boards and Commissions:
https://www.rld.nm.gov/boards-and-commissions/

Board title	Non-independent license type(s)	Independent license type(s)	IRequirements to earn independent license	Interdisciplinary sup allowed	Group allowed	Telesup allowed
Psychologist Examiners	Unlicensed (student, trainee, associate)	Licensed psychologist	*3000 practice hours (750 client contact hours) in 2 years *750-1500 practice hours can be done at pre-doctoral internships	No	Yes	Yes, up to 50%
Social Work Examiners	Licensed Master Social Worker (LMSW)	Licensed Clinical Social Worker (LCSW) or Licensed Independent Social Worker (LISW)	*90 hours of supervision in 2-5 years *3600 practice hours (any work time)	Yes, up to 30 hrs w/ an LPCC, psychologist, or psychiatrist	Yes, up to 20 hrs in groups of no more than 6	Yes, all hrs
Counseling and Therapy Practice – separated out due to differences between license types (*continues onto next page*)						
Licensed Mental Health Counselors (LMHC)		Licensed Professional Clinical Counselor (LPCC)	*100 hours of supervision in minimum 2 years *3000 client contact hours (1000 can be done in internship)	Yes, unlimited hrs w/an LCSW, psychologist, or psychiatrist	Yes, in groups of no more than 6	Yes, all hrs
Licensed Associate Marriage and Family Therapist (LAMFT)		Licensed Marriage and Family Therapy (LMFT)	*200 hours of supervision in minimum 2 years *1000 client contact hours	Yes, same as LMHC, but with appropriate experience in marriage and family therapy	Yes, up to 100 hrs, in groups of no more than 6	Yes, all hrs

Licensed Substance Abuse Associate (LSAA)	Licensed Alcohol and Drug Addiction Counselor (LADAC)	*50-200 hours of supervision in minimum 1-3 years *1000-3000 client contact hours *Requirements decrease w/more formal education	Yes, same as LMHC, but with appropriate experience with substance use counseling	Yes, in groups of no more than 6	Yes, all hrs
Art therapy does not have a specific non-independent license; typically someone working towards this has an LMHC	Licensed Professional Art Therapist (LPAT)	*100 hours of supervision in minimum 2 years *3000 client contact hours (1000 can be done in internship)	Yes, same as LMHC, but with appropriate experience with art therapy	Yes, in groups of no more than 6	Yes, all hrs

New Mexico Medical Board: https://www.nmmb.state.nm.us/

Non-independent license type(s)	Independent license type(s)	Requirements to earn independent license	Interdisciplinary sup allowed	Group allowed	Telesup allowed
Unlicensed (student, trainee)	Licensed medical doctor	*2 years of post-doctoral supervised work	Physicians or chiefs-of-staff only	No	No

New Mexico Board of Nursing:
http://nmbon.sks.com/

Non-independent certification type(s)	Independent license type(s)	Requirements to earn independent license	Interdisciplinary sup allowed	Group allowed	Telesup allowed
Licensed Practical Nurse (LPN)	n/a	No independent license; must be supervised for any procedure that goes "beyond basic preparation for practical nursing"	Yes, any type of nurse or physician	No	No
Registered nurse (RN) permit-to-practice	Registered nurse (RN)	No time frame required – once individual has passed licensing test	No, RN supervisor only	No	No
Graduate Nurse Practitioner (GNP) permit-to-practice	Certified Nurse Practitioner (CNP) (type of Advanced Practice Registered Nurse [APRN])	No time frame required – once individual has passed licensing test	Physician, CNP, or Certified Nurse Specialist only. Must be direct when prescribing	No	No
Graduate Clinical Nurse Specialist (GCNS) permit-to-practice	Certified Nurse Specialist (CNS) (type of Advanced Practice Registered Nurse [APRN])	No time frame required – once individual has passed licensing test	Physician, CNP, or CNS only. Must be direct when prescribing	No	No

Becoming an Approved Supervisor

Some professions require that supervisors apply to become approved to supervise licensees under their board for a non-independently licensed supervisee's supervision to count towards independent licensure. The goal of this is to ensure that supervisors have received adequate supervisory principles, as well as to provide exposure to that professions or certification's values and ethics to interdisciplinary supervisors.

Supervisors should be familiar with the rules and regulations set for each profession under which they are approved to provide supervision, including ethical standards, professional conduct, and relevant laws. More is covered on ethical guidelines in supervision in **Section 7** of this guide.

Below are the requirements for the licenses and certifications that require additional training to become a supervisor as of June 2024.

New Mexico Children Youth and Families Behavioral Health Services (housed within New Mexico State University's Center of Innovation): https://centerofinnovationnm.org/

Certification type	CEU requirement	Application fee	Who can get this approved status	Renewal required
Certified Family Peer Support Worker (CFPSW)	An 18-hour training that is only available through NMSU COI	No	Any type of supervisor, including non-independently licensed	No
Certified Youth Peer Support Worker (CYPSW)	A 9-hour training that is only available through NMSU COI	No	Any type of supervisor, including non-independently licensed	No

New Mexico Regulation and Licensing Division Boards and Commissions:
https://www.rld.nm.gov/boards-and-commissions/

Board	CEU requirement	Application fee	Who can get this approved status	Renewal required
Social Work Examiners	A 6-hour supervisory course, selected from a list of approved courses kept on the board website	No	Any type of supervisor, including non-independently licensed	No
Counseling and Therapy Practice	9 hours total *3 CEUs in general supervision *6 CEUs in supervisory ethics Individual can select the courses as long as it is clearly related	$75	Counselors, social workers, psychologists, psychiatrists	Yes, every 2 years – must submit same CEU requirement every time

Summary

Rules and regulations for licensing and certifications vary considerably in New Mexico. This includes what is required for obtaining higher licensure, as well as what is required for billing purposes. There are many resources for getting more information and support on these topics. Next, we will cover some of the methods for providing clinical supervision via supervisory models.

Section 6: Models of Clinical Supervision

The purpose of clinical supervision models is to ensure that the supervisor has guidance on how to foster growth and navigate difficulties within the supervisory relationship. Models also help support supervisors with ensuring that the focus of the time is not strictly administrative. This is part of high-quality practice, covered in more depth in **Section 8**. No one model can capture all needs, and *many supervisors will use a combination of models* to suit the needs of their supervisees, client populations, and agency (Bernard and Goodyear, 2009).

Because there are hundreds of supervision models and plentiful foundational texts on these, no one model will be covered in-depth here. Below is a summary on select models; this section ends with references for additional reading. Readers should keep in mind that all models naturally have limitations. Individuals will also need to consider factors such as culture, language, and the historical implications of behavioral health treatment for some communities when deciding on models that will be right for them and their setting.

Psychotherapy-based models

Psychotherapy-based models of supervision often feel like a natural extension of the work being done with clients because the supervisor and supervisee conceptualize sessions through the lens of the theory (Falender & Shafaanske, 2008). Thus, there is an uninterrupted flow of terminology, focus, and technique from the supervisee's work to the supervision session, and back again. Psychotherapy-based models do not have to be limited to supervisees doing therapeutic work, although certified and credentialed supervisees may need more supervisor training and guidance on these to benefit from said approaches.

Cognitive Behavioral: This model makes use of observable cognitions and behaviors, particularly of the supervisee's professional identity and their reaction to the client (Hayes, Corey, & Moulton, 2003). Cognitive-behavioral techniques used in supervision include setting an agenda for supervision sessions, bridging from previous sessions, assigning homework to the supervisee, and capsule summaries by the supervisor (Liese & Beck, 1997).

Constructivist/Postmodern: This is an umbrella term for therapeutic and supervisory models that are theoretically grounded in the notion that reality and truth are subjective and individualized, rather than being confined to one objective explanation. Supervisors take a consultation role in these models and support the supervisee in finding their own answers, as well as conduct reflective activities on issues such as the impact of culture and language on perspective. Because of the non-directive nature of these models, they may be most appropriate with supervisees who already have at least some experience in the profession (Bernard and Goodyear, 2009). Two primary types of constructivist supervision models are:

- *Narrative:* This model focuses on both the stories of clients and supervisees. The supervisor both assists with the supervisee's work with clients on interpreting their stories, as well as developing their own professional story. The supervisor gives up the role as an expert in this dynamic and primarily adopts a position of curiosity that avoids complex reflections (e.g., asking how the supervisee felt in the session rather than making an observation on how they appear to have felt), with the goal of being collaborative (Bernard and Goodyear, 2009).

- *Solution-Focused:* This model focuses on goal setting, problem-solving, and a strengths-based perspective, including use of interventions such as the *miracle question* (e.g., if the desired change happened tomorrow, what would that look like?) (Bernard and Goodyear, 2009). Hsu (2009) has identified seven components of a session of solution-focused supervision: 1) a positive opening followed by a description of the problem; 2) identifying positive supervision goals; 3) exploring exceptions for both supervisees and clients; 4) reflecting on the supervisee's anxieties around hypothetical outcomes and worst-case scenarios; 5) giving supervisee feedback and clinical education; 6) coaching the supervisee on identifying a first step for their next session with the client; 7) supervisor follow-up in future supervisions.

Feminist: This is a social-justice oriented model developed in the 1970s out of a feminist political philosophy, specifically regarding how minoritized groups are treated in behavioral health. The supervisor and supervisee should work collaboratively, while also openly acknowledging the inherent power imbalance between a supervisor and supervisee. Porter (2009) describes four stages of feminist clinical supervision: 1) guiding the supervisee to fully explore and understand the client's identified problems; 2) reflecting on the client's social location, including oppression and discrimination they face; 3) reflecting on biases and privileges both in the supervisee-client relationship and the supervisor-supervisee relationship; and 4) encouraging macro-level participation that would promote well-being for one or more clients.

Integrative: This refers to producing a conceptual framework that synthesizes the best of two or more theoretical approaches to produce an outcome richer than that of a single theory (Haynes, Corey, & Moulton, 2003). True theoretical integration is not simply an eclectic approach, as it requires an adherence to the underlying assumptions of each individual theory. This can involve more work for the supervisor, particularly with less experienced supervisees who may feel more comfortable with the structure of a single approach and/or may require more clinical education from the supervisor about the what and why behind the supervisor's framework (Bernard and Goodyear, 2009).

Person-Centered/Humanistic Relationship: This model assumes that the supervisee has the resources to effectively develop as a professional without interpretation or direction from the supervisor. The supervisor serves as a collaborator with the supervisee and should provide an environment in which the supervisee can be open to their experience and fully engaged with the client (Lambers, 2000). In person-centered therapy, as developed by Carl Rogers, "the attitudes and personal characteristics of the therapist and the quality of the client-therapist relationship are the prime determinants of the outcomes of therapy" (Haynes, Corey, & Moulton, 2003, p. 118). Person-centered supervision adopts this tenet as well, relying heavily on the supervisor-supervisee relationship to facilitate effective learning and growth in supervision.

Psychodynamic: This model includes a focus on things such as affective reactions, defense mechanisms, transference, and countertransference. Frawley-O'Dea and Sarnat (2001) classify psychodynamic supervision into three categories:

- *Client-centered:* This began with Freud and focuses supervision on the client's presentation and behaviors. The supervisor's role is didactic, with the goal of helping the supervisee understand and treat what the client is bringing to session. The supervisor is seen as the uninvolved expert who has the knowledge and skills to assist the supervisee, thus giving the supervisor considerable authority (Frawley-O'Dea & Sarnat, 2001).

- *Supervisee-centered:* This came into popularity in the 1950s, focusing on the content and process of the supervisee's experience as a provider, such as resistance, anxiety, and learning problems (Frawley-O'Dea & Sarnat, 2001; Falender & Shafranske, 2008). The supervisor's role in this approach is still that of the authoritative, uninvolved expert (Frawley-O'Dea & Sarnat), but is more experiential due to the focus on the supervisee (Falender & Shafranske).

- *Supervisory-matrix-centered:* This not only attends to material of the client and the supervisee, but also examines the relationship between supervisor and supervisee. The supervisor is required to "participate in, reflect upon, and process enactments, and to interpret relational themes that arise within either the therapeutic or supervisory dyads" (Frawley-O'Dea & Sarnat, 2001, p. 41). This includes examining parallel process, as covered in **Section 2**.

Systemic: This model highlights the role of the supervisor and supervisee within any system, which is often focused on any services with multiple people in the room (e.g., family therapy, relationship counseling, group therapy), but can also include the supervisor-supervisee dyad or group (Bernard and Goodyear, 2009). This requires attention to the dynamics of all involved parties, including the supervisor, as well as reflection by the supervisor and supervisee on the systems they belong to, such as family-of-origin. Celano, Smith, & Kaslow (2010) identify the five essential supervisory components of this model as: 1) conceptualizing a systemic formulation; 2) helping the supervisee forge a systemic therapeutic alliance; 3) reframing problems so they can be resolved more productively; 4) building cohesion & skills while managing negative interactions within the system; 5) understanding and applying evidence-based models.

Developmental Models

Many models in this category define progressive stages of supervisee development from novice to expert, each stage consisting of discrete characteristics and skills (Haynes, Corey, & Moulton, 2003). Supervisors must accurately identify the supervisee's current stage and provide feedback and support appropriate to that developmental stage, while at the same time facilitating the supervisee's progression to the next stage (Littrell, Lee-Borden, & Lorenz, 1979; Loganbill, Hardy, & Delworth, 1982; Stoltenberg & Delworth, 1987). Supervisors use an interactive process known as *scaffolding* (Zimmerman & Schunk, 2003), which encourages the supervisee to use prior knowledge and skills to produce new learning. Throughout this process, the supervisee is both exposed to new information and skills and developing advanced critical thinking skills through supervision. This is not a linear process, and supervisee can be in different stages simultaneously (ex. a supervisee may be at mid-level development overall but experience high anxiety when faced with a new client situation).

Integrative Developmental Model (IDM): This is one of the best-know developmental models and was created in the 80s and 90s by Cal Stoltenberg, Brian McNeill, and Ursula Delworth over several publications (Falender & Shafranske, 2004; Haynes, Corey, & Moulton, 2003). IDM has three stages of development, the first being the least experienced and the third being the most. The supervisor's role is to use skills and approaches that correspond to the level of the supervisee. For example, when working with a level-1 supervisee, the supervisor needs to balance the supervisee's high anxiety and dependence by being supportive and prescriptive. The same supervisor when supervising a level-3 supervisee would emphasize supervisee autonomy and engage in collegial challenging. A consistent mismatch between the supervisor's approach and the supervisee's developmental level can result in challenges. For example, a supervisor who demands autonomous behavior from a level-1 supervisee is likely to intensify the supervisee's anxiety, while a level-3 supervisee could feel they are being micromanaged or that their experience is being ignored if they are not given sufficient autonomy.

Reflective Developmental Models: Reflective models are some of the longest used in behavioral health and is first mentioned by John Dewey in 1933. These models in general have supervisees evaluating trigger events (a professional situation where the supervisee felt surprise, discomfort, and/or confusion) to achieve a new perspective on what occurred. All supervisors use reflective supervision to different degrees because of the universality of supervisors and supervisees encountering trigger events they need to evaluate. These are also essential skills for a supervisee development towards independent practice or self-supervision, where one is able self-monitor as they gain more experience and work with less oversight (Bernard and Goodyear, 2009). "Unlike reflections that provide an exact image, reflection in professional practice goes beyond the original to shed light on what might be. In this way, reflection in is inherently developmental" (Bernard and Goodyear, 2009, pg. 37). Reflective thinking and models are used in numerous professions; here are two examples specifically designed within healthcare and social services, although there are many more.

- *Driscoll's "What" Model:* Originally developed by John Driscoll in the 1990s to inform nursing practice, this model asks three simple "what" questions as a reflective practice: 1) "What?" (a description of the event/experience); 2) "So What?" (reflecting on feelings and actions around the event); and 3) "Now what?" (learning from the experience and possible next steps). The goals are to gain insight on the trigger event and generate practice-based knowledge (Driscoll, 2006).

- *Look, Listen, and Learn:* This model was developed specifically around doing work in child welfare and other practice with families with young children, although could be applied to numerous settings. The three primary components are: 1) allowing adequate time and space to reflect; 2) a collaborative supervisory alliance; and 3) regularity of supervision (and, if it is not, reflection on why). This model emphasizes the need for a safe and honest supervisor-supervisee relationship where the supervisee can talk about their thoughts and feelings about their work without this verging into a therapeutic relationship (Parlakian, 2001).

Ronnestad and Skovholt's Lifespan Model: This model has six phases of development: The Lay Helper, The Beginning Student Phase, The Advanced Student Phase, The Novice Professional Phase, The Experienced Professional Phase, and The Senior Professional Phase. The first three phases roughly correspond with the three IDM levels (above), while the second three reflect increasingly advanced practice over the course of an individual's professional career. Ronnestad and Skovholt (2003) also identified 14 themes that are important to professional development, which are heavily focused on the ongoing need for learning and reflection throughout one's career.

Systemic Cognitive-Developmental Supervision (SCDS): This Piaget-influenced model, popular in marriage and family therapy, was written by Sandra Rigazio-Digilio, Stephen Anderson, Thomas Daniels, and Allen Ivey in the 1990s. SCDS focuses on four different thinking orientations that supervisees can have in their practice and developing competency in all of them over time. Unlike some developmental models, none of the four orientations are considered more advanced than another. The goal is for the supervisor to identify which are supervisee's primary orientation(s) and how to help them foster these while navigating the shortcomings of over relying on what feels most comfortable, then expand skills in the other orientations. The four orientations are: 1) sensorimotor (easily feeling and processing emotions); 2) concrete (easily seeing behavioral cause-and-effect); 3) formal (good case conceptualization skills); and 4) dialectic (good at seeing other perspectives and challenging their own thinking) (Bernard and Goodyear, 2009).

Process Models

While process models can include addressing therapeutic modalities and supervisee developmental stages, their primary focus is on analyzing the process and experience of supervision itself. These models often can be complex and are more likely to consider larger system and societal issues than other supervision models (Bernard and Goodyear, 2009).

Bernard's Discrimination Model: Originally published by Janine Bernard in 1979, this model is one of the most commonly used and researched process models. The model is comprised of three separate foci for supervision (i.e., intervention, conceptualization, and personalization) and three possible supervisor roles (i.e., educator, counselor, and consultant) (Bernard & Goodyear, 2009). The supervisor could, in any given moment, respond from one of nine ways (three roles x three foci). For example, the supervisor may take on the role of educator while focusing on a specific intervention used by the supervisee in the client session, or the role of counselor while focusing on the supervisee's conceptualization of the work. Because the response is always specific to the supervisee's needs, it changes within and across sessions.

Critical events in supervision model (CESM): Written in the early 2000s by Nicholas Ladany, Myrna Friedlander, and Mary Lee Nelson, this model uses psychotherapy-based task analysis to review events that supervisees bring to supervision. Once a start to an event has been identified, called a marker, the supervisor then moves into one or more interaction sequences to focus on the issues relevant to the supervisee's event: supervisory alliance, therapeutic process, personal feelings, countertransference, parallel processes, self-efficacy, normalization, skill-building, knowledge-building, multicultural awareness, and evaluation. The supervisor intervenes directly with the supervisee with the goal of working towards a resolution to the event that results in an increase in the supervisee's knowledge, skill, self-awareness, and/or supervisory alliance (Bernard and Goodyear, 2009).

Hawkins & Shohet Model: This model focuses on seven supervisory foci that a supervisor may have in any given moment, which Peter Hawkins and Robin Shohet describe as "the seven-eyed model of supervision" (Bernard and Goodyear, 2009, pg. 52). These foci or modes are: 1) how the client presented in session (according to the supervisee); 2) the strategies and interventions used by the supervisee; 3) the relationship between the client and supervisee; 4) the internal processes of the supervisee; 5) the supervisory relationship; 6) the supervisor focusing on their own process (including thoughts/biases about the client); 7) mezzo/macro considerations such as agency culture and professional community. The model also encourages supervisory attention to five factors that can influence these foci, such as supervisory style, supervisee developmental stage, theoretical orientation of both the supervisor and supervisee, the supervision contract, and type of supervision (individual or group). The supervisor actively intervenes in this model with the goal of being a stabilizing force for a supervisee who is feeling uncertain (Bernard and Goodyear, 2009).

Systems Approach to Supervision (SAS): In this model, the heart of supervision is the relationship between supervisor and supervisee, which is mutually involving and aimed at bestowing power to both members (Holloway, 1995). Holloway describes seven dimensions of systemic supervision, all connected by the central supervisory relationship. These dimensions are the functions of supervision, the tasks of supervision, the client, the trainee, the supervisor, and the institution (Holloway, 1995). The function and tasks of supervision are at the foreground of interaction, while the latter four dimensions represent unique contextual factors that are, according to Holloway, covert influences in the supervisory process. Supervision in any particular instance is seen to be reflective of a unique combination of these seven dimensions.

Target Issues Models

Unlike many other models that are more general, models in this category are focused on specific supervision issues and/or populations. Many of these models are newer while also drawing on past supervision model research. Below are a few examples relevant to practice in New Mexico.

Components for Enhancing Clinician Experience and Reducing Trauma (CE-CERT): Brian Miller and Ginny Sprang developed this model in 2017 out of concern for the amount of compassion fatigue and burnout they saw in behavioral health and the overwhelming focus on recovery from that being during a provider's personal time. The model focuses on 5 components: 1) experiential engagement (acknowledging and experiencing feelings that come with engagement with clients rather than disconnecting or dissociating); 2) reducing rumination on traumatic stories; 3) conscious narrative (assimilating a narrative in order to calm); 4) reducing emotional labor (enhancing skills to decrease perceived burden of the job); and 5) parasympathetic recovery during work hours. The supervisor plays an active role in developing these components in each supervisee and in the overall organization, rather than making secondary trauma recovery solely an individual supervisee's responsibility (Miller and Sprang, 2017).

Queer People of Color (QPOC) Resilience-Based Model: Developed by Anneliese Singh and Kirstyn Yuk Sim Chun in 2010, this model seeks to address issues of both racism and heterosexism can play in supervision and clinical practice, as many multicultural models only address one or the other. Additionally, many models assume that supervisors are predominantly members of majority groups, while this model accounts for supervisors who are part of one or more marginalized groups. The model focuses both on supervisee and supervisor development through three themes: awareness of privilege and oppression; affirmation of diversity; and supervisor empowerment. There are six competencies to develop in this model along all three themes: supervisor-focused personal development; supervisee-focused personal development; conceptualization; skills; process; and outcomes. Resilience is the centerpiece of this model and touches on all six competencies "in recognition that resilience developed in response to repression can serve as a resource to supervisors" (Singh and Chun, 2010, p. 40).

Synergistic Model for Multicultural Supervision (SMMS): This model is focused on supporting supervisors with cross-cultural supervision. Developers Anne Ober, Darcy Granello, and Malik Henfield combined three components into one model: 1) Bloom's Taxonomy (tracking supervisee's multicultural knowledge, comprehension, application, analysis, synthesis, and evaluation); 2) Ancis and Ladany's (2001) 4-phase Heuristic Model of Non-oppressive Interpersonal Development (adaptation, incongruence, exploration, and integration), where a supervisee can be at various stages of across their various identities; and 3) Sue, Arredondo, and McDavis' (1992) three Multicultural Counseling Competencies (attitudes/beliefs, knowledge, and skills). SMMS can be used not only to track supervisee development in multicultural practice, but in other competencies as well (Bernard and Goodyear, 2009).

Summary

There are a wide variety of clinical supervision models to address the needs of supervisees, their clients, and supervisors. While model components can vary considerably, a common factor is that the aim is towards keeping clinical supervision focused on improving care. Supervisors are responsible for identifying the model(s) they are using and discussing this with the supervisee so they can get the most out of the supervisory time.

Now that we have established the who, what, and how of clinical supervision, we will spend the next two sections defining and exploring ethics and high-quality practice, mentioned several times in this Guide so far, and how these can be promoted through supervision.

Section 6 References

Ancis, J. R., & Ladany, N. (2001). A multicultural framework for counselor supervision. In L. J. Bradley & N. Ladany (Eds.), *Counselor supervision: Principles, process, and practice* (pp. 63–90). Brunner-Routledge.

Bernard, J. M. (1979). Supervisor training: A discrimination model. *Counselor Education and Supervision*, 19, 60-68.

Bernard, J. M., & Goodyear, R. K. (2009). Fundamentals of clinical supervision (4th ed.). Needham Heights, MA: Allyn & Bacon.

Celano, M. P., Smith, C. O., & Kaslow, N. J. (2010). A competency-based approach to couple and family therapy supervision. *Psychotherapy: Theory, Research, Practice, Training*, 47(1), 35–44. https://doi.org/10.1037/a0018845

Driscoll, J. (Ed.). (2006). *Practising clinical supervision: A reflective approach for healthcare professionals*. Elsevier Health Sciences.

Falender, C. A., & Shafranske, E. P. (2004). Clinical supervision: A competency-based approach. Washington, DC: American Psychological Association.

Haynes, R., Corey, G., & Moulton, P. (2003). *Clinical supervision in the helping professions: A practical guide* (1st ed.). American Counseling Association.

Holloway, E. (1995). Clinical supervision: A systems approach. Thousand Oaks, CA: Sage.

Hsu, W.-S. (2009). The components of the solution-focused supervision. *Bulletin of Educational Psychology*, 41(2), 475–496.

Lambers, E. (2000). Supervision in person-centered therapy: Facilitating congruence. In E. Mearns & B. Thorne (Eds.), Person-centered therapy today: New frontiers in theory and practice (pp. 196-211). London: Sage.

Liese, B. S., & Beck, J. S. (1997). Cognitive therapy supervision. In C. E. Watkins, Jr. (Ed.), Handbook of psychotherapy supervision (pp. 114-133). New York: John Wiley & Sons.

Littrell, J. M., Lee-Borden, N., & Lorenz, J. A. (1979). A developmental framework for counseling supervision. *Counselor Education and Supervision*, 19, 119-136.

Loganbill, C., Hardy, E., & Delworth, U. (1982). Supervision: A conceptual model. *Counseling Psychologist*, 10, 3-42.

Miller, B., & Sprang, G. (2017). A components-based practice and supervision model for reducing compassion fatigue by affecting clinician experience. *Traumatology*, 23(2), 153–164. https://doi.org/10.1037/trm0000058

Parlakian, R. (2001). *Look, listen, and learn: Reflective supervision and relationship-based work*. Washington, D.C: Zero to Three.

Porter, N. (2009). Feminist and multicultural underpinnings to supervision: An overview. *Women & Therapy*, 33:1-2, 1-6, DOI: 10.1080/02703140903404622

Ronnestad, M. H. & Skovholt, T. M. (2003). The journey of the counselor and therapist: Research findings and perspectives on professional development. *Journal of Career Development*, 30, 5-44.

Singh, A. & Sim Chun, K.Y., (2010). From the margins to the center: Moving towards a resilience-based model of supervision for queer people of color supervisors. *Training and Education in Professional Psychology*, vol. 4, 1, pp. 36–46

Stoltenberg, C. D., & Delworth, U. (1987). *Supervising counselors and therapists*. San Francisco: Jossey-Bass

Sudak, D. M., Codd, R. T. III, Ludgate, J., Sokol, L., Fox, M. G., Reiser, R., & Milne, D. L. (2016). *Teaching and supervising cognitive behavioral therapy*. John Wiley & Sons, Inc.

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Multicultural Counseling and Development*, 20(2), 64–88.

Section 7: Ethics in Clinical Supervision

What are ethics and values?

Ethics pertain to the beliefs we hold about what constitutes correct conduct. According to experts in the field, ethics are more than just rules; they are aspirational goals that help guide us in making decisions with the best intentions and practices at their core (Corey et al., 2018). Ethics shape our professional conduct, guiding us to act with integrity, fairness, and respect in all our interactions. They are the moral compass that directs us in complex and challenging situations, ensuring that our actions benefit those we serve and uphold the standards of our profession. As supervisors it is key that we understand, model and teach ethical principles to our supervisees. We do this to protect clients and as gatekeepers in the field.

Values "are the beliefs and attitudes that provide direction to our everyday living" (Corey et al., 2018, p. 13). They are the core principles that define what we consider important and worthwhile. Values influence our behavior, decisions, and interactions with others. They shape our priorities and guide us in determining what is right and wrong in various contexts. In the realm of clinical supervision, values help supervisors and supervisees align their actions with their personal and professional ideals, fostering a consistent and principled approach to their work.

Clinical supervision is a primary way to explore ethics and values with supervisees. Supervisors have responsibility and liability to ensure supervisees are following professional best practices and not causing harm. For example, a supervisor is the primary person responsible for intervening if a supervisee's judgment appears to be impaired in a way that could result in unethical practice.

To effectively support our supervisees, supervisors must have a comprehensive understanding of ethics. This involves several key components:

- *Understanding institutional ethics:* It is crucial for supervisors to be familiar with the ethical guidelines established by relevant boards and associations. These guidelines provide a framework for ethical decision-making and professional conduct.
- *Utilizing ethical decision-making models:* Supervisors should employ structured approaches to navigate ethical dilemmas. These models help in systemically analyzing situations, considering all relevant factors, and making informed decisions that uphold ethical standards.
- *Modeling best practices:* Supervisors should exemplify ethical behavior in all professional actions. By demonstrating integrity, honesty, and respect, supervisors set a powerful example for their supervisees to follow.

The remainder of this section will focus on the first two bullet points in the hopes of informing the third. Additionally, we will end with ethical topics specific to supervision, such as informed consent.

Ethical Guidelines and Clinical Supervision

Various boards and associations provide ethical guidelines for licensed professionals. These include:

- American Board of Clinical Social Work (ABECSW)
- American Counseling Association (ACA)
- American Psychological Association (APA)
- Approved Clinical Supervisor (ACS)
- Association for Counselor Education and Supervision (ACES)
- Commission on Rehabilitation Counselor Certification (CRCC)
- National Association of Social Workers (NASW)
- National Board of Certified Counselors (NBCC)
- New Mexico Office of Peer Recovery and Engagement (NM OPRE)

These organizations establish ethical standards that ensure professionals conduct themselves in ways that protect clients' welfare, maintain professional integrity, and uphold the dignity of the profession. It is the responsibility of both the supervisor and supervisee to be familiar with the ethical guidelines relevant to their practice, including the supervisor being familiar with the guidelines of their supervisees' licenses and certifications. In some cases, information about ethical guidelines for other disciplines is provided in that discipline's approved supervisor process; see **Section 5** for more details on this.

While these ethical guidelines vary among professions, they are generally more similar than different and share the same ethical principles. These principles include:

- *Autonomy:* Respecting the supervisee's and client's independence and self-determination.
- *Nonmaleficence:* Avoiding harm and ensuring actions do not cause damage.
- *Beneficence:* Acting in the best interest of supervisees and clients, promoting their well-being.
- *Justice:* Ensuring fairness, equality, and impartiality in all professional dealings.
- *Fidelity:* Maintaining trustworthiness, loyalty, and commitment to professional responsibilities.
- *Veracity:* Upholding honesty and transparency in all interactions.

All of the professional ethics guidelines include guidance about clinical supervision. Again, these are more similar than different among professions. Below is an example of the twelve core areas of ethical supervision identified by ACES.

1. *Initiating supervision:* Setting the stage for a productive supervisory relationship.
2. *Goal setting:* Defining clear, achievable objectives for supervision.
3. *Giving and receiving feedback:* Facilitating open, constructive communication.
4. *Conducting supervision:* Managing the supervision process effectively.

5. *Supervisory relationships:* Building a strong, supportive, and professional relationship.
6. *Diversity and advocacy considerations:* Addressing and advocating for diverse needs and perspectives.
7. *Ethical considerations:* Ensuring all actions and decisions adhere to ethical standards.
8. *Documentation:* Maintaining accurate and thorough records.
9. *Evaluation:* Assessing the progress and effectiveness of supervision.
10. *Supervision format:* Choosing appropriate methods and formats for supervision.
11. *The supervisor:* Recognizing the responsibilities and development needs of the supervisor.
12. *Supervision preparation:* Engaging in ongoing training and consultation.

Best practices suggest that supervisors should incorporate these dimensions throughout their supervisory work to ensure comprehensive and ethical supervision. Incorporating these dimensions with ethical principles into discussions during clinical supervision helps supervisees understand and apply them in their practice.This integration ensures that ethical considerations are consistently prioritized, fostering a culture of ethical awareness and action.

A strong understanding of ethics and ethical practices is vital for providing effective supervision and achieving good clinical outcomes. Ethical practice is a key component of professional competence and acts as a gatekeeper for the profession. It ensures that clients receive quality care, that supervisees develop into competent and ethical practitioners, and that the profession maintains its integrity and public trust. Ultimately, good ethical practice protects clients and ensures the provision of quality care to those seeking help.

Ethical Decision-Making Models

When faced with an ethical dilemma, an ethical decision-making model can be a helpful tool for evaluating the best course of action. There are a number of existing models, including the ETHIC Model (Congress, 2000), the General Decision-Making Model (Dolgoff et al., 2011), the Forester-Miller and Davis' Ethical Decision-Making Model (Forester-Miller & Davis, 2016), and Reamer's Ethical Decision-Making Framework (Reamer, 2018). While elements with these can vary depending on when they were written and with which profession in mind, common elements include identifying the nature of the ethical dilemma, reviewing the relevant ethical codes, and evaluating the decision made.

It is beneficial for supervisors to be familiar with one or more models so they can coach supervisees through these steps when a dilemma arises. These models can help providers be more confident in their ethical decision-making and help build supervisee critical thinking skills, particularly for those who hope to practice independently in the future.

Clinical Supervision and Informed Consent

While informed consent is typically thought of as applying to the therapeutic relationship, this is also a crucial aspect of supervision, given the power differential between supervisor and supervisee. This process involves clearly communicating with supervisees about:

- *Expectations for supervision:* Outlining what supervisees can expect from the supervision process.
- *Meeting times:* Establishing regular, consistent supervision sessions.
- *Agency policies and emergency procedures:* Ensuring supervisees understand the rules and protocols of the organization.
- *Ethical and legal considerations:* Highlighting key ethical and legal guidelines that govern practice.
- *Dual relationships:* Clarifying boundaries to prevent conflicts of interest.
- *Reporting procedures:* Explaining how and when to report concerns or issues.

Supervisees should also be informed about many of the topics previously discussed in this Guide, such as supervisor and supervisee roles and responsibilities (**Section 2**) and theoretical orientation/ supervision model (**Section 6**).

Having this information provided in writing via a supervisory contract gives a method for supervisors and supervisees to discuss these explicitly and revisit as needed. See **Section 9** for more information about writing supervisory contracts and other documentation associated with supervision.

Additional training

This information in this section is compiled from a comprehensive training conducted by the New Mexico Clinical Supervision Academy. For more information on this valuable resource, please visit the Clinical Supervision Academy: https://clinicalsupervisionacademy.com/

Summary

Ethics are a critical component of clinical supervision and needs to be explicitly covered throughout a supervisory relationship. There are many resources across behavioral health disciplines to inform ethics in clinical supervision. Next, we will cover high-quality practice, of which ethics is a component.

Section 7 references

Congress, E.P. (2000). What social workers should know about ethics: Understanding and resolving practice dilemmas. Advances in Social Work, 1(1), 1–25. https://doi.org/10.18060/124

Corey, G., Corey, M.S., and Corey, C. (2018). Issues and ethics in the helping professions (10th ed). Cengage Learning.

Clinical Supervision Academy. (2023). Training cohort 3 July 2023-March 2024. Retrieved from https://clinicalsupervisionacademy.com/

Dolgoff, R., Harrington, D., & Loewenberg, F. M. (2011). Ethical decisions for social work practice (9th edition). Brooks/Cole Pub Co.

Forester-Miller, H., & Davis, T. (2016). A practitioner's guide to ethical decision-making. Alexandria, VA: American Counseling Association. https://www.counseling.org/docs/default-source/ethics/practioner-39-s-guide-to-ethical-decision-making.pdf?sfvrsn=10/1000

Reamer, F. G. (2018). Social work values and ethics (5th edition). Columbia University Press.

Section 8: Clinical Supervision and High-Quality Practice

What is High-Quality Practice?

The term practice refers to the collective set of actions used to plan and deliver interventions and support. Practice takes place in collaboration with the person(s) served and the social and service-related networks and supports available to help meet the person's individualized and/or family needs. Practice must be guided by self-determination and individual choice. The purpose of practice is to help a person or family to achieve an adequate level of:

- Well-being (e.g., safety, stability, permanency for dependent children, physical and emotional health);
- Daily functioning (e.g., basic tasks involved in daily living, as appropriate to a person's life stage and ability);
- Basic supports for daily living (e.g., housing, food, income, health care, childcare); and
- Fulfillment of key life roles (e.g., a child being a successful student or an adult being a successful parent or employee).

High-quality practice, then, is when behavioral health services are delivered in a way that effectively supports individuals and families with reaching these goals, using both research on what interventions work (or *evidenced-based research*) and provider knowledge and experience of what is effective and culturally responsive in the local community (or *practice-based evidence*).

Five basic functions of quality practice must be performed for each client served to achieve the greatest benefits and outcomes. These functions, listed below, are the foundation of high-quality practice and underlie all successful intervention strategies. Because these functions are essential to achieving positive results with clients served, New Mexico's Behavioral Health Services Division (BHSD) expects that each person served will, at a minimum, be served in a manner that consistently provides and demonstrates these core practice functions.

The basic functions of quality practice are:

1. Engaging Service Partners
2. Assessing and Understanding the Situation
3. Planning Positive Life-Change Interventions
4. Implementing Services
5. Getting and Using Results

This section will first cover how to foster high-quality practice in clinical supervision, followed by agency-level considerations for supervisors about how to implement this throughout an organization.

Addressing High-Quality Practice in Clinical Supervision

Clinical supervision is the foundation for assuring consistent, high-quality practice for the community. In this regard, every part of this Guide is related to high-quality practice, hence it has been referenced throughout. This Guide introduces concepts of what supervision is, licensure and certification rules, supervision models, and ethics first to create the context of what some of the components of clinical supervision are, before getting into the more complex questions of why and how to provide clinical supervision in a way that promotes high-quality practice. There are also upcoming sections on documentation (see **Sections 9** and **10**), which is also part of high-quality practice.

Supervision that supports high-quality practice, first and foremost, involves oversight of an individual's work. This may seem like an obvious component, and also can be neglected in favor of administrative tasks. This oversight includes:

- Providing support and consultation during scheduled supervisions and as needed;
- Reviewing and growing the supervisee's case formulation skills as appropriate for the scope of the position, including diagnosing;
- Reviewing the fit of the interventions selected by the supervisee with an individual client's needs;
- Working with the supervisee on writing and articulating clinical reasoning for all aspects of their job duties, including developing and adjusting treatment plans;
- Reviewing documentation;
- Engaging in direct observation;
- Providing support and debriefs following crises;
- Discussing how care is being coordinated across the organization and between other organizations where clients receive services (see **Section 11** for more about this in regards to integrated health); and
- Providing timely, meaningful, and actionable evaluation.

Key elements of high-quality supervision in behavioral health include:

1. *Competence:* Supervisors should possess the necessary expertise and qualifications in both counseling and supervision as mandated by licensure boards and the State of New Mexico HSD and BHSD.

2. *Establishing Goals:* Clinical supervision for both licensed and credentialed professions should include setting clear and achievable goals for the supervision process and be time limited. This should align with the counselor's developmental needs, clinical theoretical orientation, and professional objectives. For both licensed and credential professionals this can include identifying specific areas of professional development and steps to achieve a specific goal.

3. *Feedback and Evaluation:* Clinical supervisors are responsible for providing constructive feedback on the counselor's performance, including strengths and areas for improvement, based on direct observation, case discussions, and other relevant data.

4. *Reflective Practice:* Clinical supervisors should encourage supervisees to engage in reflective practice, critically evaluating their own thoughts, feelings, and actions in therapeutic interactions, case management and/or peer support.

5. *Ethics:* Clinical Supervisors ensure that that supervision addresses ethical considerations and dilemmas, providing concrete steps and reasoning for ethical decisions. It is recommended that Clinical Supervisors identify and use an Ethical Decision-Making Model to help ground them in an ethical dilemma. This can be done with supervisees who are both licensed and credentialed professionals. See **Section 6** for more on ethics.

6. *Cultural Humility:* Clinical Supervisors ensure that supervisees are culturally responsive and practice cultural humility in their service provision. Supervisors support supervisees to practice, understanding the complexities and importance of culturally responsive care. Cultural humility emphasizes self-awareness, openness, and lifelong learning about others and differences including an understanding of diversity, equity, inclusion and belonging with service provision, both clinical and nonclinical. It involves recognizing and respecting the complexity of various cultural identities, beliefs, and practices, as well as acknowledging one's own cultural biases and limitations and how that might affect high-quality services practices and provision.

7. *Supervisory Relationship:* Clinical supervisors must create a trusting and respectful supervisory relationship characterized by openness, honesty, and confidentiality. Supervisees must feel safe to confront mistakes, learn and shift and feel supported on their specific learning trajectory. This includes offering appropriate emotional support, validation, and encouragement to the supervise, particularly during challenging cases or periods of professional growth.

8. *Continuous Learning:* Clinical Supervisor must engage in ongoing professional development and stay informed about current research, best practices, and emerging trends in counseling and supervision. They must maintain any requirements set forth by their state licensing board as well as any other requirements set forth by the State of New Mexico.

9. *Evaluation and Accountability:* Clinical Supervisors should monitor the supervisees' progress towards achieving supervision goals, holding them accountable for ethical and professional standards. Clinical supervisors should establish ways of evaluating performance and provide opportunities for supervisees to give feedback to supervisors.

10. *Flexibility:* Clinical supervisors must adapt supervision approaches and techniques to meet the unique needs and learning styles of the supervisor, as well as the demands of different counseling settings. Clinical supervisors should have a basic understanding of the different theoretical orientations and make it their theoretical orientation explicit to their supervisees.

11. *Responsibility:* As a clinical supervisor it is your responsibility to review the codes for which your supervisee is mandated. As a supervisor, your responsibility is to know, review and model the guideline as put forward by the APA, ACA and NASW.

The Practice Wheel—A High-Quality Practice Model

The *practice wheel* is an example of a behavioral health practice model that can be used by an organizations leadership to define the principles and organizing functions used by practitioners. Models such as the Practice Wheel can inform both service provision and clinical supervision practices and serves to provide a basic structure for both.

The practice wheel encompasses the core values and expectations for providing services to clients. The basic functions illustrated in the practice wheel include:

- Response to cultural identity and need
- Engagement
- Assessment and understanding
- Pathway to case closure and/or a long-term guiding view
- Intervention planning
- Implementation of supports and services
- Tracking and adjustment and
- Teamwork and coordination, which acts as the center of the practice wheel and is an essential component to the other eight basic functions.

This framework functions to organize casework and service delivery, to guide the training and supervision of staff, and clarify quality measures and accountability. Supervision and training could progress along the practice wheel, with each function as a topic of focus to strength and operationalize expectations.

You can access a copy of the practice wheel at: https://cssp.org/wp-content/uploads/2019/03/QSR-Advocacy-System-Reform.pdf

Organizational Considerations and High-Quality Practice

All organizations stand to benefit from promoting high-quality practice and clinical supervision within their organizations. By allowing adequate time for supervisors to clinically oversee their team, organizations increase the quality of their services and fidelity to evidenced-based practice models, while decreasing critical incidents and staff turnover. Organizations should ensure they have a large enough number of supervisors to meet the organization's supervisory needs and that these supervisors are able to promote high-quality practice, rather than being consumed by administrative demands. Organizations can promote this by having policies and procedures that ensure that:

- Clinical Supervision is conducted in a manner that provides adequate attention to each supervisee and quality oversight for the cases.
- Clinical Supervision occurs frequently and follows a structured process that includes individual & group, clinical oversight, and regular access to supervisors.
- Both individual and group clinical supervision occurs multiple times during any month with documentation evidence that clinical supervision has occurred accordingly.
- The organization has a Quality Improvement Program, which includes process improvement approaches, relevant data collection, fidelity measures and data for outcome monitoring.
- All individual practitioners', group practices' and facilities' Quality Improvement Programs should have a Clinical Practice Improvement program that:
  - Utilizes the findings from its Clinical Supervision to improve the provider performance.
  - Addresses care planning consistent with wraparound planning approaches; system of care principles; and a recovery philosophy.
  - Includes process improvement approaches, relevant data collection, fidelity measures and data for outcome monitoring.
  - Has a review protocol is in place, which should examine strengths and improvements in the following areas:
    - ☒ Engagement
    - ☒ Teamwork
    - ☒ Assessment & understanding
    - ☒ Outcomes & goals
    - ☒ Intervention planning
    - ☒ Resources
    - ☒ Adequacy of interventions
    - ☒ Tracking and adjustment

Additionally, New Mexico's Behavioral Health Services Division (BHSD) has made high-quality practice a focus area for all service providers. This includes promoting values around individualized strengths-based treatment that is developmentally and culturally responsive, includes natural supports, and is trauma-informed. BHSD promotes also early intervention and integrated teaming with the goal of using the least restrictive services.

BHSD will support organizations to consistently measure their outcomes with clients using Integrated Quality Service Reviews (I-QSR) Clinical Supervision and Quality Improvement strategies based on their organization's comprehensive and ongoing self-assessments. Agencies are encouraged to develop strong internal clinical practice development activities including integration of the I-QSR or other data-driven fidelity models. Agencies who would like more support with this are encouraged to contact BHSD directly.

Summary

High-Quality Practice is the cornerstone of all behavioral health practice; no aspect of the work should be done without consideration of how we can achieve the best outcomes with clients. Clinical supervision is a core component of how high-quality practice is implemented across the behavioral health system. Leaders in organizations also play a role in high-quality practice by supporting consistent time for clinical supervision and providing support for quality improvement so supervisors have data to illustrate what is or is not contributing to quality across programs.
Now that we have established some of the why and how of clinical supervision, we pivot to two sections on the skill of writing about clinical and supervisory encounters. The purpose is to provide best practices on how to conduct and teach these skills to create a paper trail illustrating the values and skills described in this guide so far.

Section 8 references

Center for the Study of Social Policy. (2019). *Quality service reviews: a mechanism for case-level advocacy and system reform*. Retrieved from https://cssp.org/wp-content/uploads/2019/03/QSR-Advocacy-System-Reform.pdf

Section 9: Clinical Supervision and Clinical Writing

As supervisors working with clinical professionals both licensed and credentialed, supporting supervisees with clinical documentation is key to providing good quality care. Frederic Reamer, a leader in social work ethics, describes clinical documentation as "one of the most important skills in behavioral health practices…the clinical need for thorough, accurate and timely documentation to ensure quality service delivery cannot be overemphasized" (Reamer, 2009). Clinical documentation is what justifies services, document progress and funds many behavioral health services through managed care and other funding through foundations and grants. As supervisors, it is our duty to ensure that our supervisees are able to meet the expectations of clinical documentation. Teaching supervisees how to capture what happened in a session, how to organize their assessment and how to document safety is key to high-quality care.

The best method of teaching documentation is *The Golden Thread*, a sequence of clinical documentation that flows from the intake assessment, treatment planning, session notes and discharge. This model supports the demonstration of ongoing clinical need, treatment and rationale for discharge. Each piece or part of documentation must flow logically from one to another. Additionally, an outside reviewer (auditor, third party payor) must be able to see the connections.

Golden Thread Part 1: The Biopsychosocial Assessment

The Biopsychosocial assessment (BPS) is an assessment that is the start to the thread of a clinician's understanding of treatment. It is a cohesive, comprehensive summary of the initial interview that establishes clinical significance for treatment and establishes the rationale for treatment and treatment modalities. The BPS should first start by identifying the client's strengths and should incorporate all resilient and protective factors. This includes identifying other domains outside of the traditional areas of focus and should include both spirituality/religion as well as a client's ecological development (Davis, 2023). **Pages 55**-65 provides examples of both adult and youth assessments that comprehensively cover all of these areas, and **pages 64**-66 are worksheets that can assist with formulation and clinical reasoning during the assessment or as needed. For more ideas about clinical writing in case conceptualization, go to https://positivepsychology.com/case-conceptualization-examples/

Best practice indicates that this type of assessment should include the biological/biomedical, psychological and social development throughout the client's lifespan. Davis et al. (2023) emphasize the importance of conducting such assessments from a strength-based approach recognizing and emphasizing "client's inherent resilience capacities and strengths, fostering personal growth, resilience and posting change instead of solely addressing deficits or pathology…the goal is to provide personalized and empowering interventions aligned with the client's individual and cultural background" (Davis et al., 2023, pg. 3).

While developing the BPS, clinicians compile information and demonstrate skill in information gathering and decision making. Clinical supervisors provide support in helping the clinician justify diagnosis and establish a plan of care. This is the beginning of the "map" of information that starts from the intake and moves throughout treatment.

A crucial component of the BPS is clinical case formulation. This section is essential in summarizing, supporting, and justifying treatment, intervention, and trajectory of treatment. This is where a clinician establishes and supports the clients need for care, and within the biomedical model, establishes medical need. It is where the assessor provides the initial information and recommendations for treatment. It helps examine the pertinent factors influencing a person seeking services and provides a comprehensive picture of what the person needs in their life. This is where a clinician can also recommend services including therapeutic, medical and additional care from credential service providers (ex. CCSS). It is important that supervisees and supervisors alike are knowledgeable not just about the services available at their organization, but the full spectrum of services available in their community.

Because new information can emerge over the course of services as rapport is built, assessment and formulation are also *ongoing* processes. Clients who are in services longer-term should have a new BPS conducted annually. Additionally, new information or formulations should be reflected in the treatment or service plans (see below).

Golden Thread Part 2: Treatment/ Service Plans

The treatment or service plan is the tool that guides both the clinician and the client to work together on treatment goals. In most programs, service plans must be completed at the onset of treatment and updated at least every 90 days, although this varies depending on the program. It is the supervisor's responsibility to ensure supervisees receive training on rules and regulations around when their plans should be created and updated. Service plans should include a history of presenting problems or current needs and goals of objective that can help the identified need.

There are multiple components to a service or treatment plan. These include:

- *Goals:* these are general, perhaps intangible, broad, and abstract. Goals are strategic and can be broken down into short-term and long-term goals. They should reflect what was identified in the presenting problems and should include aspects of the BPS(ES) to support change and overall well-being.

- *Objectives:* these are specific and measurable. They might have a narrow focus with concrete outcomes.

A standard way to compose these goals and objectives are the use of SMART goals:

- **S**pecific
- **M**easurable
- **A**chievable
- **R**ealistic, and
- **T**ime-limited.

Using SMART goals in a service plan allows clinicians to more effectively identify specific goals related to the reasons why the client is seeking services and is a way to monitor the efficacy of treatment. This is to the benefit of not just the supervisee and the supervisor, but also the client.

Goals setting is only one part of the service plan. This plan is an agreement between the client and the clinician. The plan should be in the language of the client and should have minimal to no "clinical speak" because it must be accessible to the client. This means treatment plans and service plans must be in Spanish for monolingual Spanish speakers, for example, and is line with best cultural practices.

Discharge planning must be part of the service plan including helping the client identify what they are planning when services terminate (where are they going to be living, who will be their supports). Clinicians must estimate the length of stay. Like the BPS, best practice indicates a strength-based approach and ensures a collaborative process with the client in the creation and execution of the plan.

Clinicians should include in the Service Plan their theoretical orientation, modalities of treatment, clinical interventions and clearly identify assessing when goals have been met. Service plans are living documents and should be updated as goals are met. They should be review and updated at the frequency mandated for the level of care (at least every 90 days) to ensure that treatment is progressing, goals are being met and the client is making progress towards a successful discharge. The worksheet on **page 67** can be used to assist in developing interventions towards goals at any stage of a client's services.

Part 3 of the Golden Thread: Progress Notes

Progress notes must flow from the BPS and treatment or service plan. Clinicians should connect each session to the overall treatment, modalities, and Evidence-based practices (EBPs) that were identified in the service plan. Common formats for progress notes include Data, Assessment, and Plan (DAP) notes, as well as Subjective, Objective, Assessment, and Plan (SOAP) notes. Regardless of what format is used, notes should include what objectively occurred and identify salient information of the session and describe what intervention(s) the clinician used during the session.

Notes should include a form of assessment that describes how the client seemed during the session and how they respond to the intervention. This section should identify any risk factors you might want to highlight and any plans for safety. This section should also include any assessment about the client or the session that would be good to document.

Notes should include some plan for future sessions that could include homework assigned as well as time and date of next session. It is best to keep plans open-ended and flexible to meet clients changing needs at each session, but always connected to the service plan.

Treatment notes are a way to track progress and can help adjust treatment as needed. As treatment changes, the plan of service must also change. As an example, if sessions are regularly focused on issues that are not in the treatment or service plan, this may be a sign to make updates to the plan. Treatment notes also allow for payment and reimbursement and are a tool to justify service.

Best practice indicates that each client participating in a group, family or conjoint therapy (couples, relationships) have their own clinical note. Copying and pasting notes into group members files is not advisable as each individual shows up with their own need and subjective experience, as well as needing an objective assessment of what happened in the session. It is recommended to have group notes that identify group behaviors as well as individual contribution in session. Group notes can have their own formatting and/or can be included with a DAP or SOAP note for each session. For SOAP note examples, go to: https://positivepsychology.com/soap-notes-counseling/

Documentation and Communication

It is important for supervisees to know what to include in a BPS, Service Plans and Progress Notes. As the supervisor it is imperative that you teach supervisees to write for the audience of clinical documentation. This can be different depending on your setting and the specific population that you serve. Examples include legal courts, third-party payors, and auditors. Clinical documentation should not be where supervisees are informing supervisors of what happened in a session. Supervisors should teach supervisors to write a snapshot of what happened and to omit sensitive details. This is to protect the client and to ensure that the documentation is serving its purpose.

Providers who conduct services in languages other than English have the additional labor of formulating and writing their assessments and notes into English. Supervisors should help supervisees learn how to best capture significant clinical information so that critical details are not getting "lost in translation." This includes supporting supervisees with accessing training in the language in which they conduct services, as discussed in **Section 2**.

Summary

Teaching documentation to supervisees is an important component of overall high-quality practice. Rather than merely "checking a box" or fulfilling billing requirements, clinical documentation should be a tool in providing and evaluating care. The next section covers documentation in supervision, a parallel but distinct skill.

Adult Biopsychosocial Assessment

Indentifying Information:
(Client name, gender identity, date of birth and age, race, ethnicity, and nationality [if relevant], language spoken, socioeconomic status, living arrangements)

Referral:
(Source, Nature of Request)

Source of Data:
(Interview, observation, written materials, consultations and collateral, assessment scores)

Client Strengths:
(Include client's positive interests, traits, skills, family dynamics, resiliency, motivations)

Presenting Problem:
(Describe the problems for which the client came in for help, include client's definition of the problem, needs and expectations, a brief history of the presenting problem [duration, prior attemps to solve problem, other agencies and therapy services], include a risk assessment)

History of Presenting Problem:
(Identify presenting problem, duration, severity, contributing factors of triggers, relevant life events)

Home Environment:
(Describe current home, other household members, neighborhood, and socioeconomic factors)

Family History:
(Significant family members present in childhood, family environment, history of abuse [indicate type], family history of abuse, legal problems and/or mental illness)

Educational and Employment History:
(School history and current status, highest level of education, degrees earned, challenges and goals, current employment)

Quality of Life History and Current Functioning:
(Please indicate any issues with the following)
Financial:
Living Situation
Legal History
Supervision Needs
Transportation:
Keeping Appointments:
Reading or Writing:
Managing Money:

Obtaining Dental Care:
Adequate Nutrition:
Health/Hygiene:
Using Leisure Time:

Religious and Spiritual Involvement:
(Identified religion [if any], level of involvement with and support from the religious community, other spiritual practices. Identify how these impact daily life if any. Clarify if any spiritual or religious beliefs impact decision making. Are there any internal struggles or conflicts with these beliefs? How does spiritually and religion provide a sense of meaning making, if any)

Ecological Development:
(Identify the client relationship to their natural environment, emphasizing the elements that contribute to wellbeing, how nature positively influences them, their relationship with nature and their health. Highlight any natural disasters and their coping to such events. Identify any environmental concerns that the client might have)

Physical Functioning, Health Conditions and Medical Background:
(Physical development, general healthy, disabilities and current functioning, history of disease, accidents, genetic predistortions and prescription medications)

Date of last physical exam:
Self report on current health status (poor, fair, excellent):
Appetite disturbance and duration:
Sleep disturbance and duration:
Allergies:
Current Pain (0-10, location):
Current Physical Problems:
Major Medical/Surgical History:
Medications:

Type	Prescribing Doctor	Dosage	When Started

Over the Counter Medication:

Type	Prescribing Doctor	Dosage	When Started

Behavioral Health History:
Identify all previous mental/psychiatric treatment received, dates, diagnosis, is coordination of care needed, suicidal history including attempts if any and with what)

Trauma History:
(Identify any trauma events that have occured throughout the client's lifetime. This should include any attachment disruptions, physical, emotional and/or sexual abuse, or assault. Please identify the events chronologically if possible)

Substance Use History:
(Include substances used, frequency, age at first use, patterns, family history. If significant history, please use CAGE assessment)

- Have you felt the need to cut down on your drinking?
- Do you feel annoyed by people complaining about your drinking?
- Do you ever feel guilty about your drinking?
- Do you ever drink an eye-opener in the morning to relieve shakes?

Military History:
(Include dates served, and family history)

Mental Status Exam

OBSERVATIONS

Appearance	Neat	Disheveled	Inappropriate	Bizarre	Other
Speech	Normal	Tangential	Pressured	Impoverished	Other
Eye Contact	Normal	Intense	Avoidant	Eyes Closed	Other
Motor Activity	Normal	Restless	Tics	Slowed	Other
Affect	Full	Constricted	Flat	Labile	Other
Comments					

MOOD

Euthymic	Anxious	Angry	Depressed	Euphoric	Irritable	Other
Comments						

COGNITION

Orientation Impairment	None	Person	Place	Purpose	Time
Memory Impairment	None	Immediate	Intermediate	Remote	Other
Attention	Normal	Distracted	Other		
Comments					

PERCEPTION

Hallucinations	None	Auditory	Visual	Other
Disassociation	None	Derealization	Depersonalization	Other
Comments				

THOUGHTS

Thought Process	Coherent	Distorted	Visual	Other	
Cognitive Functioning	Low	Consistent with Education	Inconsistent with Education	Highly Functioning	Other
Suicidality	None	Ideation	Plans	Means	Intent
Homicidally	None	Ideation	Plans	Means	Intent
Delusions	None	Grandiose	Paranoid	Religious	Other
Comments					

BEHAVIOR

Cooperative	Guarded	Hyperactive	Agitated	Paranoid
Aggressive	Bizarre	Withdrawn	Other	
Comments				

INSIGHT	Good	Fair	Poor
JUDGMENT	Good	Fair	Poor

Summary of Safety Concerns
(Include safety issues and preliminary plans for addressing them)

Cultural Assessment
Cultural background:
Language/s spoken
Socioeconomic: (Low, Middle, High)
Family Activities:
Special Requests/needs due to cultural factors:

Clinical Case Formulation:
(Summarize/formulate information gathered, identify underlying factors contributing to presenting problems and need for services, factors in differential diagnosis referrals or follow-up necessary, cultural considerations, etc. Identify diagnostic criteria to support working diagnosis)

DSM-5/ICD-10 Category

1.

2.

Treatment Recommendations:

Estimated Length of Treatment:

Report Completed by:_____ Date:_____

Clinical Supervisor: _____ Date:_____

Child Biopsychosocial Assessment

Indentifying Information:
(Client name, gender identity, date of birth and age, race, ethnicity, and nationality [if relevant], language spoken, socioeconomic status, living arrangements)

Referral:
(Source, Nature of Request)

Source of Data:
(Interview, observation, written materials, consultations and collateral, assessment scores, interview with parents)

Client Strengths:
(Include client's positive interests, traits, skills, family dynamics, resiliency, motivations. If a younger child, also include what parents/caregiver identifies as strengths.)

Presenting Problem:
(Describe the problems for which the client came in for help, include client's definition of the problem, needs and expectations, a brief history of the presenting problem [duration, prior attemps to solve problem, other agencies and therapy services], include a risk assessment. Include both the child's and parents'/caregivers' description of the presenting problem.)

History of Presenting Problem:
(Identify presenting problem, duration, severity, contributing factors of triggers, relevant life events. Include both the child's and parents'/caregivers' description of the history of the presenting problem.)

Home Environment:
(Describe current home, other household members, neighborhood, and socioeconomic factors. Include both the child's and parents'/caregivers' description of the home environment.)

Family History:
(Significant family members present in childhood, family environment, history of abuse [indicate type], family history of abuse, legal problems and/or mental illness. Include both the child's and parents'/caregivers' description of family history.)

Educational and Family Employment History:
(School history and current status, highest level of education, degrees earned of family members if relevant and challenges and goals, current caregiver employment. List the school the child attends and list any additional notes of education challenges and identified needs [IEPs and other school accommodations.])

Developmental History
(Highlight major milestones in development (crawling, walking, talking, toileting). Highlight anything significant in birthing parent's pregnancy.

Quality of Life History and Current Functioning:
(Please indicate any issues with the following for parents, family and relevant to the child).
Financial:
Living Situation:
Legal History:
Supervision Needs:
Transportation:
Keeping Appointments:
Reading or Writing:
Managing Money:
Obtaining Dental Care:
Adequate Nutrition:
Health/Hygiene:
Using Leisure Time:

Religious and Spiritual Involvement:
(Identified religion [if any], level of involvement with and support form the religious community, other spiritual practices. Identify how these impact daily life if any. Clarify if any spiritual or religious beliefs impact decision making. Are there any internal struggles or conflicts with these beliefs? How does spirituality and religion provide a sense of meaning making, if any. Include both the child's and parents'/caregivers' perspective and experience of spirituality and/or religion).

Ecological Development
(Identify the client relationship to their natural environment, emphasizing the elements that contribute to wellbeing, how nature positively influences them, their relationship with nature and their health. Highlight any natural disasters and their coping to such events. Identify any environmental concerns that the client might have. Include both the child's and parents'/caregivers' description and experience of ecological development. Include both the child's and parents'/ caregivers' and exeperience of ecological development).

Physical Functioning, Health Conditions and Medical Background
(Physical development, general healthy, disabilities and current functioning, history of disease, accidents, genetic predistortions and prescription medications)
Date of last physical exam:
Self report on current health status (poor, fair, excellent):
Appetite disturbance and duration:
Allergies:
Current pain (0-10, location):
Current Physical Problems:

Major medical/surgical history:
Medications:

Type	Prescribing Doctor	Dosage	When Started

Over the Counter Medication:

Type	Prescribing Doctor	Dosage	When Started

Behavioral Health History:
(Identify all previous mental/psychiatric treatment received, dates, settings, diagnosis, is coordination of care needed, suicidal history including attempts if any and with what)

Trauma History:
(Identify any trauma events that have occurred throughout the client's lifetime. This should include any attachment disruptions, physical, emotional and/or sexual abuse, or assault. Please identify the events chronologically if possible)

Substance Use History:
(Include substances used, frequency, age at first use, patterns, family history. If significant history, please use CAGE assessment)

- Have you felt the need to cut down on your drinking?
- Do you feel annoyed by people complaining about your drinking?
- Do you ever feel guilty about your drinking?
- Do you ever drink an eye-opener in the morning to relieve the shakes?

Military History:
(Include dates served, and family history)

Mental Status Exam

OBSERVATIONS						
	Appearance	Neat	Disheveled	Inappropriate	Bizarre	Other
	Speech	Normal	Tangential	Pressured	Impoverished	Other
	Eye Contact	Normal	Intense	Avoidant	Eyes Closed	Other
	Motor Activity	Normal	Restless	Tics	Slowed	Other
	Affect	Full	Constricted	Flat	Labile	Other
	Comments					

MOOD

Euthymic	Anxious	Angry	Depressed	Euphoric	Irritable	Other
Comments						

COGNITION

Orientation Impairment	None	Person	Place	Purpose	Time
Memory Impairment	None	Immediate	Intermediate	Remote	Other
Attention	Normal	Distracted	Other		
Comments					

PERCEPTION

Hallucinations	None	Auditory	Visual	Other
Disassociation	None	Derealization	Depersonalization	Other
Comments				

THOUGHTS

Thought Process	Coherent	Distorted	Visual	Other	
Cognitive Functioning	Low	Consistent with Education	Inconsistent with Education	Highly Functioning	Other
Suicidality	None	Ideation	Plans	Means	Intent
Homicidally	None	Ideation	Plans	Means	Intent
Delusions	None	Grandiose	Paranoid	Religious	Other
Comments					

BEHAVIOR

Cooperative	Guarded	Hyperactive	Agitated	Paranoid
Aggressive	Bizarre	Withdrawn	Other	
Comments				

INSIGHT	Good	Fair	Poor

JUDGMENT	Good	Fair	Poor

Summary of Safety Concerns
(Include safety issues and preliminary plans for addressing them)

Cultural Assessment
Cultural background:
Language/s spoken
Socioeconomic: (Low, Middle, High)

Family Activities:
Special Requests/needs due to cultural factors:

Clinical Case Formulation:
(Summarize/formulate information gathered, identify underlying factors contributing to presenting problems and need for services, factors in differential diagnosis referrals or follow-up necessary, cultural considerations, etc. Identify diagnostic criteria to support working diagnosis)

DSM-5/ICD-10 Category
1.

2.

Treatment Recommendations:

Estimated Length of Treatment:

Report Completed by:_____Date:_____

Clinical Supervisor: _____Date:_____

Clinical Reasoning Worksheet

10 Basic Clinical Reasoning Questions to Guide Case Formulation and Intervention Planning

Presented below are 10 clinical reasoning questions intended for use by practitioners, clinicians, and supervisors. These questions may be applied throughout a person's service process. Answers to these questions can help guide the clinical case formulation for a person receiving services as well as guide intervention planning, implementation, and completion or stepping down of interventions. When applied, these questions work well in group supervision situations.

1. People Involved: Who are the people involved in supporting and serving this person? How well are they engaged, involved, and committed to helping this person get better, do better, and stay better?

---

2. Expectations: What outcomes of intervention are people expecting to be achieved? The person? The family, life partner, and/or key supporters? The school or employer? The court? Other service providers?

---

3. Causes & Contributions of Presenting Problems: What bio-psycho-social factors, life circumstances, and underlying issues explain the person's presenting problem(s) and current unmet needs?

---

4. Risk Factors: Based on history and tendencies, what things could go wrong in this person's life? What must be done to avoid or prevent future harm, life disruption, pain, loss, or undue hardship?

---

5. Functional Strengths & Assets: What are the person's functional strengths, aspirations for change, and life assets that can be built up to solve the problem(s) that brought the person/family into services?

---

6. Critical Unmet Needs: What presently critical unmet needs would have to be fulfilled in order for this person to get better, do better, and stay better?

---

7. Necessary Changes: What things in the person's life would have to change in order for the person to achieve and maintain adequate well-being, have essential supports for living, function adequately in daily activities, and fulfill key life roles - as appropriate to life stage, capacities, and preferences?

---

8. Outcome Indicators: What life conditions, when met, will indicate that the person's problem(s) is/are solved and critical needs are met (e.g. achieved adequate well-being, has essential supports for living, functions adequately in daily activities, and fullfils key life roles)?

---

9. Intervention Strategies: What combination and sequence of intervention strategies are likely to bring about desired life changes and meet the youth's life-change goals or the adult's personal recovery goals?

---

10. Results-Based Decisions: How will people know and decide: (1) That interventions are being delivered and are working as planned? (2) When interventions should be changed or stopped? (3) When life-change outcomes have been substantially achieved? (4) When the person's need are met, conditions for safe case closure are present, and intervention efforts can be safely and successfully reduced, transitioned, or concluded?

Bio-Psycho-Social Assessment

Note: a bio-psycho-social assessment organizer is used for noting historyc & current favtors that explain person's present situation and state of need. Used to answer clinical questions and plan a case formulation.

Key Factors	Biological Domain	Psychological Domain	Social Domain	
Explaining a Person's Life Circumstances/ Problems	**Genetic, developmental, medical, toxicity, temperamental factors**	**Cognitive style, intra-psychic conflicts, defense mechanisms, self-image, meaning of symptoms**	**Social-relationships family/peers/others**	**Social-environment cultural/ethnicity, social risk factors**
Predisposing → (Vulnerabilities that tend to increase risks of the presenting problems)	Family psychiatric history, toxic exposures in utero, birth complications, developmental disorders, regulatory disturbance, traumatic brain injury (TBI)	Insecure attachment, problems with affect modulation, rigid or negative cognitive style, low self-image.	Childhood exposure to maternal depression, domestic violence, late adoption, temperament mismatch, marital conflicts.	Poverty, low socioeconomic status, teenage parenthood, poor access to health or mental health care
Precipitating → (Stressors and life events having a time relationship with the onset of symptoms and may serve as triggers)	Serious medical illness or injury, increasing use of alcohol or drugs	Conflicts around identity or separation-individuation arising at developmental transitions, such as puberty onset or graduation from high school	Loss or separation from close family member, family moved with loss of friendships, interpersonal trauma	Recent immigration, loss of home, loss of supportive services (e.g. respite services, school placement)
Perpetuating → (Ongoing life challenges and sources of needs)	Chronic illness, functional impairment cause by cognitive defects or learning disorder	Use of self-destructive coping mechanisms, help-rejecting personality style, traumatic re-enactments	Chronic marital family discord, lack of empathy from parent, developmentally inappropriate expectations	Chronilly dangerous or hostile neighborhood, trans-generational problems of immigration, lack of culturally competent services
Protective → (Functional strengths, skills, talents, interests, assets, work, supportive elements of the person's relationships)	Above-average intelligence, easy temperament, special talents or abilities, physical attractiveness, factors related to emotional intelligence	Ability to be reflective, ability to modulate affect, positive sense of self, adaptive coping mechanisms, other skills that build resiliency	Positive parent-child relationships, supportive community and extended family, family resources that support good health, development	Community cohesiveness, availability of supportive social network, well-functioning child/ family team
Predictive → (Potential for change, areas most amenable to change as well as potential obstacles to positive change)	Sustained good health -or- worsening illness perisisting pattern of sobriety or addiction	Adaptive to unfolding life changes -or- resistant to current change efforts	Supportive friends and family members -or- destructive friends or toxic family relationships	Positive supports for life changes -or- ongoing unssolved social issues (undocumented or court orders)

Adapted from Baker, P. The child and adolescent psychiatry evalution. Oxford, UK: Blackwell Scientific, Inc.; 1995.

Case Formulation Worksheet

1. Person's Situation: A brief demographic, clinical, and functional description of the person and the life circumstances that require intervention.

Present Vulnerabilities (Predisposing Factors)

Such as physical disease, nental disorder, poverty, self-endangering behaviors, critical unmet needs.

Present Stressors & Triggers (Precipitating Factors)

Such as physical disease, nental disorder, poverty, self-endangering behaviors, critical unmet needs.

Drivers & Sustainers (Perpetuating Factors)

Such as addiction, homelessness, revictimization, chronic illness, negative life choices with related adverse consequences.

2. Presenting Problem(s):

Life events and circumstances that brought the person into the service system for protection, treatment, and/or care.

Major Predictors (Prognostic Factors)

Such as changes in health status, motivation for change, adaptation to change, changes in life style choices, availability of essential supports.

Severity of Clinically Significant Distress & Impairment in Functioning

To what degree presenting problems lead to clinically significant distress and impairment (using DSM-5 levels of severity)?

☐ Mild Degree ☐ Moderate Degree ☐ Severe Degree

Person's Desired Life Changes:

Note the person's major desired life changes & recovery goals.

3. Solution Possibilities for Life Change & Recovery - For Use in Intervention Planning:

A. Strategies to Meet Any Critical, Un-Met Needs:

B. Strategies to Prevent Harmful Things that Could Happen Again:

C. Strategies to Improve Well-Being and Basic Supports for Living:

D. Strategies to Improve Daily Functioning & Life Rold Fulfillment:

Planning Worksheet

Person's Situation: a brief demographic, clinical, and functional description of the person and the person's life circumstances that require intervention.

GENERAL GUIDANCE: This worksheet is designed to help **conceptualize and organize intervention planning** for a person receiving services. It links together the **Life Change Outcomes** planned with and for the person, the **Intervention Strategies** that will be used to bring about **Outcomes/Life Changes**, and **Actions** planned to implement intervention

LOGIC OF APPROACH: The practitioner should first plan to meet any **Compelling Urgencies** requiring **Immediate Action** to prevent harm. After any such urgencies are addressed, focus next on any **Life Outcomes related to Achieving Well-Being** (e.g. safety, health, stability/permanency) and **Life Outcomes related to Supports for Living** (e.g. income, food, housing, health care). Once needs for well-being and supports for Irving are being met, the focus shifts to **Life Outcomes related to adequate Daily Functioning and fulfilling Key Life Roles**. This progression of meeting essential needs and strategic life changes should enable the person to achieve and maintain an adequate daily life situation and gain greater independence from the service system. When selecting among near-term goals and strategies, the practitioner should give priority to any **Ready Opportunities** for getting **Early and Repeated Successes**. Likewise, ***Priority*** should be given any important life outcome that could be easily and readily achieved, leading to **Early Victories** or **Rapid Complections** in life change effors.

ORDER AND PACE OF INTERVENTION: 1) Work from **Urgent to Strategic**, from **Practical to Clinical**, and from **Outcomes to Actions**; 2) **Define Outcomes** in operational terms **then Select Intervention Strategies** for their attainment; 4) Select Strategies having **Ready Opportunities for Action**; 5) Select Strategic Options that can **Achieve a Rapid Outcome that Improves the Trajectory of the Person's Life**; 6) **Sustain Motivation** for life change by **Gaining Early and Repeated Successes**; and, 7) **Avoid a Scope and Pace of Action that would Overwhelm the Person's Life Situation** and could Cause Resistance and Loss of Motivation.

Outcomes by Priority	Intervention Strategies (Methods Used to Make Changes)	Intervention Actions (Implementation Steps)
1. Compelling Urgency: Prevent harm		
2. Early Success: Turn an important corner		
3. Rapid Completion: Achieve a key victory		
4. Capacity Building: Build for long-term		

Section 9 references

Aggarwal NK, Jarvis GE, Gómez-Carrillo A, Kirmayer LJ, Lewis-Fernández R. The Cultural Formulation Interview since DSM-5: Prospects for training, research, and clinical practice. *Transcultural Psychiatry*. 2020;57(4):496-514. doi:10.1177/1363461520940481

Aggarwal, N. K., Lam, P., Diaz, S., Cruz, A. G., & Lewis-Fernández, R. (2020). Clinician perceptions of implementing the cultural formulation interview on a mixed forensic unit. *Journal of the American Academy of Psychiatry and the Law*, 48(2), 216–225.

Davis, A., and Athan, A. (2023). Ecopsychological development and ecodistress during matrescence. *Ecopsychology*, 1-13. https://doi.org/10.1089/eco.2022.0084

Davis, A. (2023). The biopsychosocial (ecological-spiritual) assessment. [Unpublished manuscript]

Edwards, L. M., Burkard, A. W., Adams, H. A., & Newcomb, S. A. (2017). A mixed-method study of psychologists' use of multicultural assessment. *Professional Psychology: Research and Practice*, 48(2), 131–138. https://doi.org/10.1037/pro0000095

Falicov, Cecilia (January 2017). "Multidimensional Ecosystemic Comparative Approach (MECA)", *Encyclopedia of Couple and Family Therapy* (pp.1-5).

Gallardo, M. E., & Gomez, D. I. (2015). The clinical interview with Latina/o clients. In K. F. Geisinger (Ed.), Psychological testing of Hispanics: Clinical, cultural, and intellectual issues (2nd ed., pp. 171–187). American Psychological Association. https://doi.org/10.1037/14668-010

La Roche, M. J., Fuentes, M. A., & Hinton, D. (2015). A cultural examination of the DSM-5: Research and clinical implications for cultural minorities. *Professional Psychology: Research and Practice*, 46(3), 183–189. https://doi.org/10.1037/a0039278

Reamer, F.G. (2009). *The social work ethics casebook: cases and commentary*. NASW Press.

Sanchez, A. L., Comer, J. S., & LaRoche, M. (2021). Enhancing the responsiveness of family-based CBT through culturally informed case conceptualization and treatment planning. *Cognitive and Behavioral Practice*. Advance online publication. https://doi.org/10.1016/j.cbpra.2021.04.003

Tierra Nueva Counseling Center. (2023). *Examples of clinical documentation (BPS)*. Santa Fe, NM: Tierra Nueva Counseling Center.

Section 10: Clinical Supervision Documentation

Supervision documentation can sometimes be overlooked because it is often not scrutinized as closely as documentation completed for services. However, this documentation is extremely important for monitoring professional development, completing evaluations, and tracking progress towards higher licensure, as well as fulfilling requests of auditors.

Supervision contract or agreement

A foundational tool for a strong professional relationship between supervisors and supervisees across disciplines is a co-created supervision agreement or contract. It models ethical practices similar to service planning and holds both parties accountable for the professional boundaries of the relations. This document formalizes the supervision relationship and sets clear expectations for both parties involved and can help maintain a good working relationship as well as ensure that good quality care is being provided to the clients under the agency's care. Contracts should be reviewed frequently and should include the following:

- *Roles and Responsibilities:* Define the specific duties and responsibilities of both the supervisor and the supervisee. This includes outlining what is expected from each party in terms of preparation, participation, and follow-through on agreed-upon actions.

- *Objectives:* Establish clear, measurable goals and objectives for the supervision process. These should align with the professional development needs of the supervisee and the standards of the profession. These can also include goals that the supervisee wishes to complete and should have a time frame for when the goals will be achieved.

- *Frequency and Duration of Meetings:* Specify the schedule for supervision sessions, including how often they will occur and the length of each session. Regular, consistent meetings are crucial for ongoing support and development, and to for determining quality of client care.

- *Confidentiality:* Detail the confidentiality agreements within the supervision relationship, ensuring both parties understand the boundaries and limits of confidentiality, particularly concerning client information and sensitive discussions, as well as client safety and mandated reporting.

- *Evaluation Methods:* Describe how the supervisee's progress will be assessed. This may include formal evaluations, self-assessments, and feedback sessions. As a supervisor, it is important to communicate clear criteria for evaluation to help both parties understand the benchmarks for success.

- *Conflict Resolution:* Provide a framework for addressing conflicts or issues that may arise during supervision. This should include steps for mediation and resolution to maintain a productive and professional relationship.

- *Termination Clause:* Outline the conditions under which the supervision relationship may be terminated by either party. This includes notice periods and any steps that should be taken prior to termination to address underlying issues.

Supervision contracts should be tailored to fit the specific needs and regulations of various disciplines, such as social work, counseling, or clinical psychology, and should comply with the standards set by licensing and credentialing bodies. Similar contracts can be created for credential professionals and peer support. It demonstrates how the supervisor and supervisee are going to work together in the supervisory relationship and gives all parties a document to refer back to if expectations are not being met. Clear expectations lead to better service provisions and working relationships between supervisor and supervisee.

Supervision Notes

Thorough documentation of each supervision session is critical for tracking the supervisee's progress and providing a structured record of discussions and decisions. Supervision notes should include the following details:

- *Session Details:* Record the date, time, and type of supervision session (individual or group). This helps in maintaining an accurate timeline of the supervision process. and document when you met with your supervisee.

- *Agenda and Topics Discussed:* List the key topics and cases discussed during the session. This provides a clear overview of the session's focus and ensures all relevant issues are addressed.

- *Achievements:* Document specific goals and objectives that were addressed and any progress made. Highlighting achievements helps in recognizing the supervisee's growth and development.

- *Areas of Concern:* Note any issues or challenges that need attention, including ethical or professional concerns. This section is crucial for identifying areas where the supervisee needs further support or improvement.

- *Feedback:* Include constructive feedback provided to the supervisee, noting both strengths and areas for improvement. Feedback should be specific, actionable, and linked to the supervisee's development goals.

- *Follow-Up Actions:* Outline any follow-up actions or homework assigned to the supervisee, and note any follow-up needed from previous sessions. This ensures continuity and accountability in the supervision process.

For group supervision, it is important to document the contributions and learning experiences of each participant, ensuring individual progress is tracked within the group context. A supervision note should be created for each meeting that you have with your supervisees.

Supervision Feedback

Feedback is a vital component of the supervision process, benefiting both the supervisee and the supervisor. Effective documentation of feedback includes:

- *For the Supervisee:* Provide detailed, constructive feedback on their performance, clinical skills, and professional development. This should be specific, actionable, and tied to the goals outlined in the supervision contract. Regular feedback helps supervisees understand their progress and areas needing improvement.

- *For the Supervisor:* Supervisees should have opportunities to provide feedback on the supervision they receive. This can be documented through periodic evaluations or feedback forms. This reciprocal feedback process helps supervisors refine their approach and address any concerns or suggestions from supervisees.

An example form for a supervisor evaluating a supervisee is available on **pages 69**-70. While not required, there are several tools that can be helpful for both supervisors and supervisees to provide feedback. These include:

- Supervisory Working Alliance Scale - for supervisees to evaluate supervisory dynamic: https://www.starshipcare.com/wp-content/uploads/2021/12/super_work_invent_supervisee.pdf
- Supervision Outcomes Survey - for supervisees to overall evaluate their supervisor and the supervision: https://louisville.edu/psychology/graduate/files/supervision-outcomes-survey-clinical_e-form
- Self-Assessment of Competencies in Supervision - for supervisors to evaluate themselves: https://www.asha.org/siteassets/uploadedFiles/Self-Assessment-of-Competencies-in-Supervision.pdf
- Cross-Cultural Counseling Inventory - for supervisors to evaluate supervisees' cultural competence: https://www.mededportal.org/action/downloadSupplement?doi=10.15766%2Fmep_2374-8265.9950&file=MedEdPORTAL_9950.zip

Timelines for completion of supervisory documentation

The frequency of documentation updates varies depending on the supervision model and organizational requirements. General best practices include:

- *Supervision Notes:* Document each supervision session promptly, ideally within 24 hours, to ensure accuracy and detail and capture what happened in the session with more accuracy. Supervisors should sign notes and have the supervisee sign notes to ensure that it reflects what the supervisor experienced in the meeting.

- *Progress Evaluations:* Conduct formal evaluations of the supervisee's progress at regular intervals, such as quarterly or biannually. These evaluations should be comprehensive and reflective of the supervisee's development over time. Depending on the supervisor's style, they can include narrative form, self-reflection or a documented conversation. Updating the supervision contract to reflect new goals or growth is also important.

- *Feedback Forms:* Collect feedback from supervisees throughout the year to help supervisors adjust and meet the supervisee's needs. This helps in continuously improving the supervision process and addressing any emerging issues. This can be done in a face-to-face meeting or through anonymous feedback surveys. It is important that it is done with some frequency.

Documentation of supervision meetings

The documentation of supervision meetings is essential for guiding both the supervisor and supervisee. It serves as a comprehensive record to monitor progress, provide essential feedback, and ensure continuity from session to session. Effective documentation supports the professional development of the supervisee and helps maintain a high standard of clinical practice. Both the supervisor and supervisee should maintain detailed records of their sessions, ensuring transparency and accountability.

This information is compiled from a comprehensive training for clinical supervisors. For further resources and guidance on effective supervision practices, please refer to the New Mexico Clinical Supervision Academy's comprehensive training programs and materials available at the Clinical Supervision Academy: https://clinicalsupervisionacademy.com/

Summary

There are several types of documentation that can and should be completed throughout the supervisory process. This is for the benefit of both supervisors and supervisees.

We now pivot to supervision in a specialty but growing area of clinical practice, integrated care.

Supervision Evaluation

Key Areas of Evaluation

Competencies

Supervisors Communication using counseling internventions with supervisee such as	**Comments and Ratings**	**Rating** 1 2 3 4 5 Strongly Diagree Disagree Neutral Agree Strongly Agree
Open ended questions		
Closed questions		
Summarizing		
Reflection of feelings		
Turning in to nonverbal language		
Use of motivational interviewing		
Problem identification		
Mutual goal setting		
Use of humor, role playing		
Creative supervisory alliance with trust and support		
Overall empathy		
Skillful feedback		
Ensures that services to clients are safe, ethical, and competent		
The capacity to recognize and facilitate co-evolving relationships between supervisee and super-visor, addressing problems that arise.		

Rating				
1 **Strongly Diagree**	2 **Disagree**	3 **Neutral**	4 **Agree**	5 **Strongly Agree**

I have a supervision contract with my supervisor that we have created together	
I feel like my time in supervision is used productively with my supervisor	
I feel like I am able to provide feedback to my supervisor	
I feel like I have a trusting relationship with my supervisor	
My supervisor is available when I need them	
I feel confident in asking for help from my supervisor	

Comments: _____

_____

_____

_____

_____

_____

_____

Supervisors name _____ **Supervisees name** _____**(optional)**

Section 10 References

- Carrier, S. L., Wong, D., Lawrence, K., & McKay, A. (2022). Preliminary validation of a new competency tool for evaluating assessment skills in professional psychology trainees. *Training and Education in Professional Psychology*, 16(2), 166–172. https://doi.org/10.1037/tep0000394

- Clinical Supervision Academy. (2023). *Training cohort 3 July 2023-March 2024*. Retrieved from https://clinicalsupervisionacademy.com/

- Kaslow, N. J., Farber, E. W., Ammons, C. J., Graves, C. C., Hampton-Anderson, J. N., Lewis, D. E., Lim, N., McKenna, B. G., Penna, S., & Cattie, J. E. (2022). Capability-informed competency approach to lifelong professional development. *Training and Education in Professional Psychology*, 16(2), 182–189. https://doi.org/10.1037/tep0000392

- Tierra Nueva Counseling Center. (2023). *Supervision evaluation documentation: Supervisor and supervisee evaluation*. Santa Fe, NM: Tierra Nueva Counseling Center.

Section 11: Clinical Supervision and Integrated Healthcare

What is Integrated Healthcare?

Integrated healthcare (IH) involves a high level of collaboration and communication with multiple professionals for the care of a person. IH addresses whole-person care through physical, mental/behavioral, and social health needs. The goals of IH include addressing a person as a whole and an understanding of the interoperability of physical, mental, and social health, as well as reducing patient stress by interconnecting several care providers.

In some organizations, IH may be housed in one facility where a team of coworkers collaborate. In others, IH may fall to the responsibility of a care coordinator or a delegated team member who collects information from multiple providers, hosts teaming meetings to collaborate on care, and/or communicates between the identified recipient of care and the interdisciplinary team. The use of care coordinators creates a centralized point of communication for providers. Integration of care exists on a continuum from basic coordination to full transparent integration of all aspects of care.

In a rural setting, the integration of care may come in the form of a care coordination model such as Care Link New Mexico (CLNM). Care Coordination at the CLNM level is the promotion of many areas, including:

- Providing education to the individual
- Supporting individuals in identifying healing needs
- Screening for multiple areas of health concern
- Referring to services
- Assisting individuals in understanding the need for specialized care
- Developing health goals
- Identifying a treatment team
- Intervening to address and overcome potential barriers to care

In IH there is a high level of communication and collaboration between multiple levels of care. Developing a comprehensive treatment plan helps patients increase access to resources or subject matter expertise, reduce their travel burden, and increase the continuity of care they receive between providers.

Supervisory Considerations in Integrated Health

Effective clinical supervision in an IH setting should seek to address all aspects of whole health and generate an understanding of how to effectively engage an individual in the development and follow through of their care. This may include supporting the supervisee with learning medical terminology relevant to the setting, such as common diagnoses, procedures, and acronyms used by the medical members of the team, as these are infrequently taught in behavioral health education programs.

Clinical supervision should also address skills development of conducting effective interdisciplinary team staffing with multiple providers to ensure the individual's health needs are being addressed and information from all providers is being shared. Collaborative communication and effective meeting and leadership skills should be included in the clinical supervision to help care coordinators to lead effective team meetings and effectively share pertinent health information with the identified treatment team for an individual.

At any level of integration, each team will likely include a mix of licensed providers, certified and credentialed professionals, and natural supports. Having providers of varied backgrounds creates a team around the individual who can use the collective expertise of each other to help address needs effectively without duplication of services. However, this teaming also comes with a couple of particular challenges that supervisors should pay attention to:

1. *Medical hierarchy.* Historically, medical professions have run teams from a hierarchical rather than collaborative perspective. While this has begun to change for several reasons, including the growth of IH and interdisciplinary teaming, behavioral health providers are sometimes not heard out in medical settings. Supervisors are responsible for setting the tone in these environments and ensuring that all team members are treated as equal partners as part of IH best practice. Teams who regularly do not work together or have appreciation for each other's contributions would be considered minimally integrated (SAMHSA-HRSA Center for Integrated Health Solutions, 2020). In some cases where the supervisor's work is overseen by a physician or an Advanced Practice Registered Nurse (APRN), improving this dynamic may involving advocacy on the part of the supervisor for their ability to be heard by the team as well.

2. *All team members staying within their scope.* As covered throughout this guide, each provider type has a role to play and an ethical responsibility to maintain within the bounds of that role, including but not limited to what is allowed by the license or certificate held by the individual. For behavioral health providers, this first and foremost means not providing medical advice, such as recommending medications or supplements, or speculating on medical diagnosis. Supervisors should be clear with supervisees that these are responsibilities of the medical team members. However, supervisors can work with supervisees on bridging mental health and medical as is appropriate to their scope, which could include:

a. Asking the team if medical/biological causes of symptoms have been ruled out before assuming they are being caused by a mental health condition;
b. Directing clients back to the appropriate provider if asked a question that is outside of their scope;
c. Assisting clients with alleviating barriers to attending medical appointments;
d. Coaching clients on developing a list of questions and concerns before appointments; and
e. Helping clients develop routines that support their medical goals, such as an alarm or schedule for taking medications.

Each team member staying within their scope supports the collaborative environment, shows respect for each other's contributions, and is both ethical and best practice.

Promoting Whole-Person Care through Clinical Supervision in Any Setting

Even in settings where a care coordination program or integrated care facility is not present, clinical supervision can be used to increase skills with providers to begin to look at whole-person care. Clinical supervision that focuses on IH, regardless of the setting, should promote the following aspects of care:

- Conducting a thorough needs assessment of the individual to address physical and mental health, substance use, and social determinants of health;
- Ensuring appropriate referrals are discussed and made in response to presented health needs;
- Developing effective, collaborative communication.
- Addressing privacy and ethical issues in interdisciplinary communication;
- Educating the workforce about integrated health approaches to encourage increased critical thinking about whole-person care;
- Identifying, engaging, and updating of treatment teams, as identified by the individual, to include both natural and professional supports and services; and
- Ensuring that the individual's voice and choice are reflected in the goals set for their health and that those goals are communicated to the entire treatment team.

Effective clinical supervision should encourage the use of open-ended questions with the individual to ensure that the full picture of health needs is being obtained, encouraging frequent and effective communication among providers.

The following resource, *Tip Sheet for Practitioners In integrated Care Settings.(Practice Principles and Functions for Use in Community Behavioral Health Centers To Support Wellness, Youth Resiliency, and Adult Recovery)*. (Link below) is an excellent resource for providers who want to understand more about integrated health care. The following practice areas and clinical techniques are addressed in this document related to integration of behavioral health and primary care.

Integrated Health Practice Areas

- Recognition, connection, and rapport
- Engagement and commitment
- Screening, detection, response and monitoring
- Assessment and formulation
- Organizing questions used in assessment and case formulation
- Addressing wellness and recovery goals with teamwork
- Planning interventions, strategies, and supports
- Situation tracking, treatment plan adjustments, transitions and discharge
- Integrated Health Clinical Techniques
- Solution-focused brief therapy
- Motivational Interviewing

Tip Sheet for Practitioners in Integrated Care Settings

Summary

Integrated Healthcare is an exciting newer area of practice for behavioral health providers where clients can get comprehensive care from medical and mental health providers working together. Even in settings where integration has not occurred, behavioral health providers can take additional steps to ensure they are considering the co-occurring medical needs of their clients.

Section 11 References

American Psychological Association. (June 2022). Behavioral health integration fact sheet. https://www.apa.org/health/behavioral-health-factsheet.pdf

American Psychiatric Association (n.d.). Learn about the collaborative care model. https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/learn

SAMHSA-HRSA Center for Integrated Health Solutions. (2020). Six levels of collaboration/integration (core descriptions). https://www.thenationalcouncil.org/wp-content/uploads/2020/01/CIHS_Framework_Final_charts.pdf

SAMHSA's National Center of Excellence for Integrated Health Solutions
https://www.samhsa.gov/national-coe-integrated-health-solutions

Section 12: Quick Links to Resources by Section

This document is intended to list helpful links by section for ease of use. Only sections with relevant links are listed here.

Section 2: The Clinical Supervision Experience

American Psychological Association Guidelines for Clinical Supervision in Health Service Psychology: https://www.apa.org/about/policy/guidelines-supervision.pdf

Association for Counselor Education and Supervision of the American Counseling Association Best Practices in Clinical Supervision: https://acesonline.net/wp-content/uploads/2018/11/ACES-Best-Practices-in-Clinical-Supervision-2011.pdf

Child-Parent Psychotherapy]. (2022, January 20). Countertransference in the Treatment of Maltreated Children [Video]. Youtube.com. https://www.youtube.com/watch?v=q0BfqCX6DZ0

Cross-Cultural Supervision: Racial/Ethnic Minority Supervisees' Perspectives. (n.d.). Retrieved from https://egrove.olemiss.edu/cgi/viewcontent.cgi?article=1036&context=jcrp

Falender, C. A., Grus, C., McCutcheon, S., Goodyear, R. K., Ellis, M. V., Doll, B.,...Kaslow, N. J. (2016). Guidelines for clinical supervision in health service psychology: Evidence and implementation strategies. *Psychotherapy Bulletin*. Retrieved from: https://societyforpsychotherapy.org/guidelines-clinical-supervision-health-service-psychology/

Guilman, S. R. (2015). Beyond interpretation: The need for English-Spanish bilingual psychotherapists in counseling centers. James Madison Undergraduate Research Journal, 2(1), 26-30. Retrieved from http://commons.lib.jmu.edu/jmurj/vol2/iss1/5

How unintentional but insidious bias can be the most harmful https://www.youtube.com/watch?v=mgvjnxr6OCE

National Association of Social Workers Best Practice Standards in Social Work Supervision: https://www.socialworkers.org/LinkClick.aspx?fileticket=GBrLbl4BuwI%3d&portalid=0

National Latino Behavioral Health Association: https://nlbha.org/

National Latino Behavioral Health Association's Behavioral Health Interpreter training: https://nlbha.org/projects/behavioral-health-interpreter-training-bhit/

New Mexico Highlands University's Bilingual/Bicultural MSW program: https://www.nmhu.edu/landing-masters-of-social-work/

Substance Abuse and Mental Health Services Administration's Quick Guide on Clinical Supervision and Professional Development of the Substance Abuse Counselor: https://store.samhsa.gov/sites/default/files/sma13-4770.pdf

The Clinical Supervision Relationship
https://files.santaclaracounty.gov/migrated/The%20Clinical%20Supervision%20Relationship.pdf

University of New Mexico's Rural Psychiatry annual spring conference that is solely in Spanish:
https://app.smartsheet.com/b/publish?EQBCT=67cc80bd03594061b64b48a52121b3ff

U.S. Department of Health and Human Services Office of Minority Health. (n.d.). *Culturally and Linguistically Appropriate Services (CLAS) Behavioral Health Implementation Guide*. Retrieved August 16, 2024, from https://minorityhealth.hhs.gov/clas-behavioral-health-implementation-guide

Section 4: An Introduction to Certified and Credentialed Professionals

New Mexico Credentialing Board of Behavioral Health Professionals. (n.d.) https://nmcbbhp.org/

New Mexico Recovery Project. (n.d.). https://nmrecovery.org/opre-pre-application

Section 5: Clinical Supervision in New Mexico

New Mexico Behavioral Health Services Division: https://nmrecovery.org/

New Mexico Children Youth and Families Behavioral Health Services (housed within New Mexico State University's Center of Innovation): https://centerofinnovationnm.org/

New Mexico Office of Peer Recovery and Engagement (OPRE)
https://yes.nm.gov/nmhr/s/office-of-peer-recovery-and-engagement?language=en_US

New Mexico Regulation and Licensing Division Boards and Commissions: https://www.rld.nm.gov/boards-and-commissions/

New Mexico Medical Board: https://www.nmmb.state.nm.us/

New Mexico Board of Nursing: http://nmbon.sks.com/

Section 7: Ethics in Clinical Supervision

American Board of Clinical Social Work (ABCSW) Code of Ethics: https://www.abcsw.org/code-of-ethics

American Counseling Association (ACA) Code of Ethics: https://www.counseling.org/docs/default-source/default-document-library/ethics/2014-aca-code-of-ethics.pdf?sfvrsn=55ab73d0_1

American Psychological Association (APA) Code of Ethics: https://www.apa.org/ethics/code

Association for Counselor Education and Supervision (ACES) Best Practices: https://acesonline.net/wp-content/uploads/2018/11/ACES-Best-Practices-in-Clinical-Supervision-2011.pdf

Commission on Rehabilitation Counselor Certification (CRCC) Code of Ethics: https://crccertification.com/code-of-ethics-4/

Forester-Miller, H., & Davis, T. (2016). A practitioner's guide to ethical decision-making. Alexandria, VA: American Counseling Association. https://www.counseling.org/docs/default-source/ethics/practioner-39-s-guide-to-ethical-decision-making.pdf?sfvrsn=10/1000

National Association of Social Workers (NASW) Code of Ethics: https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

NAADAC, the Association for Addiction Professionals (2021). NAADAC/NCC AP Code of Ethics. Alexandria, VA: NAADAC. from: https://www.naadac.org/assets/2416/naadac_code_of_ethics_112021.pdf

National Board of Certified Counselors (NBCC) Code of Ethics: https://nbcc.org/Assets/Ethics/NBCCCodeofEthics.pdf

New Mexico Clinical Supervision Academy: https://clinicalsupervisionacademy.com/

Section 8: Clinical Supervision and High-Quality Practice

Quality Service Reviews A Mechanism for Case-Level Advocacy and System Reform (includes the High-Quality Practice Wheel: https://cssp.org/wp-content/uploads/2019/03/QSR-Advocacy-System-Reform.pdf

Section 9: Clinical Supervision and Clinical Writing

How to Write Case Conceptualization: https://positivepsychology.com/case-conceptualization-examples/

What are SOAP notes in counseling? (includes examples): https://positivepsychology.com/soap-notes-counseling/

Section 10: Clinical Supervision Documentation

Cross-Cultural Counseling Inventory: https://www.mededportal.org/action/downloadSupplement?doi=10.15766%2Fmep_2374-8265.9950&file=MedEdPORTAL_9950.zip

Self-Assessment of Competencies in Supervision: https://www.asha.org/siteassets/uploadedFiles/Self-Assessment-of-Competencies-in-Supervision.pdf

Supervision Outcomes Survey: https://louisville.edu/psychology/graduate/files/supervision-outcomes-survey-clinical_e-form

Supervisory Working Alliance Scale: https://www.starshipcare.com/wp-content/uploads/2021/12/super_work_invent_supervisee.pdf

Section 11: Clinical Supervision and Integrated Healthcare

American Psychological Association. (June 2022). Behavioral health integration fact sheet. https://www.apa.org/health/behavioral-health-factsheet.pdf

American Psychiatric Association (n.d.). Learn about the collaborative care model. https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/learn

SAMHSA-HRSA Center for Integrated Health Solutions. (2020). Six levels of collaboration/integration (core descriptions). https://www.thenationalcouncil.org/wp-content/uploads/2020/01/CIHS_Framework_Final_charts.pdf

SAMHSA's National Center of Excellence for Integrated Health Solutions
https://www.samhsa.gov/national-coe-integrated-health-solutions

Tip Sheet for Practitioners in Integrated Care Settings

Quick Links to Additional Cultural Resources by Topic

Articles available at no cost:

Native:
Thomason, Timothy (2011) "Recommendations for Counseling Native Americans: Results of a Survey," Journal of Indigenous Research: Vol. 1: Iss. 2, Article 4.
https://digitalcommons.usu.edu/kicjir/vol1/iss2/4/

PDF from the University of New Mexico: Guiding Principles for Engaging in Research with Native American Communities (2012)
https://hsc.unm.edu/vision2020/common/docs/guiding_principles_research_native_communities2012.pdf

Culture/General:
American Psychological Association (2017). Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality.
https://www.apa.org/about/policy/multicultural-guidelines

Arredondo, P., Tovar-Blank, Z.G., & Parham, T.A. (Summer 2008). Challenges and Promises of Becoming a Culturally Competent Counselor in a Sociopolitical Era of Change and Empowerment. Journal of Counseling & Development, 86, 261-268.
Free download available using this link:
https://www.researchgate.net/publication/263115720_Challenges_and_Promises_of_Becoming_a_Culturally_Competent_Counselor_in_a_Sociopolitical_Era_of_Change_and_Empowerment

Arredondo, Patricia (March 2008). Using Professional Leadership to Promote Multicultural Understanding and Social Justice. Journal of Pacific Rim Psychology, 2(1) 13-17.
https://scholar.archive.org/work/v3yplmwnfvdznei3wdaaqyog3u/access/wayback/
https://www.cambridge.org/core/services/aop-cambridge-core/content/view/E2DCC6F94B39AD8E1E4DACD56E073594/S1834490900000179a.pdf/div-class-title-using-professional-leadership-to-promote-multicultural-understanding-and-social-justice-div.pdf

DiAngelo, R. (2018). *How white people handle diversity training in the workplace: Confronted with their own shortcomings, white employees often shut down the dialogue—or frame themselves as victim*. GEN. https://gen.medium.com/
https://medium.com/gen/how-white-people-handle-diversity-training-in-the-workplace-e8408d2519f
This article can be downloaded at no cost. However, the site—"Medium" requires the user create an account to access the article

Articles available for purchase:

Latinx:
Gallardo, M. E., & Gomez, D. I. (2015). The clinical interview with Latina/o clients. In K. F. Geisinger (Ed.), Psychological testing of Hispanics: Clinical, cultural, and intellectual issues (2nd ed., pp. 171–187). American Psychological Association.
https://doi.org/10.1037/14668-010

General Culture:
Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. American Psychologist, 53(4), 440 448. https://doi.org/10.1037/0003-066X.53.4.440
https://psycnet.apa.org/buy/1998-00766-022

Books:

Latino Families in Therapy Second Edition
Amazon Link:
https://www.amazon.com/Latino-Families-Therapy-GUILFORD-THERAPY/dp/1462522327
This book provides an up-to-date conceptual framework and hands-on strategies for culturally competent clinical practice with Latino families and individuals. Practitioners and students gain an understanding of the family dynamics, migration experiences, ecological stressors, and cultural resources that are frequently shared by Latino families, as well as variations among them.

You Tube Video: How unintentional but insidious bias can be the most harmful https://www.youtube.com/watch?v=mgvjnxr6OCE