CLINICAL SUPERVISION IMPLEMENTATION GUIDE

A practical implementation guide for community-based behavioral health specialty organizations

Practical Resources and Tools

October 5, 2018

Introduction

This **Clinical Supervision Implementation Guide** is offered as a practical guide for clinical supervisors to support their local clinical practice. It includes topics addressing clinical supervision implementation within community-based behavioral health specialty organizations. Only the first section reflects some policies from the Behavioral Health Services Division, Human Services Department. Otherwise, the balance of the materials are gleaned from local practice and/or national research. All attempts were made to properly credit sources. In 2019, we anticipate state agency rule changes that will further support growing the behavioral health workforce and align with best practices. This is a 'living document"; we encourage readers to make ongoing contributions to its content

Acknowledgements

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I. Clinical Supervision and Clinical Practice Guidelines, Behavioral Health Services Division, Human Services Department

A. Overview:

Clinical supervision instructs, models, and encourages self-reflection of the supervisee's acquisition of clinical and administrative skills through observation, evaluation, feedback, and mutual problem-solving. However, it should be understood that there might be opportunities in which the clinical supervisor chooses to give professional direction based on experience, expertise, and/or for ethical or safety concerns. Clinical supervision is delivered within the supervisor's professional practice license and ethical standards.

Clinical supervision is provided to all treatment/clinical staff who are either employed or under contract by a provider organization such as group practices or behavioral health specialty organization or an individual provider.

- Clinical supervisors need to meet the standards for clinical supervision as defined by their professional practice board.
- Clinical supervisor responsibilities: provide support, consultation, and oversight of clients' treatment to include: assessment of needs; diagnoses/differential diagnoses (MH, SA, and COD); clinical reasoning and case formulation which addresses documentation; treatment planning and implementation; refining treatment goals and outcomes; selecting interventions and supports; coordination of care; tracking and adjusting interventions. All of the above should be:
    - Continuously reviewed and adjusted according to an individual's status, success and challenges.
    - Teaching the importance of retaining continuity throughout all documentation.
    - Ensuring plans, interventions, goals, and supports are appropriate to diagnosis.
- Clinical Supervision assures that discharge planning starts at the initiation of treatment and is continually developed throughout treatment. The discharge plan assures ongoing support for the individual's continued recovery and success.
- Clinical Supervision assures that an appropriate safety and crisis management plans are in place at the onset of service delivery.
- Clinical Supervision addresses ethics and ethical dilemmas as aligned with the appropriate professional practice board.

Clinical Supervisors will document date, duration, and the content of supervision session for their supervisee(s), which may include a professional development plan. All

documents pertaining to clinical supervision will be readily available to the supervisee.

B. Staff Qualifications:

A clinical supervisor has been approved by their respective professional licensing board as having met board requirements for providing clinical supervision. Please see http://www.rld.state.nm.us/boards/default.aspx for current requirements.

C. Guidelines for Clinical Practice and Clinical Supervision

1. Introduction:

The term *practice* refers to the collective set of actions used to plan and deliver interventions and supports. 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 and is 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, child care), and
- **Fulfillment of key life roles** (e.g., a child being a successful student or an adult being a successful parent or employee).

2. Basic Expectations of High Quality Practice:

There are five basic functions of quality practice that must be performed for each person served to achieve the greatest benefits and outcomes. These functions listed below are foundational to quality practice and underlie all successful intervention strategies. Because these functions are essential to achieving positive results with clients served, the Behavioral Health Services-Division expects that each person served will, at a minimum, be served in a manner that consistently provides and demonstrates these core practice functions. Providing services to all clients in accordance with these practices is a top priority, and the Behavioral Health Services Division will support organizations to consistently measure their occurrence with clients served using Integrated Quality Service Reviews (iQSR), 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 iQSR or

other data-driven fidelity models.

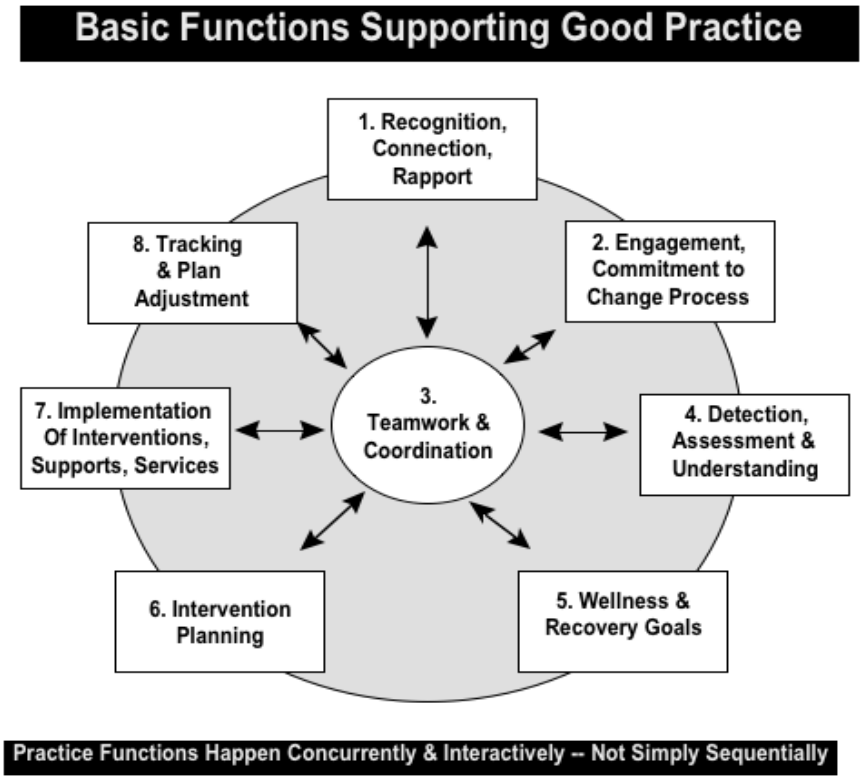
3. Basic Functions of High Quality Practice:

This practice framework sets forth the actions/functions used by frontline practitioners to partner with a person receiving services to bring about positive life changes that assist the person by maintaining successes and managing challenges as they occur. Typical activities in practice include engaging the client and other key stakeholders in a connected, unifying effort through teamwork and fully understanding the person, their needs and environment. It also includes collaboratively defining results to be achieved, selecting and using intervention strategies and supports, resourcing and delivering planned interventions and supports, and tracking and adjusting intervention strategies until desired outcomes are achieved.
The basic functions of quality practice are:

- Engaging Service Partners
- Assessing and Understanding the Situation
- Planning Positive Life-Change Interventions
- Implementing Services
- Getting and Using Results

4. The Practice Wheel: A Practice Model Defines the Principles and Organizing Functions Used by Practitioners

The practice framework also encompasses the core values and expectations for providing services. The framework functions to organize casework and service delivery, to guide the training and supervision of staff, and clarifies quality measures and accountability. Basic practice functions are illustrated in the “practice wheel” diagram below. The practice wheel can be utilized to guide supervision by providing a framework and expectations for working with persons receiving services. For example, supervision and training could progress along the practice wheel with each function as a topic of focus to strengthen and operationalize expectations.



5. Clinical Supervision as a Foundation For Strong Clinical Practice:

Clinical Supervision is the foundation for assuring consistent, high quality practice. It provides a mechanism for clinical practice improvement at both an individual staff level as well as at the organizational level.

6. Individual Practitioner Level Supervision:

The Clinical Supervision for individual frontline practitioners should consistently:

- Provide support, consultation, and oversight of clients' treatment to include assessment of needs; diagnoses/differential diagnoses (MH, SA, and COD); clinical reasoning and case formulation, to include documentation; treatment planning and implementation; refining treatment goals and outcomes; selecting interventions and supports; coordination of care; tracking and adjusting interventions.
  - All of which should be continuously reviewed and adjusted according to an individual's status, success and challenges. Teach the importance of retaining continuity throughout all documentation.
  - Ensure plans, interventions, goals, and supports are appropriate to diagnosis; and, aligned with the supervisee's theoretical orientations

- Use parallel process where the supervisee's development is being addressed alongside the emerging clinical issues.

- Address the supervisee's steps to insure an individual's active involvement at all levels and that the individual voice and choice are clearly represented and documented.
- Assure that discharge planning starts at the initiation of treatment and is continually developed throughout treatment. The discharge plan assures ongoing support for the individual's continued recovery and success.
- Assure that an appropriate safety and crisis management plans are in place at the onset of service delivery.
- Address ethics and ethical dilemmas as aligned with the appropriate professional practice board.

7. Group Level Supervision:

In addition to reinforcing multi-disciplinary teaming, group supervision can serve as a good teaching/training venue in which provider trends are highlighted (e.g. engagement, population profiles, and the presenting severity/types of disorders, theoretical orientation and case conceptualization.) The Clinical Supervisor's experiences in group supervision can also inform and strengthen the work of the entire team through the use of a recognized Clinical Practice Improvement model.

8. Organizational Level Benefits of Clinical Supervision:

- Assures high quality treatment for individuals.
- Creates clearly defined treatment goals which are measurable and time limited
- Assures the treatment plan is a living, working document with the individual.
- Ensures proper documentation of care and can help with program integrity issues
- Ensures staff are trained and properly implementing Evidenced-based Practices.
- Ensures fidelity to evidenced based practice models (e.g. Multisystem Therapy, Integrated Dual Diagnosis Treatment, Substance Abuse Matrix model)
- Improves staff development and employee retention
- Provides a risk management tool (e.g. Reduction of critical incidence)

9. Organizational Expectations:

Agencies are expected to have policies and procedures that assure that:

- Clinical Supervision is conducted in a manner that ensures 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 to evidence that clinical supervision has occurred accordingly.
- All individual practitioner's, group practices' and facilities' Quality Improvement Program should have a Clinical Practice Improvement program that:
  - Utilizes the findings from its Clinical Supervision to the 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 should examine strengths and improvements in the following areas:
    - Engagement
    - Teamwork
    - Assessment & understanding
    - Outcomes & goals
    - Intervention planning
    - Resources
    - Adequacy of interventions
    - Tracking and adjustment

10. Guiding Values and Principles of Practice

The Behavioral Health Services Division, Human Services Department and the New Mexico Behavioral Health Collaborative hold the following values and principles for practice in the provision of services to all individuals, youth and families served within the public behavioral health system:

- Individual/family- driven, individualized and needs-based
- Developmentally appropriate
- Inclusive of family or natural supports
- Offers an array of services & supports
- High quality
- Community-based.

- Culturally and linguistically aware and accepting
- Use of early identification and intervention
- Integrative approach
- Trauma responsive
- Strength-based
- Outcome based
- Least restrictive
- Recognize perseverance and resiliency/ trauma informed

11. State Monitoring of Clinical Practice and Clinical Supervision

Medicaid funded and state funded agencies who wish to use non-independently licensed providers will need to submit the Supervisory Certification Attestation Form. Contact (bilfornil.bhsd@state.nm.us). A staff roster must accompany the attestation with each independent and non-independent provider listed. For the supervisors, please include a letter from the licensing Board designating them as supervisors (LCSW or LISW) or their most recent CEUs in supervision that accompanied their last license renewal (LPCC.) Once approved, the provider will need to submit their Supervisory Certification notice to the MCO's and Medicaid so that they can render services.

Each time the provider brings on a new non-independently licensed provider, or changes supervisors, they will need to submit an updated roster (with all the columns filled out). For Supervisors, please include a letter from the licensing Board designating them as supervisors (LCSW or LISW) or their most recent CEU's in supervision that accompanied their license renewal (LPCC).

12. Clinical Supervision Documentation:

The organization's documentation will include:

- Policies that describe the provider's clinical supervision of all treatment staff including their Human Resources requirements for the clinical supervisor (credentials, job description, skill sets, training requirements and schedules).
- Procedures will include:
  - A template that documents when and how clinical supervision is provided to individuals and multidisciplinary teams in individual and group settings;
  - Annual training plan for all staff that provide treatment services.
  - Backup contingency plans for periods of clinical supervisor staff turnover.

13. Clinical Practice Improvement:

The organization's Quality Improvement Program must have a Clinical Practice Improvement component that:

- Addresses care planning consistent with holistic and comprehensive care planning, system of care principles and, a recovery and resiliency philosophy;
- Examines the provider's strength and weaknesses in the clinical care functions of: engagement, teamwork, assessment & understanding, outcomes & goals, intervention planning, resources, adequacy of intervention, and tracking & adjustment;
- Includes process improvement approaches, relevant data collection, fidelity measures and data for outcome monitoring;
- Evaluates the outcomes of its clinical interventions and develops improved strategies.

14. Technical Assistance from the State:

- State staff will monitor agencies for compliance with this clinical supervision requirement should the need arise.
- Dedicate resources and personnel (i.e., state employees or contracted clinicians) to provide technical assistance in identifying acceptable and appropriate policies and procedure through the Supervisory Certification process.
- Explore use of telehealth video conferencing as a tool in clinical supervision.
- Provide Clinical Reasoning and Case Formulation training and consultation to Clinical Supervisors.
- Provide training and supports for supervising specific to those working in integrated settings and teams.

II. The Clinical Supervision Experience

A. Introduction:

Supervision is part of one's professional practice, education and training in which the supervisor and supervisee collaborate to develop the supervisee's skills in evidence-based and effective promising practices as well as to protect the welfare of clients served. The provider organization of both the supervisor and supervisee will benefit from having formal agreements (or contracts), expectations, and policies related to the provision of supervision. Modifications may be necessary in the event that an organization is not able to provide a supervisor from within (internal to the provider). In these situations, the organization will benefit from having specific policies and contracts with external supervisors to ensure that all parties are familiar with the expectations, legal responsibilities, and roles. Furthermore, organizations as well as all supervisors and supervisees will benefit from a comprehensive understanding of the provider policies, state licensing board regulations, and documentation that may differ depending upon disciplines. For example, many boards stipulate specific requirements to become an eligible supervisor, documentation, and required hours. Please consult all these resources prior to initiation of the clinical supervision experience. (See Appendix F for further information on regulations.)

B. Best Practice Guidelines

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

- **American Psychological Association Guidelines for Clinical Supervision in Health Service Psychology**
- **Association for Counselor Education and Supervision of the American Counseling Association Best Practices in Clinical Supervision**
- **National Association of Social Workers Best Practice Standards in Social Work Supervision**

C. The Clinical Supervision Relationship

Both supervisor and supervisee will benefit from understanding their roles and the professional responsibilities that each person has in order to uphold their responsibilities and understand the expectations that come along with such an important relationship. The **Clinical Supervision Relationship** (link) addresses critical responsibilities of both parties.

D. 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. The **Rights**

and Responsibilities addresses these in a coherent framework compiled from multiple sources.

E. The Supervision Plan

An effective clinical supervision plan is a well-developed agreement or contract resulting in appropriate care for patients, professional growth for the supervisee, and management of liabilities and roles. These agreements contain an outline of goals of supervision, the structure of supervision and duties/responsibilities of both supervisor and supervisee. Agreements for group vs. individual supervision will be different. Acquiring clinical supervision outside of the provider organization intensifies the need for a well-developed supervision plan to make clear the management of liabilities and responsibilities. Development of an effective supervision plan with collaboration of supervisor and provider will insure a successful outcome for all involved. Examples are below for your reference and modification:

- **Counselor Supervision Contract**
- **Substance abuse counselor supervision agreement**
- **Psychology supervision contract**
- **Social work supervision contract**

F. Documenting supervision: Clinical Supervision Record

The documentation of supervision meetings is essential to guide both the supervisor and supervisee. It serves as a record to monitor and provide essential feedback and evaluation for the supervisee and assure continuity of follow-up from session to session. Some disciplines suggest that *both* supervisor and supervisee maintain documentation of their progress tacking supervisory sessions.

The clinical supervision record template inserted below contains helpful elements that may be pertinent to agencies implementing the Treat First (TF) in New Mexico. Areas in which to record specific client feedback from TF check-in and TF overall evaluation of the clinician by the client is incorporated along with additional content items and quality indicators. The form may be revised according to each organization's requirements as well as individual supervision needs. Group supervision formats may indicate further modifications to the form.

Additional examples of supervision records include:

- **Documenting Supervision**
- **Supervisor Session: Bridging Form**

Following documentation of the supervisory session, the **Supervisory Session Bridging Form** may be utilized to facilitate the supervisory alliance between supervisor and supervisee and provide them with essential feedback to enhance supervision.

Clinical Supervision Record - Treat First

Date: **Starting Time:** **Ending Time:**

Supervisee/Employee: **Supervisor:**

Circle Method(s): Ind/Group; In-person or via teleconference webcam; live, audio recording, Other:

Clinical Issues discussed (do not include patient info): **% of supervision: _____**

Ethics & Legal Issues
Informed Consent / Confidentiality / Releases of Information
Competency
Dual Relationships / Boundaries
Case Conceptualization
Risk Assessment / Crisis Intervention
Safety Planning Diagnosis / Assessment Substance Use Treatment Trauma Informed Care Treatment Planning
Client Progress & use of measures/ Assessments of progress
Team Meetings / Treatment Team collaboration!
Evidence Based Practice / Promising Practices
Practice/ Intervention skills
Emergent client situations
Multicultural / Diversity Issues; Language
Community Supports/Information & Referrals
School/Employment issues for clients
Documentation / Progress Notes
Individual/Family/Group issues
Termination / Discharge issues
Transference / Countertransference
Supervisee emotional reactivity
Supervisee self-exploration / Self-awareness
Supervisee self-care
Duties /expectations / responsibilities
Professionalism
Communication skills of supervisee
Time management of supervisee
Attitude/Judgment of supervisee
Problem solving of supervisee
Flexibility of supervisee
Supervision Goals & Objectives
Supervisee Training Plan
Policy / Procedures
Licensure requirements for supervision

Data / Productivity issues discussed **% of supervision: _____**

Patient Satisfaction Surveys
Treat First (TF) Session Check-In
Treat First Overall Evaluation of Work Together
Caseload
New Assessments (same-day intakes / TF)
Monthly Productivity Encounters: Individual / Group:
No-shows / Cancellations
Treatment Plans current (90 days)
Notes completed and locked within 48 hours
Peer Review Chart Audits

Training discussed **% of supervision: _____**

Online/provider req'd
CEUs
CPR / CPI

Administrative discussed **% of supervision: _____**

Community involvement
Licensure renewal / requirements

Resources / literature / material discussed **% of supervision: ___**

Supervisee strengths/challenges **% of supervision: _____**

Tasks to be completed:

Comments/Observations:

Signatures

Supervisor:

Supervisee

III. Clinical Supervision Preparation Tools

The Case Discussion Guide for Reflective Practice (**See Appendix C**) serves to structure reflective case discussion in supervision and supports both supervisor and supervisee. The Case Discussion Guide for Reflective Practice is especially useful for new supervisors to build a flow of reflective conversation without getting lost in conversation with a supervisee. This guide is also useful in preparing supervisees for sessions by clarifying what occurs during clinical supervisions sessions and setting a standard of expectation for preparation and participation in sessions.

The following are organizers for practice and casework based on a traditional bio-psycho-social grid. These organizers can be used to assist supervisees in preparing for supervision sessions, with a secondary benefit of building strong habits in clinical reasoning and case formulation. While use of these organizers is strongly supported, it is not suggested that all organizers be used every-time for every supervision session. These organizers are tools for supervisors and supervisees to make efficient use of the clinical supervision time and to build reasoning skills in practitioners. (**See Appendix D** for fillable forms that can be downloaded**.)**

On the next page, the first of the organizers, the **Bio-Psycho-Social** (BPS) Framework, is presented. It is a tool used for organizing information about a person's life situation to help reveal importation fact patterns necessary developing a clinical understanding. A basic bio-psycho-social grid gives a foundation for gathering and organizing information about a person in services or seeking services, providing a holistic view of the person.

The BPS framework provided below synthesizes data into easily understood components, called the "5-Ps". The "5-Ps" identify Predisposing, Precipitating, Perpetuating, Protective, and Predictive Factors that each and every practitioner should know about a person's life situation as a basis for developing a clinical case formulation, documentation, and work with a person. These "5-Ps" are applied across a person's physical, psychological, and social history and present situation to develop clinical insights that will be useful in planning interventions, supports, and services.

Bio-Psycho-Social Assessment

Note: A bio-psycho-social assessment organizer is used for noting historic & current factors that explain a 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 disturbances, 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 caused 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	Chronically 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, persisting 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 unsolved social issues (undocumented or court orders)

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

The **Clinical Reasoning Worksheet** works to guide supervisees towards a clinical question for the supervision session, and to organize for oral presentation of a case for supervision. This organizer is particularly suited for new practitioners.

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 & Contributors 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?

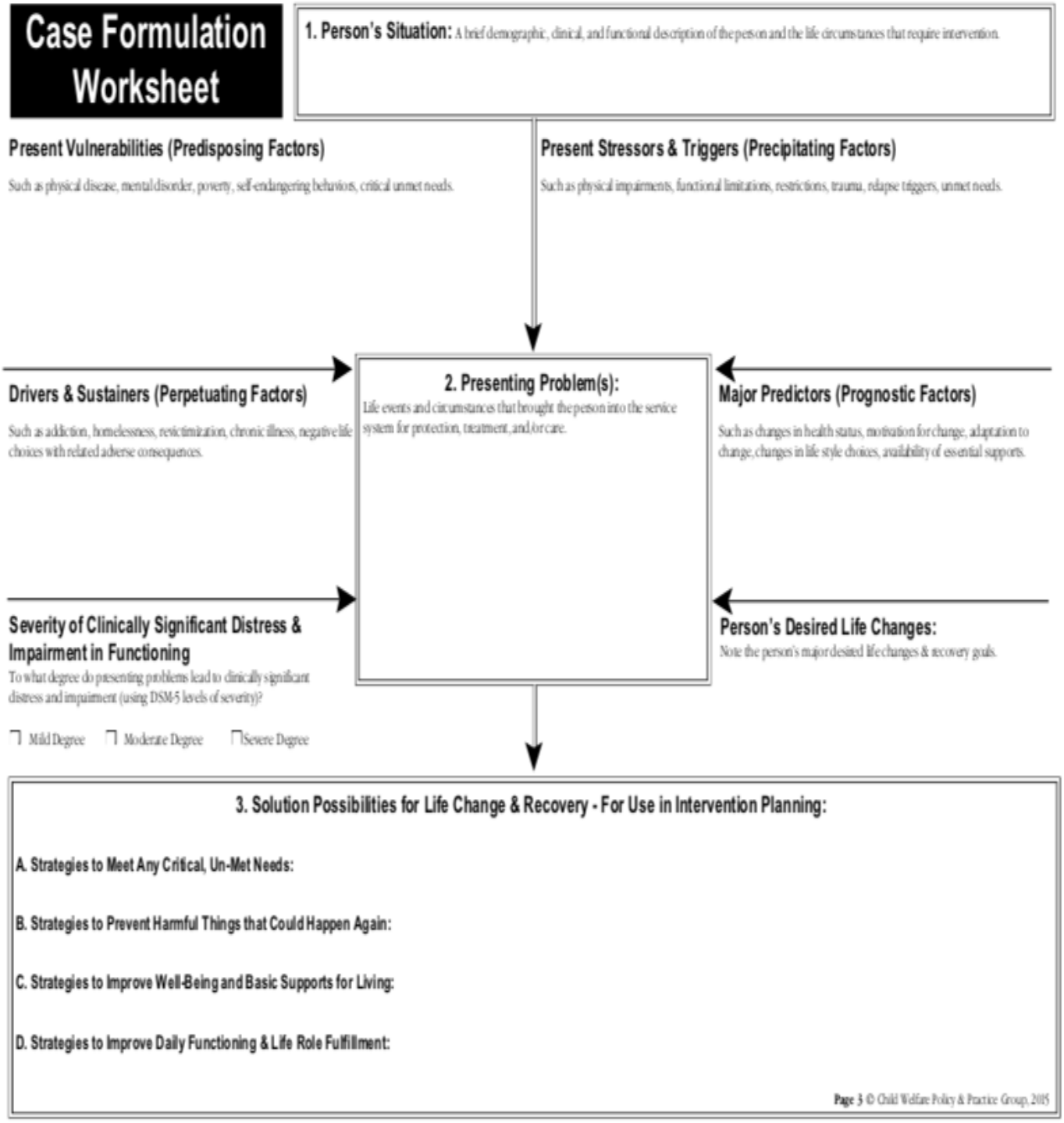
7. Necessary Changes: What things in the person's life would have to change in order for the person to achieve and maintain adequate well-being, have essential supports for living, function adequately in daily activities, and fulfill key life roles - as appropriate to life stage, capacities, and preferences?

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 fulfills 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 needs are met, conditions for safe case closure are present, and intervention efforts can be safely and successfully reduced, transitioned, or concluded?

The **Case Formulation Worksheet** examines the pertinent factors influencing a person in services and build understanding of the whole picture of the person in context of a person's life experience.



The **Planning Worksheet** can be used with a practitioner is "stuck" in what actions should be taken next, when there is decreased or difficulty engaging a person in services, early in the delivery of care to build rapport and trust, or to organize and deconstruct actions in response to crisis or an emerging crisis.

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 strategies.

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 living 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 from 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 Completions** in life change efforts.

ORDER AND PACE OF INTERVENTIONS: 1) Work from **Urgent to Strategic,** from **Practical to Clinical,** and from **Outcomes to Actions**; 2) **Define Outcomes** in operational terms and **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 Priorities	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		

IV. Models of Clinical Supervision, Defined

A. Psychotherapy-based models of supervision often feel like a natural extension of the therapy itself. "Theoretical orientation informs the observation and selection of clinical data for discussion in supervision as well as the meanings and relevance of those data (Falender & Shafaanske, 2008, p. 9). Thus, there is an uninterrupted flow of terminology, focus, and technique from the counseling session to the supervision session, and back again.

1. Psychodynamic Approach to Supervision: As noted above, psychodynamic supervision draws on the clinical data inherent to that theoretical orientation (e.g., affective reactions, defense mechanisms, transference and countertransferece, etc.). Frawley-O'Dea and Sarnat (2001) classify psychodynamic supervision into three categories: patient-centered, supervisee-centered, and supervisory-matrixcentered. Patient-centered began with Freud and, as the name implies, focuses the supervision session on the patient's presentation and behaviors. The supervisor's role is didactic, with the goal of helping the supervisee understand and treat the patient's material. 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).

    a. Supervisee-centered psychodynamic supervision came into popularity in the 1950s, focusing on the content and process of the supervisee's experience as a counselor (Frawley-O'Dea & Sarnat, 2001; Falender & Shafranske, 2008). Process focuses on the supervisee's resistances, anxieties, and learning problems (Falender & Shafranske). The supervisor's role in this approach is still that of the authoritative, uninvolved expert (Frawley-O'Dea & Sarnat), but because the attention is shifted to the psychology of the supervisee, supervision utilizing this approach is more experiential than didactic (Falender & Shafranske).

    b. The supervisory-matrix-centered approach opens up more material in supervision as it not only attends to material of the client and the supervisee, but also introduces examination of the relationship between supervisor and supervisee. The supervisor's role is no longer one of uninvolved expert. Supervision within this approach is relational and the supervisor's role is 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 an examination of parallel process, which is defined as "the supervisee's interaction with the supervisor that parallels the client's behavior with the supervisee as the therapist" (Haynes, Corey, & Moulton, 2003).

2. Cognitive-Behavioral Supervision As with other psychotherapy-based approaches to supervision, an important task for the cognitive-behavioral supervisor is to teach the techniques of the theoretical orientation. Cognitive-behavioral supervision makes use of observable cognitions and behaviors—particularly of the supervisee's professional identity and his/her 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).

3.Person-Centered Supervision Carl Rogers developed person-centered therapy around the belief that the client has the capacity to effectively resolve life problems without interpretation and direction from the counselor (Haynes, Corey, & Moulton, 2003). In the same vein, person-centered supervision assumes that the supervisee has the resources to effectively develop as a counselor. The supervisor is not seen as an expert in this model, but rather serves as a "collaborator" with the supervisee. The supervisor's role is to provide an environment in which the supervisee can be open to his/her experience and fully engaged with the client (Lambers, 2000). In person-centered therapy, "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.

B. Developmental Models of Supervision

In general, developmental models of supervision define progressive stages of supervisee development from novice to expert, each stage consisting of discrete characteristics and skills. For example, supervisees at the beginning or novice stage would be expected to have limited skills and lack confidence as counselors, while middle stage supervisees might have more skill and confidence and have conflicting feelings about perceived independence/dependence on the supervisor. A supervisee at the expert end of the developmental spectrum is likely to utilize good problem-solving skills and be reflective about the counseling and supervisory process (Haynes, Corey, & Moulton, 2003).

For supervisors employing a development approach to supervision, the key is to 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). To this end, a supervisor uses an interactive process, often referred to as "scaffolding" (Zimmerman & Schunk, 2003), which encourages the supervisee to use prior knowledge and skills to produce new learning. Throughout this process, not only is the supervisee exposed to new information and counseling skills, but the *interaction* between supervisor and

supervisee also fosters the development of advanced critical thinking skills. While the process, as described, appears linear, it is not. A supervisee may be in different stages simultaneously; that is, the supervisee may be at mid-level development overall, but experience high anxiety when faced with a new client situation.

1. Integrated Development Model: One of the most researched developmental models of supervision is the Integrated Developmental Model (IDM) developed by Stoltenberg (1981) and Stoltenberg and Delworth (1987) and, finally, by Stoltenberg, McNeill, and Delworth (1998) (Falender & Shafranske, 2004; Haynes, Corey, & Moulton, 2003). The IDM describes three levels of counselor development:

    - Level 1 supervisees are generally entry-level students who are high in motivation, yet high in anxiety and fearful of evaluation;
    - Level 2 supervisees are at mid-level and experience fluctuating confidence and motivation, often linking their own mood to success with clients; and Level 3 supervisees are essentially secure, stable in motivation, have accurate empathy tempered by objectivity, and use therapeutic self in intervention. (Falender & Shafranske)

    As noted earlier, the IDM stresses the need for the supervisor to utilize skills and approaches that correspond to the level of the supervisee. So, 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. If a supervisor was to consistently mismatch his/her responses to the developmental level of the supervisee, it would likely result in significant difficulty for the supervisee to satisfactorily master the current developmental stage. For example, a supervisor who demands autonomous behavior from a level-1 supervisee is likely to intensify the supervisee's anxiety.

2. Ronnestad and Skovholt's Model

    In the most recent revision (2003), the model is comprised of six phases of development. The first three phases (*The Lay Helper, The Beginning Student Phase,* and *The Advanced Student Phase*) roughly correspond with the levels of the IDM. The remaining three phases (*The Novice Professional Phase, The Experienced Professional Phase,* and *The Senior Professional Phase*) are self-explanatory in terms of the relative occurrence of the phase in relation to the counselor's career. In addition to the phase model, Ronnestad and Skovholt's (2003) analysis found 14 themes of counselor development. These are:

1. Professional development involves an increasing higher-order integration of the professional self and the personal self
2. The focus of functioning shifts dramatically over time from internal to external to internal.
3. Continuous reflection is a prerequisite for optimal learning and professional development at all levels of experience.
4. An intense commitment to learning propels the developmental process.
5. The cognitive map changes: Beginning practitioners rely on external expertise, seasoned practitioners rely on internal expertise.
6. Professional development is long, slow, continuous process that can also be erratic.
7. Professional development is a life-long process.
8. Many beginning practitioners experience much anxiety in their professional work. Over time, anxiety is mastered by most.
9. Clients serve as a major source of influence and serve as primary teachers.
10. Personal life influences professional functioning and development throughout the professional life span.
11. Interpersonal sources of influence propel professional development more than 'impersonal' sources of influence.
12. New members of the field view professional elders and graduate training with strong affective reactions.
13. Extensive experience with suffering contributes to heightened recognition, acceptance and appreciation of human variability.
14. For the practitioner there is a realignment from self as hero to client as hero.

C. Integrative Models of Supervision

Haynes, Corey, and Moulton describe two approaches to integration: technical eclecticism and theoretical integration.

1. Technical eclecticism tends to focus on differences, chooses from many approaches, and is a collection of techniques. This path calls for using techniques from different schools without necessarily subscribing to the theoretical positions that spawned them. In contrast, *theoretical integration* refers to a conceptual or theoretical creation beyond a mere blending of techniques. This path has the goal of 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, p. 124).

2. Bernard's Discrimination Model: Today, one of the most commonly used and researched integrative models of supervision is the Discrimination Model, originally published by Janine Bernard in 1979. This 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.

3. Systems Approach: In the systems approach to supervision, 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 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). 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.

D. <u>Reflective Supervision:</u>

The three building blocks of reflective supervision—reflection, collaboration, and regularity—are outlined below. {The author 's description reflects a child/family context.}

1. Reflection

   Reflection means stepping back from the immediate, intense experience of hands-on work and taking the time to wonder what the experience really means. What does it tell us about the family? About ourselves? Through reflection, we can examine our thoughts and feelings about the experience and identify the interventions that best meet the family's goals for self-sufficiency, growth and development.

   Reflection in a supervisory relationship requires a foundation of honesty and trust. The goal is to create an environment in which people do their best thinking—one characterized by safety, calmness and support. Generally, supervisees meet with supervisors on a regular basis, providing material (like notes from visits with families, videos, verbal reports, etc.) that will help stimulate a dialogue about the work. As a team, supervisor and supervisee explore the range of emotions (positive and negative) related to the families and issues the supervisee is managing. As a team, they work to understand and identify appropriate next steps.

   Reflective supervision is not therapy. It is focused on experiences, thoughts and feelings directly connected with the work. Reflective supervision is characterized by

active listening and thoughtful questioning by both parties. The role of the supervisor is to help the supervisee to answer her own questions, and to provide the support and knowledge necessary to guide decision-making. In addition, the supervisor provides an empathetic, nonjudgmental ear to the supervisee. Working through complex emotions in a "safe place" allows the supervisee to manage the stress she experiences on the job. It also allows the staff person to experience the very sort of relationship that she is expected to provide for clients and families.

2. Collaboration

   The concept of collaboration (or teamwork) emphasizes sharing the responsibility and control of power. Power in an infant/family program is derived from many sources, among them position in the organization, ability to lead and inspire, sphere of influence and network of colleagues. But most of all, power is derived from knowledge—about children and families, the field, and oneself in the work. While sharing power is the goal of collaboration, it does not exempt supervisors from setting limits or exercising authority. These responsibilities remain firmly within the supervisor's domain. Collaboration does, however, allow for a dialogue to occur on issues affecting the staff person and the program.

3. Regularity

   Neither reflection nor collaboration will occur without regularity of interactions. Supervision should take place on a reliable schedule, and sufficient time must be allocated to its practice. This time, while precious and hard to come by, should be protected from cancellation, rescheduling, or procrastination. That said, everyone working in infant/family programs knows that there are times when scheduling conflicts or emergencies arise, making it necessary to reschedule supervision meetings. When this happens, set another time to meet as soon as possible. If the need to reschedule arises frequently, it makes sense to consider why this is happening. Is the selected time an inconvenient one? Is the supervisor or the staff member overburdened, or is either having difficulty with time management skills? Is there some tension in the staff/supervisory relationship prompting either party to postpone their meeting?

   It takes time to build a trusting relationship, to collaborate, and to share ideas, thoughts, and emotions. Supervisory meetings are an investment in the professional development of staff and in the future of the infant/family program. Staff will take their cues from leaders: do program directors make time for supervision? Do the program's leaders "walk the talk"?

   Excerpted from Parlakian, R. (2001). Look, listen, and learn: Reflective supervision and relationship-based work. Washington, D.C: ZERO TO THREE.

E. <u>Reflective Supervision Infant Mental Health</u>

Professionals who provide services to infants and young children and their families involved in child protective services face multiple daily challenges. Working with stressed and traumatized infants/young children and their families, as well as the systems charged with providing services and oversight, affects professionals on many levels. These early professionals (mental health providers, developmental specialists, early interventionists, home visitors, family educators, Head Start teachers, public health nurses, child welfare workers and others) in turn require support and ongoing professional development to provide perspective, increase their skills, and avoid burn-out. Reflective supervision, a practice that has evolved from the multi-disciplinary field of infant mental health, provides the support needed by practitioners who are exposed to the intense emotional content and life experiences related to their work with families. An ongoing professional development process, reflective supervision provides a way for professionals working with very young children to reach greater understanding of their own responses, as well as the babies and adults they work with, and as a result, facilitating quality practice and intervention.

For more information:

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

V. Clinical Supervision-Methods and Types

A. Methods of Clinical Supervision

1. In person clinical supervision is defined as the supervisee and supervisor face-to-face in same physical setting.

2. Tele supervision is defined as utilization of HIPPA compliant teleconferencing technology such as ZOOM platform that provides face-to-face supervision with a supervisee and supervisor. This can be either individual or group. Utilization of telephone or email can complement this type of supervision. Although this type of supervision was initially employed in rural and frontier settings, where the supervisee and supervisor may be physically located some distance from each other, this has more recently been applied in urban settings as well. Encryption should be utilized at all times with attention to licensure and interstate boundaries regarding location of the supervisor and supervisee. It is important to check with your state professional board regarding rules allowing tele supervision. (See Appendix F)

B. Type of Clinical Supervision

1. Individual Clinical Supervision: Clinical individual supervision is defined as one supervisee and one supervisor in face-to-face supervision. It is important to check with your state professional board regarding numbers of hours required in individual supervision.

2. Group Supervision: Clinical group supervision is defined as two or more supervisees in face to face supervision with one supervisor. It is important to check with your state professional board regarding numbers of hours allowed or required in group supervision and the size of the group permitted.

3. Interdisciplinary supervision in behavioral health is defined as receiving clinical supervision from someone in someone who is not in your profession such as a social worker receiving supervision from a licensed clinical psychologist, psychiatrist or licensed professional clinical counselor. It is important to check with your state professional board regarding rules allowing interdisciplinary supervision and the number of hours allowed. (See Appendix F.)

C. References:

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VI. C**linical Supervision Session: BRIDGING FORM**

This form may be utilized to facilitate the supervisory alliance between supervisor and supervisee and provide them with essential feedback to enhance supervision.

Supervisee: Date:

Part A (To be completed shortly after supervision session)

1. What stands out to you about our last supervision? Thoughts, feelings, insights?

_____

_____

_____

2. On a 10 point scale, how would you rate the following items: (a to d)

Not at all		A little bit		Moderately		Much		Very Much
1	2	3	4	5	6	7	8	9 10

a) Helpfulness/effectiveness of supervisor: ____

What was helpful?

_____

_____

What was not helpful?

_____

_____

b) How connected you felt to your supervisor: ___

c) How engaged/involved you felt with the topics being discussed: __

d) How present you were in the supervision: ___

3. What would have made the supervision more helpful or a better experience?

_____

4. What issues came up for you in the supervision that are similar to your daily life problems?

5. What risks did you take in supervision?

Part B (to be completed just prior to the next supervision session)

1. What were the high and low points of your clinical work this week?

2. What items, issues, challenges or positive changes do you want to put on the agenda for our next supervision?

3. How open were you in answering the above questions? (0 to 100%)

4. Anything else you'd like to add

VII. Behavioral Health Integration

A. Integration and collaborative care are often used when discussing health care innovation and delivery. Three levels of collaborative care can be described as coordinated care, co-located care, and integrated care (Hunter, Goodie, Oordt, & Dobmeyer, 2017). In coordinated care the providers will share information at a distance and as needed. In co-located care the providers are in close proximity and collaboration is more common, but each provides services in traditional roles. Truly integrated care has providers working in seamless service delivery models with high level collaboration between disciplines, shared information systems, and common work spaces. Hunter, Goodie, Oordt, and Dobmeyer (2017) use an example of the primary care behavioral health model to provide examples of integrated behavioral health services. This model is a truly integrated behavioral health provider working alongside of primary care providers. The model allows for quick screening and interventions and is specifically designed to not impede the fast pace of primary care. Other models include integration of primary care providers into traditional specialty behavioral health services. Behavioral health providers that have only worked in specialty behavioral health will face new challenges as integration becomes more of a reality (Robinson & Reiter, 2013). Understanding levels of integration, collaboration, co-location, and team-based care will certainly be important tools for clinical supervision. The ability to provide clinical supervision in multiple environments, populations, and varying levels of integrated behavioral health services are crucial as innovation in health care continues.

B. Tools:

1. Five Levels of Integration

   Self-Assessment Tool: Five Levels of Behavioral Health Integration

2. A Quick Start Guide to Behavioral Health Integration for Safety-Net Primary Care Providers

   A Quick Start Guide to Behavioral Health Integration for Safety-Net Primary Care Providers

C. References

Hunter, C. L., Goodie, J. L., Oordt, M.S., & Dobmeyer, A. C. (2017). *Integrated behavioral health in primary care; Step-by-step guidance for assessment and intervention* (2nd ed.). Washington, DC: American Psychological Association.

Robinson, P. J., & Reiter, J. T. (2013). *Behavioral consultation and primary care* (2nd ed.). Switzerland: Springer International Publishing.

VIII. Where to locate training approved for CEU's

The approved trainings to meet various professional continuing education requirements vary by the relevant Boards. Here are some leads to possible courses.

For Psychologists:

New Mexico Psychological Association (online CE courses)
https://www.nmpsychology.org/page/33

American Psychological Association (continuing education programs)
http://www.apa.org/education/ce/index.aspx

National Register of Health Service Psychologists (member-only)
https://www.nationalregister.org/member-benefits/continuing-education/

For Social Workers:

National Association for Social Workers New Mexico
https://naswnm.org/

APPENDICES
Contents

Appendix A: Evaluation Tools

Several tools for evaluation of the supervisor and supervisee exist. Various examples are offered below to facilitate the evaluation and development of the supervisee. In addition, the competencies of the supervisor are critical. Thus, a self-assessment for the supervisor is offered to promote ongoing competency development. These documents may be modified according to organization requirements as well as consideration of the supervisory model (e.g., process, competency-based, CBT, psychodynamic, etc.) being applied in practice.

- Therapist Evaluation Checklist:
http://www.cfalender.com/assets/therapist-evaluation-checklist1.pdf

- Supervisor Evaluation Form

http://cfalender.com/assets/supervisor-evaluation-form3.pdf

- Supervisor Competency Self-Assessment

http://societyforpsychotherapy.org/wp-content/uploads/2016/10/Appendix-Special-Feature.pdf

- Key Areas for Evaluation of Clinical Supervision form:

This tool is intended to be used as a framework and guide for clinical supervision. The intent is to provide feedback to supervisors regarding their quality of supervision. The tool is broken up into two sections: Specific skills competencies, and Theoretical models. To best use this tool, a supervisor will record a supervision session with their supervisee, after obtaining the supervisee's consent. The session will be reviewed with the supervisor during a supervisors' group meeting. All supervisors participating in this meeting will receive a copy of this tool and rate each domain as the pre-recorded session is being viewed. The supervisor is encouraged to share feedback, answer questions, and rate themselves during this process. Please note that this process is intended for growth and support and should be done through a strengths based approach.

Key Areas for Evaluation of Clinical Supervision

COMPETENCIES	RATINGS / COMMENTS			
	Comment	Exemplary	Standard	Unaccept-able
Supervisor's communication uses counselling interventions with supervisee, such as:				
a. Open-ended questions				
b. Closed questions				
c. Paraphrasing				
d. Summarization				
e. Reflection of feelings				
f. Tuning into nonverbal language				
g. Information giving				
i. Use of Motivational Interviewing				
j. Problem identification				

COMPETENCIES	RATINGS / COMMENTS			
	Comment	**Exemplary**	**Standard**	**Unaccept-able**
Supervisor's communication uses counselling interventions with supervisee, such as:				
k. Mutual goal setting				
l. Use of humor, role playing, etc.				
m. Creating therapeutic climate/alliance (e.g. trust, rapport)				
n. Overall empathy				
o. Skillful feedback				
p. Focuses/connects to professional development				
q. Ensures that service to client is safe, ethical and competent				
r. The capacity to recognize and facilitate the co-evolving relationships between the worker-client and supervisor-worker-client relationships, identifying and addressing problems that arise. Explore various relationships of staff; supervisor/staff; management, etc and issues are addressed as needed.				

COMPETENCIES	RATINGS / COMMENTS			
	Comment	**Exemplary**	**Standard**	**Unacceptable**
Supervisor's communication uses counselling interventions with supervisee, such as:				
s. Culturally sensitive approach				
t. Knowledge of the service delivery protocol and treatment standards as well as the ethical mandates of relevant professional bodies and the ability to provide such information, as relevant in supervisory session.				
u. Use of supervision log constantly				
v. Advanced knowledge of the major issues experienced by clients (e.g. mental illness, alcoholism, drug abuse)				
w. Emphasis on self-care/staff wellness				
x. Supervisor has printed and brought to supervision, Caseload Performance Report and referred to it during supervision session.				

MODELS OF SUPERVISION MATRIX	
MODELS	**COMMENTS**
Psychotherapy-based Models of Supervision	
Psychodynamic Approach to Supervision	
Supervisee-Centered Psychodynamic Supervision	
Supervisory-Matrix-Centered Approach	
Cognitive-Behavioral Supervision	
Person-Centered Supervision	
Developmental Models of Supervision	
Integrated Development Model	
Ronnestad and Skovholt's Model	
Integrative Models of Supervision	
Technical Eclecticism	
Bernard's Discrimination Model	
System's Approach	
Reflective Practice/Supervision	

- Supports self-reflections of the supervisee.	
- Discusses awareness of one's individual and cultural beliefs, values and biases.	
- Continues to provide feedback during collaboration.	
Use of Self	
- Supports supervisee's initiation of ideas.	
- Expects the supervisee to have clear, rationales for theoretical approach.	
- Discusses and plans how to talk to parents about the strengths and vulnerabilities of their child.	
- Continues to give direct input and evaluative feedback.	

Appendix B:

Treat First Approach Tip Sheets:

Practice Tips & Clinical Techniques

Appendix C:

Case Discussion Guide for Reflective Practice

(This example is for a Child & Family Case. Can be modified for Adults)

INTRODUCTION

Purpose

The Discussion Guide is intended to create opportunities for reflective case practice discussions between caseworkers, practitioners, and supervisors.

The Discussion Guide may be most helpful when used to

- Identify successes and opportunities
- Affirm good practice when observed in the case
- Suggest options for overcoming any barriers encountered
- Provide assistance to the caseworker or care coordinator as needed
- Discover a worrisome case trajectory and plan actions accordingly

---

QSR Practice Principles

In this example, the Discussion Guide uses five QSR Principles to assess areas of practice that are critical to attaining positive outcomes for children and families.

1. Engaging Service Partners	• Do you have a trust-based working relationship with the child, family, and other service providers?
2. Understanding the Situation	• Do all involved understand the child and family situation well enough to make a positive difference?
3. Planning Positive Life-Changing Interventions	• Is service planning an ongoing process, reflective of the current situation and helping to achieve desired outcomes for the child and family?
4. Implementing Services	• Are services appropriate to meet the need? • Is the implementation and coordination of services timely, competent, and of sufficient intensity to achieve desired outcomes?
5. Getting and Using Results	• Are current efforts leading to positive results? • Is knowledge gained through experience being used to refine strategies, solve problems, and move the case forward?

Using the Guide

Using the Discussion Guide is optional. It may be used in any format that accommodates the needs of the local office as long as it is helpful and affirming to frontline workers, practitioners, and supervisors.

1. ENGAGING THE CHILD AND FAMILY IN A CHANGE PROCESS

• Have you engaged the child, family, and other service partners in an ongoing trust-based working relationship?

Strength	Opportunity	Areas to Be Explored
		The team meets with the child and family face-to-face and identifies their strengths, needs, and underlying issues.
		The family has identified and communicated their strengths and needs to those who provide services.
		The family has stated how they believe their needs can be met.
		The child and family are engaged as active participants in the service process.
		The service team includes the important people in the child's life (school, medical, legal, juvenile court, mental health, other service providers, church, mentors, friends, extended family, others)
		Every service team member is committed to helping and achieving positive outcomes. There is a strong sense of urgency in meeting near-term needs and long-term goals evident in the attitudes and actions of team members.
		There is a reliable support network involved with this child and family.

Next steps to improve engagement:

2. UNDERSTANDING THE CHILD AND FAMILY SITUATION

• Does everyone on the service team understand the child and family well enough to improve their levels of well-being, daily functioning, sustaining supports, and role performance?

Strength	Opportunity	Areas to Be Explored
		The presenting problems and underlying issues are clearly identified and agreed upon by the service team.
		The child's functional status in daily settings is accurately assessed and understood in context by service team members.
		Any issues related to education, substance abuse, mental health, developmental or physical disabilities are diagnosed and understood.
		Known risks of harm (abuse, neglect, domestic violence, health crisis, suicide) are understood.
		A safety plan in place, used, as needed, and understood. The safety plan is evaluated and refined after each use.
		Any special needs, risks of harm, transition requirements, or needs for further assessments are understood and addressed effectively by the service team.
		The team clearly understands what things must change for the child and family to get better, do better, and stay better.
		All other interveners in the child's life participate in developing a 'big picture' understanding of the case situation.
		All other interveners are part of the service team and/or know what services are being provided.

Next steps to improve understanding of the child and family situation:

3. PLANNING POSITIVE LIFE-CHANGING INTERVENTIONS

• Is planning for the child and family an ongoing process that reflects the child's situation and what must change?

• Are planned interventions designed to meet near-term needs and long-term outcomes for the child and family?

Strength	Opportunity	Areas to Be Explored
		The child and family are engaged as active participants in the service planning process and have a trust-based relationship with those involved with them in the service process.
		The strategies and supports in the case plan are consistent with the strengths, needs and goals of the child and family.
		Focal problems, functional challenges, risks, and underlying issues are reflected in the choice of goals and strategies.
		The planning process includes family team conferencing.
		There is a long-term guiding view that focuses on the child living in a safe, appropriate and permanent home in the near future.
		Known transitions between settings, levels of care, providers and life stages are recognized are being addressed.
		The planning process is building sustainable supports (formal and informal) to enable the family to function safely after services are completed.
		Strategies, interventions, and supports are individualized to fit the child and family situation.
		All service team members support the service planning process.
		Treatment efforts are unified among providers.

Next steps to improve planning of services:

4. IMPLEMENTING STRATEGIES AND SUPPORTS TO GET RESULTS

• Is implementation of planned intervention strategies, supports, and services -- timely, competent, and of sufficient intensity, duration, and consistency to achieve the desired results?

Strength	Opportunity	Areas to Be Explored
		The child and family are engaged as active, ongoing participants in the service process.
		Supports, services, and interventions are implemented consistent with case plan goals, strategies and requirements.
		Supports, services, and interventions are provided in a timely, adequate, competent, and culturally-respectful manner by all service providers.
		The service team has timely feedback about services provided as well as about service problems encountered.
		Services are adjusted as a result of feedback received.
		The case plan is modified when goals are met, strategies are found not to work, or when circumstances change.
		Service team members are fulfilling their roles and responsibilities to insure desired outcomes.
		Safety/health procedures are implemented correctly and effectively.
		Concurrent planning, where indicated, is being implemented in a timely and appropriate manner.
		Service efforts are integrated and coordinated across providers to maximize benefits and reduce duplication.

Next steps to improve implementation of services:

5. GETTING AND USING POSITIVE RESULTS

- **Are interventions leading to positive results and outcomes?**
- **Is knowledge of results being used to improve intervention efforts?**

Strength	Opportunity	Areas to Be Explored
		Intervention strategies, supports, and services are tracked to detect any implementation problems and evaluated to determine their effectiveness in producing desired results.
		Positive changes are being observed in the problems that brought/keep the child and family in services.
		The child is demonstrating functional improvement in routine daily activities and academic performance.
		The family is demonstrating functional improvement in safe and dependable caregiving.
		Known risks of harm are being reduced or properly managed through effective strategies.
		Transition planning for the child is in process and effectively supporting any life changes and adjustments.
		An adequate, sustainable support network is being established that will stay with the family after case closure.
		Results are being used to shape strategy, solve problems, and determine readiness for step-down or case closure.

Next steps to improve results and use results to improve service efforts:

REFECTIONS ON PRACTICE IN THIS CASE

Successes in Achieving Results

- **What supports, interventions, or engagement techniques are working now?**
- **In what observed ways are the child and family getting better, doing better, and staying better now?**
- **What makes current strategies and supports successful?**
- **Why is the family responding favorably to the service process?**

Factors Limiting Progress or Results

- **Are any child or family factors limiting progress in this case? If so, how?**
- **Are problems in accessing necessary intervention strategies, supports, and services for this child and family limiting progress in this case? If so, what are they?**

- **Are any local conditions of practice (e.g., caseload sizes, staff turnovers, vacancies, waiting lists, travel and distance issues) limiting progress in this case? If so, what are they?**

Case Trajectory Concerns

- **Are there any unfolding circumstances that could lead to harm, hardship, or poor down-stream outcomes for the child and family? Is so, what are they?**

- **What steps, if any, should be taken to improve the trajectory of this case and achievement of desired outcomes for this child and family?**

Assistance to Move Case Practice Forward

- **Which of the following sources of assistance would help you most right now?**

Training – on the use of a new skill or technique related to this case.

Modeling and Mentoring – on the use of a new skill, technique, or role in this case.

Supervisor Assistance – in solving a case-specific problem.

Specialty Consultation – to conduct a specialized assessment or perform a complex intervention in this case.

Multi-Organization Support – to integrate information, coordinate planning and services across providers, and integrate funding sources in this case.

Other – assistance of a unique nature not covered above.

Appendix D

Clinical Reasoning Organizers

The following “Organizers” are discussed in Section 3. Clinical Supervision Preparation Tools.

Appendix E: Statutes and Regulations

Introduction:

The Licensing Boards provide specific regulations and direction for each discipline. In addition, New Mexico has specific reporting requirements and statutes related to:

The following citations address:

- Children Youth and Families Department
- Human Services Department – Critical Incident Reporting

Adult Protective Services

Children's Protective Services (CYFD)

Critical Incident Reporting (HSD)

New Mexico Licensing Boards

Counseling and Therapy Board

Psychology

Social Work

Appendix F:

State Licensing and Credentialing Boards

Licenses and credentials serve an important public safety function to behavioral health fields. 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.

Many behavioral health professions in New Mexico have an independent licensure that providers can gain 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 and supervision standards for their various supervisees to avoid providing erroneous information that can delay a supervisee's progression to independent licensure.

The following is a listing of the behavioral health licensing and credentialing boards in the state with a brief overview of the supervision rules specific to these boards, as well as where to find more details, as of June 2018.

- New Mexico Board of Nursing: http://nmbon.sks.com/
    - Supervision is required for some types of nurses, primarily those given a permit-to-practice prior to being fully licensed.
        - RN permit-to-practice: supervision from an RN only. To see the current rules on this, see the NMAC "Title 16 Occupational and Professional Licensing → Chapter 12 Nursing and Health Care Related Providers → Part 2 Nurse Licensure → 16.12.2.10 Licensure Requirements for Registered and Practical Nurses"
        - LPN: all LPNs must receive direct supervision to do any procedures that goes "beyond basic preparation for practical nursing." To see the current rules on this, see the NMAC "Title 16 Occupational and Professional Licensing → Chapter 12 Nursing and Health Care Related Providers → Part 2 Nurse Licensure → 16.12.2.10 Licensure Requirements for Registered and Practical Nurses"
        - GNP permit-to-practice: supervision can be from a physician, CNP, or CNS; direct supervision is specifically required to prescribe. To see the current rules on this, see the NMAC "Title 16 Occupational and Professional Licensing → Chapter 12 Nursing and Health Care Related Providers → Part 2 Nurse Licensure → 16.12.2.13 Advanced Practice Registered Nurse (APRN) Certified Nurse Practitioner (CNP)"

        - GCNS permit-to-practice: supervision can be from a CNS, CNP, or a physician in their specialty; direct supervision is specifically required to prescribe. To see the current rules on this, see the NMAC "Title 16 Occupational and Professional Licensing → Chapter 12 Nursing and Health Care Related Providers → Part 2 Nurse Licensure → 16.12.2.15 Advanced Practice Registered Nurse (APRN) Certified Nurse Specialist (CNS)"
    - For all nurses, supervision can only be done face-to-face and with an appropriate provider who is within the organization at which the supervisee is working. For more details, see the NMAC "Title 16 Occupational and Professional Licensing → Chapter 12 Nursing and Health Care Related Providers → Part 2 Nurse Licensure → 16.12.2.7 Definitions"

- New Mexico Board of Social Work Examiners: http://www.rld.state.nm.us/boards/social_work.aspx
    - To earn an LCSW or LISW, LMSWs are required to complete a certain number of supervision hours and hours in practice (which includes all work and is not limited to client contact hours), with only some of the supervision hours being permissible through group supervision. As of June 2018, this is 90 hours of supervision and 3,600 practice hours, with 20 hours of group supervision permitted. To see the current rules on this, see the website's "Rules and Laws → Chapter 63 Social Workers → 16.63.11 NMAC: Independent Social Worker → 16.63.11.8 Qualification for Licensure"
    - LMSWs can only earn supervision with supervisors approved by the Board of Social Work Examiners. To become an approved supervisor, the clinician must take a supervision class and then submit the certificate along with a form to the board.
        - To find a list of approved classes, see the website's "Forms and Applications → Supervision Classes → Approved Supervision Classes"
        - To apply to become an approved supervisor, see the website's "Forms and Applications → Supervision Forms → Supervision General Directions and Application"
        - Who is an approved supervisor? See the Approved Supervisors List under the website's "Forms and Applications → Supervision Classes → Approved Supervisors List"
    - LMSWs can only receive a limited number of supervision hours from an approved supervisor who is not an LCSW or LISW. As of June 2018, this is 30 hours. To see the current number of permissible hours, see the website's "Rules and Laws → Chapter 63 Social Workers → 16.63.11 NMAC: Independent Social Worker → 16.63.11.8 Qualification for Licensure"

- Telesupervision is permitted for all supervision hours. For more details, see the website's "website's "Rules and Laws → Chapter 63 Social Workers → 16.63.1 NMAC: General Provisions → 16.63.1.7 Definitions"

- New Mexico Counseling and Therapy Practice Board: http://www.rld.state.nm.us/boards/counseling_and_therapy_practice.aspx
  - All counseling licenses require a certain number of supervision hours and client contact hours to be completed. The amount varies by license.
    - LPCC or LPAT: As of June 2018, LMHCs must complete 3000 hours of client contact and 100 hours of supervision, with no limits on individual versus group supervision. Some of these client contact hours can be done in an internship, depending on type of license.
      - LPCC: Up to 1000 client contact hours can be done in an internship. To see the current rules on this, see the website's "Rules and Laws → Chapter 27 Counselors and Therapist Practitioners → 16.27.4 NMAC: Requirements for Licensure as a Professional Clinical Mental Health Counselor (LPCC) → 16.27.4.11 Documentation Required of Licensure"
      - LPAT: Up to 750 client contact hours can be done in an internship. To see the current rules on this, see the website's "Rules and Laws → Chapter 27 Counselors and Therapist Practitioners → 16.27.7 NMAC: Requirements for Licensure as a Professional Art Therapist (LPAT) → 16.27.7.10 Applicants for Licensure"
    - LMFT: As of June 2018, LAMFTs must complete 1000 hours of marriage and family client contact and 200 hours of supervision; up to 100 of the supervision hours can be done in group. To see the current rules on this, see the website's "Rules and Laws → Chapter 27 Counselors and Therapist Practitioners → 16.27.6 NMAC: Requirements for a Marriage and Family Therapist (LMFT) → 16.27.6.9 Applicants for Licensure"
    - LADAC: As of June 2018, LSAAs must complete 1000 hours of client contact and 50 hours of supervision. To see the current rules on this, see the website's "Rules and Laws → Chapter 27 Counselors and Therapist Practitioners → 16.27.11 NMAC: Requirements for Licensure with Examination as an Alcohol and Drug Abuse Counselor (LADAC) → 16.27.11.9 Applicants for Licensure"
  - All counseling licenses can receive supervision from most types of independently licensed behavioral health providers, with no limits on hours from interdisciplinary supervisors. However, most of the licenses require the supervisor to have specialization in the respective field (e.g. substance use for those seeking LADAC, art therapy for those seeking LPAT, marriage/family

therapy for those seeking LMFT). To see the current rules on this, see the "appropriate supervision" section for each individual license's rules, the directions to which are above.
    - There are no limits indicated for any of the counseling licenses regarding supervision to be done by televideo versus face-to-face. To see the current rules on this, see the website's "Rules and Laws → Chapter 27 Counselors and Therapist Practitioners → 16.27.19 NMAC: Approved Supervisors"

- New Mexico Medical Board: http://www.nmmb.state.nm.us/
    - To become a licensed medical doctor (which includes psychiatrists), a postgraduate trainee must work for at least 3 years and have their work observed directly by at least 2 physicians, chiefs of staff, or department chairs (no specific number of hours indicated) who can recommend them for licensure. To see the current rules on this, see the website's "Rules and Statues -> Governing Statutes and Rules → Physicians: Licensure Requirements → 16.10.2.10 Medical License by Endorsement"

- New Mexico Office of Peer Recovery and Engagement: http://newmexico.networkofcare.org/mh/content.aspx?id=11894
    - Certified Peer Support Workers do not have any specific supervision requirements. Please see their website for more information.

- New Mexico Psychologist Examiners Board: http://www.rld.state.nm.us/boards/Psychologist_Examiners.aspx
    - To become a licensed psychologist, an associate must complete a certain number of hours in practice (some of which need to be client contact hours) while under supervision; pre-doctoral supervised experience can account for some of these hours. As of June 2018, 3000 practice hours are required, with 750 of these hours being client contact hours; up to 1500 hours in an APA-approved pre-doctoral internship or 750 hours in a non-APA-approved pre-doctoral internship can be applied to the total 3000. For see the current rules on this, see the website's "Rules and Laws → Chapter 22 Psychologists and Psychologist Associates → 16.22.6 NMAC: Psychologists – Predoctoral and Postdoctoral Supervised Experience → 16.22.6.8 Supervised Experience Leading Towards Licensure"
    - Psychologist associates can only receive supervision from psychologists. There are no limits on whether this supervision is individual or in a group. For more details on this, see the website's "Rules and Laws → Chapter 22 Psychologists and Psychologist Associates → 16.22.6 NMAC: Psychologists – Predoctoral and

Postdoctoral Supervised Experience → 16.22.6.8 Supervised Experience Leading Towards Licensure"

- Predoctoral supervision can occur with an off-site supervisor with no indicated limits, while a postdoctoral supervision only allows for some telesupervision if the supervisor and supervisee live far apart. As of June 2018, 2 hours of telesupervision per month are allowed if the supervisee and supervisor live more than 100 hours apart. For more details on this, see the website's "Rules and Laws → Chapter 22 Psychologists and Psychologist Associates → 16.22.6 NMAC: Psychologists – Predoctoral and Postdoctoral Supervised Experience → 16.22.6.8 Supervised Experience Leading Towards Licensure & 16.22.6.9 Conditions of Postdoctoral Supervision"
- Postdoctoral supervision requires a documented supervisory plan approved by the board in order for the board to accept the hours. This plan can be done at the end of the supervision time, but is recommended to be submitted prior to or at the beginning of the supervised practice. For details on what this plan should contain, see the website's "Rules and Laws → Chapter 22 Psychologists and Psychologist Associates → 16.22.6 NMAC: Psychologists – Predoctoral and Postdoctoral Supervised Experience → 16.22.6.10 Postdoctoral Supervisory Plan"

Appendix G: Additional References

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