Supervisor Refresher

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PRESENTED AT THE 57TH ANNUAL SOUTHWESTERN SCHOOL FOR BEHAVIORAL HEALTH STUDIES CONFERENCE, AUGUST 14, 2025

Time	Topic	Concepts covered
8:15 AM - 9:45 AM	Arizona Rules and Laws review **RPL** **THE BUSINESS OF SUPERVISION** **Kari**	Rules Documentation Contracting Skills Methods: supervision settings and evaluation
9:45 AM - 10:00 AM	BREAK	
10:00 AM - 11:30 AM	Supervision theories and models **M** review **THE ART OF SUPERVISION** **Vicki**	Roles and Rules, Skills, Methods and Techniques
11:30 AM - 1:00 PM	Lunch on your own	
1:00 PM - 1:45 PM	Methods of evaluation review **E** **THE RESPONSIBILITY OF SUPERVISION** **Kari/Vicki**	Evaluation
1:45PM - 2:30 PM	Guest: Tobi Zavala	Troubleshooting
2:30 PM - 2:45 PM	BREAK	
2:45 PM - 4:15 PM	Case studies, Getting unstuck, Discussion **C, S** **THE SCIENCE OF SUPERVISION** **Kari/Vicki/Ashley**	Continuing Education, Roles
4:15 PM	You Did it!	Closure/feedback/exchange kindness

Key content areas
R **Roles/responsibility**
S **Skills**
M **Methods**
E **Evaluation**
P **Private practice**
L **Exemptions to Licensure**
C **Continuing training and Documentation**

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Welcome & Introductions

- What setting do you currently provide clinical supervision?
- What do you see as the most important part of your supervision practice?
- What is the greatest barrier to your effective supervision practice?
- What one piece of advice do you have for clinical supervisors?
- What are you hoping to get out of our 6 hour training today?

Rules and Laws:
The Business of Supervision

KARI LOGSDON, MSFT, LMFT

Business of Supervision

- Arizona Rules & Statutes/AZBBHE Updates/Reminders
- Reoccurring Board Findings
- Handling Clinical Practice Dilemmas/Errors
- Clinical Supervision in Agency Settings in Arizona
- Clinical & Supervision Documentation
- Contracting

Arizona Statutes and Rules Review

Arizona Statutes: Title 32, Chapter 33: Behavioral Health Professionals

Arizona Administrative Code: Title 4, Chapter 6 Board of Behavioral Health Examiners

February 2025: Launched a new website! bbhe.az.gov

Arizona Revised Statutes Title 32 – Professions and Occupations Chapter 33 – Behavioral Health Professionals

- Article 1: Board of Behavioral Health Examiners
  - (Definitions, Unprofessional Conduct, BBHE)
- Article 2: Academic Review Committee
- Article 3: Licensure
- Article 4: Regulation
- Article 5: Social Work
- Article 5.1: Social Work Compact
- Article 6: Counseling
- Article 6.1: Licensed Professional Counseling Compact
- Article 7: Marriage and Family Therapy
- Article 8: Substance Abuse Counseling

Arizona Administrative Code (A.A.C) Title 4: Professions and Occupations Chapter 6: Board of Behavioral Health Examiners

Letters to Licensees

July 17, 2024

Dear AZBBHE Licensee,

The Board would like to take this time to highlight a portion of Arizona State law pertaining to behavioral health professional licensure renewal. The following information can be found in the Arizona Revised Statutes Title 32, Chapter 33, Article 3; Licensure.

90 Day Reinstatement Is Not A Grace Period

Pursuant to A.R.S. § 32-3277 if you allow your license to expire:

1. You may not practice under your license.
2. You have 90 days from the date of expiration to submit your renewal application, you may not practice until you have submitted your completed renewal application.
3. In order to obtain licensure after the 90 day window, you must submit an application for licensure through the initial licensing process and meet the current requirements.

A.R.S. § 32-3277 expired licenses; reinstatement

A. A person who does not renew a license is ineligible to practice pursuant to this chapter.

B. The board may reinstate an expired license if the person submits an application for reinstatement within ninety days after the expiration of the license. The application must document to the board's satisfaction that the applicant has met the renewal requirements prescribed by this chapter and include a late renewal penalty prescribed by the board rule.

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September 13, 2024

Dear AZBBHE Licensee,

The Board would like to take this time to highlight several significant changes affecting licensees and provide recent Board updates and resource information. Please continue to visit the website for updates and the most current information.

- Senate Bill 1062 : *Effective September 14, 2024*
  Behavioral Health Professionals; Addiction Counseling: On April 23, 2024, Governor Hobbs signed SB1062 which replaces statutory use of the term *substance abuse counseling* with the term *addiction counseling*. It also expands the practice of substance abuse counseling to include treatment for all forms of addiction that are a persistent, compulsive dependence on a behavior or substance. Defines *practice of addiction counseling* as the application of general counseling theories, principles and techniques to the specialized needs of persons who are experiencing an addiction that is a persistent, compulsive dependence on a behavior or substance, including mood altering behaviors or activities known as process addictions. With the expansion of scope, it is important to know that you must stay within your scope of competency which means your education, training and experience. Please see the FAQ Sheet on our website.
- Senate Bill 1062 : The Bill also made changes to A.R.S. § 32-3274 to ease the licensure by endorsement requirements for behavioral health professionals, reducing the necessary time licensed or certified in another jurisdiction from three years to one year.
- Senate Bill 1173: *Effective September 14, 2024*
  Licensed Professional Counselors; Compact: On April 2, 2024, Governor Hobbs signed SB1173 which adopts the Licensed Professional Counselor Compact, permitting licensed professional counselors to obtain licensure in other Compact states. The Counseling Compact is an interstate compact, or a contract among states, allowing professional counselors licensed and residing in a compact member state to practice in other compact member states without need for multiple licenses. The Compact is not yet active. Development and implementation are projected to be completed sometime in 2025. Additional information surrounding the Counseling Compact can be found on the Counseling Compact website. This implementation is overseen by the Counseling Compact and Arizona has no influence over the implementation date. Please continue to check the Counseling Compact website and direct your questions there.

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- Senate Bill 1036: *Effective September 14, 2024*
  Social Work Compact: On June 21, 2024, Governor Hobbs signed SB1036 which adopts the Social Work Licensure Compact, permitting social workers to obtain licensure in other Compact states. The Social Work Compact is an interstate compact, or a contract among states, allowing social workers licensed and residing in a compact member state to practice in other compact member states without need for multiple licenses. The Compact is not yet active. Additional information surrounding the Social Work Licensure Compact can be found on the Social Work Licensure Compact website. This implementation is overseen by the Social Work Compact and Arizona has no influence over the implementation date. Please continue to check the Social work Compact website and direct your questions there.

- House Bill 2473: *Effective September 14, 2024*
  Licensure Renewal; Fee Waiver: On March 29, 2024, Governor Hobbs signed HB2473 which amended

A.R.S. § 32-3272 resulting in the waiving of the renewal fee for an associate level licensee if the licensee has submitted the renewal application and the licensee's application for independent licensure is pending at the time of renewal.

The most current information can be found on the Arizona Board of Behavioral Health Examiners website along with quick guides, "cheat sheet" resources, Board meeting minutes, audio, and copies of our quarterly newsletters.

The Board sincerely thanks you for your continued service and commitment to the people of Arizona.

Respectfully,

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ARIZONA
Board of Behavioral Health Examiners

HB 2001

The Board is excited to share that Governor Hobbs recently signed a bill (HB 2001) into law that includes the following.

A.R.S. 32-3271(A)(13) will allow intern clinicians to continue seeing clients for up to 90 days while in the process of applying for licensure at their practicum site under qualified clinical supervision provided by a person who provided direct supervision to them during their practicum.

The Board in collaboration with stakeholders and the legislature, believe this is a positive change that will allow for continuity of care for clients between internship and licensure of new clinicians.

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Important Notes

- This law **does not go into effect until 90 days after the legislative session ends** (anticipated effective date will be sometime during September, 2025).
- This only applies in situations where an intern clinician/practicum student continues to practice at the site of their practicum and while under qualified clinical supervision by a person who provided direct supervision to them during their practicum.
- The rules for direct client work experience and clinical supervision will apply (R4-6-211 and 212).
- More to follow in the coming months before it becomes effective!

New Quarterly Newsletters contain important updates

AUTOMATIC EXAM APPROVALS FOR LCSW APPLICANTS

Effective May 13, 2025, the Arizona Board of Behavioral Health Examiners has implemented a new process that automatically approves Licensed Clinical Social Worker (LCSW) applicants to sit for the ASWB Clinical Exam if they have applied in good faith.

AZBBHE Facebook Page post important reminders and updates!

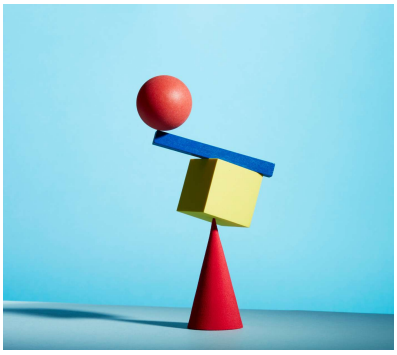
IF YOU CHOOSE TO UTILIZE AI WHEN WORKING WITH CLIENTS, DO IT RESPONSIBLY.

The client should be made aware of it in the informed consent and the AI language should be reviewed for accuracy.

Proposed Rulemaking Status

Impaired Professional Program (IPP)

- The IPP is a confidential program for the monitoring of licensees who are chemically dependent, or who have psychiatric, psychological, or behavioral health disorders that may be impacting their ability to safely practice behavioral health.
- A licensee's participation in the IPP remains confidential as long as they remain compliant with the SCRA established with the Board.



https://bbhe.az.gov/impaired-professional-program

Who is eligible to participate in the IPP?

- Complaints received from the public and background information regarding the licensee.
- Licensee voluntarily requests admission or accepts an offer of admission to the IPP.
- Licensee agrees to undergo an appropriate evaluation by a Board-approved professional.
- Licensee agrees in writing to comply with all elements of the IPP Stipulated Confidential Recovery Agreement ("SCRA").
- Licensee acknowledges that chemical dependency, psychiatric, psychological or behavioral health disorders are impairing their ability to safely and competently practice behavioral health.

 https://bbhe.az.gov/impaired-professional-program

November 9, 2023: BBHE Report on Letter Writing

Board members discussed the writing of letters for clients, completing paperwork, evaluative documentation or to third-parties about a client's disability(ies), required accommodation(s), or capacity to work. The Board noted the potential for conflict of interest, exploitation of clients, and dual relationships when such letters are written. Writing such letters requires specific training, competency, and a level of objectiveness.

Conflict of Interest, Exploitation, and Dual Relationship: It is inappropriate for a licensee who is providing psychotherapy to a client, to write letters to a third-party about the client's disability(ies), required accommodation(s), or capacity to work, because of the potential for conflict of interest, exploitation of the client, and dual relationship.

Scope of Practice: Furthermore, the writing of a letter to a third-party about a client's disability(ies), required accommodation(s), or capacity to work, is outside of the scope of practice for counseling, social work, marriage and family therapy, and substance abuse counseling. While some licensees may possess the competency to write such letters due to training or credentials received outside of their AZBBHE licenses, they may not do so for any client to whom they are also providing psychotherapy.

The Board will continue to review cases on an individual basis to determine competency and adequate training of the practitioner with regard to letter writing. For additional details of the discussion, listening to the full audio recording is highly encouraged (Time Stamp 4:10:50).

 https://bbhe.az.gov/sites/default/files/2025-01/November%209%2C%202023%20Minutes_0.pdf

2025 Reoccurring Board Findings

- ARS 32-3251: Unprofessional Conduct:
- A.R.S. § 32-3251(16)(k), engaging in any conduct or practice that is contrary to recognized standards of ethics in the behavioral health profession or that constitutes a danger to the health, welfare or safety of a client (10)
- A.R.S. § 32-3251(16)(l) engaging in any conduct, practice or condition that impairs the ability of the licensee to safely and competently practice the licensee's profession (6)
- A.R.S. § 32-3251(16)(p) failing to conform to minimum practice standards as developed by the board as it relates to (9)
  - A.A.C. R4-6-1101, Consent for Treatment (9)
  - A.A.C. R4-6-1102, Treatment Plan (8)
  - A.A.C. R4-6-1103, Client Record (6)
  - A.A.C. R4-6-1104, Financial and Billing Records (4)
  - A.A.C. R4-6-1106, Telepractice (3)

2025 Reoccurring Board Findings

- A.R.S. § 32-3251(16)(m), engaging or offering to engage as a licensee in activities that are not congruent with the licensee's professional education, training or experience (8)
- A.R.S. § 32-3251(16)(kk), failing to make client records in the licensee's possession promptly available to the client, a minor client's parent, the client's legal guardian or the client's authorized representative on receipt of proper authorization to do so from the client, a minor client's parent, the client's legal guardian or the client's authorized representative (2)
- A.R.S. § 32-3251(16)(q), failing or refusing to maintain adequate records of behavioral health services provided to a client (4)
- A.R.S. § 32-3251(16)(t), disclosing a professional confidence or privileged communication except as may otherwise be required by law or permitted by a legally valid written release (4)

2025 Reoccurring Board Findings

- A.R.S. § 32-3251(16)(x), exploiting a client, former client or supervisee. For the purposes of this subdivision, "exploiting" means taking advantage of a professional relationship with a client, former client or supervisee for the benefit or profit of the licensee (3)
- A.R.S. § 32-3251(16)(o), failing to furnish information within a specified time to the board or its investigators or representatives if legally requested by the board. (2)
- A.R.S. § 32-3251(16)(y), engaging in a dual relationship with a client that could impair the licensee’s objectivity or professional judgement or create a risk of harm to the client. For the purposes of this subdivision, “dual relationship” means a licensee simultaneously engages in both a professional and nonprofessional relationship with a client that is avoidable and not incidental. (1)

2025 Recurring Board Findings

80% of board findings are boundary related, according to AZBBHE.

Clinicians role is to be clients therapist and nothing else.

Sexual behavior between a therapist and a current or former client is never permissible.

Yet…..there were 3 licenses revoked in July 2025 Board meeting for having sex with clients.

Clinical Practice Dilemmas/Errors

"Clinical supervision" means direction or oversight provided either face to face or by videoconference or telephone by an individual qualified to evaluate, guide, and direct all behavioral health services provided by a licensee to assist the licensee to develop and improve the necessary knowledge, skills, techniques, and abilities to allow the licensee to *engage in the practice of behavioral health ethically, safely, and competently* (R4-6-101:11).

- Clinical practice errors happen. The role of clinical supervisor has dual focus: clinician skills development and safe, competent client care.
- Expectations on how errors will be disclosed and handled can be addressed in clinical supervision contract and discussed at the beginning of the supervisory relationship.
- Clinical Supervision provides a space to reflect on the thought process, components and framework clinician held when approaching the dilemma/error for opportunity to improve and proceed forward.
- Clinical supervision must pro-actively explore and examine ethics, rules/laws and evidenced based practices.

Documentation of Clinical Practice Dilemmas/Errors

Clear and regular documentation is necessary, showing the conversations of topics addressed, steps taken to address dilemmas and/or correct errors, and expectations moving forward.

Reoccurring issues with a clinician can be addressed, in collaboration with HR if necessary, with a Growth and Development Plan or Performance Improvement Plan, which could include the following:

- Description of what aspect of the clinician's practice is below standard
- A description of how the clinician's practice must change to meet expectations
- A precise plan outlining what kind of documentation will be required from the clinician to monitor performance
- The maximum length of time available for achieving the task at hand
- Details on how the clinical supervisor will report progress and to whom these reports will be given
- An understanding of the consequences if there is a reoccurrence of suboptimal practice.

Avoiding Errors and Handling Dilemmas

- Use Ethical Decision-Making Model.
- Know your Codes of Ethics.
- Reference the Arizona Statutes and Rules.
- Seek consultation with peers/colleagues, AZBHHE, legal (maintaining client confidentiality).
- Document thinking and steps taken based on information gathered.
- Regularly review with supervisee.

Rules/Laws for Agency Settings

AHCCCS Covered Behavioral Health Services Guide (CBHSG) 01/01/2025

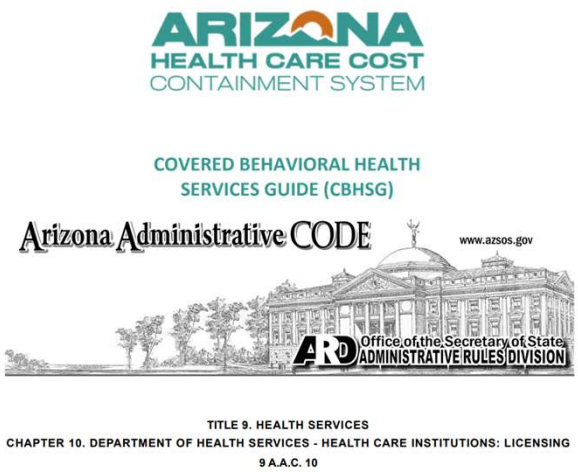
AHCCCS Fee-For-Service Provider Billing Manual

AHCCCS Medical Policy Manual (AMPM)

AHCCCS Contractors Operations Manual (ACOM)

AHCCCS IHS/Tribal Provider Billing Manual

Arizona Administrative Code (AAC) TITLE 9. HEALTH SERVICES CHAPTER 10. DEPARTMENT OF HEALTH SERVICES - HEALTH CARE INSTITUTIONS: LICENSING & SUPP. 25-2



Clinical Oversight in Agency Settings

- Behavioral Health Technicians (BHTs) and Behavioral Health Paraprofessionals (BHPPs), who provide services in the public behavioral health system, must be clinically supervised by a Behavioral Health Professional (BHP) registered with AHCCCS.
- Clinical Oversight and Supervision: The Behavioral Health Professionals (BHPs) shall be responsible for directing and overseeing the clinical care and treatment for members they are directly treating, and the services and support provided by Behavioral Health Technicians (BHTs) and Behavioral Health Paraprofessionals (BHPPs) for whom the BHP is providing supervision or clinical oversight. Refer to AAC R9-10 et seq. for specific requirements regarding oversight and supervision.
- Associate level BHPs shall only practice in compliance with clinical supervision requirements as prescribed by the Arizona Board of Behavioral Health Examiners (AzBBHE).

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

BHPs, BHTs, and BHPPs in Agency Settings

Behavioral Health Professional (BHP) – Behavioral Health Professionals providing services at IHS facilities or tribal health programs operated under the P.L. 93-638 must meet the criteria as defined in A.A.C Title 9, Chapter 20 (R9-20-101). A Behavioral Health Professional is:

a. **Arizona licensed**: A licensed psychologist, a registered nurse with at least one year of full time behavioral health work experience, or a behavioral health medical practitioner, or
b. **Arizona licensed**: A social worker, counselor, marriage and family therapist or substance abuse counselor according to A.R.S Title 32, Chapter 33 or
c. **Out of State**: An individual who is licensed or certified to practice social work, counseling or marriage and family therapy by a government entity in another state if the individual has documentation of submission of an application for Arizona licensure per A.R.S. Title 32, Chapter 33 and is licensed within one year after the submitting the application.

Per federal guidelines, AHCCCS recognizes out-of-state licensed behavioral health professionals (Social Workers, Marriage and Family Therapists and Counselors) and does not require Arizona licensure in order for the BHP to deliver services within their scope of licensure.

AHCCCS Memo, https://archive.azahcccs.gov/archive/Resources/Guides%20and%20Manuals/AHCCCS%20Covered%20Behavioral%20Health%20Services%20Guide/AppendixA1.pdf, retrieved 08/12/2025

BHPs, BHTs, and BHPPs in Agency Settings

9 AAC 10: R9-10-101: Definitions:
35. "Behavioral health professional" means:
a. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:
i. Independently engage in the practice of behavioral health, as defined in A.R.S. § 32-3251; or ii. Except for a licensed substance abuse technician, engage in the practice of behavioral health, as defined in A.R.S. § 32-3251, under direct supervision as defined in A.A.C. R4-6- 101; b. A psychiatrist as defined in A.R.S. § 36-501;
c. A psychologist as defined in A.R.S. § 32-2061;
d. A physician;
e. A behavior analyst as defined in A.R.S. § 32-2091; or
f. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse; or
g. A registered nurse with: i. A psychiatric-mental health nursing certification, or
ii. One year of experience providing behavioral health services.

https://apps.azsos.gov/public_services/Title_09/9-10.pdf

BHPs, BHTs, and BHPPs in Agency Settings

Behavioral Health Technicians (BHTs) – AHCCCS requires BHTs to meet the following requirements:

As per the Arizona Administrative Code, Title 9, Chapter 20. (A.A.C R9-20-101) the definition of a Behavioral Health Technician is an individual who meets the applicable requirements in **R9-20-204** and:

a. Has a master's degree or bachelor's degree in a field related to behavioral health or
b. Is a registered nurse or
c. Is a physician assistant who is not working as a medical practitioner or
d. Has a bachelor's degree and at least one year of full time behavioral health experience or
e. Has an associate's degree and at least two years of full time behavioral health work experience or
f. Has a high school diploma or high school equivalency diploma and:
   i. 18 credit hours of post-high school education in a field related to behavioral health completed no more than four years before the date the individual begins providing behavioral health services and two year of full time behavioral health work experience; or
   ii. Four years of full time behavioral work experience; or
g. Is licensed as a practical nurse, according to A.R.S Title 32, Chapter 15, with at least two years of full time behavioral health work experience.

AHCCCS requires providers to ensure that BHTs are in compliance with all related ADHS/DBHS policies and procedures listed in the DBHS Provider Manual and Behavioral Health Covered Services Guide. This includes compliance with **R9-20-204.**

AHCCCS Memo, https://archive.azahcccs.gov/archive/Resources/Guides%20and%20Manuals/AHCCCS%20Covered%20Behavioral%20Health%20Services%20Guide/AppendixA1.pdf, retrieved 08/12/2025

R9-10-101: Definitions
39. "Behavioral health technician" means an individual who is not a behavioral health professional who provides the following services to a patient to address the patient's behavioral health issue: a. With clinical oversight by a behavioral health professional, services that, if provided in a setting other than a health care institution, would be required to be provided by an individual licensed under A.R.S. Title 32, Chapter 33; or b. Health-related services.

https://apps.azsos.gov/public_services/Title_09/9-10.pdf

BHPs, BHTs, and BHPPs in Agency Settings

Behavioral Health Paraprofessional (BHPP) – If an individual does not meet the requirements for a BHT, they may meet the criteria for a Behavioral Health Paraprofessional per A.A.C. Title 9, Chapter 20 (R9-20-101). A Behavioral Health Paraprofessional means an individual who meets the applicable requirements in R9-20-204 and has:

a. An Associate's degree or
b. A high school diploma, or
c. A high school equivalency diploma.

Behavioral Health Paraprofessional Billing – BHPPs that provide behavioral health services at IHS facilities or tribal health programs operated under P.L. 93-638 can bill their services **under the facility** at the appropriate rate described for those services in the Medicaid State Plan if the IHS facility or tribal health program (638 providers) is registered as an AHCCCS Provider. AHCCCS does not register BHPPs as providers.

AHCCCS requires providers to ensure that BHPPs are in compliance with all related ADHS/DBHS policies and procedures listed in the DBHS Provider Manual and Behavioral Health Covered Services Guide. This includes compliance with **R9-20-204.**

AHCCCS Memo, https://archive.azahcccs.gov/archive/Resources/Guides%20and%20Manuals/AHCCCS%20Covered%20Behavioral%20Health%20Services%20Guide/AppendixA1.pdf, retrieved 08/12/2025

R9-10-101: Definitions:
34. "Behavioral health paraprofessional" means an individual who is not a behavioral health professional who provides the following services to a patient to address the patient's behavioral health issue: a. Under supervision by a behavioral health professional, services that, if provided in a setting other than a health care institution, would be required to be provided by an individual licensed under A.R.S. Title 32, Chapter 33; or b. Health-related services.

https://apps.azsos.gov/public_services/Title_09/9-10.pdf

Clinical Oversight 9 AAC 10

R9-10-101: Definitions:

49. "Clinical oversight" means:
    a. Monitoring the behavioral health services provided by a behavioral health technician to ensure that the behavioral health technician is providing the behavioral health services according to the health care institution's policies and procedures and, if applicable, a patient's treatment plan;
    b. Providing on-going review of a behavioral health technician's skills and knowledge related to the provision of behavioral health services;
    c. Providing guidance to improve a behavioral health technician's skills and knowledge related to the provision of behavioral health services; and
    d. Recommending training for a behavioral health technician to improve the behavioral health technician's skills and knowledge related to the provision of behavioral health services.

- Supervision is:
  - Provided at the same time the BHPP is performing a behavioral health service.
  - Provided by a BHP. The BHP needs to be directly responsible for the BHPP (meaning the BHP must be able to intervene during the BHPP's provision of BH services).
    - Remember: A BHPP **cannot** perform a BH service independently, or with clinical oversight. The BHPP needs supervision.

R9-10-115: BHPP and BHTs:

3. Clinical oversight is provided to a behavioral health technician to ensure that patient needs are met based on, for each behavioral health technician:
    a. The scope and extent of the services provided,
    b. The acuity of the patients receiving services, and
    c. The number of patients receiving services;

Clinical Oversight 9 AAC 10

R9-10-115. Behavioral Health Paraprofessionals; Behavioral Health Technicians

If a health care institution is a behavioral health facility or is authorized by the Department to provide behavioral health services, an administrator shall ensure that:

1. Policies and Procedures
2. Delineate what services a BHPP and BHT are allowed to provide
3. Cover supervision of a BHPP and document it
4. Cover clinical oversight of a BHT and document it, at least once each two-week period if client services provided

Issues with Clinical Oversight in Agency Settings

- Being responsible for too many BHTs and BHPPS.
- Supervising too many agencies at the same time.
- Using a “rubber stamp” to sign off on documentation.
- Not reviewing clinical documentation
- Inconsistent or intermittent supervision
- Oversight that’s not related to the behavioral health services

Clinical Oversight/Supervision in Agency Settings should include…

- Documentation Review: assessment, diagnosis and treatment plan are up to date
- Quality of intervention provided
- That the service is on the treatment plan, clinically necessary, and frequency matches.
- Timeliness of documentation.
- Ethical billing and clinical practices.
- Client safety (mandated reports and issues of client safety dealt with).
- Ongoing review of skills and knowledge related to provision of behavioral health, guidance to improve skills.
- Identifying and recommending training to improve skills and knowledge.
- Review of applicable ethics, rules, laws that pertain to behavioral health services.
- Regular and consistent oversight sessions that are also documented.
- LIVE clinical oversight and supervision.

Clinical Supervision v.s. Management

Definitions:

Clinical Supervision is an intervention by a more senior member of a profession to a more junior member or members of that same profession. This relationship is evaluative, extends over time, and enhances the professional functioning, monitors service quality, and acts as a gate-keeping process for those who are entering the profession (Bernard and Goodyear, 2004).

Supervision for licensure.

Administrative Supervision, on the other hand, is concerned with the correct, effective, and appropriate implementation of agency policies and procedures. The supervisor has been given authority by the agency to oversee the work of the supervisee. The primary goal is to ensure adherence to policy and procedure (Kadushin 1992)

For oversight of BHTs and BHPPs, one needs a BLENDED approach.

M/M Approach

"The Mentor/Monitor approach combines staff accountability role of administrative supervision with the staff development role of reflective supervision. Although the dual roles pose challenges to supervisors, regardless of their prior experience, there are benefits to organization and staff"

"Staff grow in their capacity across their areas of responsibility; they understand their daily tasks in the context of the larger organization mission and values; and communication flows directly from the administration to the staff, and vice versa, in the context of an ongoing collaborative relationship committed to staff's development and program quality" (Heller & Gilkerson, 2009, pp.130).

M/M Approach

- Provide honest performance evaluations
- Increase capacity for reflective process
- Language of mutuality to increase sharing in problem solving
  - "You seem upset, you seem to be struggling. Let's try and figure this out together. Let's pull it apart and see what we find. Please share how you are seeing the issue."
- Contain reactivity regarding staff performance, invite dialogue
- Be comfortable with the demands of accountability

(Heller & Gilkerson, 2009, pp. 123-124)

Clinical Supervision vs. Management

CLINICAL SUPERVISION	MANAGEMENT
Clinical skills	Administrative tasks
Case conceptualization	Policies and procedures
Ethical exploration	Time and attendance
Assessment, diagnosis, treatment planning, interventions	Productivity
	Caseload assignment

4 AAC 6 Documentation requirements

- Clinical record **R4-6-1101 – 1106**
- Clinical supervisor information to clients **R4-6-1101 D**
- Unrestricted access to client files **R4-5-1103 C & D**
- Confidentiality **R4-6-1105**
- Supervision record **R4-6-212 C**
- Contracts between supervisor and supervisee (Best Practice)

Clinical Supervision Documentation Requirements

1. Reviewing ethical and legal requirements applicable to the supervisee's practice, including unprofessional conduct as defined in A.R.S. § 32-3251;

2. Monitoring the supervisee's activities to verify the supervisee is providing services safely and competently;

3. Verifying in writing that the supervisee provides clients with appropriate written notice of clinical supervision, including the means to obtain the name and telephone number of the supervisee's clinical supervisor;

4. Contemporaneously written documentation by the clinical supervisor of at least the following for each clinical supervision session at each entity:

- a. Date and duration of the clinical supervision session;
- b. A detailed description of topics discussed to include themes and demonstrated skills;
- c. Beginning on July 1, 2006, name and signature of the individual receiving clinical supervision;
- d. Name and signature of the clinical supervisor and the date signed; and
- e. Whether the clinical supervision occurred on a group or individual basis;
- 5. Maintaining the documentation of clinical supervision required under subsection (C)(4) for at least seven years;
- 6. Verifying that clinical supervision was not acquired from a family member as prescribed in R4-6-101(A)(29).
- 7. Conducting on-going compliance review of the supervisee's clinical documentation to ensure the supervisee maintains adequate written documentation;
- 8. Providing instruction regarding:
- a. Assessment, b. Diagnosis, c. Treatment plan development, and d. Treatment;
- 9. Rating the supervisee's overall performance as at least satisfactory, using a form approved by the Board; and
- 10. Complying with the discipline-specific requirements in Articles 4 through 7 regarding clinical supervision.

Supervision Record

Create a supervision logbook: include at least minimal notes on the content of supervision, decisions reached, agreed actions

In some situations (e.g., risk issues) it would be good practice to document a discussion and/or agreement with clinical electronic notes.

Consultation and Ethical Decision-Making Steps documented.

Record for addressing performance/HR issues: do these belong in the supervision record?

Contracts: Who, When, Where?

- Inside agency
- Outside supervisor to an agency
- Supervised private practice

Why use supervision contracts?

Outside Supervision

- Allows you to set the parameters and boundaries of what exactly will occur and the expectations, roles, responsibilities as well as access to clients and client record.

Internal Supervision

- Even if you both work for the same agency, it's a good idea to have a contract because it helps focus the clinical supervision on clinical skills enhancement and development and is less focused on administrative/job performance evaluation.

Protects you, the supervisee/trainee, clients, and the agency/institution.
It establishes expectations, protocols and explains how supervision is going to work.

What to include (Lee and Nelson, 2022)

- State requirements
- Ethical responsibilities, codes to be followed (e.g., AAMFT, ACA, NASW), laws
- Methods of supervision/documentation requirements/confidentiality policies
- Financial issues
- Risks and benefits of supervision
- Disputes and resolution process
- Verification of hours, evaluation, feedback

Supervision contracts: When are they needed?

- Supervision contracts are completed during the first supervisory session.
- Contract goals should be reviewed every 6 months.
  - Ensures the supervision is meeting professional goals and growth and development of the clinician.
  - Modify contracts as needed.

Sample contracts

- Clinical Supervision Best Practices Recommendations (Santa Clara BHS, 2018) https://pdfslide.net/documents/santa-clara-county-behavioral-clinical-health-services-supervision-cs-commonly.html?page=1
  - Basic Supervision Contract (Falender)
  - Sample Supervision Contract (Falender)
- Falender, C. & Shafranske, E. (2021)
  - Sample Supervision Contract Template (Falender and Shafranske, 2021)
- AZBBHE Sample Contract: Supervised Private Practice

Exemption CS not employed by same agency

- If an exemption is required for a clinical supervisor not employed at the same agency as the supervisee, a sample contact form is provided below which would meet requirement A.A.C. R4-6-212.01(1)(b)(i)(ii). This form may be used by the agency/clinical supervisor as a stand alone document, however it is not required.
- Sample - Outside Contracted Supervisor Agreement form (To be executed between entities and contracted clinical supervisors)

Clinical Supervision Contracts in PP

- **Supervision Agreement:**
- A copy of the supervision agreement must be provided to the Board pursuant to A.A.C. R4-6-211(B)(2). see Sample supervision agreement
- *NOTE:* the template is provided as a sample only and contains the information required in Board rule, however additional stipulations may be included as the parties deem appropriate.

Supervision Theories and Models: The Art

VICKI LOYER, PHD, LMFT

Clinical Supervision

It serves both **facilitative and evaluative** functions,

to **enhance professional competence** and science-informed practice,

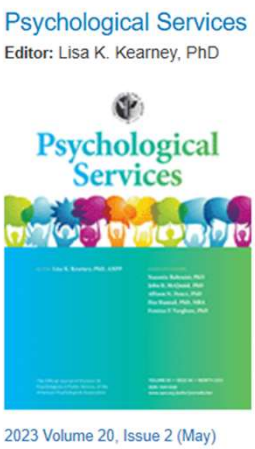
monitoring the quality of services provided,

and **ensuring adherence** to ethical guidelines

APA, 2014

Special Issue in Psychological Services:

Arzuyan, A., Lara, R., & Fu, M. (2023). Introduction to the Special Section: **Supervision in Publicly Funded Settings: Best Practices**. *Psychological Services*, *20*(2), 203–205. https://doi.org/10.1037/ser0000750



Barriers to Clinical Supervision

- **Lack of funds** available for agencies,
  - lack of access to available funds,
- **Lack of clinical supervisors** to ensure appropriate supervisor–supervisee ratio,
  - lack of communication between supervisor and supervisee
- **Burnout** due to lack of funding and resources (a high risk in publicly funded settings).

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Supervision for Addressing Burn Out or Vicarious Trauma

Adlerian supervision and counselor burnout

McCarty, D. L., Christian, D. D., & Stefurak, T. (2023). Adlerian-informed supervision: Protecting counselors from burnout and improving client outcomes in the juvenile justice system. *Psychological Services*, *20*(2), 318–325. https://doi.org/10.1037/ser0000641

- **Adlerian-informed supervision** method includes
  - Respectfully Curious Inquiry/Therapeutic Encouragement **(RCI/TE)** framework
  - **Discrimination model** of supervision (Bernard 1997)
- Goal:
  - Increase the supervisee's experience of the Crucial Cs (describe one's experience of self in four dimensions):
    - Connected
    - Count
    - Capable
    - Courage

4 Crucial C's through RCI (respectfully curious inquiry)

- Connected:
  - Humans are social creatures. Feeling disconnected creates maladaptive behaviors. Feeling support, connectedness, protects from burn out.
- Count:
  - Feeling valuable, significant, one's effort make a difference.
  - Am I doing meaningful work with clients; does my work hold meaning; am I valuable to my company and coworkers?
- Capable
  - Do I understand theory; do I have necessary skills; can I assess client needs; can I write good notes; can I manage time?
- Courage:
  - Do I have courage to do what I need to do and say what I need to say with clients and at work?
  - "that quality that prompts one to act responsibly, deliberately, and with conviction"

Discrimination Model for TE (therapeutic empowerment) (Bernard, 1997)

4 Foci

Intervention skills

Observable clinical skills used in session with clients, the evaluation of those skills, and the assessment of supervisees' skill level

Conceptualization skills:

- Exploring and evaluating how supervisees comprehend a client or situation, make sense of their own and the client's behavior, identify patterns or themes in a session, and/or choose an intervention

Personalization

- Attending to supervisees' personal style of counseling, interpersonal experiences with clients, and awareness of and way of dealing with countertransference as it arises,

Professional behavior

- Addressing behavior related to best practices in mental health and/or ethical and legal issues

Discrimination Model for TE (therapeutic empowerment) (Bernard, 1997)

- 3 Roles

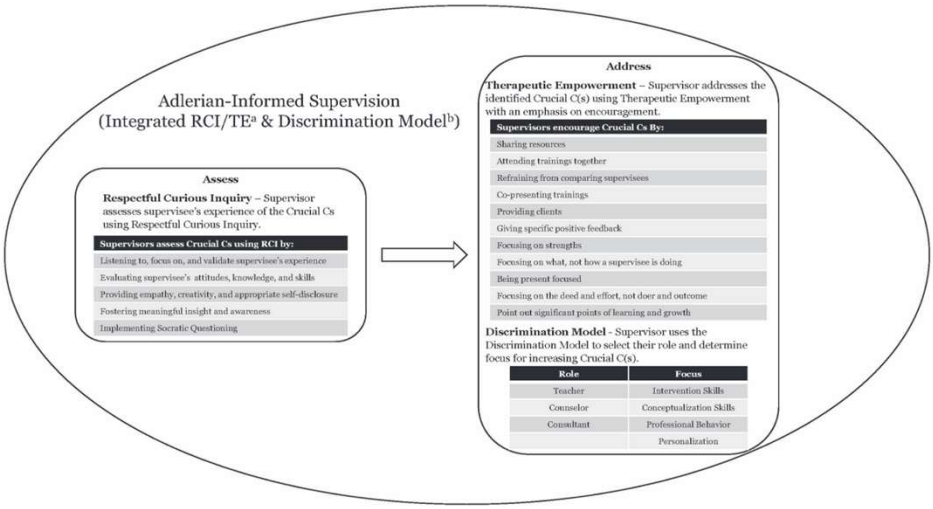
- Counselor:
  - model skills and behaviors, give direct feedback regarding a client or issues, and provide instruction related to the issue being addressed.
- Teacher:
  - help supervisees gain self-awareness regarding internal processes that might be affecting the therapeutic process
- Consultant:
  - interact with supervisees in a more collegial manner, encourage supervisees to trust their own clinical judgments/insights, and challenge them to become more independent

TE (Therapeutic Empowerment) Tools

- main tool supervisors use for TE is encouragement
- focus on the present
- On the deed and the effort instead of the doer and the outcome
- On what is being learned, relying on cooperation to address needed areas of growth.
- Supervisees experience encouragement when supervisors point out significant points of learning and growth, as opposed to remaining deficits.

Figure 1

Adlerian-Informed Supervision Process



Note. RCI/TE = respectfully curious inquiry/therapeutic encouragement.
[a] Milliren et al., 2006. [b] Bernard, 1997.

Supervision in Integrated Behavioral Health Settings

Supervision in IBH settings

Giresunlu, Y., Kemer, G., & Akpinar-Elci, M. (2024). Supervision of counselor trainees in integrated behavioral health settings. *Counselor Education and Supervision*, *63*(2), 117–130. https://doi.org/10.1002/ceas.12296

What is involved in Supervision in Integrated Care

Integrated care practice involves addressing a client's overall biopsychosocial health. It includes:

- medical providers—whose focus is treatment of common medical problems
- behavioral health providers—whose focus is on patient's mental health and behavioral issues
  - collaboration addresses conditions that contribute to patients' chronic medical illnesses, life stressors and crises, and stress-related physical symptoms

Supervision involves:

- mentoring supervisees on administrative and interdisciplinary work in IBH settings
- supervisee-focused and process-oriented supervision.

Behavioral Health Counselors in IBH

Roles: 30-60 min individual therapy; group therapy, family support, consultation with the primary care providers (PCP) and the clients, providing knowledge on chronic medical conditions (e.g., diabetes, asthma) and co-occurring conditions.

Knowledge and competencies: psychopharmacology, medical culture, co-morbidity of mental health, and physical health conditions

Interprofessional Education (IPE) addresses gaps in the integration of mental health into primary care, to resolve operational, cultural, and educational challenges and barriers by having various professions learn from each other to move toward collaboration.

Supervision Specific to IBH Settings

Typically Acknowledged:

1. Address administrative issues (e.g., signing on notes, overseeing supervisees' logs, and reviewing treatment plans and biopsychosocial reports),
2. Educate trainees about professional/organizational culture differences, and answer medically related questions about patients, including medication management and medical terminology as part of their responsibilities.
3. Earn the trust of supervisees, provide feedback, and enhance their motivation.

Additionally recommended

1. Develop a detailed supervision contract between the supervisor and the supervisee.
2. Document the practice model supervisees are using, including its strengths and challenges.
3. Structure supervision according to the level of collaboration involved in clinical care.
   a. Doherty and colleagues (1996) introduced a five-step collaboration model for behavioral health psychology interns. The model proposed five levels ranging from minimal collaboration (Level 1) to close collaboration in a fully integrated setting (Level 5), where supervision depended on the integration level of the setting.

Findings from Supervisors in IBH Settings

There are two distinct factors in supervision:

1. Mentoring supervisees on administrative and interdisciplinary work
2. Supervisee-focused and process-oriented supervision

Factor 1: Mentoring supervisees on administrative and interdisciplinary work

addressing administrative components of IBH setting
- navigating healthcare, Medicaid regulations

focusing on treatment planning and the need to incorporate health history and compounding issues

responding to challenges involving staff's engagement with clients
- discussing ways to develop a professional relationship with staff in other roles, attending to supervisees' concerns related to professional identity in an interdisciplinary environment, assisting supervisees with establishing and maintaining boundaries with other health professionals including attention to dynamics

exposing supervisees to administrative components of the IBH site
- attending interprofessional staff meetings

assisting supervisees to communicate assertively and confidently with physicians/medical staff as mental health experts

Factor 2: Supervisee-focused and Process-oriented supervision

exhibiting openness, transparency, and genuineness in my relationship with the supervisees

helping supervisees develop clinical strategies and techniques to work with clients

growth- and awareness-focused supervisee considerations
- encouraging supervisees to discover their own style of providing counseling

broaching culture and diversity within supervision to ensure cultural competency in supervisees' work with clients

assisting supervisees to explore issues outside of the counseling session that may be interfering their work

Factor 1 and Factor 2

Ethical guidelines and accreditation standards
- meeting with supervisees weekly
- following and maintaining federal guidelines

Observing and processing supervisees' counseling sessions in supervision

Building a collaborative relationship with their supervisees
- paying attention to build and maintain a working alliance with my supervisees using a person-centered approach
- collaborating with my supervisees in creating a safe space for our supervision experience
- discussing resources to use and offer working with my clients
- being intentional with modeling their supervisees
  - assisting with and modeling how to establish and maintain boundaries with clients

Supervisor differences in focus

Factor 1: Supervisors with more clinical background and graduate-level supervision training appeared to focus on the bigger picture of how counselors/supervisees were integrated and may be oriented in IBH settings (e.g., organizational aspects of IBH setting, interdisciplinary focus).

Factor 2: Supervisors held less clinical experience and had mainly workshop trainings in clinical supervision. These supervisors focused more on the supervisees, their growth as counselors, and the supervisory relationship

Supervision in Community Mental Health Settings

Community Based Supervision to Address Supervision Barriers

Schriger, S. H., Boroshok, A. L., Khan, A. N., Wang, L., & Becker-Haimes, E. M. (2023). A case example of community-based supervision to overcome barriers and support the implementation of exposure therapy. *Psychological Services*, *20*(2), 343–352. https://doi.org/10.1037/ser0000665

Gold Standard Supervision (Schriger , et al (2022)

Content (i.e., therapeutic concepts discussed)

- Active ingredients of the relevant model/Evidence Based Practice (EBPs)
- Address issues pertaining to diversity and multicultural competence

Process (i.e., strategies and techniques used during supervision)

- **Focus** on active ingredients of the relevant EBPs (e.g., exposure, behavioral activation, cognitive restructuring)
- Use **Methods** that have been demonstrated to be the most effective at producing behavior change and improving treatment fidelity: Active, supervisor-initiated, experiential learning strategies such as role-playing, modeling, reviewing recorded therapy sessions
- Use these **tools**: Agenda setting, didactic skills training, formative feedback, scaffolded problem solving

Barriers to Gold Standard in CMH (Schriger , et al (2022)

1. Administrative Burden

- administrative tasks (e.g., notes, billing, insurance compliance documentation) May occupy more than 22% of supervisor's time
- Administrative content sharply reduces the time that can be spent (1) on case conceptualization and (2) identifying and practicing the treatment techniques.

2. Risk Management

- Suicidality, abuse, homicidality

3. Limited Live supervision

- Self-report (traditional weekly supervision) is unreliable – 0 to 1.5% sessions are supervised live.

4. Clinician Isolation

- Heavy reliance on independent contractors
- Limited opportunities for team building across clinicians.

Table 1
Barriers to Community Mental Health Supervision and Strategies to Address Them

Community mental health supervision barriers	Strategies used to address these barriers
General challenges	
Lack of time in individual supervision to discuss clinical content due to administrative content	Moving administrative content to biweekly group supervision and utilizing individual supervision to discuss exposures
Inability to discuss clinical content in individual supervision due to (nonemergent) pressing clinical questions and risk management	Weekly, optional drop-in supervision
Limited opportunities for live supervision or video-recorded review	Videotaped mock sessions with feedback; leveraging the telehealth platform to conduct live supervision
Exposure-specific challenges	
Limited opportunity to brainstorm tailored exposure plans for clients, particularly for clients with complex needs	Drop-in supervision and group supervision preserve individual supervision time to focus on exposure plans
Limited organizational support for exposure	Group supervision emphasizes the importance of exposure for all clients; facilitates an expectation that clinicians will support one another in exposures
Limited opportunity for feedback on exposure skills	Group supervision role-play; videotaped mock sessions with feedback
Isolation/limited opportunity for team building	Group supervision allows for development of team ethos and cultivation of peer support

3-part Strategy to Overcome Barriers

- Emphasize efficiency (e.g., combining supervision and didactics)
- Minimize cost (e.g., leveraging group supervision when appropriate to reduce supervisory burden).

Involves:

(1) One hour of biweekly group supervision

(2) optional drop-in supervision

(3) video-recorded simulated clinical sessions with feedback

Group Supervision (1 Hr, Every Other Week)

1. 10-15 min of group supervision sessions are always reserved for administrative tasks
   - Discussion of billing compliance, notes, identifying which treatment plans are due soon for updates, etc
   - General check in: One clinical challenge and one clinical success
2. The remaining 45 min of group supervision is used in one of three ways:
   - (a) targeted case discussion (case presentation from one or more clinicians followed by an open forum)
   - (b) exposure role-plays (1x per month): practice core competencies, targeted practice of techniques (clinician plays their client, other clinician plays role of clinician)
   - (c) didactic content (Guest presentation on a difficult area or area being learned)

Weekly Drop-in Supervision (1 Hr Per Week; Optional)

- Similar to "office hours."
- 1 hr meeting hosted by a clinical supervisor over video conferencing software.
- Clinicians drop in at any time to discuss pressing clinical or administrative tasks.
- Most often for non-emergency/risk management.
- Not intended for emergencies or on-call
- Highest acuity prioritized
- Frees up individual supervision for review of cases and skill development

Individual Supervision With Occasional Live Supervision (1 Hr, Weekly)

Freed of administrative content

- Administrative content is transferred to group supervision
- allows for maximized focus on clinical content and planning of targeted exposures.

A confidential environment

- where clinicians may be more comfortable asking questions and disclosing growth edges, mistakes, and relevant personal information to their supervisors without having to do so in front of their peers or other supervisors.

Use of telehealth platform to provide “bug in the ear” supervision for live supervision

Videotaped Feedback in Simulated Client Session (Clinicians Pair Up Twice Annually)

Other live option:

- Clinicians are paired up to complete two mock exposure sessions; in one session, the clinician role-plays the client and in the other, they role-play the clinician.
- Simulated sessions are recorded using videoconferencing software and shared with their supervisor for review and feedback.

What you can expect: Stage of supervisee's learning

- Perceptual Skills:
  - ability to observe and understand what you are seeing
- Conceptual Skills:
  - ability to make therapeutic sense out of what you are seeing
- Executive Skills:
  - ability to use the information in a therapeutic process
- Evaluative Skills:
  - Assess what they have done
- Professional Skills:
  - How they conduct therapy

(adapted from S. Woolley)

Principles used in Supervision

(Holt, et al, 2015) Part 1

1. **Assess for impairment**
   - Client Is moderately or severely impaired: Case management to meet basic needs
2. **Develop a relationship**
   - Develop a relationship
   - Empathy and genuine caring
   - Resolve relationship ruptures
3. **Address Resistance**
   - Use of directive intervention
   - Learn to stay out of the power struggle

Principles used in Supervision

(Holt, et al, 2015) Part 2

4. Identify Coping Styles

- Externalizing Clients
  - impulsivity, social gregariousness, emotional liability, and external blame for problems
  - benefit more from direct behavioral change and symptom reduction efforts,
  - Choose skill building over Insight and awareness.
- Internalizing Clients
  - low levels of impulsivity, indecisiveness, self-inspection, and overcontrol
  - benefit more from self-inspection, self-understanding, insight, interpersonal attachments, and self-esteem
  - Choose insight over building new social skills.

5. Readiness for change

- more advanced stages of readiness for change (e.g., preparation, action, maintenance) are more likely to improve than lower stages of readiness (precontemplation, contemplation).

Methods of Evaluation

Responsibilities of Supervision

Evaluation in Clinical Supervision is required…

- R4-6-212 © 9: Rating the supervisee's overall performance as at least satisfactory on the independent licensure application.
- "Was engaged in the supervised practice of counseling (including assessment, diagnosis and treatment) that met the Board's requirements as reported above. Was observed during supervised hours to have demonstrated satisfactory competency in clinical documentation, consultation, collaboration and coordination of care related to clients to whom the person provided direct care. Has a rating of at least satisfactory in overall performance."
- Assesses areas of strength and needs for clinical skills development
- Ensures quality client care
- Ensures professional competence
- Gives feedback to the supervisor on overall supervision experience

Evaluation in Clinical Supervision

- Smooth evaluation process requires a collaborative relationship between Supervisor and Supervisee and methods for evaluation need to be discussed in the beginning supervision sessions so there are no surprises.
- Evaluation can be difficult because supervisees may not be comfortable asking for feedback and supervisors want to be liked which can prevent clear, concise, fair and accurate evaluation.
- How do you manage this in your supervisory relationships?

Evaluation in Clinical Supervision

- Power differential between supervisor and supervisee exists
  - Evaluation should be mutual and multiple sources for evaluation considered (clients, direct observation (audio, video, live), notes, co-therapy, therapist reflection/self-report).
  - The least desirable feedback is unannounced observation by supervisors followed by vague, perfunctory, indirect, or hurtful delivery (Powell & Brodsky, 2004).
- Evaluation can bring out people's defensiveness and anxiety…what are some successful and unsuccessful ways to handle it?

Keys to Success in Evaluation

- Strong Rapport
- Frequency you conduct evaluation is regular
- Both formal evaluation and ongoing feedback
- Consultation with mentors regarding resistance
- Address conflicts immediately
- Be attentive and present
- Be respectful
- The function of evaluation is support and growth
- Feedback should be ongoing and continuous.

Keys to Success in Evaluation

- Grow your lack of knowledge in supervisee's areas of Specialties
- Give feedback based on direct observation specific examples of areas/needs for growth, void of emotion, framing discussion to improve, growth and moving forward.
- Offer coaching on how a supervisee can do this
  - Dialogue and discussion, distinguish between requirement and recommendations
- Take developmental action if performance feedback and coaching has failed.

Evaluation in Clinical Supervision

- Areas to Evaluate:
  - Knowledge
  - Clinical skills
  - Clinical judgement
  - Diagnostic skills
  - Application of theory
  - Appropriateness of interventions
  - Boundaries
  - Awareness of cultural impacts
  - Case management
  - Ethics
  - Professionalism
- AZBBHE:
  - Assessment
  - Diagnosis
  - Treatment
  - Clinical Documentation
  - Consultation
  - Collaboration and Coordination of Client Care

Evaluation in Clinical Supervision

- Has mastered:
- In the coming year, should work toward:
- Professional Development Plan:
  - Goal:
  - Activities/Steps to take to accomplish goal?
  - Key individuals/resources to help achieve this goal:
  - I will know that my goal is achieved when:

(Heffron & Murch, 2010)

Evaluating the Supervisor: Evidence-Based Clinical Supervision Strategies Scale (EBCSS)

- Choy-Brown, M., Williams, N. J., Ramirez, N., & Esp, S. (2023). Psychometric evaluation of a pragmatic measure of clinical supervision as an implementation strategy. *Implementation Science Communications*, *4*(1), 39. https://doi.org/10.1186/s43058-023-00419-1

Not at all 1	Rarely 2	Sometimes 3	Often 4	Always 5				
In the last 30 days, …								
1. … my supervision has included feedback about my practice based on my supervisor's in vivo observations of my clinical interactions or from review of audio or video recordings.				1	2	3	4	5
2. … my supervision has included feedback about my practice based on data about the people I serve (e.g., standardized assessments, outcome measures, satisfaction surveys).				1	2	3	4	5
3. … my supervision has included feedback about my practice based on my supervisor's review of clinical progress in my charts.				1	2	3	4	5
4. … I have role played or rehearsed a clinical intervention or skill during my supervision.				1	2	3	4	5
5. … my supervisor has demonstrated a clinical intervention or skill during my supervision.				1	2	3	4	5

MATRIX: Deliberate Practice

Bar, M., Doron, A., Bronstein, I., & Mendlovic, S. (2023). The MATRIX: A deliberate practice approach for clinical supervision in the public sector. *Psychological Services*, *20*(2), 267–282. https://doi.org/10.1037/ser0000743

Challenges of All Public Psychotherapeutic Services:

Principles of **distributive justice** (i.e., overarching equality of access to scarce health resources)

- Gatekeeping function by supporting decision-making processes such as rationing care (Walton & Grenyer, 2002), responsible not only for those who get treated, but also for those who do not.
- Continuously judge treatment progress (e.g., Lambert et al., 2001), and identify early signs of treatment failure (e.g., Lampropoulos, 2011).

The model of supervision in the public sector should strive to hold an **integrative approach**, combining elements from various theoretical and technical traditions

Supervision is actually the most expensive single investment of staff time in the training of psychotherapy practitioners

These cases are extremely hard to manage, constantly undermining the therapist's ability to manage the therapeutic hour (e.g., intense confrontations, frequent alliance ruptures, and violations of patient–therapist boundaries). Expectedly, therapists dealing with such cases daily may be at higher risk of experiencing feelings of incompetence and burnout.

Relationship-Focused Interventions.

The transformative power of the therapeutic relationship is one of the most central concepts in psychodynamic theory

Unproductive sequences of talk

- The nine combinations of the MATRIX aim to mark the most "natural" areas of psychodynamic therapy: talking about the patient, the therapist, and the dyad
- Content left outside the scheme (i.e., any fragment that cannot be attributed to either patient, therapist, or dyad) would be less relevant to the core therapeutic action, and therefore, is less productive in the context of a therapeutic conversation.
- Its dose–effect relationship is similar to other types of therapeutic interventions, with low to moderate use being the most effective (1–7 TOM fragments per session, to be exact), whereas too few or too many are unhelpful or even harmful.

Deliberate Practice and Improved Outcomes

DP involves individualized, goal-oriented training, targeting skill improvement through repetition, immediate feedback, and iterative refinement

The time psychotherapists spend engaged in DP significantly predicts better treatment outcomes

The MATRIX framework is compatible with all four fundamental elements of DP:

- (a) a focused and systematic effort to improve performance based on clear identification of learning objectives;
- (b) guidance from a knowledgeable other (e.g., supervisor);
- (c) immediate and ongoing feedback; and
- (d) ongoing, successive refinement (Miller et al., 2018).

Coding and Congruence

Figure 2
The Structure of MATRIX Code

Speaker	Focus	Dimension
Who spoke?	*About whom?*	*About what?*
Patient	Patient	Content
Therapist	Therapist	Interrelation
	Dyad	Potential
	Out-of-Matrix	

Figure 4
Patient–Therapist MATRIX Congruence

P:	I want to make this move, but I can't stand the thought that I might fail.	PPI	incongruent
T:	This fear paralyzes you.	TPP	congruent
P:	It's like I'm standing behind this huge wall that I can't move forward.	PPP	congruent
T:	You are actually locked inside your own walls.	TPP	incongruent
P:	This is the first time I ever talk about it with anyone. It helps.	PPC	incongruent
T:	Maybe together we can break somehow through this wall.	TDI	

Note. PPI = patient/patient/interrelation; TPP = therapist/patient/potential; PPP = patient/patient/potential; TPP = therapist/patient/potential; PPC = patient/patient/content; TDI = therapist/dyad/interrelation.

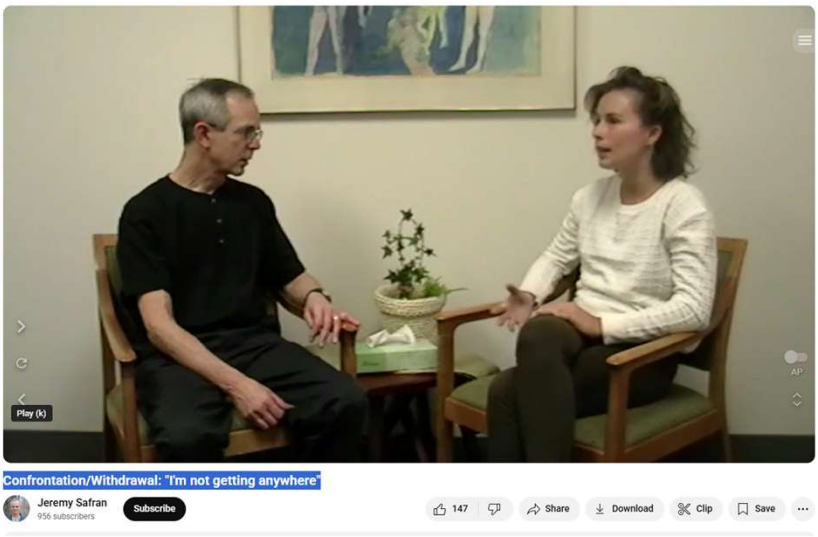
Using the Matrix model of supervision

Confrontation/

Withdrawal:

"I'm not getting anywhere"

https://www.youtube.com/watch?v=nblFvpbetoE



Coding of Vignette

4.	T	Are you feeling angry at me?	TPC	T' echo P's code, focusing on another feeling (anger).
5.	P	I mean, I am feeling angry that the therapy isn't working … like … I have been saying … I am feeling angry that like I am still in the place that I'm in … even though I have been trying … I am just like feeling pissed in general … you know …	PPC	P' echoes T's code, articulating her anger.
6.	T	Right, so, you know … I understand that you are pissed in general … but … are you angry at me? I mean … it sounds to me … my senses here are that you are really angry at me right now, and if you are, I really want to know about it …	TPC	T' echoes P's anger at him.
7.	P	Well, I guess there is a part in me that … like … a little angry that you are not helping me … I came to this therapy because I wanted to feel better … and, yeah … and I guess I am feeling angry that that's not what I am getting from you … that's what I am trying to get … so …	PPI	P' explains the *reason* for her anger (i.e., relations between contents).
8.	T	You sound really exasperating to me … How does it feel to tell me about this?	TPC	T' does not echo P's explanation, emphasizing her current feelings instead.
9.	P	It feels hard …. I mean … It feels hard to say that I am angry … that's like not a feeling, that's not a comfortable thing, not a comfortable thing to feel … It just like makes me … like … It's like …. yeah …	PPI	P' reveals a conflict: on one hand, she is dissatisfied; on the other hand, she does not feel comfortable expressing it.

Other areas to measure with MATRIX:

Self Disclosure: **TTx**

- the therapist is saying something about the therapist's content/interrelation/potential.
- any verbal statement, intentional or unintentional, that reveals something personal about the therapist

Measure occurrence of TTx, introduce "dose-effect" relationship in psychotherapy.

Transference: "TDx"

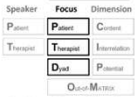
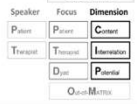
- The patient's past conflicts will manifest themselves in the "here-and-now" of the relationship with the therapist. Thus, the shared, inseparable experience of the therapeutic dyad should be repeatedly highlighted for its importance.
- the therapist is saying something about the dyad

Easily identify such interventions and deliberately exercise them during supervision.

Follow the patient's consecutive code to examine the tolerability of these sensitive interventions.

Coding the MATRIX for Deliberate Practice

Table A1
The MATRIX-Mini-Manual Psychodynamic Psychotherapeutic Sessions

Step	Purpose	Procedure	Remarks
1.	Preparing the clinical material	Use transcripts of recorded/videotaped sessions, or (less recommended) written verbatim performed immediately after the session.	We recommend transcribing the entire session, though using only parts of the session is possible.
2.	Fragmenting the session	Most statements do not require any fragmenting, and are ready for the coding procedure. However, some statements (usually, those of the patient) are longer, and contain different focuses ("who is the subject about?"). In such cases, a fragmentation is in order. Statements are broken only when there is a change of the subject, so each fragment has only one subject.	For example, this patient's statement will be broken into two consecutive fragments: *Before fragmentation* *P: It is unbearable, I cannot stand it anymore … I know you're mad at me, for not doing the work we agreed on ….* *After fragmentation* *P:* It is unbearable, I cannot stand it anymore … [the subject is the patient] *P: I know you're mad at me, for not doing the work we agreed on …* [the subject is the therapist]
3.	Inserting fragments into a table	All fragments are inserted into a 4-column Table: (1) fragment's number; (2) the fragment; (3) MATRIX code (currently blank); and (4) remarks (currently blank)	See Table 4 for an example.
4.	Predetermine out-of-MATRIX fragments	Any fragment that does not refer to either patient, therapist or dyad (e.g., a childhood experience of the patient's mother, a chatter about the weather) is considered as "out-of-MATRIX," and coded patient out-of-MATRIX (POM) or therapist out-of-MATRIX (TOM), according to their speaker.	Nonunderstandable statements (e.g., "mm-hm") are regarded as insignificant, and should not be coded.
5.	Determine the speaker	Mark the fragment's speaker—either the *P* (patient) or *T* (therapist)—as the first letter of the MATRIX code.	
6.	Determine the focus	Determine the fragment's focus ("who is this fragment about?")—either the *P* (patient), *T* (therapist), or *D* (dyad)—as the second letter of the MATRIX code.	
7.	Determine the dimension	Determine the fragment's dimension ("what is this fragment about?")—either *C* (content), *I* (interrelation), or *P* (potential)—as the third letter of the MATRIX code. For detailed information and examples of each dimension, see "The MATRIX" section and Table 1.	

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Evaluation in Agency Settings of BHTs, BHPPs and Associate BHPs

BHA

Behavioral Health Aide/Practitioner
Knowledge & Skills Checklist

BHA Name: **Supervisor Name:**
Date Begun: **Date Completed:**

This is a: ☐ **BHA Self-Assessment** ☐ **Supervisor Assessment**

Current BHA Certification Level: ☐ Not Certified ☐ BHA-I ☐ BHA-II ☐ BHA-III ☐ BHP

This BHA is applying for level: ☐ BHA-I ☐ BHA-II ☐ BHA-III ☐ BHP

CHECKLIST INSTRUCTIONS:
Checklist must be completed for initial certification and each time a BHA/P wishes to renew certification or advance to a higher certified practice level.

- **Column 1** lists competency areas and the items to be rated.
- Rate the BHA's current skill level (T, I, II, III, or P) for each item in **Column 2** (regardless of a BHA's current certification level, they may be rated below, at, or above that certification level on any item).
- In **Column 3**, score a "**1**" if BHA meets or exceeds the skills level for which they are applying; score a "**0**" if BHA does not meet minimum rating for which they are applying.
- Write any notes in **Column 4**. Applicant must score at or above minimum skill level on 80% of items in a subcategory to be considered for next-level certification.

1 Competency	2 BHA Skill Level Rating	3 Meets min. Skill Level	4 Notes

Note: Some competencies or items are only applicable to BHA-II, III, and Ps. Please see Checklist for designated items that are only applicable to certain BHA certification levels.

Before rating a BHA on the Competency Checklist, review the Rating Guide below. This Guide outlines the common characteristics of a worker at each BHA skill level:

Level →	Trainee-Prior to BHA Certification	BHA-I	BHA-II	BHA-III	BHP
Typical					

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Evaluation in Agency Settings of BHTs, BHPPs and Associate BHPs

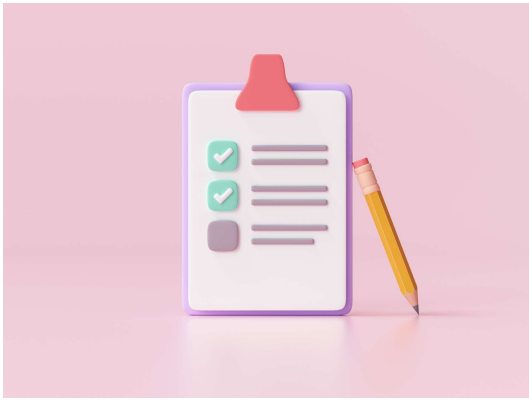
Level →	Trainee-Prior to BHA Certification	BHA-I	BHA-II	BHA-III	BHP
Typical developmental level:	Beginning Proficiency	Basic Proficiency	Intermediate Proficiency	Advanced Proficiency	Independent
Skill level:	Is learning the basic skill	Has developed the basic skill	Has intermediate level skill, recognizes when to seek assistance	Has advanced skill	Use the advanced skill flexibly
Supervision/ structure required:	Extensive and close/High	Frequent Moderately High	Occasional Moderate	Less frequent Minimal	Less frequent Minimal

BHA/P Knowledge and Skills Checklist

For example, if evaluating an individual to determine if they have mastered competencies at the BHA-III level, keep in mind that he or she should be at an advanced level of proficiency on that competency, and require minimal supervision and direction to perform the competency.

BHA Knowledge and Skills Checklist

I. Working with Others (12 Areas)
II. Screening and Assessment (17)
III. Planning Services (10)
IV. Providing Services (43)
V. Linking to Community Resources (11)
VI. Community Education and Advocacy (12)
VII. Cultural Competency and Individualizing Care (14)
VIII. Documenting (5)
IX. Professional and Ethical Practice (23)
X. Professional Development (7)



Supervision Methods

- Supervision Sessions
  - Individual, Dyad, Group (3-6)
  - Connect theory to treatment
- Direct Observation
  - Live, audio/video recordings
  - Review clinical documentation
- Skills building
  - Role Play
  - Readings
- Instruction
  - Assessment, Diagnosis, Treatment Planning, Treatment
- Self-Report
  - Case conceptualization presentation
  - Reflective Practice
- Feedback/Evaluation
- Setting

Supervision Skills

- Administrative
  - Structure
  - Clear role/boundaries
- Evaluative
  - Method for Evaluation
  - Give and Receive Feeback
- Clinical
  - Clinical Skills
  - Documentation
  - State Requirements
- Supportive
  - Curiosity
  - Compassion
  - Critical Thinking/Crisis

Supervision Skills

- **Addressing Burnout:** Recognizing and addressing potential burnout in supervisees.
- **Promoting Professional Development:** Encouraging ongoing learning and growth beyond the immediate supervision experience.
- **Conflict Resolution:** utilizing self-reflection, co-regulation, responsibility, and values, guide conflict resolution.
- **Boundaries:** setting good boundaries with supervisees is crucial for productive and beneficial supervisory relationship.
- **Clear and Effective Communication:** Supervisors should be able to clearly convey information, expectations, and feedback to supervisees. This includes active listening and ensuring the supervisee understands the information being shared.
  - **Constructive Feedback:** Providing feedback that is specific, actionable, and delivered in a supportive manner is crucial for growth.
  - **Reciprocal Feedback: e**ncouraging supervisees to provide feedback to the supervisor fosters a collaborative and open environment.

Gatekeeping

- Ensuring that individuals who are unsuitable do not enter the profession:
  - Identifying Supervisee with Problems of Professional Competence.
- Problems of professional competence:
  - Difficulty acquiring or maintaining developmentally appropriate levels of skill, functioning, attitudes, and/or ethical, professional, or interpersonal behavior across one or more settings.

Case Study and Consultation: Art and Science

VICKI LOYER, PHD, LMFT; KARI LOGSDON, MSFT, LMFT, ASHLEY CLARK, MA, LAMFT

Case Study

- Supervisee: Associate level MFT, in her second year of supervised practice
- Clients:
  - Heterosexual, Caucasian couple (John 45 years old, Hannah 42 years old)
  - Together 3 years, married 6 months, Second marriage for each, FOO trauma for each, John former Military,
  - Hannah: Past suicide attempt, John: Past Substance Abuse
- Reason for treatment: High marital conflict
- Supervisee concern: Inconsistant progress, feeling ineffective, stuck in the couples' process. Supervisee has actively staffed this case in group supervision/team meetings. Supervisee is in contact with primary therapists of each member of the couple and monitoring suicide risk.
- At the 12th session – Couple presented in active conflict, supervisee had difficulty moving the couple from the waiting room into therapy room and redirecting conflict. Supervisee expressed feeling failed and burned out. Supervisee requested the supervisor come into the session for support in structuring/managing the session dynamics.

Your Turn! Case Consultation