CoLab
Community & Behavioral Health Policy

UW Medicine
DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES

Supervising Clinical Mental Health Providers

Strengthening clinical supervision in mental healthcare

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INTRODUCTION

Guide Overview

Quality supervision is paramount to quality mental health care. Clinical supervision for behavioral health providers has three primary aims: to develop competent clinicians, to support clinicians in their own experience of the work, and to promote safe and effective therapy, thereby ensuring client welfare. Clinical supervisors are ethically responsible for evaluating and ensuring clinicians are competent and do not pose risk of harm to the clients they are serving.

The following guide serves to be a resource for clinical supervisors, particularly those working within community mental health settings and those who supervise clinicians administering evidence-based practices. This guide is intended both for those who are just embarking on their supervisor role as well as those who have been a supervisor for years. While there are many comprehensive resources about supervision available, this guide intends to be a distillation of key best practices for supervision that provides practical and accessible guidance. Throughout the guide, you will find hyperlinks to resources relevant to the topic being discussed.

Supervision comprises many competencies and skills. While there may be overlap, what makes someone a competent clinician does not necessarily make them a competent supervisor. Often in community mental health organizations, clinicians are promoted to supervisor based on their clinical skill, productivity, and longevity with the organization. While these are crucial factors, they do not necessarily correlate with effectiveness and competency as a supervisor, and often mean that newly promoted supervisors require additional training and skill-building around supervision. Supervision is a distinct and separate skillset from providing therapy, although similar parallel processes exist between supervisor/supervisee and clinician/client relationships. With these dynamics in mind, this guide aims to provide an accessible, easy-to-digest compilation of best practices to support quality supervision.

Regardless of one's supervision style or approach, all aspects of competent and ethical supervision are inherently trauma informed, intersectional, culturally responsive, and rooted in equity. Thus, this guide begins with a discussion of these frameworks as foundations for the rest of the content, with the aim of integrating them through the guide rather than as "add-on" considerations that are separate from the rest of the best practices. We intentionally place these sections at the beginning of the guide to serve as a lens through which to view the rest of the content.

Process of Guide Development

This guide was uniquely developed and informed by multiple forms of knowledge. These sources include both the academic literature and the lived experience and expertise of behavioral health supervisors, clinicians and leaders. To develop this guide, we gathered a group of community behavioral health supervisors from across the state of Washington with diverse lived experience and identities to form a supervisor advisory team. We met regularly with this advisory team over a period of months as part of a collaborative, ongoing partnership to identify needed and relevant tools for supervision practice. We used an iterative, participatory approach informed by their feedback in every stage of guide development.

In addition to the incredible contributions of the supervisor advisory team, we gathered

feedback from a multitude of external content reviewers to provide diverse and varied perspectives from across the field. Reviewers included behavioral health providers and supervisors, social workers in non-profit organizations, therapists and supervisors working in domestic violence agencies, and behavioral health organizational leaders. Although this guide cannot fully encapsulate the vast range of experiences in providing behavioral health care, we hope it is a starting place for bridging the academic literature and provider lived experience in order to create a more relevant, accessible and informed resource for supervisors. We are deeply grateful for every person who contributed their experience and expertise to this guide. It would not be possible without you.

How to Use This Guide[1]

This guide is intended to provide guidance and support to one-on-one supervisory relationships in clinical behavioral health and therapeutic work. The information provided is primarily geared toward strengthening the interpersonal and clinical quality of supervision when supervising behavioral health clinicians. However, we would be remiss not to acknowledge that there are many other organizational and contextual factors that impact the work of supervisors and the role that supervision plays. Supervisors are often positioned as a bridge between direct clinical staff and organizational leadership, asked to simultaneously advocate for clinicians while also upholding responsibilities and requirements from organizational leadership. This can be a difficult role to play, and supervisors are frequently juggling a myriad of competing and sometimes conflicting priorities from different areas in an organization. Further, for new supervisors in particular, there is also a transition around no longer being a "peer" with other clinical staff and a shift in competing demands and responsibilities from the organization.

We acknowledge that parts of this guide may be difficult or impossible to put into practice depending on your organizational climate. So much of supervision is dependent upon how an organization structures its time, resources and culture, particularly around expectations to complete administrative and audit-related work in supervision time. At the very least, we hope it can provide a starting place to consider ways to strengthen supervision practices even within the confines of unique organizational structures and expectations.

1 Our aim is to develop an online training to support the fifteen clock-hours of training in clinical supervision required for a supervisor to become an Approved Supervisor in Washington State. More information will be released on this soon. For updates, please reach out to uwcolab@uw.edu or visit our website.

There are a few ways to use this guide depending on your needs, interests and time:

- Review the guide in full, with relevant resources and links provided throughout.
- Go directly to the At A Glance Resources for Supervisors section at the end of this guide.
- Review the separate Guide Summary that is intended to provide a condensed overview of the key principles in the guide and associated resources and links.
- If you have colleagues who are also supervisors, we encourage you to share this document and/or selected resources with them.

FRAMING THIS GUIDE

Trauma-Informed Care

Trauma-informed care is an intersectional conceptual framework and a clinical intervention approach centered on the understanding that most people have experienced some form of trauma in their lifetime, whether it is disclosed or not, and that the mental health care they receive must reflect this context. Trauma encompasses acute experiences of harm, violence or fear of violence, racial trauma, cultural trauma, intergenerational trauma, community, relational, environmental and systemic trauma. Trauma-informed care means that the provider is aware of both the visible and invisible ways in which trauma may be impacting a client's current and past lived experience, and that they provide care from a strengths-based, empowerment and healing approach that centers safety.

Broadly, trauma-informed care recognizes that people exist within a context and ecosystem, one that includes multiple forms of trauma exposure and impacts how they interact with the world and make sense of their experiences. Given this, for mental health care to be supportive and effective, it must be delivered in a way that centers the impact of trauma and is designed around trauma-specific needs and supports. Trauma-informed care is the lens through which care is provided; it holds an understanding that trauma exposure often necessitates multiple treatment needs and shows up in unique and varying ways in a client's life.

Trauma-Informed Supervision

Trauma-informed supervision, by extension, is the practice of incorporating the core tenets of trauma-informed care into the supervisory relationship. Trauma-informed supervision acknowledges that behavioral health clinicians often enter the profession with trauma histories of their own, and are also working with high-trauma clients, placing them at significant risk for vicarious trauma. This is particularly true for clinicians working in public behavioral health organizations serving primarily Medicaid-insured families, who often experience disproportionately high rates of chronic stress and trauma exposure. Trauma-informed supervision includes building relational safety with your supervisee, addressing and acknowledging power dynamics and identity in the supervisory relationship, intentionally co-creating the supervision space, defining the scope of clinical work, and centering psychoeducation, self-care and effective modeling.

Trauma-informed supervision is important for multiple reasons. First, it is central to the sustainment of clinicians in the public behavioral health field by combating burnout and recognizing the pervasive impact of secondary trauma on their wellbeing. Trauma-informed supervision acknowledges that clinicians may be impacted by trauma and creates room for their experience in providing services. Second, trauma-informed supervision increases the quality of clinical services because it supports clinicians in being present in their work. Secondary trauma can have a profound impact on a clinician's ability to be present with their clients and effectively deliver treatments, and trauma-informed supervision can serve as a buffer for these harmful effects. Lastly, many clinicians working at community behavioral health organizations are at the beginning of their careers, and yet are placed with some of the highest need and most complex clients seeking care. As newer clinicians, they may still be developing coping mechanisms and processes for how to best support themselves in this intense work, and therefore it is critical that they receive trauma-informed supervision to equip them to provide effective care to clients and themselves.

Intersectionality, Cultural Responsivity and Racial Equity in Care

The United States population, and increasingly, the clinical workforce, are growing

more diverse. Given this, it is common for supervisors to support supervisees who have different racial, ethnic and cultural backgrounds than their own (Eklund et al., 2014). With the increasing prevalence of cross-cultural supervisory relationships and the urgent need for culturally relevant, anti-racist therapeutic interventions more broadly, it is critical for supervisors to provide supervision in a culturally responsive and anti-racist way (Eklund et al., 2014).

Intersectionality is an analytical framework coined by Professor Kimberlé Crenshaw (Crenshaw, 1991). This framework describes how people hold multiple identities, (for example, race, gender, ability, sexuality), and outlines how these identities intersect with each other to create unique lived experiences. In particular, intersectionality argues that these identities cannot be separated, and that a person's experiences of multiple systems of oppression are always in relationship with each other (Crenshaw, 1991). Intersectional, culturally responsive and anti-racist supervision practices are important for several reasons. It is vital for supervisees, particularly those holding a multitude of lived experiences and historically excluded identities, to feel safe, seen and valued in the supervision space. Supervisors have a responsibility to ensure that the supervisory relationship is grounded in values of intersectionality and equity, and that racial harm and trauma are not caused. Further, culturally relevant supervision supports supervisees in providing more culturally relevant care to clients through modeling, psychoeducation, and highlighting different frameworks of care. Finally, discussing and attending to race and identity in the supervisory relationship increases trust, strengthens the supervisory relationship and likely promotes higher quality of care provided to clients (Pieterse, 2018).

Defining Culturally Responsive, Equitable Care and Supervision Models

There are a multitude of frameworks that outline culturally responsive, multicultural and equitable supervision approaches. The Association for Multicultural Counseling and Development, for example, created the Multicultural Counseling Competencies in 1992, and outlined a revised version in 2016. This version, entitled "Multicultural and Social Justice Counseling Competencies," outlines updated guidelines for how clinicians can incorporate multicultural and social justice competencies and increase quality of care. These include: "(a) understanding the complexities of diversity and multiculturalism on the counseling relationship, (b) recognizing the negative influence of oppression on mental health and well-being, (c) understanding individuals in the context of their social environment, and (d) integrating social justice advocacy into the various modalities of counseling (e.g., individual, family, partners, group)" (Ratts et al., 2016). Additional supervision models include Ancis and Ladany's (2001) "Framework for Multicultural Supervision Competencies," Helm and Carter's (1990) "White Racial Identity Development Model" and others (Eklund et al., 2014). Although there are

too many frameworks and definitions to list here, it is important to note that cultural responsivity and reflexivity in the supervisory relationship are critical for positive supervision and client outcomes. Throughout this guide, anti-racist and multicultural supervision best practices are discussed.

> *"Supervision is a pedagogy in which our raced, classed and gendered bodies are present. Culture, in all of its varied guises (Manathunga, 2009), impacts there. When we supervise across ethnic cultures, supervision becomes a pedagogical site of rich possibility as well as, at times, a place of puzzling and confronting complexity" (Grant & Manathunga, 2011, p. 351).*