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Supervision Best Practices to Recruit, Train, and Retain the Early Career Behavioral Health Workforce: A Scoping Review and Expert Interviews

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Background

The U.S. behavioral health system is strained by persistent demand for mental health and substance use disorder services exceeding the supply of qualified clinicians, which results in high caseloads and burnout (Brabson et al., 2020; Chiller & Crisp, 2012; Hallett et al., 2024). These challenges not only disrupt access to care but may also impact early career behavioral health clinicians (ECBHCs)—those within five years post-graduation and pursuing independent licensure—who require clinical supervision to independently practice (Brabson et al., 2020; Hoge et al., 2011; U.S. Government Accountability Office [GAO], 2022). National behavioral health professional associations (e.g., AAMFT, 2023; AMHCA, 2020; APA, 2014; NASW, 2013, 2021) and state regulatory bodies have identified clinical supervision as an essential component of ECBHCs' professional and clinical development (Beddoe & Maidment, 2015; Chiller & Crisp, 2012; Choy-Brown & Stanhope, 2018; Hoge et al., 2011; Noble & Irwin, 2009; O'Conner et al., 2020). Yet, ECBHCs face supervision-related barriers, including inconsistent licensure and clinical requirements, financial burdens of paying for supervision, and difficulty finding supervisors whose time and expertise align with their professional goals (Ellis et al., 2015; Hutman & Ellis, 2023; Serafin et al., 2025). Despite clinical supervision being a requisite for independent practice at the graduate-level, it remains professionally siloed and there is less consensus on what constitutes high-quality supervision. This study examines how clinical supervision has been conceptualized and measured as a workforce strategy that may help ECBHCs remain in the field. Findings can inform workforce researchers, policymakers, organizational leaders, and clinical supervisors on how to effectively use clinical supervision as a retention strategy to support ECBHCs and behavioral health workforce capacity.

Research Aims

This study examined the systemic and organizational factors that hinder or facilitate effective clinical supervision practices for ECBHCs. The research questions asked:

1. Are there specific models, techniques, practices, or interventions that have been implemented and/or evaluated to assess the effectiveness of clinical supervision among graduate-level ECBHCs?
2. What, if any, are the reported outcomes (e.g., clinician satisfaction, client satisfaction or outcomes, workforce retention) associated with ECBHCs exposure to required clinical supervision?
3. What are the common facilitators and barriers to implementing quality supervision for ECBHCs?

Methods

This study included a two-phase design that consisted of a scoping review followed by qualitative expert interviews who implement and/or study supervision (IRB #24-2368). In Phase 1, scoping review search strategy and eligibility criteria were refined in collaboration with a university librarian and applied across four databases: PubMed, PsycINFO, Social Work Abstracts, and Social Services Abstracts. Eligible studies included U.S. based peer-reviewed studies published between 2014-2024 that examined supervision models, practices, or outcomes for ECBHCs. The scoping review protocol was registered in Open Science Framework (Zerden et al., 2025). Two independent reviewers conducted title and abstract screening, followed by full-text review. Data were extracted on supervision structures, barriers, and reported outcomes, when available. Phase 2 relied on snowball sampling to recruit a purposive sample of experts involved in the delivery, training and/or research of clinical supervision for ECBHCs across the behavioral health disciplines of interest (N=12). Semi-structured interviews were conducted during summer 2025 and lasted about 30 minutes. Interviews were audio recorded via Zoom, exported for transcription, and manually audited. Reflexive thematic analysis was used to identify convergent themes and identify exemplar quotes.

Key Findings

Scoping Review Findings

A total of 2,370 articles were identified through database searches (n=2,337) and manual reference harvesting (n=33), stored in Zotero (version 7) and uploaded to Covidence. After removing duplicates (n=169), 2,201 articles underwent title/abstract screening, with 176 selected for full-text review. Of these, 167 were excluded, yielding nine U.S.-based studies. An additional two studies were excluded during extraction, resulting in seven studies included in the final review. The seven included studies employed qualitative and quantitative designs, with sample sizes ranging from 7 to 700 ECBHCs (see Table 1). None explicitly identified or evaluated a specific evidence-informed model of supervision, but general components of supervision referenced case consultation, role-playing, and video recordings during supervision. All seven studies reported benefits of supervision (e.g., improved confidence, stronger professional identity, stress management, and enhanced client care) yet these were individually focused outcomes. Studies also presented barriers associated with clinical supervision delivery including poor supervisor/supervisee fit, the need to prioritize urgent needs over other clinical questions, and time constraints. Importantly, none of the studies described or evaluated supervision as a deliberate intervention to retain ECBHCs in the field.

Expert interviews

Twelve behavioral health supervisors, educators, and researchers who deliver or study clinical supervision for ECBHCs across four disciplines and eight out of the ten Department of Health and Human Services (DHHS) regions were interviewed. Supervisors described a range of evidence-informed models they deployed, (e.g., developmental model of supervision, reflective supervision model). However, most described using an eclectic approach, which was often adapted to meet individual supervisees' needs. This involved integrating more than one theory

and/or model and varied by post-graduation training discipline and personal philosophy about clinical practice. Four primary themes emerged from thematic analysis: (1) Benefits of Supervision (e.g., skill development, confidence, strengthening professional identify); (2) Challenges to Supervision (e.g., regulatory red tape, cost, administrative burdens); (3) Adaptive Supervision Strategies (e.g., use of technology, groups, efficiency), and (4) Future Priorities and Supervision Goals (e.g., policy and licensure reforms, supervisor training and peer support). See Table 2 for theme examples and illustrative quotes.

Policy Implications

Although clinical supervision could be used as a strategic workforce intervention to strengthen, retain, and sustain ECBHCs, our scoping review found limited to no quantitative evidence of the effectiveness of supervision on long-term outcomes for ECBHCs. Expert interviews presented an eclectic approach to clinical supervision with innovation and adaptations related to technology, organizational tools, and supervision structure (e.g., groups, triads). However, significant barriers to receiving supervision and challenges to delivering supervision were found in the scoping review and interviews. While clinical supervision is a requirement for ECBHCs seeking licensure, this study found wide variability in how clinical supervision is structured and measured across professional disciplines and state guidelines. This variability in regulation can result in inconsistent standards and when combined with limited evidence on evidence-based supervisions strategies, ultimately it can affect the quality of behavioral health care delivered. The following five recommendations are ways for professions and states to target policy levers and practice change to more effective support ECBHCs as they move towards independent practice. These recommendations provide states with ways to optimally align supervision requirements with professional development needs and behavioral health workforce capacity.

Strengthen supervision training and evaluation. Interviewees articulated the need for more formalized training to prepare clinicians for their roles as supervisors and recommended establishing minimum standards on what ECBHCs should expect in their training. This will require national and state-wide professional organizations, educational institutions, and licensure oversight bodies to articulate training models for supervisees as well as for supervisors serving in these roles. However, with so little empirical evidence on how supervision can impact workforce retention, more research is needed to evaluate supervision beyond the clinical or individual level.

Limited evidence on type of supervision structure that produces outcomes. Across states, each behavioral health discipline has guidelines on clinical supervision criteria that diverge despite similar training. For example, in North Carolina, Licensed Clinical Social Worker Associates (LCSWAs) (NCSWCLB, 2025a) and Licensed Clinical Mental Health Counselor Associates (LCMHCAs) (NCBLCMHC, 2025a) are both required to complete 3,000 hours of supervised practice to qualify for independent licensure. Yet, LCSWAs can only be supervised by other clinical social workers (who also meet minimum standards) (NCSWCLB, 2025b), whereas LCMHCAs can be supervised by a range of professionals including LCSWs, Licensed Marriage and Family Therapists (LMFTs), and licensed psychologists (NCBLCMHC, 2025b).

These differences demonstrate how within one state, licensure and supervision regulations can be both restrictive and flexible depending on the behavioral health workforce type—an issue that was raised during expert interviews. These differences have implications for supervision access, especially in rural or underserved areas which have been identified as a major barrier to clinical licensure (Serafin et al., 2025). The contrast between discipline-specific and cross-disciplinary supervision models highlights the need for ongoing dialogue about regulatory alignment and professional collaboration within a state's behavioral health system. Recently, New Mexico has attempted to do this through a state-wide supervision implementation plan created through Senate Bill 3 (SB3)—Behavioral Health Reform and Investment Act (New Mexico Judicial Branch, 2025). This model emphasizes infrastructure and long-term workforce development inclusive of supervision (NMBHPA, 2025). However, study findings reinforce that there is little evidence justifying how clinical hourly requirements and supervision structure (group vs. individual hours) is established making it somewhat arbitrary as to why some states might require 3,000 clinical hours versus others who require half as many.

Investing in supervision. The financial barriers to supervision were described frequently during the expert interviews and in extracted studies (Bledsoe et al., 2021; Silva et al., 2016). When supervision is not available through an employer, the financial burden falls on ECBHCs who must pay out of pocket to find and secure clinical supervision, often with hourly rates exceeding $100 per hour (Kona et al. 2024). These costs may deter ECBHCs from independent licensure and selection of a supervisor may be influenced by costs versus fit or clinical alignment, potentially compromising the supervision quality an ECBHC receives. Funding to cover the cost of clinical supervision is one way to offset this hardship and can be modeled after a program in Virgina called Boost! (VHCF, 2025). This program is supported by the Virginia Health Care Foundation (VHCF) and funded through a mix of state appropriations, the Department of Behavioral Health and Developmental Services, and private donations to help cover the cost of clinical supervision for eligible clinicians. Boost! currently supports over 380 ECBHCs working towards independent licensure and is a potential model for other states to consider in their behavioral health workforce planning efforts (VHCF, 2025). Other financial mechanisms include allowing supervisors to bill their time for clinical supervision, especially in public-serving behavioral health settings or to provide organizations who offer clinical supervision to ECBHCs a tax benefit.

Streamline administrative processes. Qualitative interviews highlighted one of the biggest obstacles to clinical supervision which was administrative red-tape not only for supervisors to track and manage each supervisee, on top of full caseloads and especially if they had multiple supervisees, but also for ECBHCs. Embedding supervision quality metrics in the reporting and administrative processes required of ECBHCs is one way to more consistently gather standardized data on supervision. Most states require quarterly or bi-annual logging of supervision hours, materials that vary by each licensure board and state regulations. Streamlining these processes would require states to invest in enhanced data infrastructure to improve the way supervision hours are collected, tracked, and evaluated broadly.

Innovate with tele-supervision regulations and virtual supervision. Although tele-supervision (also known as virtual supervision) was not a major finding within the scoping review, it was discussed frequently throughout the qualitative interviews in multiple ways. Tele-supervision can be a technological adaptation that has facilitated ease in accessing supervision and innovation but to some, tele-supervision is a challenge given current regulation on how supervision must be offered (in-person) and within the same state. Currently, tele-supervision policies vary across the U.S. and by profession (e.g., Noon et al., 2025). These regulatory gaps may affect how behavioral health professionals are supported in their clinical roles and licensure processes (Simmons et al., 2021; Noon et al., 2025). In a report from The Blue Cross® and Blue Shield® of Minnesota Center for Rural Behavioral Health at the University of Minnesota-Mankato found that telehealth limitations regarding supervision restrict options for licensure as they require clinicians to travel long distances to receive in-person clinical supervision (Serafin et al., 2025). Efforts to expand clinical supervision opportunities could broaden the ways in which ECBHCs find and utilize supervision due to behavioral health clinician shortages (Stringer, 2025). Finally, as more states move towards compacts that facilitate licensure portability, tele-supervision and the allowing of supervision cross state-lines will need to be examined (Kim et al., 2023; Musburger et al., 2024).

Conclusions

Clinical supervision is essential to ECBHCs' skill development and career pathway towards independent licensure. However, it remains inconsistently structured and inequitably accessible. While supervision can provide demonstrable benefits for clinician confidence, competence, and well-being, poor-quality or absent supervision undermines these gains and is likely to contribute to workforce attrition. Findings from this study identified that despite innovations in practice, supervision has not been systematically measured or leveraged as a workforce intervention. Without standardization, dedicated training, and policy support, its potential to strengthen the behavioral health workforce and further support ECBHCs remains underutilized.

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Table 1. Extracted Studies (*N*=7) included in the Scoping Review

Author (Year)	Design & Sample	Profession & Setting	Supervision Structure	Key Findings Related to Supervision
Bledsoe et al. (2021)	QUAL (*N*=9); 6 states	Early-career school counselors; K–12 urban/rural schools	Occurred primarily off-site and after hours	– Participants found supervision to be a critical source of support and knowledge; improved confidence, professional growth, role clarity and alignment with discipline values; better client care, effective referrals, and enhanced group/individual counseling delivery. – Supervision was not mandated and presented barriers such as obtaining clinical supervision, securing a credentialed supervisor, supervision-related costs, and difficulty scheduling.
Cook & Ellis (2021)	QUAN (*N*=310); 16 states	Pre-licensed counselors; multiple settings	N/R	– The study sought to identify how pre-licensed counselors identified harms of supervision; 77% reported receiving inadequate supervision (e.g., embarrassment, lack of evaluative feedback). – 30% experienced supervision as harmful (e.g., dual roles, misconduct).
Cook et al. (2020)	QUAN (*N*=107); 10 states	Pre-licensed counselors	Avg. 65 min./ week; Some received supervision at job, others paid for external supervision	– Study assessed the issues pre-licensed counselors found most difficult to address during supervision. – 95% reported some degree of intentional nondisclosure. – 53% of pre-licensed counselors withheld at least one clinical concern during supervision (e.g., disagreed with supervisor; negative reaction to supervisor's attitude, countertransference).
Cook & Sackett (2018)	QUAL (*N*=7); Virginia	Pre-licensed counselors; community agencies	1 hr./week; mostly self-report; 1 live observation	– Supervisees prioritized urgent or confidence-related cases due to time limits. – Decisions were pragmatic (i.e., time constraints) rather than due to avoidance.
Cox et al. (2024)	Qualitative (*N*=7); 5 regions	Early career K-12 school counselors	N/R	– Group counseling skill development enhanced by professional community. – Barriers and limited opportunities impeded practice (e.g., lack of clarity on role, inadequate professional development; lack confidence managing group dynamics).
Glassburn (2020)	Grounded theory (*N*=26); Midwest region	New MSWs ≤18 months post-grad	Varied; some non-MSW supervisors	– Some reported effective supervision reduced stress/fatigue and improved job satisfaction. – Others had no or poor supervision, with negative outcomes (e.g., secondary traumatic stress).
Silva et al. (2016)	National survey (*N*=700); 4 regions	Early-career school psychologists	Mix of individual, group, peer, and mentoring	– 90% valued supervision; 66% said it helped manage stress and found value in peer mentoring. – Barriers included time, access, proximity, and lack of supervisor availability. – Cost was noted as a barrier to 5% of participants.

Note. All participants represented in these studies were supervisees, with all studies reporting that samples were mainly comprised of individuals who identified as female and non-Hispanic White. Not all studies reported workplace setting. Exposure to supervision or specific supervision techniques were the intervention(s) represented in all studies. QUAL denotes qualitative studies; QUAN denotes quantitative studies, all of which were cross-sectional survey designs. Region denotes the U.S. geographical regions as prescribed by author (e.g., Southeast). MSWs denotes the licensing credential for a master's degree in social work. N/R = not reported.

Table 2. Expert Interview Themes and Sub-Themes with Exemplar Quotes

Theme / Subtheme	Exemplar Quote(s)
Theme 1: Benefits of Supervision	
Skill Development & Tailored Learning	- "I think one of the benefits is that you can get really tailored, individualized consideration, somebody really engaging your intellectual curiosity and giving you constructive feedback. Whereas in a group…one of the benefits is obviously learning from everybody else, and all the opportunities for peer support and mutual aid… so that it's not all on the supervisor." (LCSW-PA) - So even as we're doing the DSM [Diagnostic and Statistical Manual of Mental Disorders], we talk about who are some of the cases that they have that may meet that [diagnosis]? What are they doing with them? We still tie in some longer down the road things, but I think that has helped with confidence is that they don't have to ask; it's just part of what we do for supervision. They don't know how they would start to do narrative therapy; it doesn't matter because we're going to talk about it." (LCSW-ID)
Confidence & Professional Identity	- "I love watching people grow in the field… seeing them become more confident and competent, and knowing I've had a hand in that process." (LCSW-WA)
Theme 2: Challenges to Supervision	
Regulatory Red Tape	- "The barriers are 100% how convoluted it is…across state lines…extremely confusing. The paperwork changes almost every single time." (LCSW-PA) - "It's a hot mess that it's all different. LCSWs and LCMHCs each need different hours…definitions of groups vary…craziest thing I've ever heard." (LCMHC-NC)
Administrative Burdens: Cost & Time Concerns	- "Not enough hours in the day…a lot of supervisors have too many supervisees and too many demands…everyone would like to be really supportive…but truly do not have enough hours in the day." (Psychologist-MN) - "Clinical productivity expectations have gotten a lot higher…hard to justify observing almost their whole session, and then give them an hour of supervision, but I'm only getting billed for one session…Psychiatrists can bill differently…in our system we don't get rewarded or compensated for supervision." (Psychologist-CA) - "Cost is prohibitive! I see people charging $500 a month…how can a social worker afford that? I try to keep it under $300." (LCSW-TX)
Retention Concerns	- "People just wanted the hours…then they leave…I've talked to people who won't work with students because they get trained up, and then they leave…hospitals offer better pay and benefits." (LCSW-WA)
Supervisor Training Gaps	- "The folks doing supervision either haven't received good supervision themselves, or they haven't dealt with their own stuff. Supervision is a different skill from therapy." (LMFT-UT)
Theme 3: Adaptive Strategies to Facilitate Supervision	
Use of Technology and Structured Review	- "I have them…tag me for review on all of their clinical work…so I can provide them feedback…Once I feel like they're in a good place…I do file reviews quarterly." (LCSW-ID) - "We started recording some of our telehealth sessions—obviously with consent—and I'd review them asynchronously. That way, I can give targeted feedback without both of us having to carve out an extra hour together." (LCSW-PA)
Triadic Supervision	- "I do love triadic supervision…two supervisees and me…when you start supervising, you become a better clinician…I recruit the other supervisee to be a co-supervisor." (JR-UT) - "Sometimes I'll pair a newer supervisee with one who's further along, so they can learn from each other. I think it normalizes asking questions and helps them hear feedback in a different voice than mine." (PhD-MN)
Preparation and Efficiency	- "When I can't be there live, I have them email me their case conceptualizations before supervision. That way, I can prepare specific questions and resources, and we can make the most of the limited time." (LCAS-NC)
Professional Development	- "Supervision goes hand in hand with postgraduate training…I still see a supervisor every other week." (LCSW-NY)
Theme 4: Future Priorities and Supervision Goals	
Supervisor Training and Peer Support	- "I would love to see clinical supervisors being required to do supervision amongst themselves, even if it's monthly. I think that that's imperative, and I do it just with my colleagues, purposefully, but it should be required because you silo yourself" (LCSW-ID) - "There's this ongoing need for a peer supervision group for supervisors. We need a safe place to talk about our own blind spots and challenges." (LCSW-NY)

Policy and Licensure Reform	- "Honestly, I wish the state would count more of the group supervision hours toward licensure. It would open up access and make it less financially burdensome for supervisees." (LCSW-ID) - "I think we need a national standard for supervision requirements. It would take away so much of the guesswork and reduce the headaches when someone moves across state lines." (LMFT-CO)

Note. LCAS = Licensed Clinical Addiction Specialist; LCMHC = Licensed Clinical Mental Health Counselor; LCSW = Licensed Clinical Social Worker; LMFT = Licensed Marriage and Family Therapist. To maintain anonymity, participants representing social work, professional counseling, and marriage and family therapists were identified by their licensure type (denoted above) and the state in which they practice. Those with a doctorate degree in psychology were identified as "psychologists" followed by the state in which they work.