Handouts/ Instructions

Dr. Meg Robertson

Table of Contents

Introduction

The handouts and instructions section is designed to help participants move from learning supervision concepts to applying them in a clear, structured, and repeatable way. Throughout this training manual, supervision has been presented as an active professional practice that requires preparation, reflection, documentation, feedback, ethical decision-making, and client-safety awareness. The materials in this section provide practical tools that support those responsibilities and help supervisors translate the concepts from each module into usable supervision behaviors.

These handouts are intended to serve as working documents rather than passive reading materials. Participants may use them during live training, asynchronous reflection, role-play exercises, case consultation, documentation review, remediation planning, and capstone preparation. Each form, checklist, worksheet, or instruction sheet is meant to create clarity around expectations, reduce ambiguity, and strengthen consistency across supervision settings. When supervisors use structured tools, they are better able to support supervisee growth while also maintaining appropriate standards, documentation, and accountability.

This section also reinforces the central themes of the manual: supervision should be relational, ethical, competency-based, culturally responsive, evidence-informed, and protective of client welfare. The handouts provide a bridge between those broad principles and daily practice. They help participants clarify roles, identify risks, organize feedback, document decisions, evaluate competence, plan remediation, and reflect on their own development as supervisors. Participants are encouraged to adapt these materials to fit their setting, jurisdiction, supervisee population, agency policies, and professional discipline. The goal is not rigid compliance with a single format, but thoughtful use of tools that make supervision more intentional, transparent, and defensible. Used consistently, these handouts can help supervisors create supervision that is not only supportive and collaborative, but also structured, accountable, and grounded in professional excellence.

Assignment Submission Instructions

Hand in your deliverables/assignments via email to www.marmentalhealththerapy@gmail.com. Your certificate cannot be sent until all deliverables and module are completed. These are not graded. However, this is a pass/fail situation as you need the clock hours to get your certificate. These assignments are designed to help make a supervisor packet to help in what you will need when you become a supervisor. **SUBJECT LINE MUST INCLUDE MODULE NUMBER.** If the assignment location is unknown, it will not be counted.

The following list are those assignments that must be sent to the above email. The list will provide the subject line needed to submit the assignment as well as indicating in-session assignments and homework assignments. Here is the list:

MODULE 1 LIVE

Role-Play (triads): Instructions (in session only, no homework assignment)
Professional Disclosure Statement Template (MODULE 1, SLIDE 24, HOMEWORK ASSIGNMENT)

MODULE 2 VIRTUAL

Deliverables 1: Jurisdictional Rules Snapshot (MODULE 2, SLIDE 7, HOMEWORK ASSIGNMENT)
Jurisdictional Rules Snapshot Template (Module 2, use this for deliverable 1)
Deliverables 2: Ethical Decision Memo (MODULE 2, SLIDE 8, HOMEWORK ASSIGNMENT)
Ethical Decision Memo Template (Module 2, use this for deliverable 2)

MODULE 3 LIVE

Interactive Drill: Model Selection (Module 3 in-session assignment, no homework)
Drill Vignette A (Module 3, Early Development) (in-session assignment, no homework)
Drill Vignette B (Module 3, Mid-Development) (in-session assignment, no homework)
Drill Debrief Rubric (Module 3, in-session assignment, no homework)
Next Step (deliverables) (MODULE 3, SLIDE 12, HOMEWORK ASSIGNMENT)
Supervision Plan Template (Module 3, use this to complete "Nexr Steps")

MODULE 4 VIRTUAL

Evaluation & Rollout (Deliverables) (MODULE 4, SLIDE 11, HOMEWORK ASSIGNMENT)
Progress Note Evaluation Rubric for Supervisees Template (use this for Evaluation & Rollout assignment)

MODULE 5 LIVE

Model Selection Drill (Module 5, Slide 8, in-session assignment, no homework)

MODULE 6 VIRTUAL

Roadmap: Create Your Own (MODULE 6, SLIDE 5, HOMEWORK ASSIGNMENT)
Roadmap (template) (use this template to complete your roadmap assignment)
Model Selection (MODULE 6, SLIDE 9, HOMEWORK ASSIGNMENT) This is a short, one-line assignment located at the bottom of this slide.
Scenario (drill) (MODULE 6, SLIDE 10, HOMEWORK ASSIGNMENT)
Cultural Formulation Interview Template (MODULE 6, SLIDE 12, HOMEWORK ASSIGNMENT)
Wrap Up/Deliverables (MODULE 6, SLIDE 13, HOMEWORK ASSIGNMENT)

MODULE 7 LIVE

Informed Consent in Supervision (MODULE 7, SLIDE 4, HOMEWORK ASSIGNMENT)
Informed Consent Template (use this template to do Module 7, Slide 4 homework assignment)
Supervision Contract Packet (MODULE 7, SLIDE 6, HOMEWORK ASSIGNMENT)
Clinical Supervision Contract (Multi-State) Template (use this template to do Module 7, Slide 6 homework assignment)
Activity: Contract Scavenger Hunt (Module 7, Slide 7 activity, in session assignment, no homework)
Model Selection Drill (Module 7, Slide 8 activity, in session assignment, no homework)
Drill Case Vignette (Module 7, Slide 9 activity, in session assignment, no homework)
Debrief (Module 7, Slide 10 activity, in session assignment, no homework)
Supervision Plan (MODULE 7, SLIDE 11, HOMEWORK ASSIGNMENT)
Supervision Plan Template (use this template to do Module 7, Slide 11 homework assignment)
Role-Play: Negotiating the Contract (Module 7, Slide 13 activity, in session assignment, no homework)
Wrap Up/Deliverables (Module 7, Slide 15 activity, in session assignment and homework assignment listed elsewhere)
Completed Supervision Contract Packet Plan (MODULE 7, SLIDE 16, HOMEWORK ASSIGNMENT)

MODULE 8 VIRTUAL

Supervision Contract Packet Template ((use this template to do Module 8, Slide 16 homework assignment)
Model Selection Drill Debrief (MODULE 8, SLIDE 10, HOMEWORK ASSIGNMENT)
Drill Debrief Report Template (use this template to do Module 8, Slide 16 homework assignment)
Wrap Up/Deliverables (MODULE 8, SLIDE 13, HOMEWORK ASSIGNMENT)
Evaluation and Remediation Template Template (use this template to do Module 8, Slide 13 homework assignment)

MODULE 9 LIVE

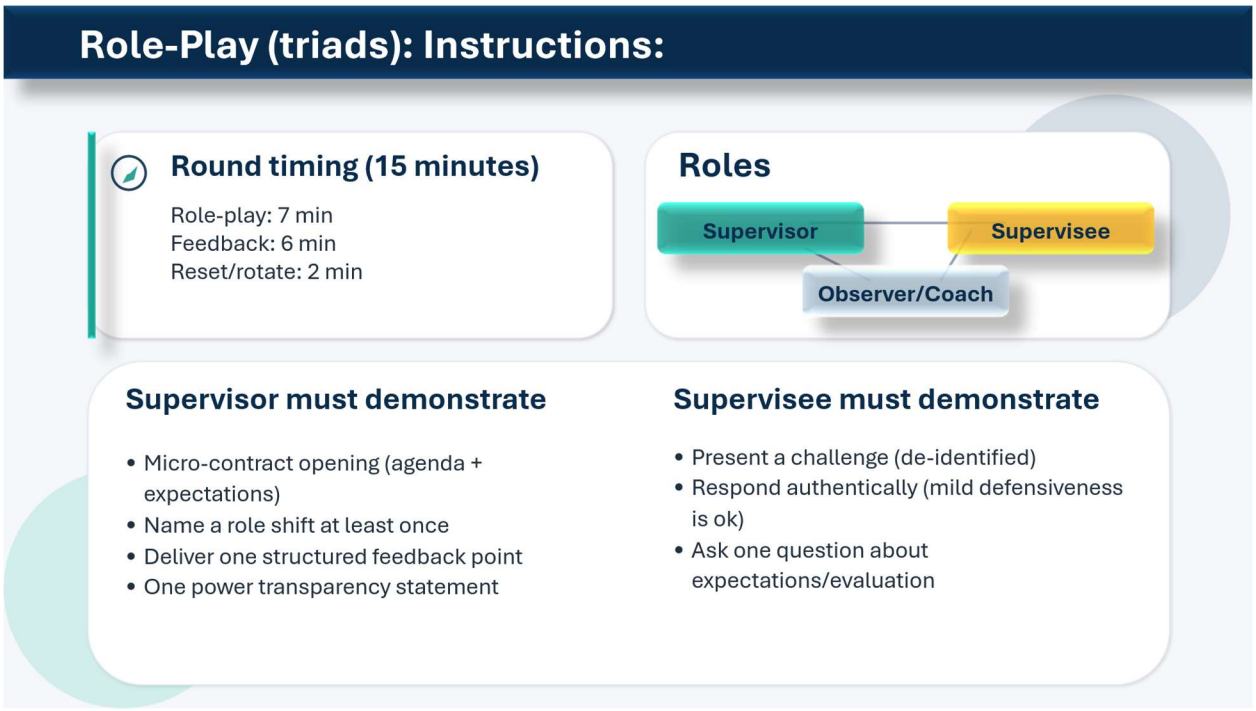
Stop-the-Line Simulation Instructions (Module 9, Slide 8 in-session activity, no homework)
Debrief Questions (Module 9, Slide 8 in-session activity, no homework)
Stop-the-Line Simulation Scenario (Module 9, Slide 9 in-session activity, no homework)
Simulated Scenario (need this for homework assignment)
Documentation Requirements (MODULE 9, SLIDE 10, HOMEWORK ASSIGNMENT)
High-Risk Documentation Template (use this template for Module 9, Slide 10 assignment)

MODULE 10 VIRTUAL

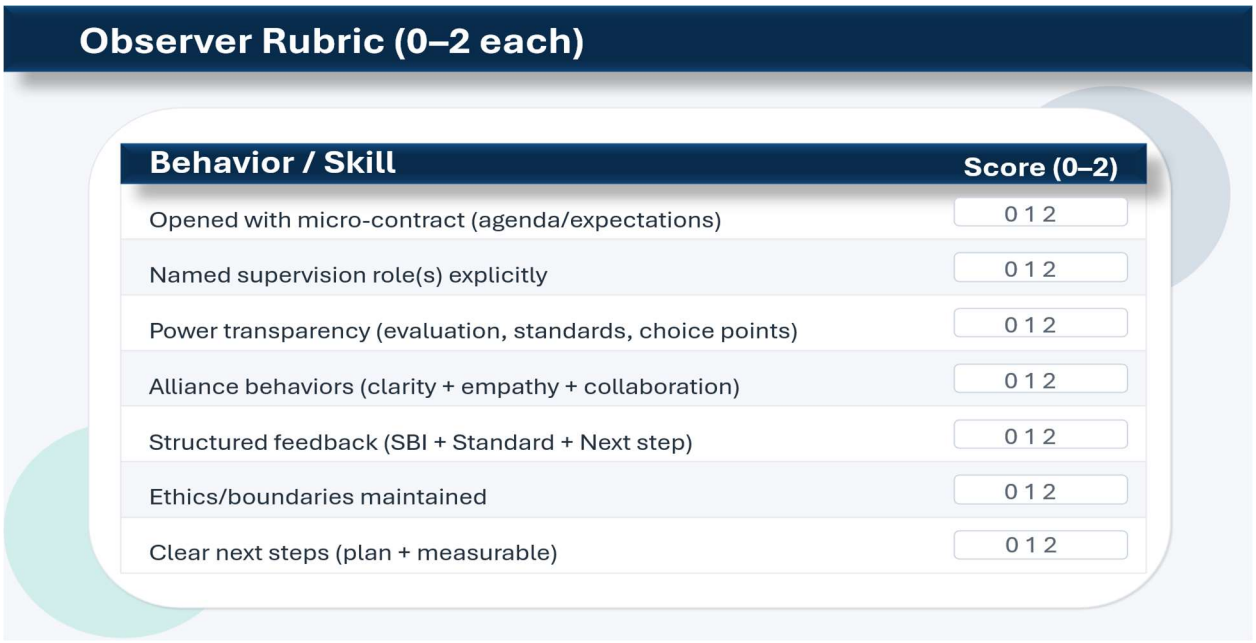
Reflection Prompts (write-up) (MODULE 10, SLIDE 12, HOMEWEORK ASSIGNMENT)
Wrap Up and Deliverables (MODULE 10, SLIDE 14, HOMEWEORK ASSIGNMENT)
Capstone Self-Assessment Template (use this template to help with Module 10, Slide 14 assignment)

Module 1 Handouts/Instructions

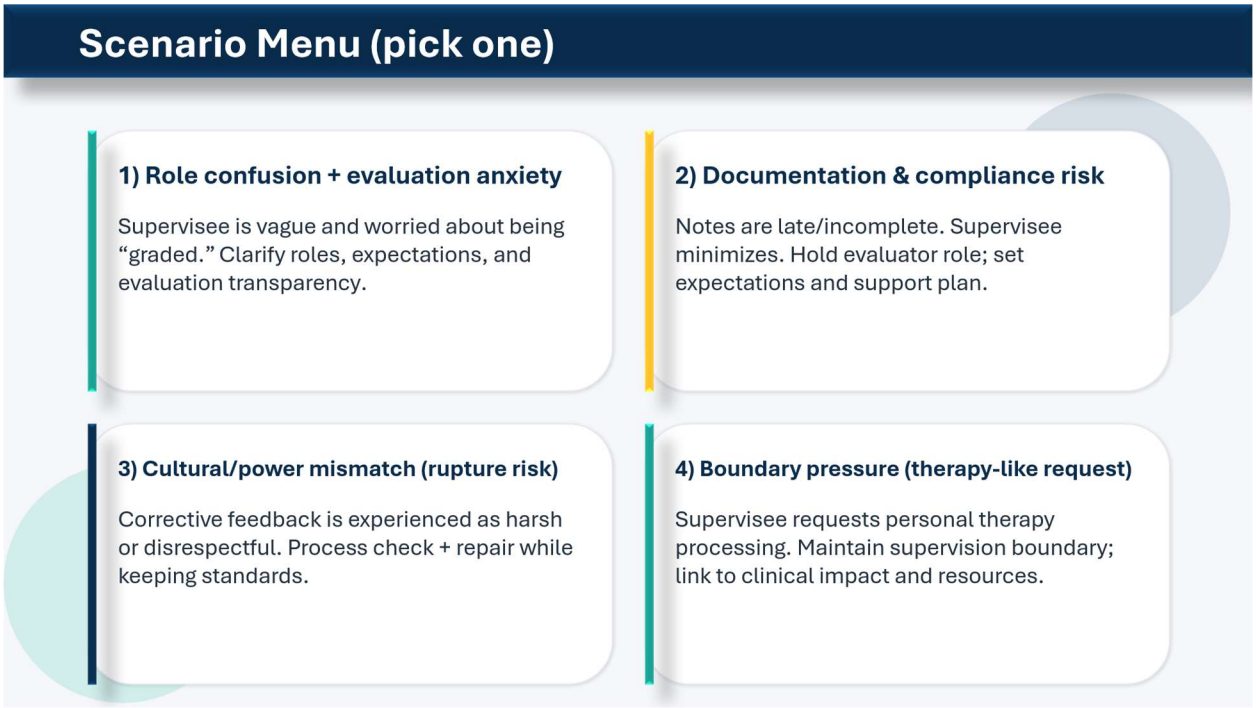
Role-Play (triads): Instructions



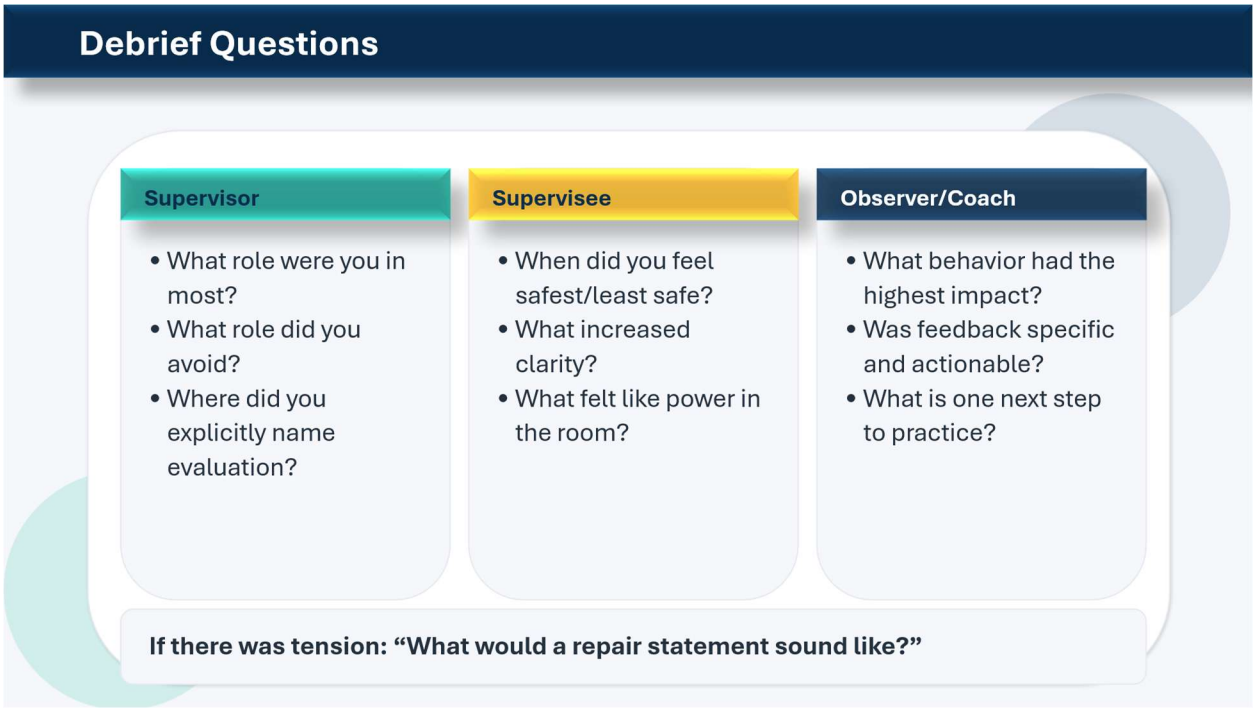
Observer Rubric (0-2 each)



Scenario Menu (pick one)



Debrief Questions



Professional Disclosure Statement Template

Clinical Mental Health Supervision
Supervisor Name: [Full Name, Degrees, Licenses]
Business/Practice Name: [Practice Name]
Effective Date: [Date]
Revision Date: [Date]

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1. Contact Information
Name: [Supervisor Full Legal/Professional Name]
Degrees/Credentials: [Degree(s), License(s), Certifications]
Business Name: [Practice or Agency Name]
Business Address: [Street Address, City, State, ZIP]
Telephone: [Phone Number]
Email: [Email Address]
Website: [Website, if applicable]
For urgent supervision matters, supervisees may contact the supervisor using the information listed above. For client emergencies, supervisees must follow agency/employer crisis procedures, applicable state law, and emergency protocols.

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2. Degrees, Credentials, and Licensure
Education and Training

Degree/Training	Institution/Provider	Location	Date Completed
[Degree or Training]	[Institution]	[City, State]	[Year]
[Degree or Training]	[Institution]	[City, State]	[Year]
[Degree or Training]	[Institution]	[City, State]	[Year]

Professional Licenses

State	Credential	License Number	Initial Date	Expiration Date
[State]	[License Type]	[License #]	[Date]	[Date]
[State]	[License Type]	[License #]	[Date]	[Date]
[State]	[License Type]	[License #]	[Date]	[Date]

Certifications and Specialized Training

Certification/Training	Provider	Date	Hours, if applicable
[Certification/Training]	[Provider]	[Date]	[Hours]
[Certification/Training]	[Provider]	[Date]	[Hours]
[Certification/Training]	[Provider]	[Date]	[Hours]

Supervision services are provided in accordance with applicable state laws, licensing board rules, ethical standards, and the supervisee's jurisdictional requirements.

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3. Clinical Competency Areas for Supervision

The supervisor is qualified to provide clinical supervision in the following areas:

- General mental health counseling, including assessment, diagnosis, treatment planning, psychotherapy, case conceptualization, documentation, and ethical practice.
- Trauma-informed counseling and trauma-related case consultation within the supervisor's training and scope of practice.
- [Couples/family counseling, if applicable.]
- [Substance use/recovery-informed counseling, if applicable.]
- [Child/adolescent counseling, if applicable.]
- [Military/veteran counseling, if applicable.]
- [Christian counseling/spiritual integration, if applicable and clinically appropriate.]
- [Telehealth practice, documentation, risk management, and multi-state practice considerations, if applicable.]

The supervisor will provide consultation and referral recommendations when a supervisee's client needs fall outside the supervisor's competence, the supervisee's scope of practice, or the legally permitted scope of services.

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4. Supervision Training and Supervision Experience

Formal Supervision Training

Training	Provider	Date	Hours
[Supervision Training]	[Provider]	[Date]	[Hours]
[Supervision Training]	[Provider]	[Date]	[Hours]
[Supervision Training]	[Provider]	[Date]	[Hours]

Supervision Experience

The supervisor has provided clinical supervision in the following settings and roles:

- [Approved/credentialed supervisor in State, since Year.]
- [Clinical supervisor for associate/pre-licensed clinicians.]
- [Group supervision facilitator.]
- [Agency-based supervision, private practice supervision, consultation, or training role.]
- [Other relevant supervision experience.]

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5. Model and Approach to Clinical Supervision

The supervisor uses an integrative, competency-based, developmental approach to clinical supervision. Supervision is designed to support ethical clinical practice, client safety, professional identity development, clinical skill growth, cultural humility, and documentation competence.

Supervision may include:

- Case consultation and case conceptualization.
- Review of assessment, diagnosis, treatment planning, and interventions.
- Discussion of ethical and legal decision-making.
- Documentation review and feedback.
- Review of risk, safety planning, mandated reporting, and crisis response.
- Role-play, skills rehearsal, and reflective practice.
- Attention to countertransference, parallel process, boundaries, and professional wellness.
- Development of clinical judgment appropriate to the supervisee's role and stage of development.

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6. Role of the Supervisor

The supervisor's role is to:

- Provide oversight to support safe, ethical, and legally compliant clinical practice.
- Help the supervisee develop competence in assessment, diagnosis, treatment planning, intervention, documentation, and risk management.
- Monitor client welfare and supervisee performance.
- Provide feedback, support, instruction, and corrective guidance when needed.
- Assist the supervisee in understanding scope of practice, professional boundaries, and applicable state requirements.
- Evaluate supervisee progress and document supervision as required.
- Initiate remediation, consultation, referral, or reporting when clinically, ethically, or legally necessary.

Supervision is a professional training and oversight relationship. It is not psychotherapy for the supervisee.

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7. Goals and Objectives of Supervision

The goals of supervision include:

1. Develop measurable clinical competencies aligned with state requirements, ethical standards, and the supervisee's professional role.
2. Strengthen clinical judgment, case conceptualization, and treatment planning.
3. Improve documentation quality and medical necessity support.

4. Increase competence in risk assessment, crisis response, mandated reporting, and safety planning.
5. Promote culturally responsive and trauma-informed care.
6. Support professional identity formation, ethical decision-making, and appropriate boundaries.
7. Encourage reflective practice, self-awareness, and sustainable professional functioning.
8. Prepare the supervisee for independent clinical practice, as applicable.

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8. Supervision Modalities

Supervision may be provided through one or more of the following methods, as permitted by applicable laws and board rules:

- Individual supervision.
- Group supervision.
- Telehealth/video supervision.
- In-person supervision.
- Case presentation.
- Chart review and documentation feedback.
- Review of recorded sessions, when permitted and properly consented.
- Live observation, when applicable.
- Skills practice, role-play, and structured feedback.

The frequency, format, and duration of supervision will be determined by state requirements, agency policy, client risk level, supervisee developmental needs, and the supervision agreement.

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9. Evaluation Procedures

Evaluation is ongoing and may include both formative and summative feedback. Evaluation methods may include:

- Review of clinical documentation, including intake assessments, progress notes, treatment plans, safety plans, and discharge summaries.
- Discussion of clinical cases and treatment decisions.
- Review of ethical decision-making and professional conduct.
- Competency checklists or state-mandated evaluation forms.
- Periodic written evaluations.
- Goal review and progress tracking.
- Feedback regarding strengths, growth areas, and required corrective action.
- Remediation planning when performance concerns are identified.

When remediation is needed, the supervisor may provide a written plan that identifies the concern, expected changes, timeline, support provided, and consequences if improvement does not occur.

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10. Confidentiality, Privileged Communication, and Limits

Supervision discussions may include client information for purposes of clinical oversight, training, documentation review, and client safety. Supervisees are expected to use the minimum necessary information and comply with HIPAA, state privacy laws, agency policy, and ethical standards.

Limits of confidentiality in supervision may include:

- Risk of harm to self or others.
- Suspected abuse, neglect, exploitation, or other mandatory reporting concerns.
- Client safety concerns.
- Unethical, impaired, or incompetent practice.
- Practice outside the supervisee's scope, competence, or legal authority.
- Court orders, subpoenas, audits, investigations, or other legal requirements.
- Required reporting to an employer, agency, licensing board, or credentialing body.
- Documentation required for supervision verification, licensure, or compliance.

Because supervision includes oversight and evaluation, information shared in supervision may be communicated when required for client safety, legal compliance, ethical practice, agency oversight, or licensure documentation.

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11. Use of Technology and Telehealth Supervision

When supervision occurs through telehealth or electronic communication, both supervisor and supervisee agree to use secure, professional, and confidential methods whenever possible. Supervisees are responsible for:

- Participating from a private location.
- Protecting client confidentiality.
- Using secure internet and approved platforms.
- Avoiding disclosure of client-identifying information through unsecured channels.
- Following state laws and agency policies regarding telehealth practice.
- Having a plan for technology failure or urgent consultation needs.

If technology fails during supervision, the supervisor and supervisee will use the agreed-upon backup plan, such as telephone contact, rescheduling, or another approved communication method.

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12. AI Usage

The supervisor may use secure and clinically appropriate artificial intelligence tools on a limited basis to assist with administrative, educational, or formatting tasks related to supervision. Examples may include drafting supervision agendas, training materials, documentation templates, or note structures.

AI does not replace supervisory judgment, clinical decision-making, ethical responsibility, or legal compliance. All AI-assisted materials must be reviewed and finalized by the supervisor. Supervisees may not enter client-identifying information, protected health information, or confidential agency information into AI tools unless the tool is specifically approved by the supervisee's organization and meets applicable privacy and security requirements. Any AI-assisted work must be reviewed for accuracy, bias, clinical appropriateness, and compliance before use.

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13. Fees and Payment Policy

Service	Fee
Individual supervision, 60 minutes	[$ Amount]
Group supervision, 60 minutes	[$ Amount]
Documentation review or consultation	[$ Amount, if applicable]

Service	Fee
Missed appointment/late cancellation fee	[$ Amount, if applicable]

Payment is due [at the time of service/monthly/by invoice].
Cancellations require [number] hours' notice unless there is an emergency.
Pro bono or reduced-fee supervision may be offered on a case-by-case basis, subject to availability and written agreement.

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14. Emergency and Crisis Procedures

Supervision is not a substitute for emergency services. Supervisees are responsible for following agency policies, state laws, and professional standards when responding to client crises.
For client emergencies, supervisees should:

1. Follow agency/employer crisis procedures.
2. Contact emergency services when there is imminent danger.
3. Use local crisis lines, mobile crisis teams, emergency departments, or law enforcement as clinically appropriate.
4. Contact the supervisor as soon as safely possible.
5. Document the risk assessment, consultation, actions taken, and follow-up plan.

For urgent supervision matters, supervisees may contact the supervisor at:
Phone: [Phone Number]
Email: [Email Address]
Backup Contact/Procedure: [Insert backup procedure]

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15. Ethical Standards

The supervisor agrees to follow applicable professional ethical codes, state licensing board laws and rules, and relevant supervision standards.
Applicable standards may include:

- [State licensing board rules.]
- [ACA Code of Ethics, if applicable.]
- [AMHCA Code of Ethics, if applicable.]
- [AAMFT Code of Ethics, if applicable.]
- [NASW Code of Ethics, if applicable.]
- [NBCC Code of Ethics, if applicable.]
- [CCE Approved Clinical Supervisor Code of Ethics, if applicable.]
- [Agency policies and procedures.]

The supervisee is also expected to follow all applicable ethical codes, laws, rules, and agency policies.

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16. Supervisee Responsibilities

The supervisee agrees to:

- Practice within legal, ethical, and professional scope.
- Come prepared for supervision.
- Present cases honestly and accurately.
- Disclose risk issues, ethical concerns, documentation problems, client complaints, and clinical uncertainty.
- Maintain timely and accurate documentation.

- Follow supervisor direction when client safety, legal compliance, or ethical practice requires it.
- Seek emergency consultation when needed.
- Protect client confidentiality.
- Maintain professional boundaries.
- Track supervision hours and licensure requirements, when applicable.
- Notify the supervisor of changes in employment, licensure status, board requirements, client risk, or agency expectations.

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17. Acknowledgment

I have received and reviewed this Professional Disclosure Statement for Clinical Supervision. I have had the opportunity to ask questions and understand the supervisor's qualifications, supervision approach, evaluation procedures, confidentiality limits, fees, emergency procedures, and ethical responsibilities.

Supervisee Name: _____

Supervisee Signature: _____

Date: _____

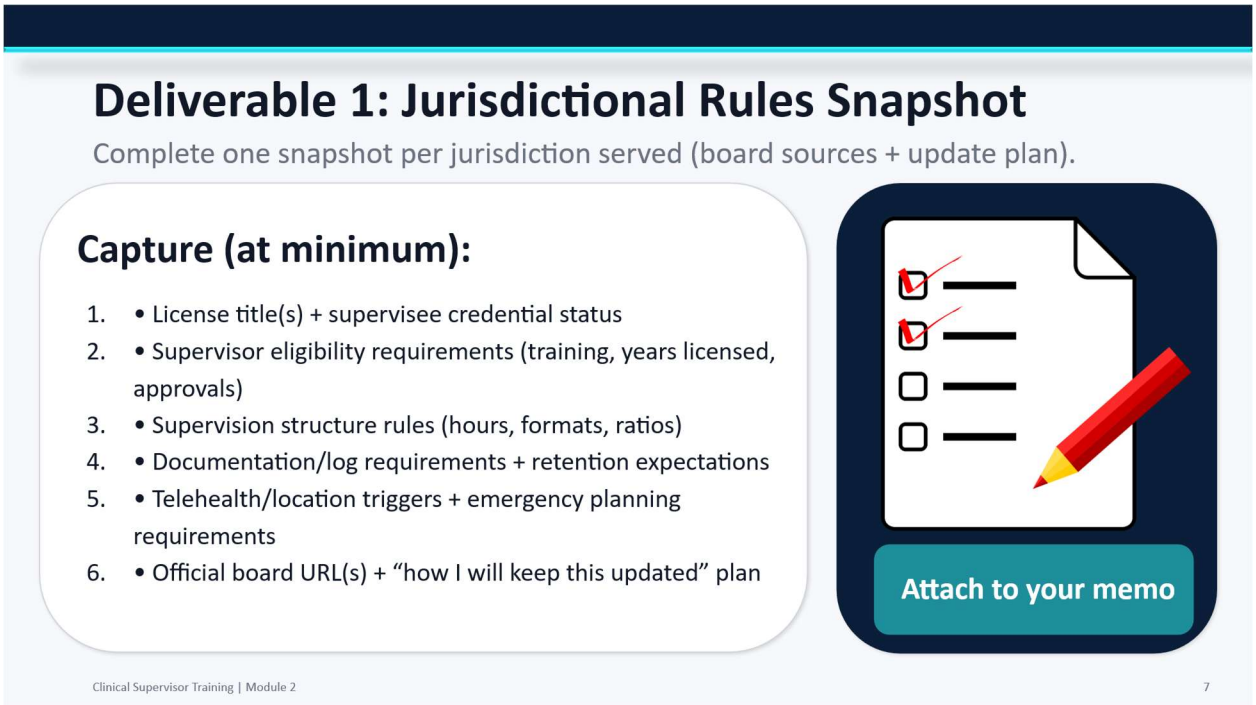
Supervisor Name: _____

Supervisor Signature: _____

Date: _____

Module 2 Handouts/Instructions

Deliverables 1: Jurisdictional Rules Snapshot



Jurisdictional Rules Snapshot Template

Jurisdiction/State: _____
Licensing Board Name: _____
Official Board Website/URL: _____
Date Reviewed: _____
Prepared By: _____
Next Scheduled Review Date: _____

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1. License Title(s) and Supervisee Credential Status
License title for independent clinician:
Example: Licensed Professional Counselor, Licensed Mental Health Counselor, Licensed Clinical Professional Counselor

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Associate/pre-licensed title:
Example: Licensed Professional Counselor Associate, Registered Associate, Resident in Counseling

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Supervisee's current credential status:
☐ Applicant
☐ Registered associate/pre-licensed clinician
☐ Licensed associate
☐ Temporary/provisional license
☐ Other: _____
Notes on title restrictions or required disclosures:

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2. Supervisor Eligibility Requirements
Minimum license required for supervisor:

Years licensed/clinical experience required:

Required supervision training hours:

Board approval required?
☐ Yes
☐ No
☐ Unsure/needs verification
Required supervisor credential/designation:

Renewal or continuing education requirements for supervisors:

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3. Supervision Structure Rules
Total supervised experience hours required:

Direct client contact hours required:

Minimum supervision hours required:

Individual supervision requirements:

Group supervision allowed?
☐ Yes
☐ No
☐ Limited/conditional
Maximum group size or ratio:

Supervision format allowed:

☐ In-person
☐ Live video/telehealth
☐ Phone
☐ Group
☐ Recorded session review
☐ Other: _____

Frequency of supervision required:

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4. Documentation, Logs, and Retention Requirements

Required supervision contract/agreement?

☐ Yes
☐ No
☐ Recommended
☐ Unsure/needs verification

Required supervision log elements:

☐ Date of supervision
☐ Duration
☐ Individual/group format
☐ Client contact hours reviewed
☐ Topics discussed
☐ Supervisor signature
☐ Supervisee signature
☐ Other: _____

Evaluation forms required by board?

☐ Yes
☐ No
☐ At application only
☐ Periodically required

Retention expectations:

Who must maintain records?

☐ Supervisor
☐ Supervisee
☐ Agency/employer
☐ All parties

Notes:

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5. Telehealth, Client Location, and Emergency Planning

Telehealth supervision permitted?

☐ Yes
☐ No
☐ Limited/conditional
☐ Needs verification

Telehealth counseling across state lines permitted?

☐ Yes
☐ No
☐ Limited/conditional
☐ Requires additional license/registration

Client location must be verified each session?

☐ Yes
☐ No
☐ Best practice/recommended

Emergency plan required for telehealth clients?

☐ Yes
☐ No
☐ Best practice/recommended

Required emergency planning elements:

☐ Client physical location
☐ Emergency contact
☐ Local crisis resources
☐ Local emergency services
☐ Safety plan
☐ Documentation of telehealth risks/benefits
☐ Backup communication plan
☐ Other: _____

Notes on location triggers:

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6. Official Board Sources and Update Plan

Primary board URL:

Rules/statutes URL:

Supervision forms URL:

Telehealth guidance URL:

Date source was last checked: _____

How I will keep this updated:

☐ Review board website every 6 months
☐ Review board website annually
☐ Subscribe to board email updates
☐ Monitor rulemaking notices
☐ Review during supervision contract renewal
☐ Confirm before accepting supervisees in this jurisdiction
☐ Other: _____

Update plan narrative:
I will review this jurisdiction's licensing board website at least every _____ months and before beginning supervision with any supervisee practicing in this state. I will verify supervision rules, telehealth permissions, documentation requirements, and emergency planning expectations using official board sources. Any changes will be documented in this snapshot and communicated to affected supervisees.

Summary of Key Compliance Risks
Top rules I must remember for this jurisdiction:

1. _____
2. _____
3. _____

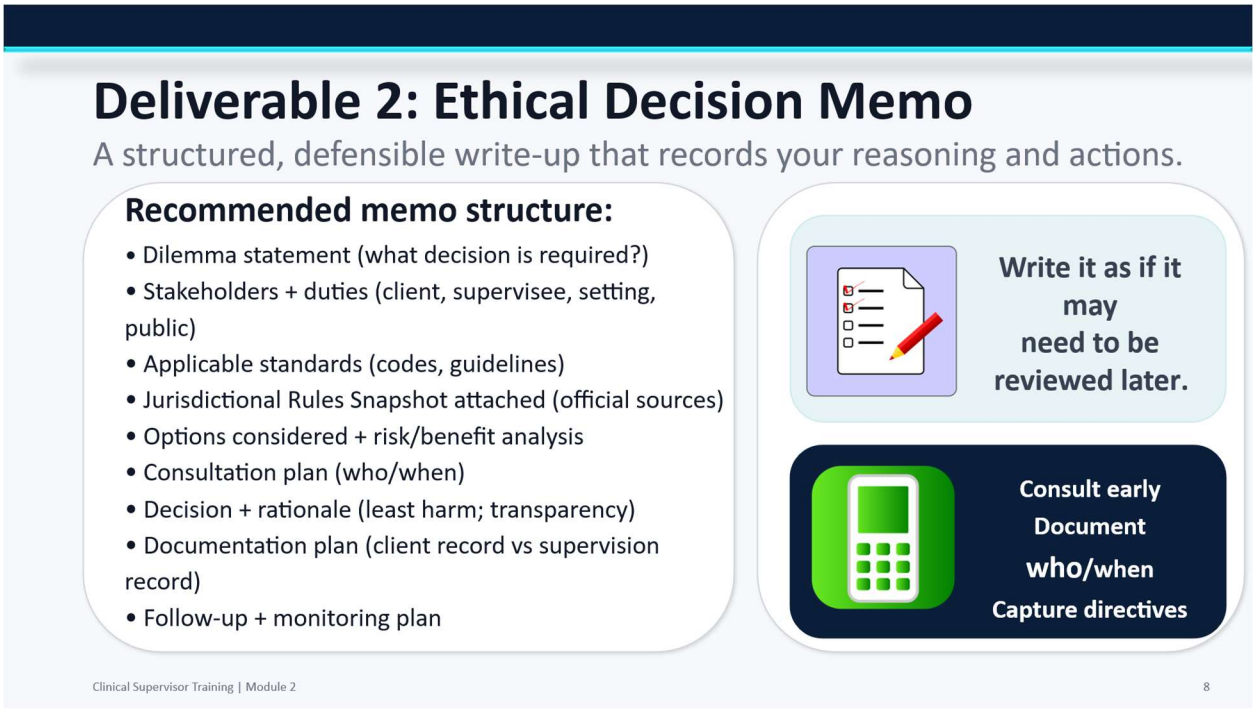
Areas needing further verification:

1. _____
2. _____
3. _____

Supervisor/Supervisee Acknowledgment
I have reviewed this jurisdictional rules snapshot and understand that supervision must follow the applicable laws, board rules, ethical standards, documentation requirements, and telehealth expectations for this jurisdiction.

Supervisee Name: _____
Supervisee Signature: _____
Date: _____
Supervisor Name: _____
Supervisor Signature: _____
Date: _____

Deliverables 2: Ethical Decision Memo (choose from scenario slide to do this exercise)



Ethical Decision Memo Template

A structured, defensible write-up that records your reasoning and actions.

Name: _____ Date: _____
Role/Position: _____ Supervisor: _____
Case/Scenario Title: _____
1. Dilemma Statement
What decision is required?

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2. Stakeholders + Duties
Who is affected and what duties are owed?

- **Client: _____**
- **Supervisee: _____**
- **Setting/Agency: _____**
- **Public/Profession: _____**
- **Other: _____**

Key duties/obligations:

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3. Applicable Standards

What ethical codes, laws, policies, or guidelines apply?

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4. Jurisdictional Rules Snapshot
What official rules or sources apply in this jurisdiction?
Jurisdiction: _____
Relevant rules/sources:

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5. Options Considered + Risk/Benefit Analysis
Option 1: _____
Benefits: _____
Risks/Concerns: _____
Option 2: _____
Benefits: _____
Risks/Concerns: _____
Option 3 (if applicable): _____
Benefits: _____
Risks/Concerns: _____
6. Consultation Plan
Who will be consulted, and when?

Directives/Guidance received:

---

7. Decision + Rationale
What decision was made, and why?

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8. Documentation Plan
What will be documented, and where?
Client record: _____
Supervision record: _____
Other documentation: _____
9. Follow-Up + Monitoring Plan
What happens next?

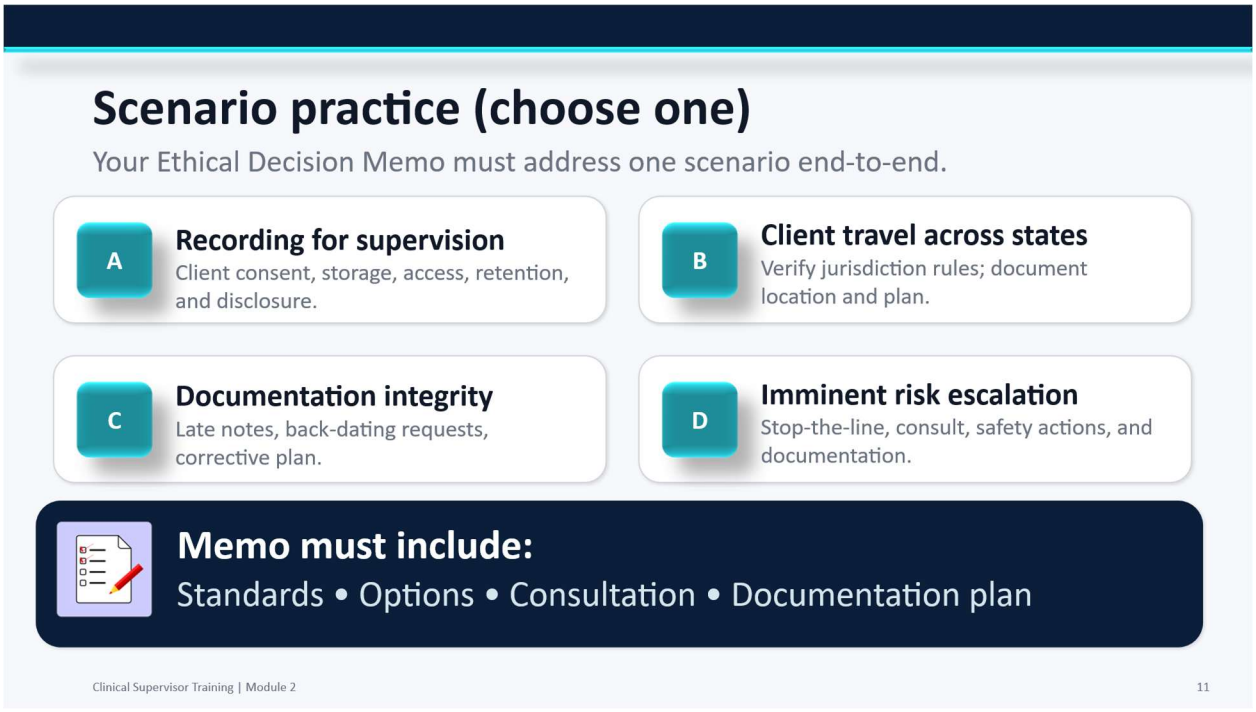
Submission Checklist

- Dilemma clearly stated

- Stakeholders and duties identified
- Standards/guidelines cited
- Jurisdictional rules noted
- Options with risk/benefit considered
- Consultation plan included
- Decision and rationale explained
- Documentation plan clarified
- Follow-up plan included

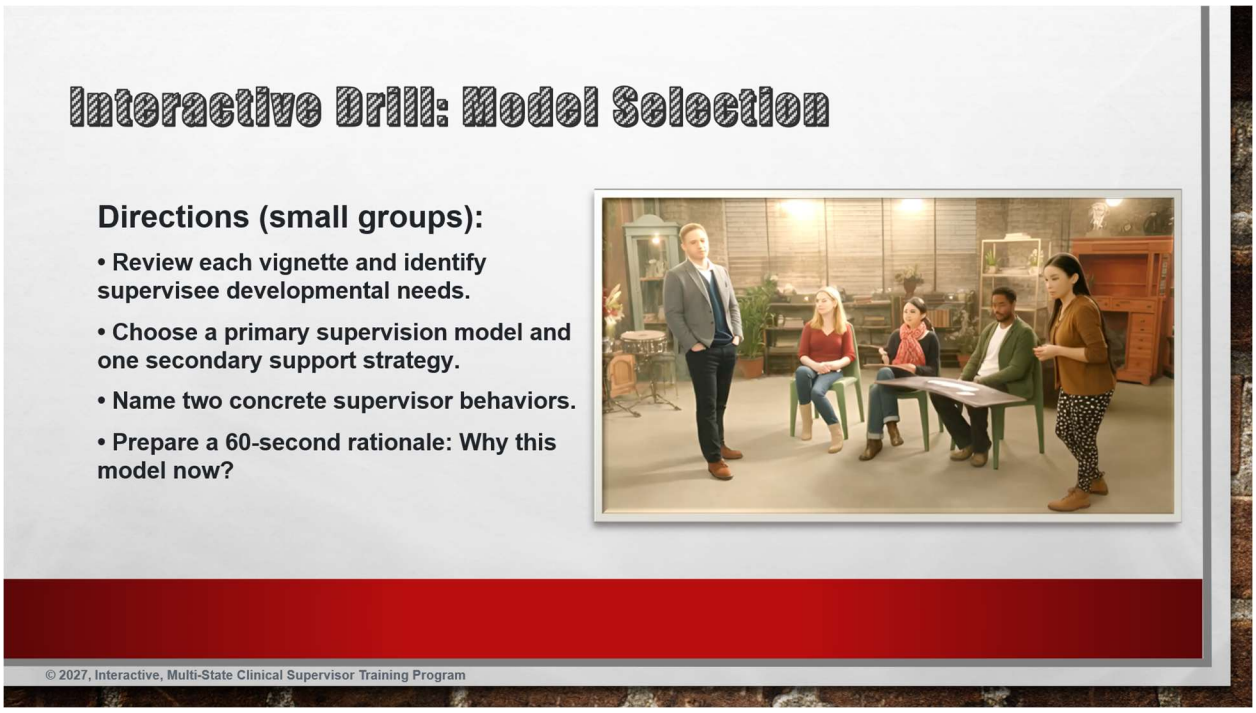
Reminder: *Write this as if it may be reviewed later. Consult early. Document who/when. Capture directives.*

Scenario Practice (choose one) (use this slide to choose dilemma statement for Ethical Decision Memo assignment)



Module 3 Handouts/Instructions

Interactive Drill: Model Selection



Explanation of Each Supervision Model

1. Discrimination Model

The Discrimination Model helps supervisors decide **where to focus** and **which role to use** in the moment. The supervisor first identifies the main supervision focus: intervention skills, case conceptualization, or the supervisee's personal/professional process. Then the supervisor chooses the most helpful role: teacher, counselor, or consultant.

For example, if a supervisee does not know how to ask a suicide-risk question, the supervisor may use the **teacher role** and model the language. If the supervisee understands the skill but feels anxious using it, the supervisor may shift into the **counselor role** to help the supervisee notice how anxiety is affecting clinical work. If the supervisee is more advanced and is weighing two possible treatment directions, the supervisor may use the **consultant role** and think collaboratively with the supervisee.

This model is useful because it keeps supervision flexible. The supervisor does not use the same approach every time. Instead, the supervisor asks, "What does this supervisee need right now: instruction, reflection, support, or collaboration?"

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2. Developmental Models

Developmental models focus on how supervisees grow over time. Early supervisees often need more structure, direction, modeling, and close oversight. As competence increases, the supervisor gradually allows more autonomy, encourages independent clinical reasoning, and shifts from direct instruction toward consultation.

For example, a beginning supervisee may need step-by-step guidance on treatment planning, documentation, and risk assessment. An intermediate supervisee may need help refining clinical judgment and managing self-doubt. An advanced supervisee may benefit from deeper reflection, professional identity development, and consultation around complex cases.

This model reminds supervisors that supervision should change as the supervisee grows. The goal is not to keep supervisees dependent, but to help them move toward responsible independence. Supervision should match the supervisee's developmental level, current competence, and risk level.

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3. Reflective/Integrative Models

Reflective and integrative models focus on the supervisee's self-awareness, use-of-self, emotional responses, case meaning-making, and ability to integrate personal insight with professional practice. These models help supervisees examine how their own reactions, assumptions, values, identity, culture, and relational patterns may shape clinical work.

For example, a supervisee may feel unusually protective of a client, frustrated with a resistant client, or hesitant to confront risk. A reflective approach helps the supervisee ask, "What is happening in me, and how might it be affecting the client?" This does not turn supervision into therapy, but it does help the supervisee become more aware of countertransference, emotional activation, cultural assumptions, and relational dynamics.

This model is especially useful when the issue is not simply skill-based. Sometimes the supervisee knows what to do technically but becomes blocked by fear, bias, uncertainty, grief, shame, or over-identification. Reflective supervision helps turn those reactions into clinical learning.

---

4. Competency-Based Supervision

Competency-Based Supervision focuses on observable skills, ethical standards, measurable outcomes, and documented growth. Rather than relying on vague impressions such as "doing well" or "needs improvement," the supervisor identifies specific competencies and gathers evidence of performance.

Common competency areas include risk assessment, documentation, case conceptualization, treatment planning, ethical decision-making, cultural responsiveness, professional behavior, and use of supervision. The supervisor evaluates these areas using evidence such as notes, recordings, live observation, role-play, case presentations, and supervisee response to feedback.

For example, instead of saying, "You need to improve your documentation," the supervisor might say, "Your notes need to include the presenting concern, intervention used, client response, risk assessment, medical necessity, and next steps. Let's review two notes together and use the rubric to measure progress."

This model is useful because it makes supervision more transparent, fair, and defensible. It also supports remediation because the supervisee knows exactly what must improve, how it will be measured, and when it will be reviewed.

How the Models Work Together

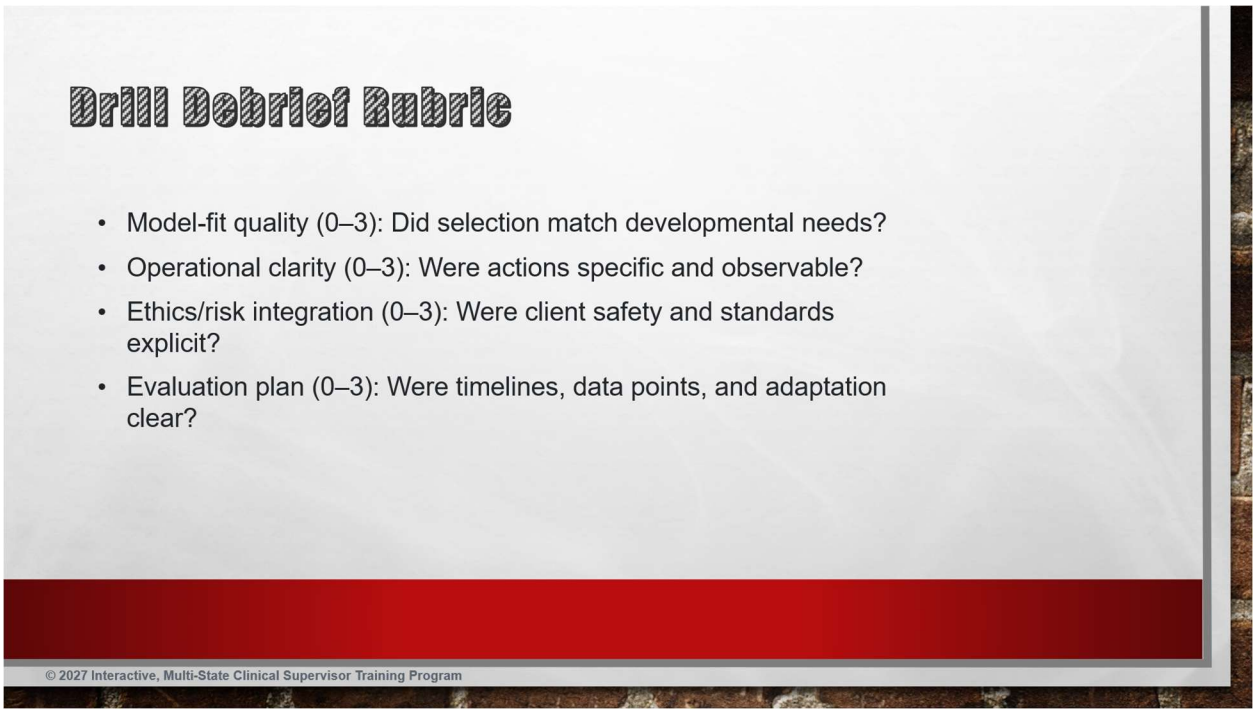
These models do not have to compete with one another. A strong supervisor may use all four. The **Discrimination Model** helps the supervisor choose the focus and role for the moment. **Developmental Models** help the supervisor adjust structure and autonomy based on the supervisee's growth. **Reflective/Integrative Models** help deepen self-awareness and clinical meaning-making. **Competency-Based Supervision** keeps the process tied to observable standards, ethics, documentation, and measurable outcomes.

Together, they help supervision become flexible, relational, structured, and accountable.

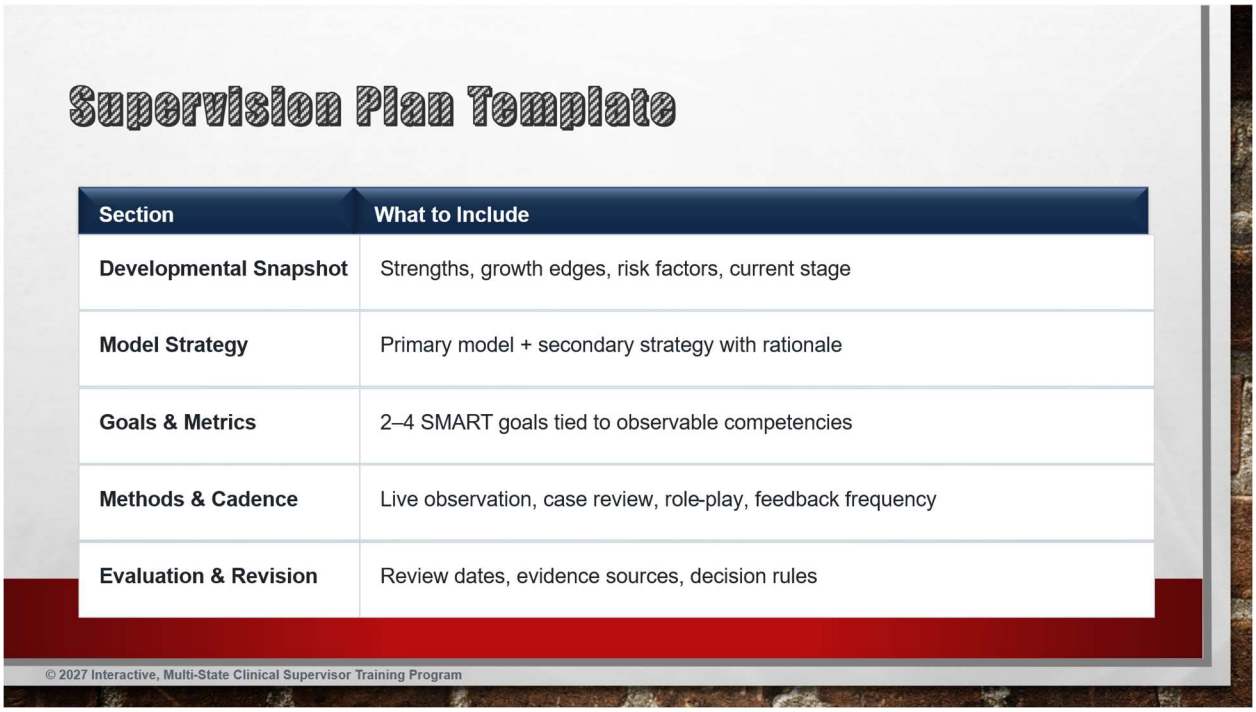
Drill Vignette A (Early Development)

Drill Vignette B (Mid-Development)

Drill Debrief Rubric



Supervision Plan Template



Implementation Plan

Implementation Plan (90-Minute Module)

0:00–0:10 | Framing + objectives + role expectations

0:10–0:30 | Model map walkthrough and examples

0:30–0:55 | Model selection drill (small groups)

0:55–1:15 | Debrief using rubric and facilitated discussion

1:15–1:30 | Build supervision plan + commitment actions

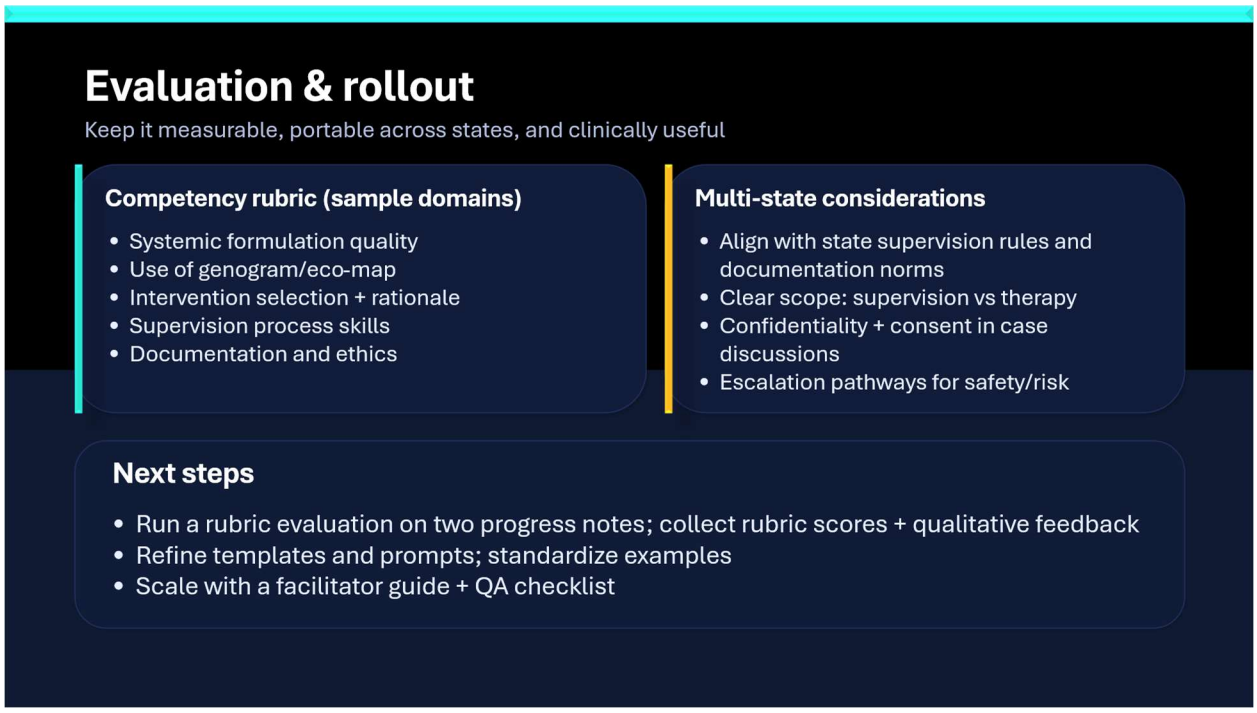
Next Step (deliverables)

Next Step: Apply Your Plan This Week

- Choose one supervisee and complete the template.
- Run a micro-cycle: model, methods, metrics.
- Submit outcomes.

Module 4 Handouts/Instructions

Evaluation & Rollout (Deliverables)



Progress Note Evaluation Rubric for Supervisees Template

Supervisee:
Supervisor:
Client Initials:
Client DOB:
Date of Service:
Rubric Score:
Use this rubric to assess clinical quality, compliance, and supervisee growth in routine progress and notes. Include date of service, supervisee, client initials only.
Scale (0–4):

- **4 = Exceeds expectations**
- **3 = Meets expectations**
- **2 = Emerging / inconsistent**
- **1 = Needs significant improvement**
- **0 = Missing / noncompliant**

Suggested benchmark: 29/36 (80.56%) minimum, with no 0 in Risk/Safety or Medical Necessity.

---

1) Clinical Relevance of Session Content
4 Note focuses on clinically meaningful themes (symptoms, stressors, behavior patterns, treatment targets); avoids irrelevant detail.
3 Mostly clinically relevant; minor tangential content.
2 Mixed relevance; important clinical material underdeveloped.
1 Mostly narrative/storytelling with little clinical focus.
0 No clinically relevant content.

---

2) Interventions Used (What clinician did)
4 Specific, accurate interventions documented (e.g., CBT reframing, grounding, MI, psychoeducation), tied to client needs.
3 Interventions documented and generally appropriate.
2 Vague intervention language ("processed," "discussed") without specificity.
1 Interventions unclear or mismatched to presentation.
0 No interventions documented.

---

3) Client Response to Interventions
4 Clearly describes client engagement and response (insight, affect shift, behavior change, resistance, tolerance).
3 Response documented but somewhat general.
2 Minimal client response detail.
1 Implied response only; little evidence of clinical impact.
0 No response documented.

---

4) Progress Toward Treatment Goals

4 Explicitly links session to treatment plan goals/objectives; includes measurable progress or barriers.
3 Goal connection present but somewhat broad.
2 Mentions goals without clear evidence of progress.
1 No clear link to goals; generic progress statement.
0 No goal/progress documentation.

---

5) Medical Necessity (for progress note context)
4 Clearly supports ongoing level of care by documenting current symptoms, functional impairment, and rationale for continued treatment.
3 Adequate necessity language with minor missing element.
2 General rationale for therapy; limited impairment detail.
1 Boilerplate/weak necessity statement.
0 No medical necessity support.

---

6) Risk, Safety, and Protective Factors
4 Risk assessed appropriately (SI/HI/NSSI/substance/psychosis as indicated), with protective factors and safety actions documented when needed.
3 Risk addressed adequately; minor omissions.
2 Incomplete risk documentation.
1 Superficial or unclear risk entry.
0 Risk omitted when clinically indicated.

---

7) Plan, Follow-Up, and Continuity of Care
4 Clear next steps: homework/skills practice, referrals/coordination, follow-up interval, and focus for next session.
3 Follow-up plan present and generally usable.
2 Plan vague or not actionable.
1 Minimal plan ("RTC") without specifics.
0 No plan/follow-up.

---

8) Documentation Quality, Professionalism, and Compliance
4 Timely, concise, objective, person-centered language; legally defensible; accurate diagnosis/time/service elements present.
3 Solid documentation with minor clarity/compliance edits needed.
2 Repetitive/wordy or occasional judgmental/unclear wording; moderate corrections needed.
1 Disorganized or potentially noncompliant style/content.
0 Major compliance/legal deficiencies.

---

9) Case Conceptualization Growth (Supervision lens)
4 Demonstrates developing clinical thinking: patterns, hypotheses, differential considerations, and rationale for intervention choice.
3 Sound conceptual thinking with growing depth.
2 Emerging conceptualization; mostly descriptive.

1 Limited conceptual thinking; task-only documentation.
0 No evidence of conceptualization.

Scoring Grid (36 points total)

Criterion	Score (0–4)
1. Clinical Relevance	
2. Interventions Used	
3. Client Response	
4. Progress Toward Goals	
5. Medical Necessity	
6. Risk & Safety	
7. Plan & Continuity	
8. Documentation Quality/Compliance	
9. Case Conceptualization Growth	
Total / 36	

Performance bands (suggested):

- **32–36:** Advanced
- **27–31:** Competent
- **24–26:** Borderline / needs targeted coaching
- **<24:** Remediation plan indicated

Supervisor Feedback Prompts (quick use)

- "What intervention did you choose, and why this one for this client today?"
- "What changed for the client in-session that shows clinical impact?"
- "Where is medical necessity evident in this note?"
- "How does this note show movement toward treatment plan goals?"
- "What risk factors/protective factors are active right now?"
- "What should be different in the next note?"

Facilitator Guide

Evaluation & Rollout

Keep it measurable, portable across states, and clinically useful.

Purpose

This facilitator guide supports implementation of the evaluation and rollout process for the supervision training module. The goal is to help facilitators evaluate participant competence using a structured rubric, adapt the training for multi-state use, and improve the materials through feedback, standardization, and quality assurance.

This guide is designed for use during live training, asynchronous review, workbook completion, supervision skill practice, and pilot testing of templates or progress note evaluation activities.

I. Facilitator Preparation

1. Review the Training Focus

Before facilitating, review the module's major emphasis:

Evaluation should be:

- Measurable
- Clinically useful
- Portable across states
- Linked to observable competencies
- Consistent with supervision rules and documentation expectations
- Clear enough to support feedback, remediation, and rollout

2. Gather Materials

Prepare the following materials before the session:

- Competency rubric
- Two sample progress notes
- Evaluation worksheet or scoring form
- Qualitative feedback form
- Multi-state supervision rule reminder sheet
- Documentation expectations template
- Facilitator QA checklist
- Participant reflection prompts

3. Clarify the Evaluation Task

Participants should understand that the rubric is not simply a grading tool. It is a supervision tool that helps supervisors identify strengths, gaps, risk concerns, documentation issues, and training needs.

Facilitator framing statement:

"Today we are practicing how to evaluate clinical documentation and supervision-related competencies in a way that is measurable, fair, clinically useful, and adaptable across jurisdictions."

II. Competency Rubric Domains

The facilitator should explain each sample domain before participants begin scoring.

1. Systemic Formulation Quality

This domain evaluates whether the participant can understand the client within a broader relational, cultural, family, community, and contextual system.

Look for:

- Clear description of relational patterns
- Attention to family or social context
- Recognition of systemic stressors
- Connection between client symptoms and environment
- Avoidance of overly individualistic explanations

Facilitator prompt:

"Does the note show how the client's concern fits within a larger relational or systemic context?"

---

2. Use of Genogram / Eco-Map

This domain evaluates whether the participant can use visual or conceptual mapping tools to understand family structure, support systems, stressors, and relational patterns.

Look for:

- Family or support-system mapping
- Identification of key relationships
- Connection between the map and treatment planning
- Attention to strengths and stressors
- Use of genogram or eco-map data to guide clinical reasoning

Facilitator prompt:

"Does the participant use mapping information to deepen the case formulation, or is it simply listed without clinical meaning?"

---

3. Intervention Selection and Rationale

This domain evaluates whether interventions are appropriate, intentional, and clearly connected to the client's needs and goals.

Look for:

- Intervention named clearly
- Intervention fits the presenting concern
- Rationale is stated or implied
- Intervention connects to treatment goals
- Note explains why this intervention was clinically appropriate

Facilitator prompt:

"Can we tell why this intervention was chosen for this client at this time?"

---

4. Supervision Process Skills

This domain evaluates the participant's ability to use supervision effectively and demonstrate supervision-related behaviors.

Look for:

- Reflection on clinical reasoning
- Openness to feedback
- Identification of consultation needs
- Awareness of limits of competence
- Ability to connect supervision feedback to improved practice

Facilitator prompt:

"Does the participant show evidence of learning, reflection, and responsible use of supervision?"

---

5. Documentation and Ethics

This domain evaluates whether the note is clinically clear, ethically appropriate, and sufficiently documented for continuity of care and review.

Look for:

- Medical necessity
- Risk assessment when relevant

- Client response to intervention
- Plan or next steps
- Confidentiality and appropriate detail
- No unnecessary or inappropriate information
- Clear distinction between clinical facts and interpretation

Facilitator prompt:
"Would this note support continuity of care, ethical practice, and reasonable review?"

III. Suggested Facilitation Flow
Step 1: Open the Activity
Time: 5 minutes
Explain the purpose of the evaluation exercise.
Suggested script:
"In this activity, we will evaluate two progress notes using a competency rubric. The goal is not perfection. The goal is calibration. We want to practice identifying what is clinically useful, what is missing, and what would make the note stronger across different supervision settings and jurisdictions."

Step 2: Review the Rubric
Time: 10 minutes
Walk participants through each rubric domain. Emphasize that scores should be based on observable evidence in the note, not assumptions about the clinician.
Suggested script:
"Score only what is visible in the documentation. If the clinician may have done something but did not document it, we cannot give full credit for it."

Step 3: Score Progress Note 1
Time: 15 minutes
Participants independently score the first note.
Ask them to identify:
- One strength
- One missing element
- One ethical or documentation concern
- One suggested revision

Facilitator prompt:
"What evidence in the note supports your score?"

Step 4: Group Calibration
Time: 10–15 minutes
Compare scores across participants. Discuss differences in scoring.
Ask:
- Where did scores cluster?
- Where did scores differ?
- What evidence did people use?

- Was the rubric language clear enough?
- Would this scoring hold up across different supervisors?

Facilitator emphasis:
"Rubric scoring becomes stronger when evaluators can explain their score with evidence."

Step 5: Score Progress Note 2
Time: 15 minutes
Repeat the process with a second note. Encourage participants to apply what they learned from the first calibration round.
Prompt:
"This time, pay close attention to intervention rationale, documentation ethics, and whether systemic formulation is actually visible."

Step 6: Collect Qualitative Feedback
Time: 10 minutes
Ask participants to complete a brief feedback form.
Suggested questions:

1. Which rubric domain was easiest to score?
2. Which domain was hardest to score?
3. What rubric language needs clarification?
4. What examples would help future participants?
5. What changes would make this tool more useful in actual supervision?

Step 7: Identify Rollout Revisions
Time: 10 minutes
Facilitator documents recommendations for improving the tool.
Focus on:

- Clarifying scoring anchors
- Adding examples
- Improving templates
- Standardizing prompts
- Addressing multi-state requirements
- Strengthening documentation expectations
- Identifying facilitator training needs

IV. Multi-State Facilitation Considerations
Because supervision rules vary across jurisdictions, facilitators should avoid presenting one state's rule as universal. Instead, use a portable structure that participants can adapt.
Facilitator Reminders
Before rollout, confirm that materials address:

- State supervision rules
- Documentation norms
- Scope of supervision versus therapy
- Confidentiality and consent in case discussions
- Telehealth and jurisdiction issues

- Escalation pathways for safety and risk
- Mandated reporting requirements
- Record storage and retention expectations

Suggested facilitator language:
"This template is a supervision training tool. Before using it in practice, adapt it to your state rules, agency policies, payer requirements, and professional code of ethics."

V. Standardized Feedback Language

Facilitators may use the following sentence stems during evaluation and discussion.

When a note is strong:
"This note is strong because the intervention, client response, and next step are clearly connected."

When a note lacks rationale:
"The intervention is named, but the clinical reason for choosing it is not yet clear."

When systemic formulation is weak:
"The note describes the individual concern, but it does not yet show how family, relational, cultural, or environmental factors shape the case."

When documentation is vague:
"This would be stronger if the note included observable details rather than broad clinical impressions."

When ethical documentation is needed:
"Because this involves risk, the documentation needs to show assessment, consultation if applicable, rationale, action taken, and follow-up."

When supervision use is missing:
"The note would be strengthened by identifying what the clinician brought to supervision or how supervision feedback informed the next step."

VI. Rollout Plan

Phase 1: Pilot
Use the rubric with two sample progress notes. Collect scores and qualitative feedback.
Pilot goal: Determine whether the rubric is understandable, usable, and clinically relevant.

Phase 2: Refine
Revise templates, prompts, and examples based on feedback.
Refinement goal: Improve clarity, scoring consistency, and ease of use.

Phase 3: Standardize
Create a facilitator guide, participant worksheet, sample scored notes, and QA checklist.
Standardization goal: Make the process repeatable across facilitators and settings.

Phase 4: Scale
Use the tool in training, supervision groups, documentation audits, or multi-state supervision preparation.
Scaling goal: Maintain quality while adapting to state-specific requirements.

QA Checklist
Evaluation & Rollout Quality Assurance

Program / Module: _____
Facilitator: _____
Date: _____
Training Format: ☐ Live ☐ Async ☐ Hybrid
State(s) / Jurisdiction(s): _____

A. Rubric Quality

QA Item	Yes	Needs Revision	Notes
Rubric domains are clearly defined.	☐	☐	
Scoring anchors are observable and measurable.	☐	☐	
Rubric avoids vague or subjective language.	☐	☐	
Each domain connects to clinical supervision competence.	☐	☐	
Rubric can be used with different progress notes or cases.	☐	☐	
Rubric supports both formative feedback and summative review.	☐	☐	
Rubric includes documentation and ethics.	☐	☐	
Rubric can identify strengths and remediation needs.	☐	☐	

B. Competency Domains

Domain	Included	Clear	Needs Example
Systemic formulation quality	☐	☐	☐
Use of genogram / eco-map	☐	☐	☐
Intervention selection and rationale	☐	☐	☐
Supervision process skills	☐	☐	☐
Documentation and ethics	☐	☐	☐
Risk assessment, if applicable	☐	☐	☐
Cultural/contextual responsiveness	☐	☐	☐
Client response and follow-up plan	☐	☐	☐

C. Progress Note Evaluation Activity

QA Item	Yes	Needs Revision	Notes
Two progress notes are available for scoring.	☐	☐	
Notes are fictional or fully de-identified.	☐	☐	
Participants receive clear scoring instructions.	☐	☐	
Participants are asked to cite evidence for scores.	☐	☐	
Activity includes individual scoring.	☐	☐	
Activity includes group calibration.	☐	☐	

QA Item	Yes	Needs Revision	Notes
Activity includes qualitative feedback.	☐	☐	
Facilitator documents common scoring discrepancies.	☐	☐	

D. Multi-State Considerations

QA Item	Yes	Needs Revision	Notes
Materials remind users to verify state supervision rules.	☐	☐	
Documentation norms are identified as jurisdiction-dependent.	☐	☐	
Scope of supervision versus therapy is clearly stated.	☐	☐	
Consent and confidentiality in case discussions are addressed.	☐	☐	
Telehealth and client-location issues are addressed if relevant.	☐	☐	
Escalation pathways for safety/risk are included.	☐	☐	
Mandated reporting language is not presented as one-size-fits-all.	☐	☐	
Materials advise consultation with board, agency, or legal resources when needed.	☐	☐	

E. Facilitator Readiness

QA Item	Yes	Needs Revision	Notes
Facilitator understands the rubric domains.	☐	☐	
Facilitator can explain scoring anchors.	☐	☐	
Facilitator has sample language for feedback.	☐	☐	
Facilitator can distinguish coaching from evaluation.	☐	☐	
Facilitator can manage scoring disagreements.	☐	☐	
Facilitator can identify ethical documentation concerns.	☐	☐	
Facilitator can address multi-state limitations appropriately.	☐	☐	
Facilitator knows how to collect and summarize feedback.	☐	☐	

F. Template and Prompt Quality

QA Item	Yes	Needs Revision	Notes
Templates are clear and easy to use.	☐	☐	
Prompts are specific and clinically relevant.	☐	☐	
Examples are standardized across training materials.	☐	☐	
Forms avoid unnecessary complexity.	☐	☐	
Instructions are written in plain language.	☐	☐	

QA Item	Yes	Needs Revision	Notes
Handouts are consistent with slide content.	☐	☐	
Participant deliverables are clearly identified.	☐	☐	
Materials are ready for reuse across cohorts.	☐	☐	

G. Feedback and Revision Log
Common participant questions:

Rubric domains needing clarification:

Examples that should be added:

Templates or prompts needing revision:

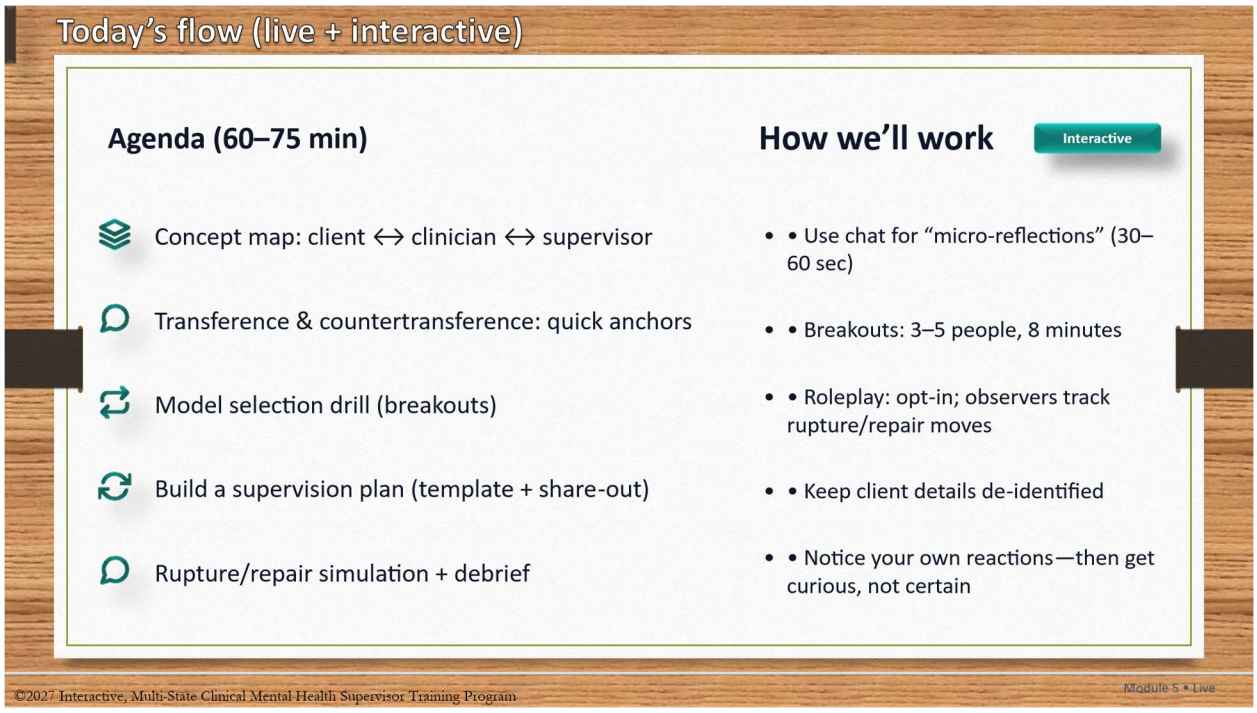
Multi-state concerns identified:

Recommended revisions before next rollout:

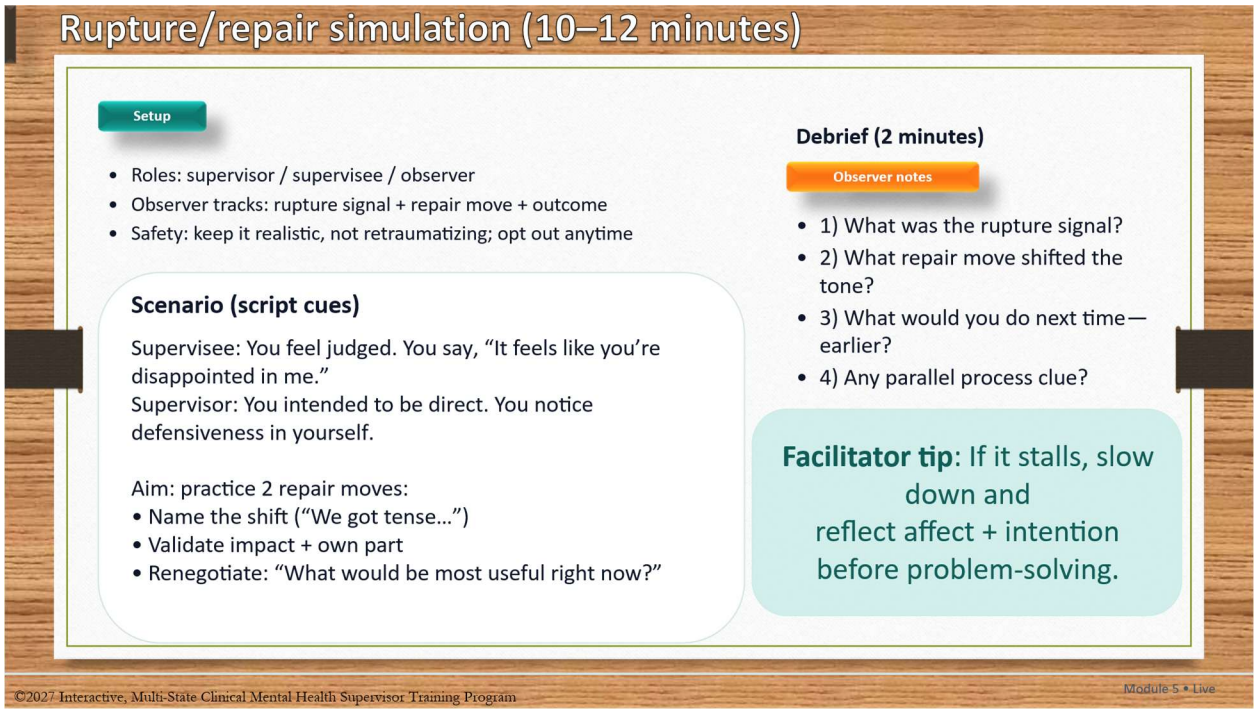
H. Final QA Sign-Off
Ready for rollout?
☐ Yes
☐ Yes, with minor revisions
☐ No, significant revision needed
Facilitator / Reviewer: _____
Date: _____
Notes:

Module 5 Handouts/Instructions

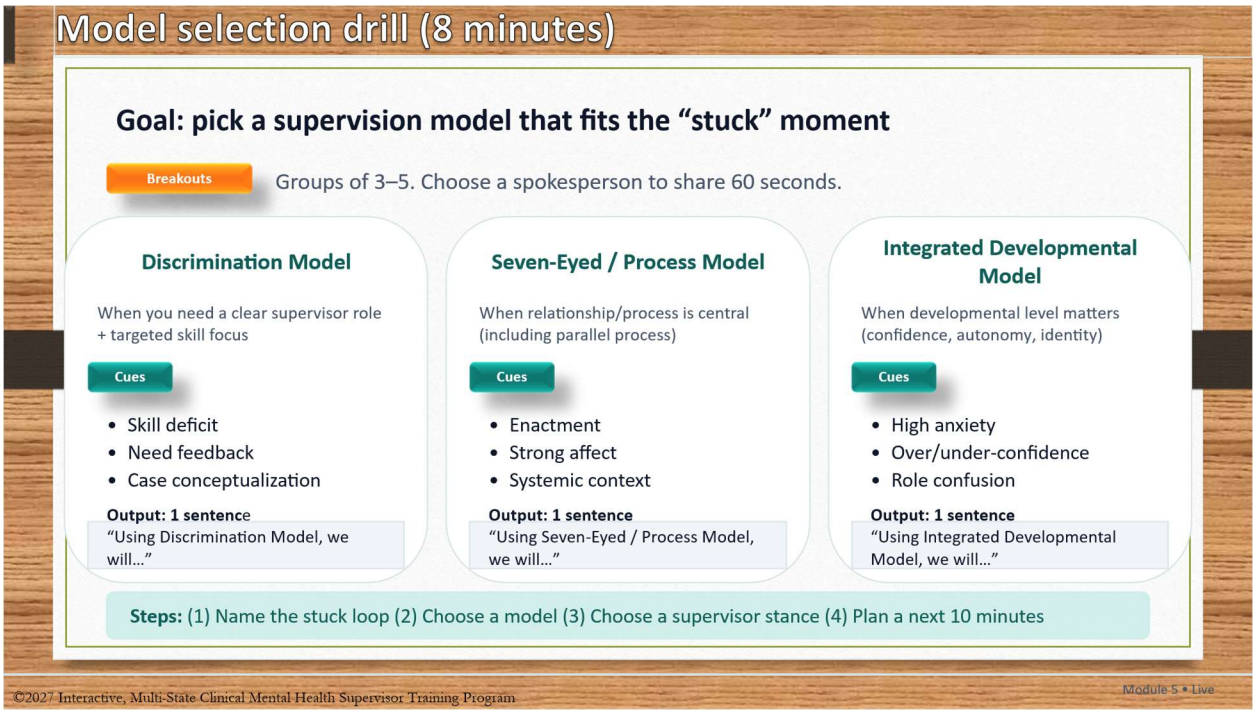
Agenda



Rupture/Repair Simulation



Model Selection Drill



Drill Explained

This slide introduces an **8-minute model selection drill** designed to help supervisors choose the best supervision model when a supervision session feels "stuck." The goal is not to discuss every possible model in depth, but to quickly identify what kind of stuck moment is happening and then select a model that gives the supervisor a clear next step.

The activity works best in **small breakout groups of 3–5 people**. Each group chooses a spokesperson who will report back in about 60 seconds. The group's task is to look at the supervision problem, name what is stuck, choose one supervision model, identify the supervisor's stance, and plan what the next 10 minutes of supervision should look like. The slide gives three model options.

The **Discrimination Model** is the best fit when the supervisor needs to choose a clear role and target a specific supervision focus. This model is useful when the supervisee has a skill deficit, needs direct feedback, or is struggling with case conceptualization. The supervisor may need to move into a teacher role, counselor role, or consultant role depending on what the supervisee needs. For example, the group might say, "Using the Discrimination Model, we will take a teacher stance and model how to ask a direct suicide-risk follow-up question."

The **Seven-Eyed / Process Model** is the best fit when the relationship, emotional process, or parallel process is central. This model helps supervisors look beyond the surface issue and examine what is happening between client and counselor, counselor and supervisor, or within the

broader system. It is especially useful when there is strong affect, enactment, avoidance, tension, or systemic complexity. For example, the group might say, “Using the Seven-Eyed / Process Model, we will explore how the supervisee’s frustration with the client may be repeating in supervision.”

The **Integrated Developmental Model** is the best fit when the supervisee’s developmental level matters. This model helps the supervisor adjust structure, support, and autonomy based on the supervisee’s confidence, competence, identity development, and readiness. It is especially useful when the supervisee is anxious, overconfident, underconfident, or confused about their role. For example, the group might say, “Using the Integrated Developmental Model, we will provide more structure and reassurance while helping the supervisee practice one concrete intervention.” The bottom of the slide gives the four steps for the exercise: **name the stuck loop, choose a model, choose a supervisor stance, and plan the next 10 minutes.** In other words, participants are not just naming a theory; they are using the theory to guide immediate supervisory action.

Each Model Explained

1. Discrimination Model

The **Discrimination Model** helps the supervisor decide **what to focus on** and **which supervisory role to use** in the moment. It is especially useful when the supervisee is stuck because of a skill gap, unclear case conceptualization, or need for direct feedback.
This model asks the supervisor to choose both a **focus** and a **role**.

The three common focus areas are:

Intervention skills: What the supervisee is doing in session.
Example: “How did you respond when the client disclosed suicidal thoughts?”

Case conceptualization: How the supervisee understands the client, diagnosis, treatment direction, or presenting problem.
Example: “What do you think is maintaining this client’s anxiety?”

Personalization/process: How the supervisee’s own reactions, anxiety, values, or relational patterns may be affecting the work.
Example: “What happened inside you when the client became angry?”
The supervisor also chooses a role:

Teacher: Provides instruction, modeling, or correction.

Counselor: Helps the supervisee reflect on emotional reactions that affect clinical work.

Consultant: Collaborates with the supervisee to think through options.

This model is useful because it gives the supervisor a quick way to respond to the supervisee's actual need. For example: "Using the Discrimination Model, I will take a teacher role and focus on intervention skills by modeling how to ask a direct risk-assessment question."

---

2. Seven-Eyed / Process Model

The **Seven-Eyed Model**, also called a **process model**, helps the supervisor look at the relationship patterns and emotional processes happening in the case and in supervision. It is especially useful when the issue is not simply a skill deficit, but something relational, emotional, systemic, or parallel.

This model is helpful when there is:

Strong emotion
Avoidance
Defensiveness
Confusion
Parallel process
Relational tension
Cultural or systemic complexity

The model encourages the supervisor to look at several "eyes" or areas of focus, such as the client, the supervisee's interventions, the client-supervisee relationship, the supervisee's emotional response, the supervisor-supervisee relationship, the supervisor's own response, and the broader system.
For example, a supervisee may feel frustrated with a client who "never follows through." Then, in supervision, the supervisor may begin feeling frustrated with the supervisee for the same reason. That may be a **parallel process**. The dynamic between client and counselor may be repeating between supervisee and supervisor.

A supervisor using this model might say: "Using the Seven-Eyed / Process Model, we will explore what is happening relationally between the client and supervisee, and whether that same pattern is showing up in supervision."

This model is especially useful when supervision needs to slow down and ask, "What process is happening here?"

---

3. Integrated Developmental Model

The **Integrated Developmental Model** focuses on the supervisee's growth level. It helps the supervisor adjust structure, support, feedback, and autonomy based on the supervisee's current stage of development.

This model is useful when the supervisee's confidence, competence, identity, or independence is the main issue.

Beginning supervisees often need more:

- Structure
- Direction
- Modeling
- Reassurance
- Frequent feedback
- Close monitoring

Intermediate supervisees may need help with:

- Fluctuating confidence
- Developing independence
- Managing anxiety
- Strengthening case conceptualization
- Integrating feedback

Advanced supervisees often need more:

- Autonomy
- Consultation
- Professional identity development
- Complex case discussion
- Leadership preparation

This model reminds the supervisor that the same intervention will not fit every supervisee. A new supervisee may need step-by-step instruction, while a more advanced supervisee may need collaborative consultation.

For example: "Using the Integrated Developmental Model, we will provide more structure because the supervisee is anxious and underconfident, but we will also ask them to identify one intervention they would try before the supervisor gives direction."

This model is especially useful when asking, "How much structure and autonomy does this supervisee need right now?"

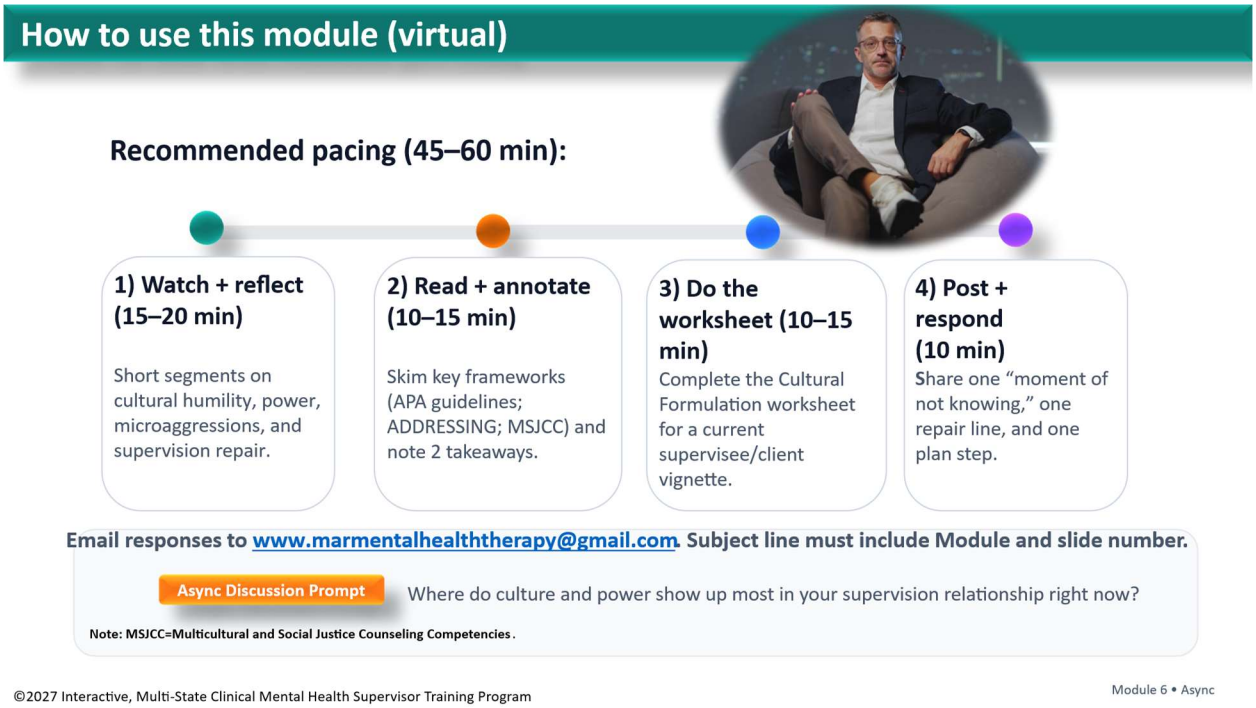
Quick Comparison

Model	Best Used When	Main Question
Discrimination Model	The supervisee needs a clear focus, role, or skill direction	"What should I focus on, and what role should I take?"
Seven-Eyed / Process Model	Relationship dynamics, emotion, or parallel process are central	"What process is happening beneath the surface?"
Integrated Developmental Model	The supervisee's developmental level affects the supervision need	"How much structure, support, and autonomy does this supervisee need?"

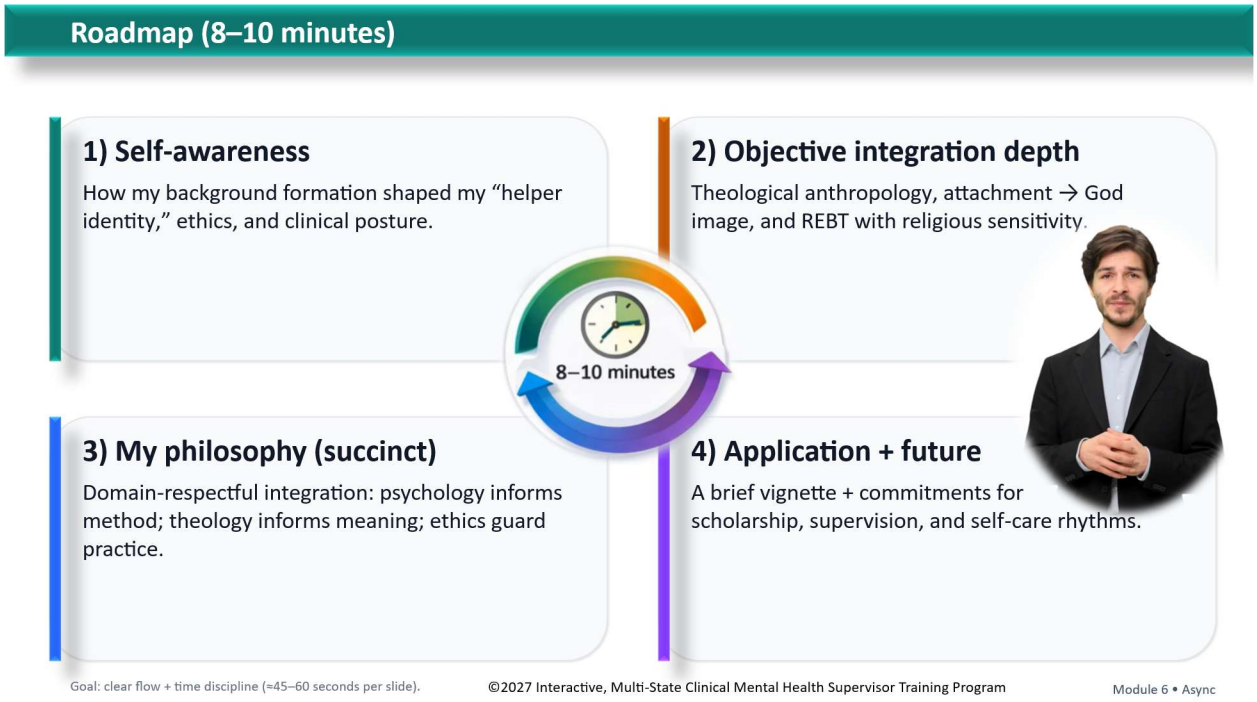
Together, these models help the supervisor move from theory to action. The supervisor identifies the stuck point, chooses the model that best fits the moment, selects a supervisory stance, and plans the next 10 minutes of supervision.

Module 6 Handouts/Instructions

Course Overview



Roadmap: Create Your Own



Roadmap: **[Insert Timeframe]**

Purpose of this segment:
This roadmap provides a clear overview of the presentation flow, key content areas, and pacing expectations.

---

1) [Section Title]
Focus:
[Briefly describe the first topic or opening area.]
Key takeaway:
[What should participants understand from this section?]
Time: _____ minutes

---

2) [Section Title]
Focus:
[Briefly describe the second major topic.]
Key takeaway:
[What should participants understand from this section?]
Time: _____ minutes

---

3) [Section Title]
Focus:
[Briefly describe the third topic or applied discussion area.]
Key takeaway:
[What should participants understand from this section?]
Time: _____ minutes

---

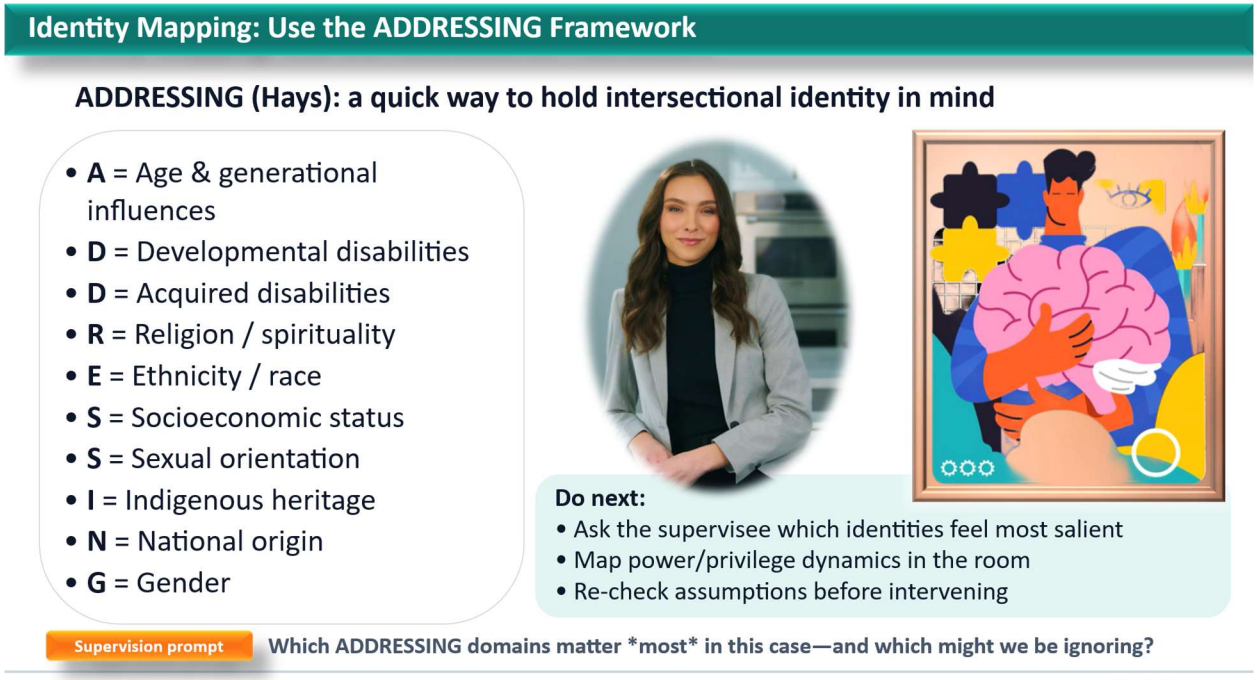
4) [Section Title]
Focus:
[Briefly describe the final application, synthesis, or future-oriented section.]
Key takeaway:
[What should participants understand from this section?]
Time: _____ minutes

Overall Goal
By the end of this segment, participants should be able to:

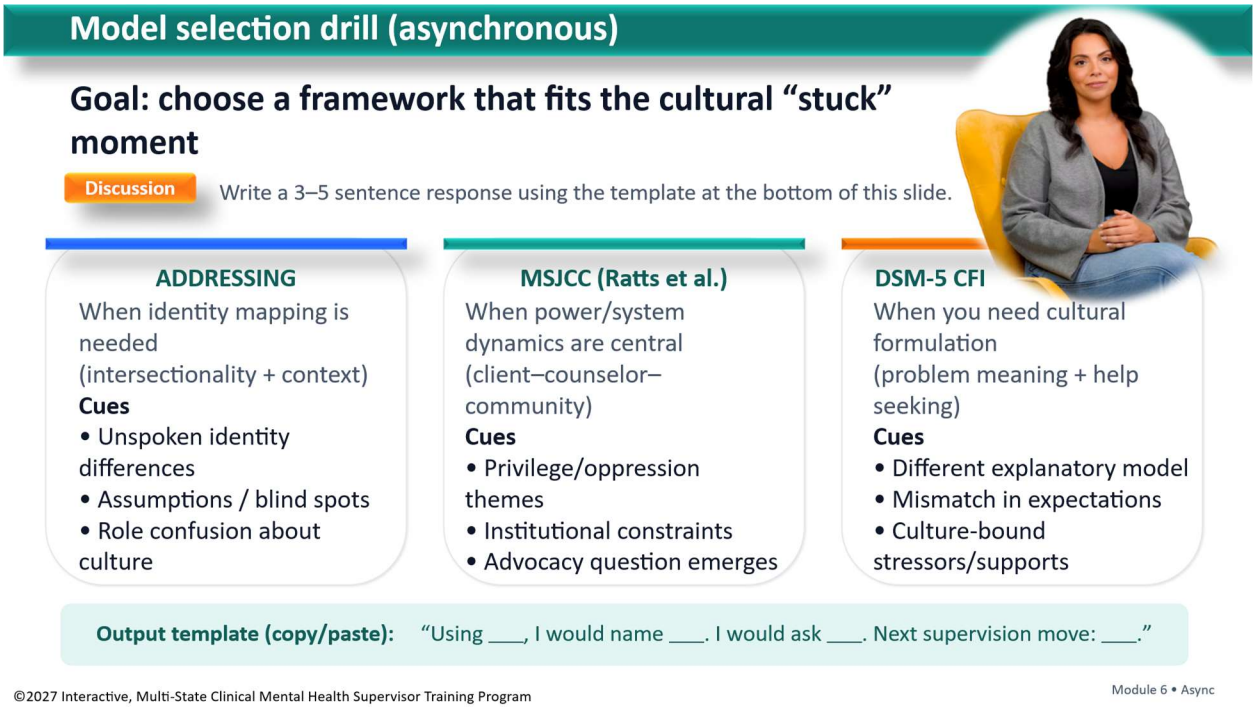
1. _____
2. _____
3. _____

Presenter Pacing Note
Total time: _____ minutes
Recommended pacing: _____ seconds/minutes per section
Transition statement:
"Today's roadmap will move from _____, to _____, then _____, and conclude with _____."

Identity Mapping



Model Selection



Models Explained

1. ADDRESSING Model

The **ADDRESSING Model** is used when the supervisor needs to help the supervisee map identity, culture, and context more intentionally. It is especially helpful when cultural factors are present but have not been clearly named.
ADDRESSING encourages the supervisor and supervisee to consider multiple areas of identity, such as age, disability, religion/spirituality, ethnicity, socioeconomic status, sexual orientation, Indigenous heritage, national origin, and gender. The goal is not to reduce a client to identity categories, but to help the supervisee notice what may be shaping the client's experience, the counseling relationship, and the supervisee's own assumptions.
This model is useful when there are **unspoken identity differences**, **blind spots**, or **role confusion about culture**. For example, a supervisee may say, "I do not think culture is relevant in this case," but the client's immigration history, faith background, military experience, or family expectations may be central to treatment. The supervisor might respond by saying, "Using ADDRESSING, I would name the possible unspoken identity factors and ask which identities may be shaping the client's experience of help, trust, and authority."
Best use: When the supervision conversation needs broader identity mapping and cultural self-awareness.

2. MSJCC Model

Multicultural and Social Justice Counseling Competencies

The **MSJCC model** is useful when the "stuck" moment involves power, privilege, oppression, institutional barriers, advocacy, or systemic context. This model moves beyond individual culture and asks how social systems affect the client, counselor, supervision process, and access to care. MSJCC helps supervisors ask questions such as: What power dynamics are operating here? What institutional barriers may be affecting the client? Is the supervisee focusing only on individual symptoms while missing systemic stressors? Does this case require advocacy, coordination, or attention to inequity?

This model is especially helpful when there are **privilege/oppression themes**, **institutional constraints**, or an **advocacy question**. For example, a client may be labeled "noncompliant," but the larger issue may involve transportation barriers, lack of insurance coverage, discrimination, language access, or fear of systems. The supervisor might guide the supervisee to consider whether the treatment plan needs to include advocacy, resource connection, or adjustment of expectations.

A sample response might be: "Using MSJCC, I would name the institutional barriers affecting this client's engagement. I would ask how power, access, and systemic stressors are shaping the client's choices. The next supervision move is to identify one advocacy-informed intervention."

Best use: When culture is connected to power, systems, access, oppression, privilege, or advocacy.

---

3. DSM-5 Cultural Formulation Interview

The **DSM-5 Cultural Formulation Interview**, or **CFI**, is helpful when the supervisor and supervisee need to understand the client's own explanation of the problem. It focuses on how the client understands their distress, what they believe caused it, what kind of help they expect, what supports matter, and what barriers may affect care.

This model is especially useful when the client and counselor have different explanatory models. For example, the counselor may view the concern as depression, while the client may understand it as spiritual distress, family conflict, grief, cultural disconnection, or physical exhaustion. The CFI helps the supervisee slow down and ask, "What does this problem mean to the client?"

It is useful when there is a **mismatch in expectations**, a **different explanatory model**, or **culture-bound stressors and supports**. For example, a client may not want individual therapy because they see healing as something that happens through family, faith community, elders, or collective support. The supervisor might say, "Using the DSM-5 CFI, I would ask how the client explains the problem and what kind of help they believe would be most useful."

Best use: When the supervisee needs to understand the client's cultural meaning-making, help-seeking expectations, and preferred supports.

Quick Comparison

Model	Best Used When	Main Question
ADDRESSING	Identity and cultural context need to be mapped	"What identities and contexts are shaping this case?"

Model	Best Used When	Main Question
MSJCC	Power, oppression, privilege, access, or advocacy are central	"What systems and power dynamics are affecting the client and counseling process?"
DSM-5 CFI	The client's meaning of the problem or help-seeking expectations are unclear	"How does the client understand the problem, and what help makes sense to them?"

Together, these models help supervisors avoid treating culture as an afterthought. **ADDRESSING** helps identify cultural and identity factors. **MSJCC** helps examine power and systems. **DSM-5 CFI** helps understand the client's own meaning-making and expectations for care.

Scenario (drill)

Scenario (drill): "I don't want to say the wrong thing"

Scenario

- A supervisee is working with a client whose cultural and religious background differs from theirs.
- The client describes family expectations and discrimination stress; the supervisee becomes careful, quiet, and avoids asking direct questions.
- In supervision, the supervisee says: "I'm afraid I'll offend them. Can you tell me what to say?"

Your response should include:

1) What cultural/power dynamic might be operating?
2) Which model fits best right now (ADDRESSING, MSJCC, or CFI)? Why?
3) One repair/permission line you would use in supervision
4) Two questions the supervisee could ask the client next session

Email responses to www.marmentalhealththerapy@gmail.com. Subject line must include Module and slide number.

Post requirements

- 1. Name the model.
- 2. Name the dynamic
- 3. Ask 1 focus question
- 4. Identify next supervisory action

4. Copy/paste template

- Using ___, I would name ___.
- I would ask ___.
- Next move: ___.

Cultural Formulation Interview Template

Cultural Formulation Interview (CFI) worksheet (template)

Use this to structure supervision discussion (adapt from DSM-5 CFI).

1) Cultural identity	How does the client describe their identities and what is most salient now?
2) Problem meaning	How does the client explain the problem? What matters most about it?
3) Stressors + supports	Cultural stressors, discrimination, community supports, strengths.
4) Help seeking	What kinds of help are acceptable? What has helped before?
5) Relationship factors	Where might culture/power show up between client–clinician and clinician–supervisor?

Email responses to www.marmentalhealththerapy@gmail.com. Subject line must include Module and slide number.

Wrap Up/Deliverables

Wrap-Up: take this into your next supervision session

Three Takeaways

- • Name culture and power as part of the clinical "here-and-now."
- • Treat strong reactions as data; ask about impact before intent.
- • Rupture is common; repair is a learnable supervision skill.

Homework (choose 1)

- 1) Add a 60-second identity + power check to your opening.
- 2) Use the worksheet for one case and post 3 bullets.
- 3) Practice one repair line: "Something shifted—can we reset?"

Core References

- • APA Multicultural Guidelines (2017)
- • Tervalon & Murray-Garcia: cultural humility
- • DSM-5 Cultural Formulation Interview (CFI)
- • MSJCC competencies (Ratts et al.)
- • Sue et al.: microaggressions
- • ADDRESSING framework (Hays)

Email responses to www.marmentalhealththerapy@gmail.com.
Subject line must include Module and slide number.

Module 6 • Async

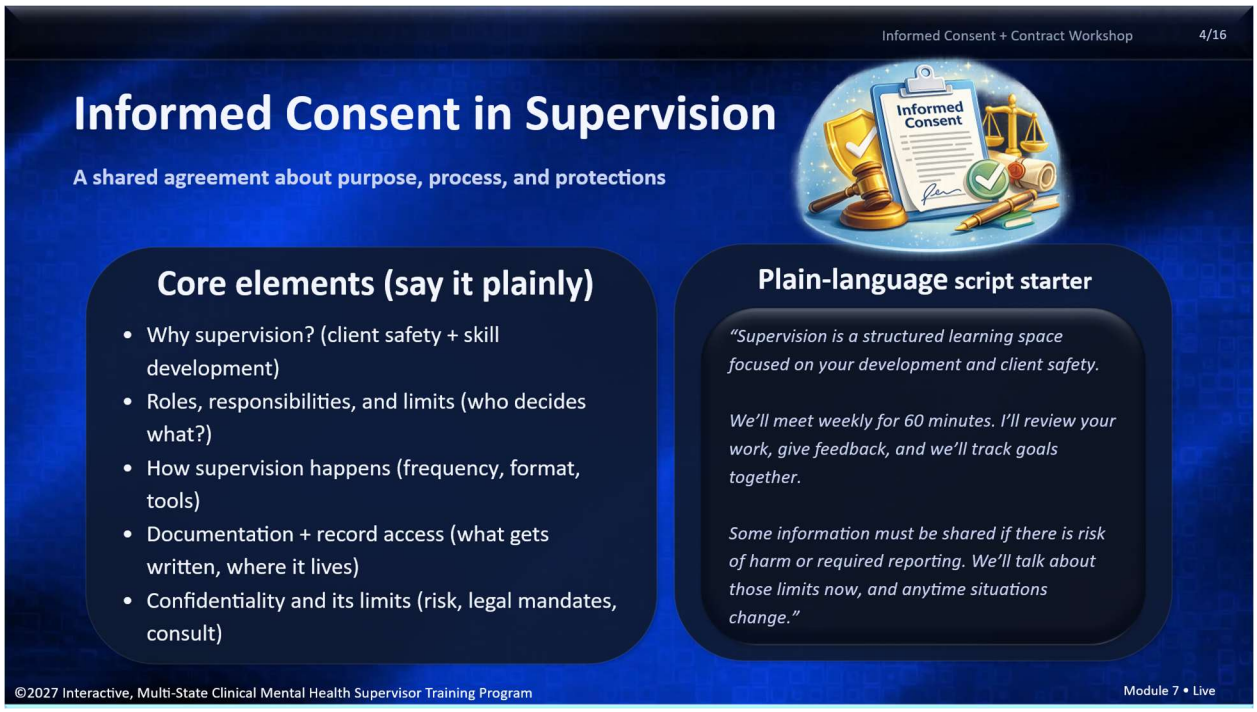
Module 7 Handouts/Instructions

Live agenda

A fast, practical build—bring your draft packet if you have one

Time	Activity	Output
0–10	Warm start + consent essentials	What is "informed consent" in supervision?
10–30	Contract packet workshop	Build/verify sections using the checklist
30–50	Model selection drill	Choose a supervision model for a case vignette
50–70	Supervision plan build	Draft a 90-day plan (goals, methods, evaluation)
70–75	Commit + close	Next steps and handoff

Informed Consent in Supervision



Informed Consent Template

Informed Consent for Clinical Mental Health Supervision

Supervisor Name: [Supervisor Name, Credentials]
Practice/Organization: [Practice or Agency Name]
Address: [Street Address, City, State, ZIP]
Phone: [Phone Number]
Email: [Email Address]
Website: [Website, if applicable]
Effective Date: [Date]

---

1. Purpose of Clinical Supervision
Clinical supervision is a professional, educational, evaluative, and administrative relationship designed to support the supervisee's development as a competent, ethical, and legally compliant mental health professional.
The purpose of supervision is to assist the supervisee in developing clinical judgment, ethical decision-making, case conceptualization, treatment planning, documentation skills, risk assessment skills, cultural humility, professional identity, and readiness for independent practice when applicable.

Supervision is not psychotherapy for the supervisee. Personal issues may be discussed only as they relate to professional development, clinical work, countertransference, boundaries, client care, ethical practice, or impairment concerns.

---

2. Supervisor Qualifications
Supervisor Name: [Name]
Degrees/Credentials: [Degrees, licenses, certifications]
Licensure:

- [State] — [License Type], License #[License Number]
- [State] — [License Type], License #[License Number]
- [State] — [License Type], License #[License Number]

Approved Supervisor Status, if applicable:

- [State/Board/Certification] — [Status or Credential]
- [State/Board/Certification] — [Status or Credential]

The supervisor agrees to provide supervision within the limits of applicable state laws, board rules, ethical standards, professional competence, and scope of practice.

---

3. Nature of the Supervision Relationship
The supervision relationship includes support, instruction, consultation, evaluation, and oversight. Supervision may include discussion of client cases, documentation review, ethical and legal issues, clinical interventions, diagnostic impressions, risk concerns, cultural considerations, telehealth practice, and professional development.
Supervision may include:

- Case consultation.
- Review of progress notes, assessments, treatment plans, and discharge summaries.
- Review of risk assessment, safety planning, and mandated reporting concerns.
- Discussion of ethical decision-making.
- Feedback on clinical skills and professional conduct.
- Review of scope of practice and competence.
- Development of goals and remediation plans when needed.
- Evaluation of readiness for continued clinical practice or independent licensure.

---

4. Supervisee Responsibilities
The supervisee agrees to:

1. Practice only within the limits of applicable law, ethics, competence, training, and supervision requirements.
2. Attend supervision as scheduled and arrive prepared.
3. Present clinical cases honestly, accurately, and in a timely manner.
4. Inform the supervisor promptly of client risk, crisis situations, mandated reporting concerns, ethical issues, complaints, documentation concerns, or possible impairment.
5. Maintain accurate and timely clinical documentation.
6. Protect client confidentiality and use the minimum necessary client information in supervision.
7. Follow agency, employer, payer, and licensing board requirements.
8. Seek consultation before acting outside the supervisee's competence or scope.

9. Follow supervisor direction when client safety, ethical compliance, or legal compliance requires it.
10. Maintain records of supervision hours if required for licensure.
11. Notify the supervisor of any change in licensure status, employment setting, client population, board requirements, or legal/ethical concerns.

---

5. Supervisor Responsibilities

The supervisor agrees to:

1. Provide supervision in a professional, ethical, and respectful manner.
2. Support supervisee growth and clinical skill development.
3. Monitor client welfare and supervisee practice.
4. Provide feedback regarding clinical strengths and areas for growth.
5. Review documentation and clinical decision-making as appropriate.
6. Assist the supervisee in identifying ethical, legal, cultural, and clinical concerns.
7. Provide direction when client safety or legal/ethical compliance requires it.
8. Maintain appropriate supervision records.
9. Complete required supervision forms or evaluations when applicable.
10. Address performance concerns through feedback, consultation, documentation, or remediation when needed.
11. Report concerns to appropriate parties when required by law, board rule, ethical code, agency policy, or client safety considerations.

---

6. Evaluation and Feedback

Supervision includes ongoing evaluation. Feedback may be informal, formal, verbal, or written. Evaluation may address clinical knowledge, ethical judgment, professional behavior, documentation quality, risk management, cultural responsiveness, boundaries, scope of practice, and readiness for increased independence.

Evaluation methods may include:

- Case discussion.
- Documentation review.
- Review of treatment plans and clinical assessments.
- Observation or review of recorded sessions, if applicable and properly consented.
- Competency checklists.
- Supervision logs.
- Written evaluations required by licensing boards or agencies.
- Remediation plans when needed.

If significant concerns arise, the supervisor may develop a written remediation plan. A remediation plan may include specific goals, required actions, timelines, additional training, increased supervision, documentation requirements, consultation, or referral for additional support.

---

7. Confidentiality in Supervision

Supervision is confidential within professional, ethical, legal, and administrative limits. Information discussed in supervision may include client information, supervisee development, clinical performance, ethical concerns, documentation issues, and professional conduct.

Because supervision is evaluative and involves responsibility for client welfare, confidentiality is not absolute.
Information from supervision may be shared when necessary with:

- Licensing boards.
- Employers or agencies.
- Credentialing bodies.
- Courts or legal authorities.
- Emergency or crisis responders.
- Other professionals involved in consultation or client care.
- Payers, auditors, or compliance reviewers when required.

---

8. Limits of Confidentiality
The supervisor may be required to disclose information if there is:

- Risk of harm to self or others.
- Suspected abuse, neglect, exploitation, or mandatory reporting concern.
- Client safety concern.
- Unethical, illegal, impaired, or incompetent practice.
- Practice outside the supervisee's scope or competence.
- Failure to follow required supervision or board rules.
- Court order, subpoena, audit, investigation, or licensing board request.
- Documentation or compliance concern requiring agency or board involvement.

The supervisor will make reasonable efforts to discuss concerns with the supervisee before disclosure when appropriate and legally permissible.

---

9. Client Confidentiality and Protected Health Information
Supervisees are responsible for protecting client confidentiality at all times. Client information discussed in supervision should be limited to the minimum necessary information needed for clinical consultation, supervision, documentation, and client safety.
Supervisees must follow:

- HIPAA requirements, when applicable.
- State confidentiality laws.
- Agency or employer policies.
- Licensing board rules.
- Professional ethical standards.
- Telehealth privacy requirements.

Supervisees should not send client-identifying information through unsecured email, text message, personal devices, or unapproved platforms.

---

10. Crisis, Risk, and Emergency Procedures
Supervision is not a substitute for emergency services. If a client presents with imminent risk, medical instability, active suicidality, homicidality, abuse/neglect concerns, psychosis requiring emergency evaluation, or another urgent safety issue, the supervisee must follow agency crisis procedures and applicable law immediately.
The supervisee agrees to:

1. Assess risk promptly and document the assessment.

2. Follow agency/employer emergency procedures.
3. Contact emergency services, crisis lines, mobile crisis teams, or law enforcement when clinically necessary.
4. Consult with the supervisor as soon as safely possible.
5. Document consultation, actions taken, safety planning, and follow-up.
6. Not wait for routine supervision when immediate action is required.

Supervisor Emergency Contact Procedure:
Phone: [Phone Number]
Backup Contact/Procedure: [Insert Procedure]
Expected Response Time: [Insert Response Time, if applicable]

---

11. Telehealth Supervision and Technology
Supervision may occur by secure video, phone, or other approved technology when permitted by law, board rule, and agency policy.
Both supervisor and supervisee agree to:

- Participate from a private location.
- Use secure technology whenever possible.
- Protect client confidentiality.
- Avoid recording supervision unless all parties have given permission and applicable policies allow it.
- Have a backup plan if technology fails.
- Verify any jurisdictional rules related to telehealth supervision.

Technology Failure Plan:
If video or audio connection fails, the supervisor and supervisee will attempt to reconnect. If reconnection is not possible, the supervisor may contact the supervisee by phone or reschedule the supervision session as clinically appropriate.

---

12. Use of Artificial Intelligence and Digital Tools
The supervisor may use secure and clinically appropriate digital tools, including AI-assisted drafting tools, for limited administrative or educational purposes such as preparing supervision agendas, documentation templates, training materials, or supervision note structures.
AI does not replace supervisory judgment, clinical expertise, ethical responsibility, or legal compliance. All AI-assisted content must be reviewed and finalized by the supervisor.
Supervisees may not enter client-identifying information, protected health information, or confidential agency information into AI tools unless the tool is specifically approved by the supervisee's organization and meets all required privacy and security standards.

---

13. Fees, Payment, and Attendance
Fee Schedule:
Individual supervision: $_____ per _____ minutes
Group supervision: $_____ per _____ minutes
Documentation review/consultation: $_____
Late cancellation/no-show fee: $_____
Payment is due: [At time of service / monthly / by invoice / other].

Supervisees are expected to attend scheduled supervision consistently. Missed sessions may affect licensure hour tracking, board compliance, client safety, or continuation of the supervision relationship.

Cancellation Policy:

Supervisees are expected to provide at least _____ hours' notice for cancellations unless there is an emergency.

---

14. Records and Supervision Documentation

The supervisor may maintain supervision records, including:

- Dates and duration of supervision.
- Format of supervision.
- Topics discussed.
- Cases reviewed.
- Risk or ethical concerns.
- Documentation reviewed.
- Feedback provided.
- Evaluation forms.
- Remediation plans, if applicable.
- Licensure verification forms, when applicable.

Supervision records may be retained according to state law, licensing board requirements, agency policy, or professional best practices.

---

15. Boundaries and Dual Relationships

The supervision relationship is professional and evaluative. The supervisor and supervisee agree to maintain appropriate professional boundaries.

Potential dual relationships, conflicts of interest, or role conflicts should be discussed as early as possible. If a conflict arises that could impair objectivity, evaluation, client care, or supervisee development, the supervisor may consult, modify the supervision arrangement, or refer the supervisee to another supervisor when appropriate.

---

16. Consultation and Referral

The supervisor may consult with other qualified professionals when needed to support ethical practice, client safety, legal compliance, or supervisee development. When possible, client and supervisee information will be de-identified unless disclosure is required or authorized.

The supervisor may recommend referral or additional consultation when:

- A client's needs exceed the supervisee's competence or scope.
- A case requires specialized care.
- A risk issue requires higher-level intervention.
- The supervisee needs additional training or support.
- The supervisor is not the appropriate person to provide oversight for a particular issue.

---

17. Complaints or Concerns

Supervisees are encouraged to discuss concerns about supervision directly with the supervisor when appropriate. If a concern cannot be resolved, the supervisee may contact the relevant agency, employer, credentialing organization, or licensing board.

Supervisor Contact: [Insert Contact Information]
Agency/Employer Contact, if applicable: [Insert Contact Information]
Licensing Board Contact, if applicable: [Insert Contact Information]

---

18. Voluntary Agreement and Right to End Supervision
Participation in supervision is voluntary unless required by employer, agency, board, or licensure requirements. Either the supervisor or supervisee may end the supervision relationship, subject to ethical duties, client welfare, board rules, documentation requirements, and any written supervision agreement.
When possible, termination of supervision should include a transition plan, final documentation, completion of required forms, and referral to another supervisor if needed.

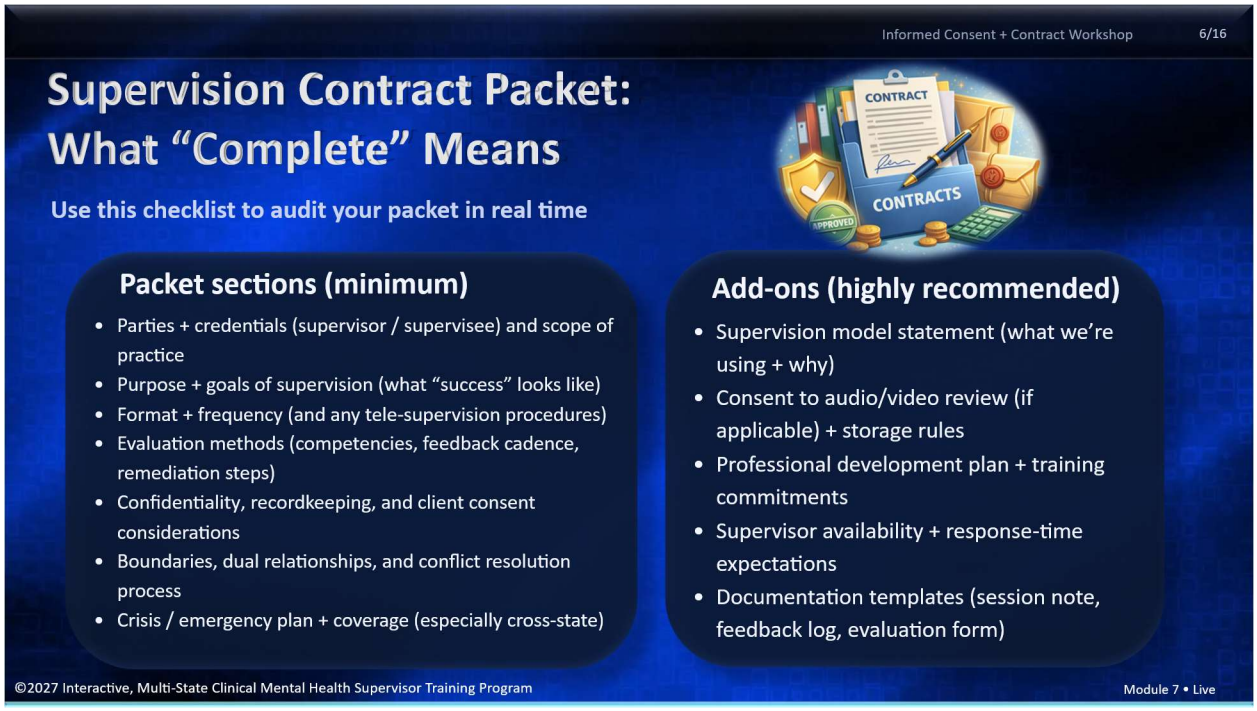
Consent to Participate in Clinical Supervision
By signing below, I confirm that:

- I have read this informed consent for clinical supervision.
- I have had the opportunity to ask questions.
- I understand the nature, purpose, risks, benefits, and limits of supervision.
- I understand that supervision is evaluative and is not psychotherapy.
- I understand the limits of confidentiality.
- I understand my responsibilities as a supervisee.
- I understand the supervisor's responsibilities.
- I understand the expectations for risk management, documentation, telehealth, fees, and professional conduct.
- I voluntarily agree to participate in clinical supervision under the terms described in this document.

Supervisee Name Printed: _____
Supervisee Signature: _____
Date: _____

Supervisor Name Printed: _____
Supervisor Signature: _____
Date: _____

Supervision Contract Packet



Clinical Supervision Contract (Multi-State) Template

This contract establishes the supervision relationship between the Supervisor and Supervisee for the purpose of promoting ethical, competent clinical practice and professional development. It is intended for multi-state use and must be adapted to the supervisor's/supervisee's discipline(s), setting policies, payer requirements, and the jurisdiction(s) in which services are delivered.

A. Contract Summary

Item	Details
Supervisor	**Name:** [ ] **Credentials:** [ ] **License:** [Type/State/Number] **NPI (if relevant):** [ ]
Supervisee	**Name:** [ ] **Credential status:** [Associate/Intern/Resident/Provisional/Other] **Registration # (if relevant):** [ ]
Setting	[Agency / Private practice / Group practice / Integrated care / Telehealth]
Practice locations / modality	[In-person sites] and/or [Telehealth states served]
Effective dates	[Start date] – [End date]
Supervision frequency/format	[e.g., 60 minutes weekly individual; 90 minutes biweekly group; plus ad hoc consult]
Supervision methods	[Case review; live observation; audio/video review; co-therapy; chart review; standardized measures review]

Item	Details
Documentation system	[EHR name / Supervision log location / secure drive]
Emergency escalation protocol	**How/when to contact:** [ ] **After-hours plan:** [ ] **Back-up supervisor:** [ ]
Fees (if applicable)	[$]/[session] **Payment terms:** [ ] **Late fee:** [ ]
Cancellation policy	[Notice required] **No-show:** [fee/expectations]

---

1. Purpose and Scope of Supervision

1.1 **Purpose.** Supervision is a structured, evaluative, and educational process designed to support ethical decision-making, clinical competence, professional identity development, and client welfare.
1.2 **Scope.** Supervision includes review of clinical work, documentation, risk management, professional conduct, and skills development aligned with the supervisee's authorized scope and training requirements.
1.3 **Not psychotherapy.** Supervision is not psychotherapy, counseling, or treatment for the supervisee. Personal topics may be discussed only insofar as they affect clinical functioning, competence, professionalism, or client safety. If personal support is indicated, the Supervisor may recommend the Supervisee seek independent services.

---

2. Roles and Responsibilities

2.1 Supervisor Responsibilities

The Supervisor agrees to:

- Provide supervision consistent with professional standards, ethical codes, and applicable jurisdictional requirements.
- Clarify the supervisor's **role, evaluative authority, and gatekeeping responsibilities**.
- Establish and maintain a supervision structure (agenda, goals, documentation, evaluation cadence).
- Provide timely feedback, guidance, and learning resources; document significant supervisory decisions and directives.
- Maintain appropriate boundaries and manage dual relationships and conflicts of interest.
- Consult/refer as appropriate (e.g., legal counsel, ethics consultation, clinical specialists) when issues exceed the Supervisor's competence or require additional expertise.
- Support the supervisee in practicing within authorized scope, and intervene when practice poses risk to clients or the public.

2.2 Supervisee Responsibilities

The Supervisee agrees to:

- Practice within their authorized scope, role, and supervision requirements, and comply with setting policies.
- Prepare for supervision (agenda, case list, questions, documentation items, outcome data as required).
- Disclose promptly any clinical situations requiring consultation, including safety risks, complex ethical issues, and scope-of-practice concerns.
- Seek consultation before acting when directed by "stop-the-line" criteria (Section 6).
- Implement supervision directives and document follow-through; raise concerns or disagreements respectfully and promptly.
- Maintain professional conduct, timely documentation, and appropriate boundaries with clients and colleagues.
- Notify the Supervisor of any changes in credential status, employment setting, or restrictions/complaints that could impact practice.

2.3 Consultation Thresholds ("When to Consult")

The Supervisee will consult the Supervisor:

- **Before** initiating high-risk interventions outside routine scope/competence.
- **Immediately** when safety concerns arise (see Section 6).
- **As soon as possible** when uncertain about ethics, boundaries, documentation, or legal obligations in the jurisdictions served.
- **Before** responding to subpoenas, complaints, or formal requests involving clinical records (see Section 3).

---

3. Confidentiality and Limits

3.1 Supervision Confidentiality

Information discussed in supervision will be treated as confidential within professional and organizational standards and will be shared only as necessary for:

- Client safety and continuity of care,
- Training and evaluation processes,
- Quality assurance and clinical governance requirements,
- Compliance with lawful and ethical obligations.

3.2 Limits of Confidentiality
Confidentiality may be limited when there is:

- **Imminent risk** of harm to self or others,
- **Suspected abuse/neglect** or other mandated reporting triggers,
- **Court orders/subpoenas** or lawful demands for records,
- **Board/regulatory inquiries** or credentialing audits as permitted/required,
- **Professional impairment** concerns affecting client welfare,
- **Organizational reporting** requirements (e.g., sentinel events, critical incidents).

3.3 Records Requests, Subpoenas, and Complaints
The Supervisee agrees to **notify the Supervisor immediately** upon receiving any subpoena, legal request, payer audit request, or complaint relating to client care, documentation, or professional conduct. No records will be released without following setting protocol and consultation with appropriate organizational leadership and/or counsel.

---

4. Informed Consent Expectations (Client Disclosures)
The Supervisee will inform clients (and document in the client record, when required by setting policy) that:

- The Supervisee is practicing under clinical supervision and may consult the Supervisor regarding client care.
- The Supervisor may review relevant portions of the client record for training, quality assurance, and oversight.
- If live observation, co-therapy, recording, or use of de-identified materials occurs, the Supervisee will obtain any additional consent required by policy and applicable jurisdictional standards.
- Clients may ask questions about supervision involvement, including the Supervisor's role and credentials, within appropriate limits.

Optional clause (insert if used):
If sessions are recorded for supervision/training, the following will be specified: purpose, storage, access, retention, and destruction timeline; and the client may refuse recording without penalty to access to services (unless required by program conditions).

---

5. Documentation Standards

5.1 Supervision Notes and Logs

- **Required supervision note frequency:** [Each session / Weekly / Other].
- Notes will include: date/time, duration, format (individual/group), key cases/themes reviewed, risk items, directives given, supervisee action items, and follow-up plan.

- If the Supervisor provides **clinical directives** (e.g., safety plan steps, mandated reporting guidance), these will be documented in supervision records, and relevant actions will be documented in the client chart as appropriate.

5.2 Storage and Security
Supervision documentation will be stored in: [EHR module / secure drive / locked file]. Access is limited to: [names/roles].
5.3 Retention
Supervision records will be retained for: [time period] consistent with organizational policy and jurisdictional requirements in the service location(s).

---

6. Safety, Scope, and "Stop-the-Line" Criteria

6.1 Immediate Consultation Required
The Supervisee will **stop and consult the Supervisor immediately** (or follow the escalation pathway) when any of the following occur:
Safety and crisis
- Suicidal ideation with plan/intent, recent attempt, or escalating risk
- Homicidal ideation, threats, or credible risk of violence
- Acute psychosis, mania, severe dissociation, intoxication/withdrawal impacting safety
- Domestic violence escalation, stalking, or imminent danger indicators
- Medical emergencies or urgent psychiatric decompensation

Mandated reporting / protection
- Suspected child/elder/vulnerable adult abuse or neglect
- Sexual exploitation or trafficking concerns
- Serious neglect/endangerment issues

Scope/competence
- Clinical presentation exceeds supervisee competence or authorized scope
- Requests for specialized assessments or interventions beyond training
- Complex boundary issues (gifts, dual relationships, contact outside sessions)

Ethics/legal-risk
- Subpoenas, court involvement, complaints, threats of litigation
- Requests for record alteration, falsification, or problematic documentation
- Confidentiality conflicts and multi-jurisdiction telehealth complications

Provider functioning
- Any impairment concern (substance use, acute mental health issue, burnout) that could compromise client care.

6.2 Escalation Pathway
- **Primary contact:** [Supervisor phone/email]
- **Response expectation:** [e.g., within 15 minutes for high-risk; within 24 hours for non-urgent]
- **Back-up supervisor/clinical lead:** [Name/contact]
- **After-hours protocol:** [On-call line / crisis protocol / emergency services guidance]

- **Documentation:** Supervisee will document crisis actions in the client record per policy; Supervisor will document supervisory guidance in supervision record.

---

7. Evaluation and Feedback

7.1 Evaluation Cadence

- **Informal feedback:** each supervision session
- **Formal evaluation:** [monthly/quarterly/midterm + final]
- **Review domains:** clinical skills, ethics, documentation, cultural responsiveness, risk management, professional conduct, and progress toward competency benchmarks.

7.2 Tools and Criteria

Evaluation may include:

- Competency-based rating form (behaviorally anchored)
- Review of notes/treatment plans
- Audio/video or live observation rating forms
- Supervisee self-assessments and learning plans
- Outcome measures (where used in the setting)

7.3 Feedback Delivery

Feedback will be:

- Specific, behaviorally anchored, and linked to client welfare and competency development
- Delivered in a timely manner with clear action steps
- Documented when it involves significant performance concerns, corrective directives, or gatekeeping decisions.

---

8. Remediation and Gatekeeping (Due Process)

8.1 Performance Concerns

Concerns may include: repeated documentation deficiencies, boundary problems, ethical lapses, clinical skill deficits, professionalism issues, safety risk mismanagement, or failure to follow supervision directives.

8.2 Due Process Steps (Typical)

1. **Informal corrective feedback** with clear expectations and timeline
2. **Written notice** of concern(s) with supporting examples/evidence
3. **Remediation plan** specifying competencies, supports, measurable targets, and deadlines
4. **Increased supervision/monitoring** (as needed), including observation or chart audits
5. **Re-evaluation** at stated checkpoints
6. **Outcome determination:** successful remediation, extension, referral, restriction of duties, or termination of supervision/placement consistent with policy and obligations to protect clients.

8.3 Gatekeeping Authority
The Supervisor retains authority to recommend restrictions, additional training, referral to higher level review, or termination of the supervision relationship when necessary to protect clients, meet ethical duties, or comply with organizational/jurisdictional requirements.

---

9. Fees and Cancellations (If Applicable)

9.1 Fees and Payment
- Fee: [$] per [60/90] minutes
- Payment due: [timeframe/method]
- Late fee: [amount/conditions]

9.2 Cancellations and No-Shows
- Cancellation notice required: [24/48] hours
- No-show fee: [ ]
- Repeated cancellations/no-shows may result in: revised schedule, required pre-payment, or termination of supervision if it compromises training requirements.

---

10. Termination, Changes, and Signatures

10.1 Termination
This contract may be terminated by:
- Mutual agreement; or
- Written notice by either party with [notice period], except when immediate termination is required due to safety, ethics, or policy issues.

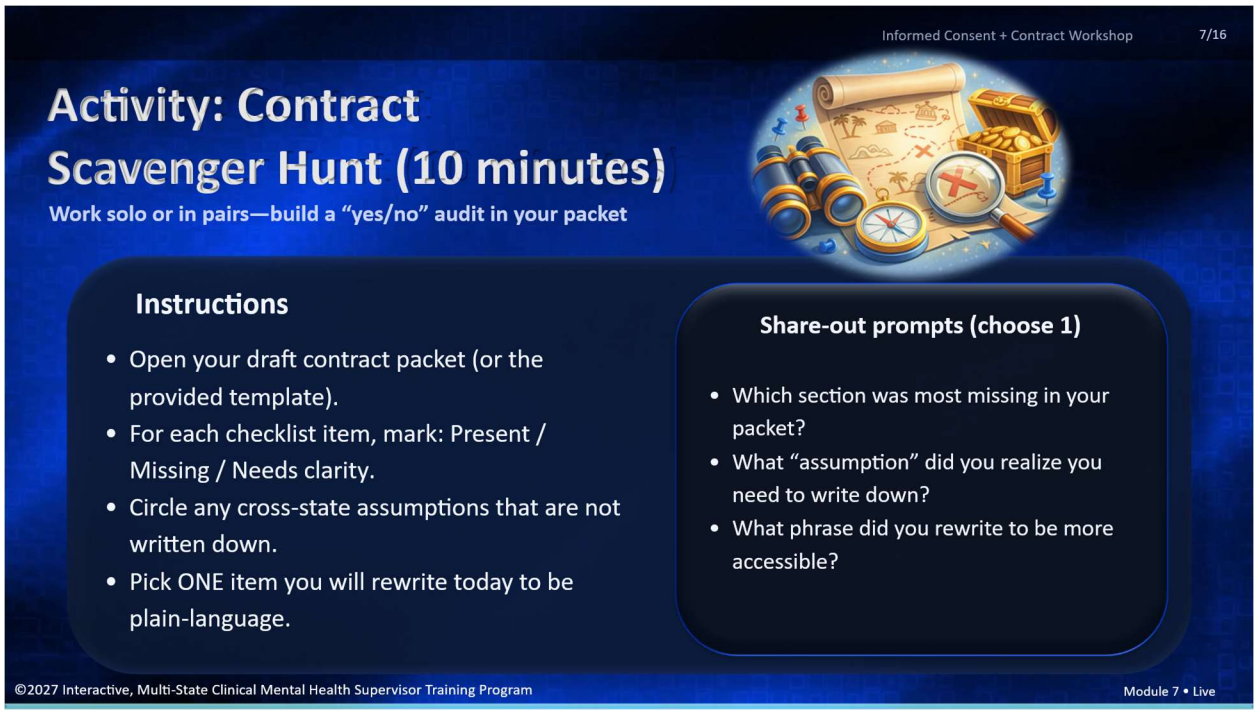
10.2 Contract Changes
All changes must be documented in writing and signed/dated by both parties.

10.3 Acknowledgment
By signing, both parties acknowledge understanding of supervision's evaluative nature, confidentiality limits, stop-the-line criteria, and the supervisee's obligation to comply with setting policy and applicable jurisdictional requirements.

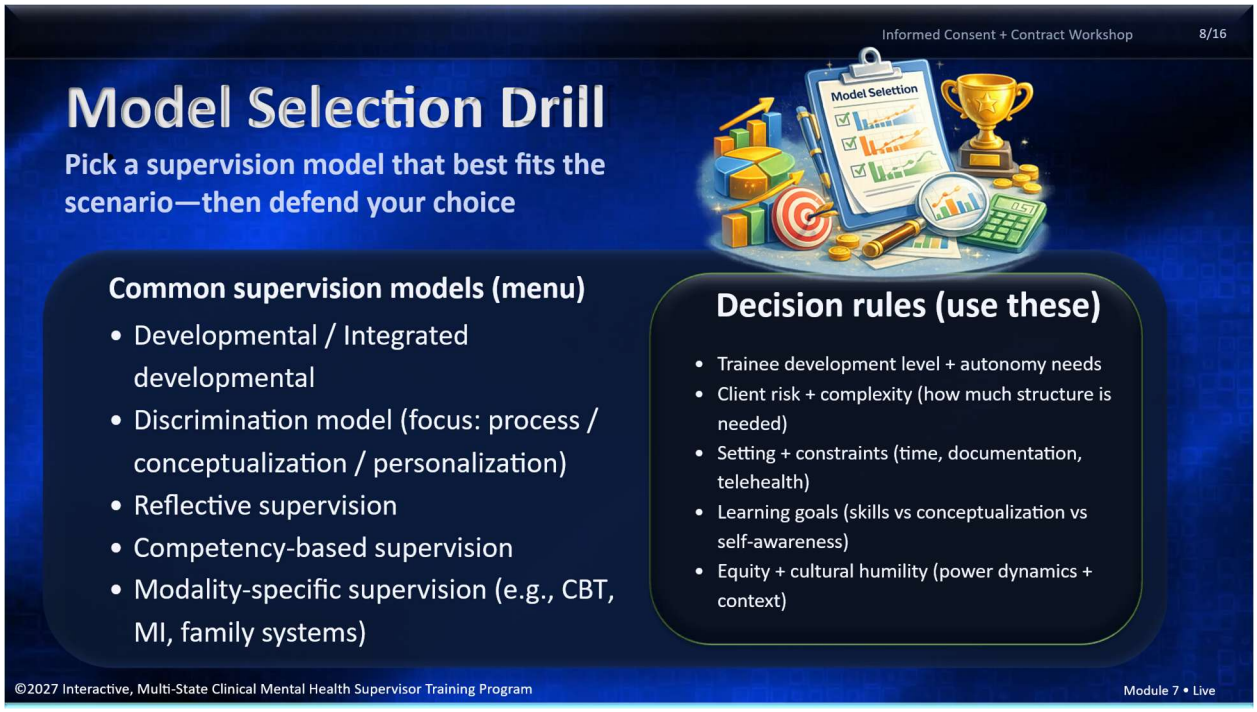
Supervisor Signature: _____ **Date:** _____

Supervisee Signature: _____ **Date:** _____

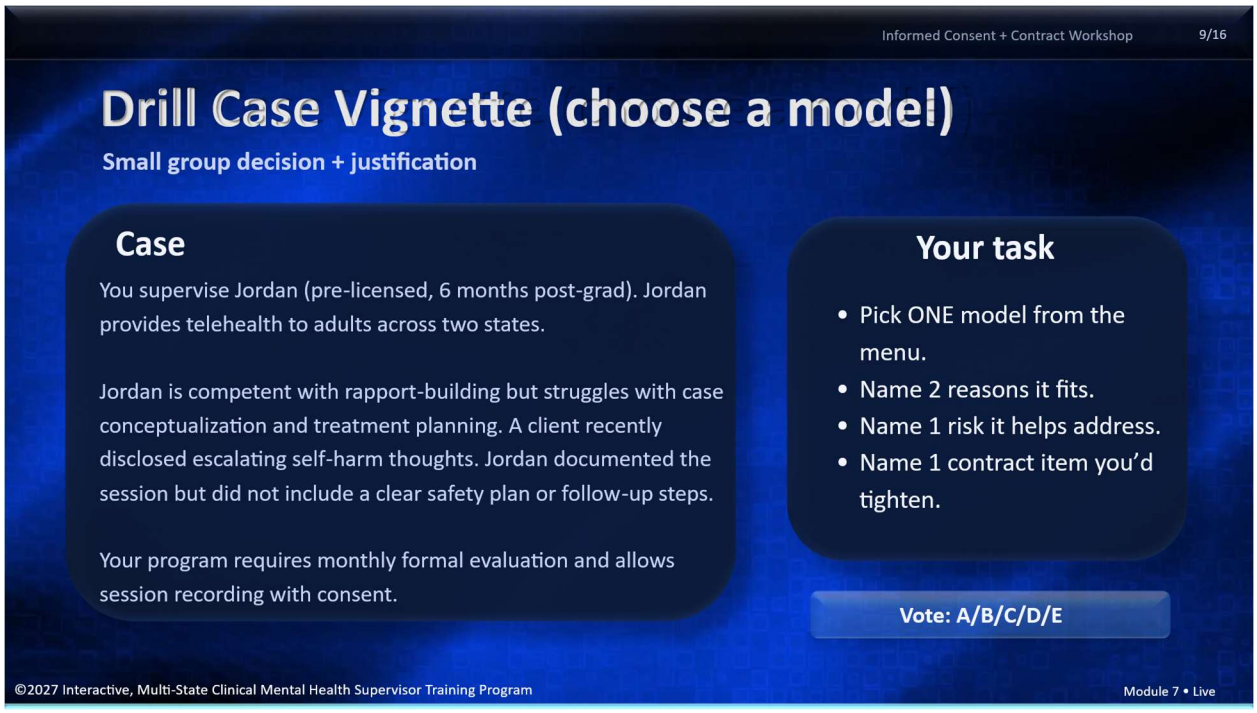
Activity: Contract Scavenger Hunt



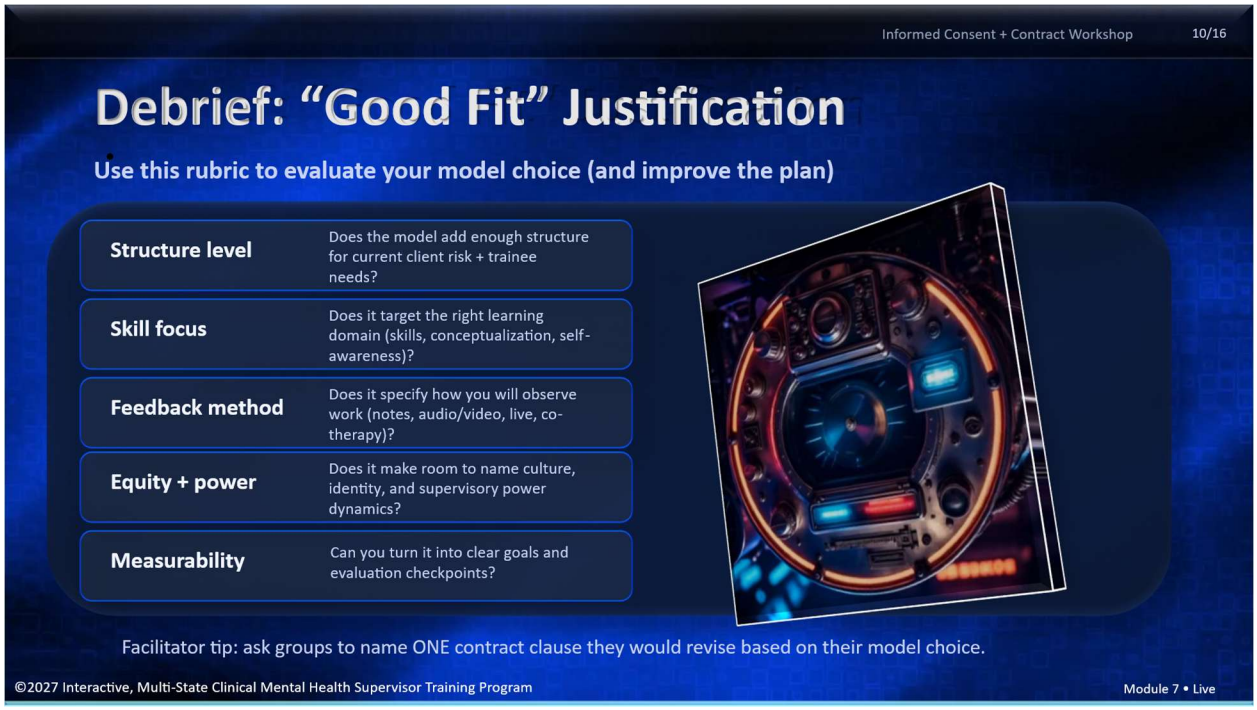
Model Selection Drill



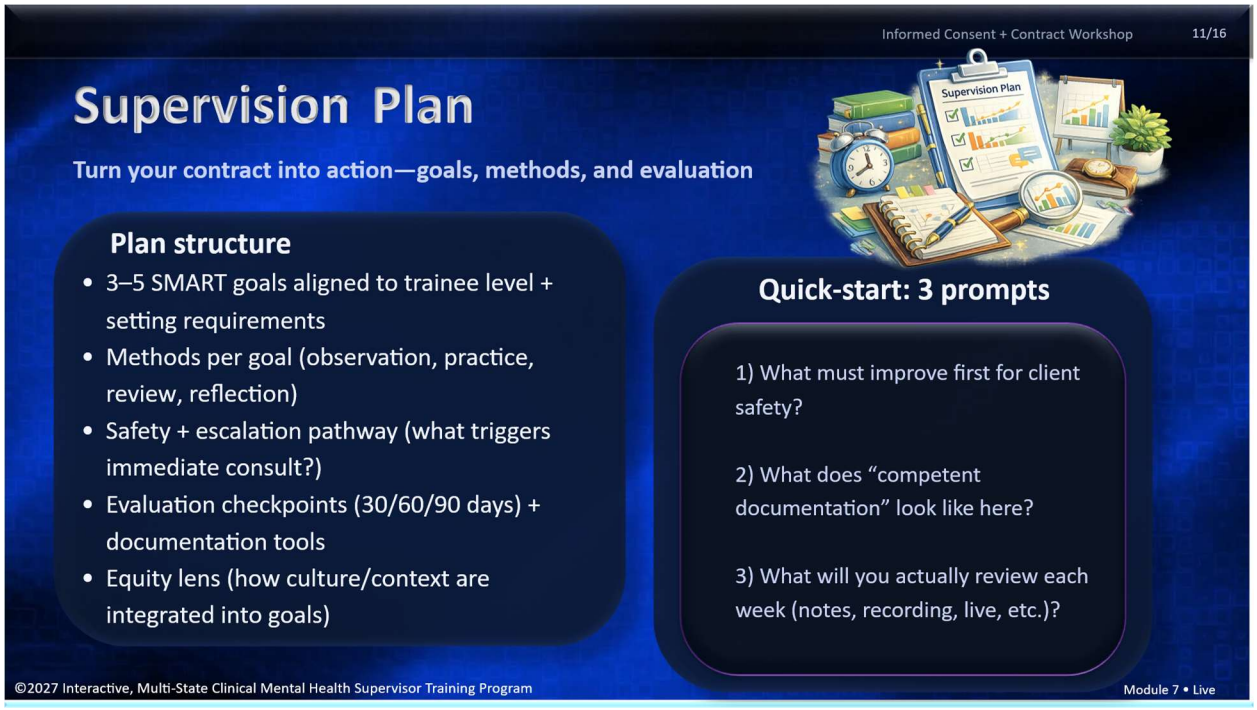
Drill Case Vignette



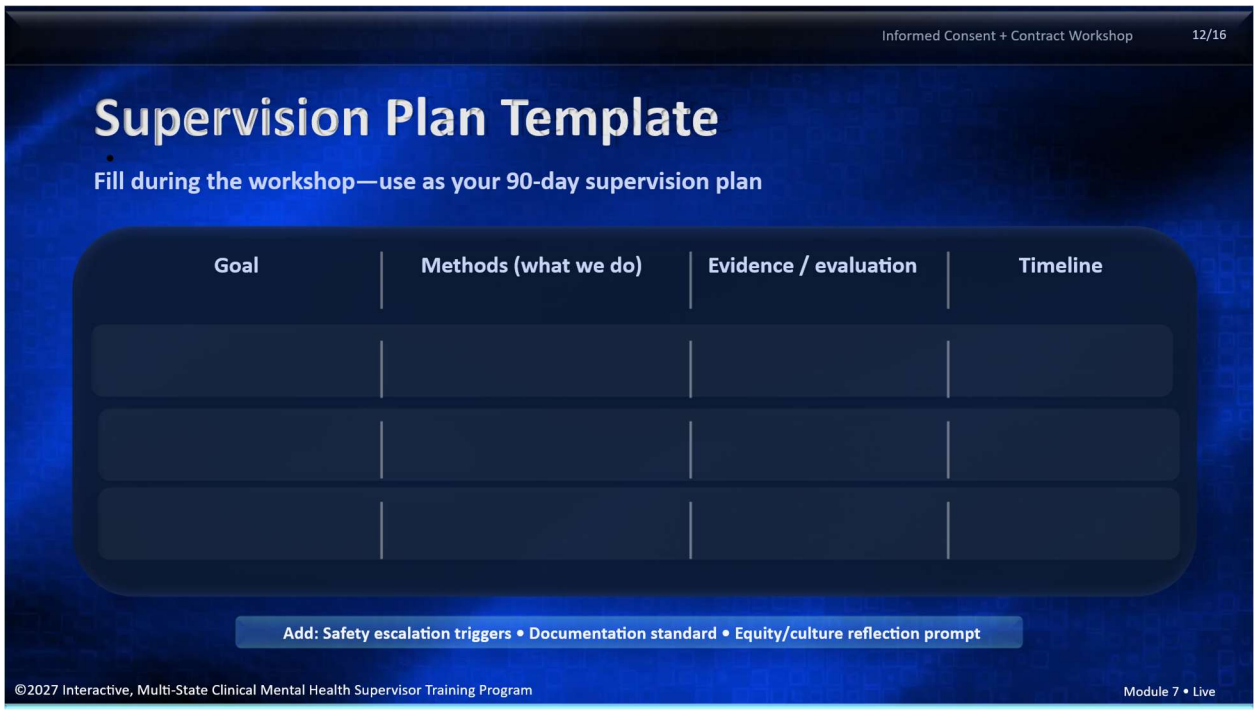
Debrief



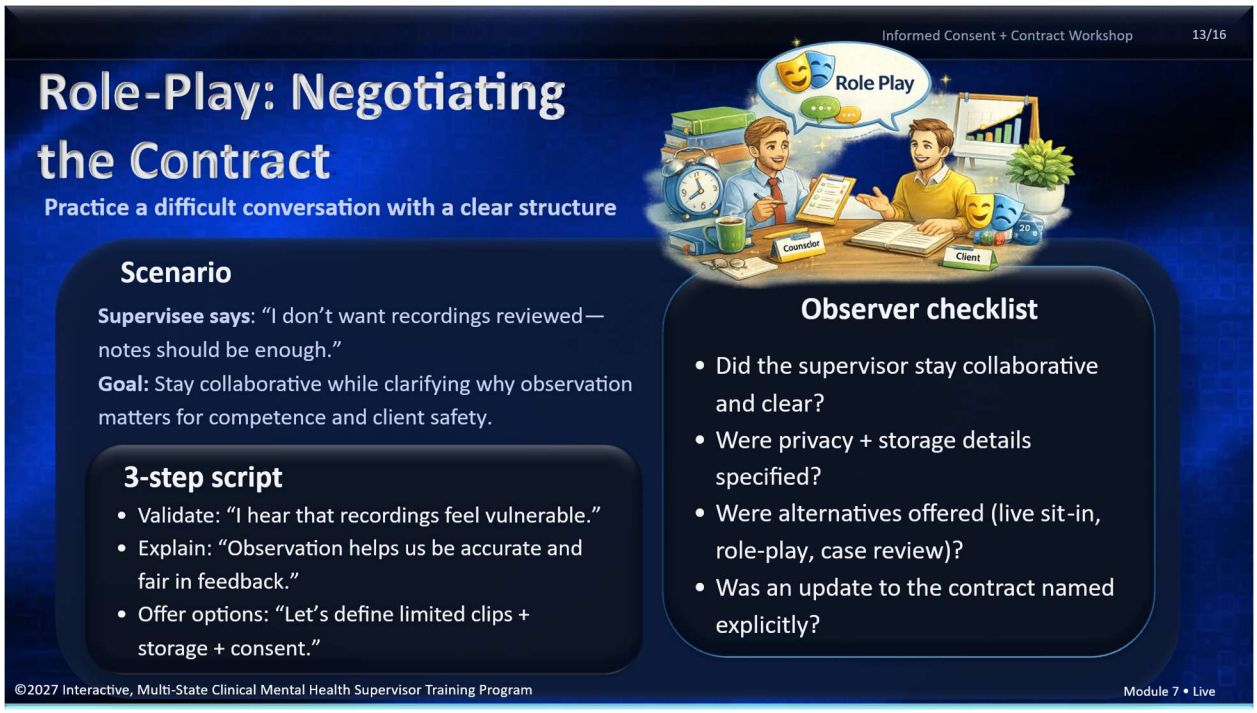
Supervision Plan



Supervision Plan Template

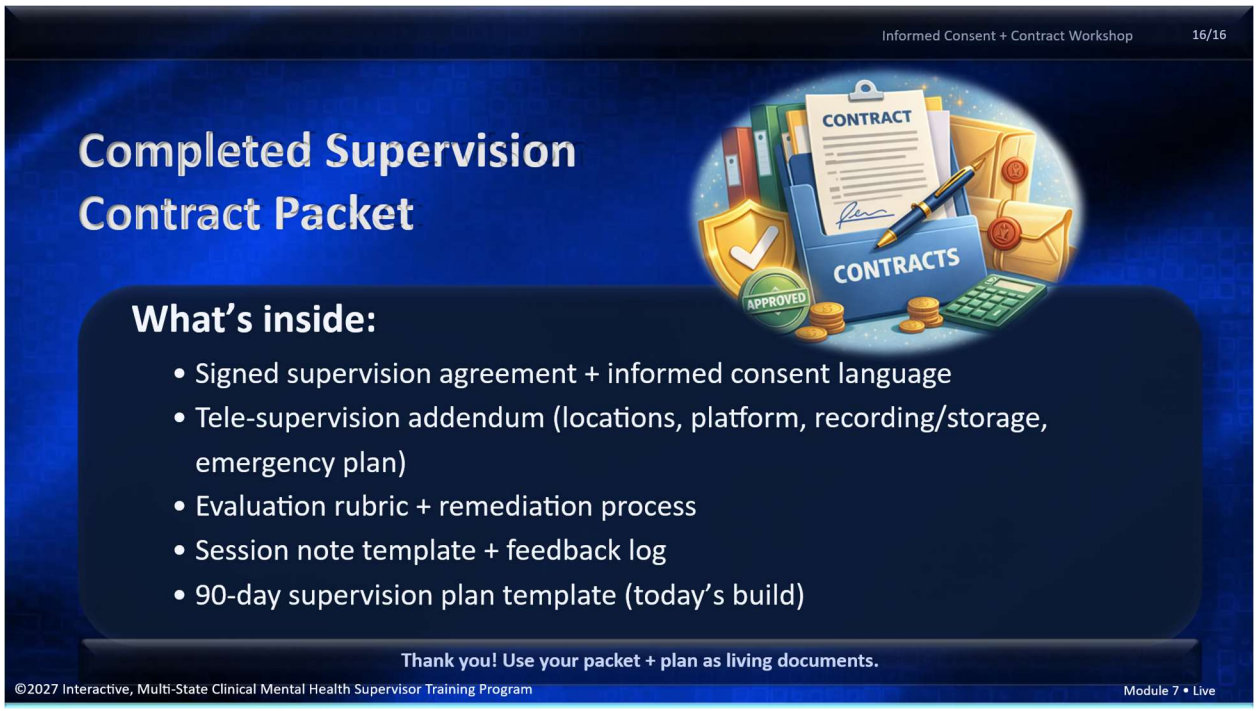


Role-Play: Negotiating the Contract



Wrap Up/Deliverables

Completed Supervision Contract Packet



Completed Supervision Contract Packet Template

Informed Consent + Contract Workshop

Supervisor: _____
Supervisee: _____
Credential Track: _____
Site/Agency: _____
State(s)/Jurisdiction(s): _____
Date Packet Initiated: _____
Date Packet Reviewed/Updated: _____

Packet Completion Checklist

Packet Item	Included	Needs Revision	Notes
Signed supervision agreement	☐	☐	
Informed consent language	☐	☐	
Tele-supervision addendum	☐	☐	
Evaluation rubric	☐	☐	
Remediation process	☐	☐	

Packet Item	Included	Needs Revision	Notes
Session note template	☐	☐	
Feedback log	☐	☐	
90-day supervision plan	☐	☐	

---

1. Signed Supervision Agreement + Informed Consent Language
Purpose of Supervision
Supervision is provided to support professional development, clinical competence, ethical practice, documentation quality, and client safety. Supervision includes supportive, educational, consultative, evaluative, and gatekeeping functions.
Roles and Responsibilities
Supervisor responsibilities:

Supervisee responsibilities:

Shared responsibilities:

Limits of Confidentiality in Supervision
Supervision is private but not absolute confidential communication. Information may be shared when required for client safety, legal/ethical compliance, agency policy, documentation review, remediation, emergency response, or credentialing/licensure requirements.
Limits discussed: ☐ Yes ☐ No
Supervisee questions addressed: ☐ Yes ☐ No

---

2. Tele-Supervision Addendum
Tele-Supervision Format
Platform used: _____
Frequency: _____
Backup contact method: _____
Location Verification
Supervisor location during tele-supervision: _____
Supervisee location during tele-supervision: _____
Client state(s)/jurisdiction(s), if discussed: _____
Recording and Storage
Will supervision be recorded? ☐ Yes ☐ No
If yes, where stored: _____
Who has access: _____
Retention/deletion plan: _____
Emergency Plan
Emergency contact process:

Escalation pathway for client safety concerns:

---

3. Evaluation Rubric

Competency Domains to Be Evaluated

Domain	Evaluation Method	Review Frequency
Clinical skills	_____	_____
Case conceptualization	_____	_____
Documentation	_____	_____
Ethical decision-making	_____	_____
Cultural responsiveness	_____	_____
Risk assessment/safety	_____	_____
Professional behavior	_____	_____
Use of supervision	_____	_____

Rating Scale

☐ 4 = Strong
☐ 3 = Meets standard
☐ 2 = Developing
☐ 1 = Concern
☐ 0 = Not demonstrated

Evaluation schedule:

☐ Monthly formative review
☐ Quarterly summative review
☐ Other: _____

---

4. Remediation Process

When Remediation May Be Used

Remediation may be initiated when concerns arise related to clinical competence, documentation, ethics, professionalism, risk management, cultural responsiveness, use of supervision, or client safety.

Remediation Steps

1. Concern identified and documented.
2. Evidence/examples reviewed.
3. Expected standard clarified.
4. Corrective actions assigned.
5. Supports provided.
6. Timeline and review dates established.
7. Progress evaluated.
8. Next step determined.

Remediation Plan Summary

Concern area:

Expected standard:

Corrective actions:

Supports provided:

Review dates:

Outcome if progress is insufficient:

5. Session Note Template
Date: _____
Supervision format: ☐ Individual ☐ Group ☐ Tele-supervision ☐ In person
Duration: _____
Agenda / Focus

Cases or Topics Reviewed

Risk / Safety Issues Discussed
☐ None reported
☐ Risk reviewed
☐ Consultation required
☐ Escalation required
Notes:

Feedback Provided

Supervisee Response / Reflection

Action Items / Next Steps

Supervisor Signature/Initials: _____
Supervisee Signature/Initials: _____

6. Feedback Log

Date	Feedback Topic	Standard/Competency	Action Step	Follow-Up Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

7. 90-Day Supervision Plan Template

90-Day Supervision Goals
Goal 1:

Goal 2:

Goal 3:

Planned Supervision Activities

Activity	Frequency	Evidence/Deliverable
Case review	_____	_____
Documentation review	_____	_____
Skill rehearsal/role-play	_____	_____
Direct observation/recording review	_____	_____
Ethics or cultural consultation	_____	_____
Feedback review	_____	_____

30-Day Checkpoint
Progress reviewed: _____
Adjustments needed: _____
60-Day Checkpoint
Progress reviewed: _____
Adjustments needed: _____
90-Day Review
Competencies strengthened:

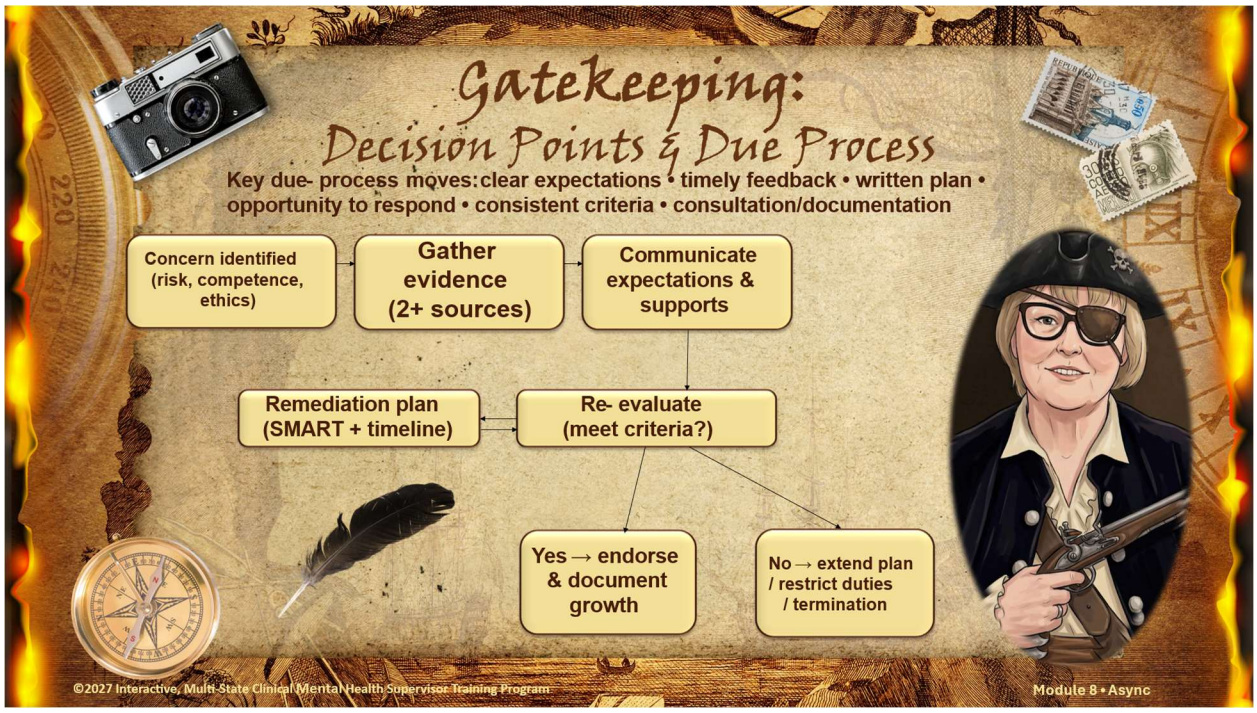
Ongoing growth areas:

Next supervision plan update due: _____

Final Packet Sign-Off
By signing below, the supervisor and supervisee acknowledge that this packet has been reviewed and will be used as a living document throughout supervision.
Supervisee Signature: _____ Date: _____
Supervisor Signature: _____ Date: _____
Next packet review date: _____

Module 8 Handuouts/Instructions

Gatekeeping Decision Points & Due Process



Model Selection Drill

Model Selection Drill Debrief

Drill Debrief Report Template

One Strong Fit, and Why

Participant/Group: _____ **Date:** _____
Scenario/Drill Focus: _____

---

1. Stuck Moment / Presenting Concern
Brief description of the supervision "stuck" moment:

Primary concern area:
☐ Mandated reporting ☐ Risk/safety ☐ Documentation ☐ Defensiveness
☐ Scope of practice ☐ Ethics/legal ☐ Cultural/systemic ☐ Other: _____

---

2. Recommended Primary Lens
Chosen supervision model/lens:
☐ Competency-Based Supervision
☐ Discrimination Model
☐ Developmental Model
☐ Reflective/Process Model
☐ Multicultural/Social Justice Framework
☐ Other: _____
Why is this the strongest fit?

Key rationale:
This lens fits because the concern is:
☐ Observable ☐ High-stakes ☐ Skill-based ☐ Developmental
☐ Relational/process-based ☐ Ethical/legal ☐ Documentation-related

---

3. Two Supervisory Interventions
Intervention 1:

Purpose: _____
Intervention 2:

Purpose: _____

---

4. Skill Rehearsal / Corrective Feedback Plan
Skill to teach or rehearse: _____

Practice method:
☐ Role-play ☐ Decision tree practice ☐ Documentation review ☐ Recording review
☐ Case consultation ☐ Corrective feedback conversation ☐ Other: _____
Corrective feedback language or action:

---

5. Defensiveness-to-Curiosity Micro-Skill
Observed or anticipated defensiveness:

Supervisor response sequence:
Reflect: _____
Name impact: _____
Invite alternative: _____

---

6. Evidence to Collect Before Review
Evidence source(s):
☐ One recording ☐ One note set ☐ Risk documentation ☐ Mandated-reporting checklist
☐ Supervision engagement ☐ Consultation record ☐ Other: _____
Evidence must show:
☐ Thresholds applied correctly
☐ Documentation complete and timely
☐ Risk section aligns with jurisdiction/setting
☐ Feedback accepted and used
☐ Consultation sought appropriately
☐ Behavior change demonstrated
Review timeline: _____ **Reviewer:** _____

---

7. Final Debrief Recommendation
"Using _____ as the primary lens, we recommend

---

because _____.
The supervisor will implement _____
and collect evidence through _____
before the next review."

Completed by: _____ **Reviewed by:** _____

Supervision Plan

Supervision Plan Template

A structure that scales across states

Section 1. Supervisee Information
Supervisee Name: _____
Credential / License Track: _____
Site / Agency: _____
State(s) of Practice: _____
Email / Phone: _____
Supervision Start Date: _____
Planned Review Date: _____

Section 2. Supervisor Information
Primary Supervisor Name: _____
Credentials / License: _____
Role: _____
State(s) of Licensure: _____
Contact Information: _____
Additional Supervisor(s) / Consultant(s):

Coverage Plan if Primary Supervisor Is Unavailable:

Section 3. Contract / Supervision Structure
Roles and Responsibilities:

Scope of Supervision:

Limits of Confidentiality:

Documentation Expectations:

Jurisdiction / State Rule Considerations:

Section 4. Cadence
Frequency of Supervision:
☐ Weekly
☐ Biweekly
☐ Monthly
☐ Other: _____
Session Length: _____
Format / Modality:
☐ In person
☐ Tele-supervision
☐ Hybrid
Emergency Coverage Plan:

Consultation Pathways / Between-Session Contact:

Section 5. Methods
Observation Plan:
☐ Live observation
☐ Audio recording
☐ Video recording
☐ Case presentation
☐ Documentation review

☐ Role-play / skill rehearsal
☐ Reflective discussion
☐ Other: _____

Observation Frequency:

Case Review Process:

Skill Rehearsal / Practice Methods:

Reflective Process Focus:

Section 6. Evaluation Plan

Formative Check-Ins:

☐ Weekly
☐ Monthly
☐ Other: _____

Summative Review Schedule:

☐ Quarterly
☐ Semiannual
☐ End of supervision period
☐ Other: _____

Competency Areas to Be Evaluated:

☐ Clinical skills
☐ Case conceptualization
☐ Documentation
☐ Ethical decision-making
☐ Cultural responsiveness
☐ Professional behavior
☐ Risk assessment / safety
☐ Use of supervision
☐ Other: _____

Criteria for Endorsement / Progression:

Section 7. Documentation Plan

Where Will Supervision Records Be Stored?

Who Has Access?

Record Retention Plan:

How Will Documentation Be Protected?

Section 8. Gatekeeping / Remediation Plan
Triggers for Concern:

Due Process Steps:

Remediation / Corrective Action Process:

Duty Restrictions if Needed:

Escalation Contacts:

Section 9. Escalation / High-Risk Oversight
Safety Issues Requiring Immediate Contact:

Mandated Reporting Procedures:

Impairment Concerns / Response Plan:

Emergency / Crisis Response Procedures:

Section 10. One-Page Summary
Supervisee: _____
Credential Track / Site / State(s):

Supervisor(s):

Cadence:

Methods:

Evaluation Schedule:

Documentation Plan:

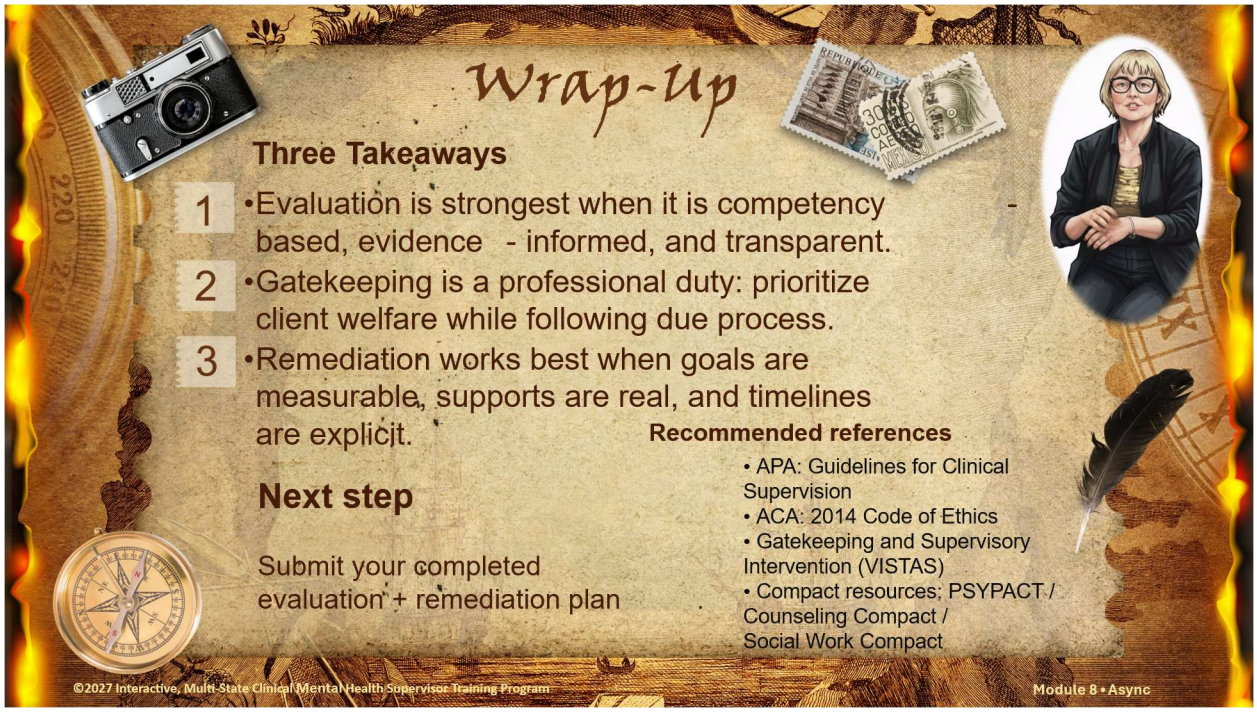
Escalation / High-Risk Plan:

Special Notes / Gatekeeping Considerations:

Section 11. Signatures
Supervisee Signature: _____ Date: _____
Supervisor Signature: _____ Date: _____
Additional Supervisor Signature: _____ Date: _____

Quick Completion Checklist
☐ Supervisee information completed
☐ Supervisor information completed
☐ Roles / scope clarified
☐ Cadence and modality identified
☐ Methods selected
☐ Evaluation plan identified
☐ Documentation plan completed
☐ Escalation / gatekeeping plan addressed
☐ Signatures obtained

Wrap Up/Deliverables



Evaluation and Remediation Template

Clinical Supervision Competency Review

Supervisee: _____
Supervisor: _____
Credential/License Track: _____
Site/Agency: _____
Review Period: _____ to _____
Date of Evaluation: _____

---

1. Evaluation Type

☐ Formative evaluation/check-in
☐ Summative evaluation
☐ Remediation review
☐ Gatekeeping concern review
☐ Final supervision review
☐ Other: _____

---

2. Competency Evaluation

Competency Domain	4 Strong	3 Meets Standard	2 Developing	1 Concern	Evidence/Notes
Ethical/legal decision-making	☐	☐	☐	☐	_____

Competency Domain	4 Strong	3 Meets Standard	2 Developing	1 Concern	Evidence/Notes
Risk assessment/safety planning	☐	☐	☐	☐	_____
Clinical documentation	☐	☐	☐	☐	_____
Case conceptualization	☐	☐	☐	☐	_____
Treatment planning	☐	☐	☐	☐	_____
Intervention skills	☐	☐	☐	☐	_____
Cultural responsiveness	☐	☐	☐	☐	_____
Professional behavior/reliability	☐	☐	☐	☐	_____
Use of supervision/feedback	☐	☐	☐	☐	_____
Administrative/procedural compliance	☐	☐	☐	☐	_____

Rating Key:
4 = Strong/independent performance
3 = Meets expected standard
2 = Developing/needs support
1 = Concern/requires structured follow-up

---

3. Strengths Observed
Primary strengths demonstrated during this review period:

Evidence supporting strengths:
☐ Observation
☐ Recording review
☐ Case presentation
☐ Documentation review
☐ Role-play/skill rehearsal
☐ Client outcome/progress indicators
☐ Supervisee reflection
☐ Other: _____
Notes:

---

4. Areas for Growth
Competency areas needing continued development:

Specific behaviors or patterns observed:

Impact on client care, documentation, ethics, or professional functioning:

Remediation Section

Complete this section if a competency concern requires structured corrective action.

5. Concern Statement

Concern area:

☐ Risk/safety
☐ Documentation
☐ Ethics/legal issue
☐ Professional behavior
☐ Clinical skill deficit
☐ Cultural responsiveness
☐ Use of supervision
☐ Scope of practice
☐ Other: _____

Clear description of the concern:

Evidence/examples:

Dates/frequency/pattern:

6. Expected Standard

What standard must be met?

Relevant policy, ethical standard, competency, or supervision expectation:

7. Remediation Goal

SMART remediation goal:

By _____, supervisee will:

How progress will be measured:

8. Required Corrective Actions

Corrective Action	Due Date	Evidence Required	Completed
_____	_____	_____	☐
_____	_____	_____	☐
_____	_____	_____	☐
_____	_____	_____	☐

Possible corrective actions:

☐ Revise documentation
☐ Complete assigned reading/policy review
☐ Submit notes for audit
☐ Complete role-play/skill rehearsal
☐ Review recording/live observation
☐ Increase supervision frequency
☐ Use checklist/template
☐ Consult before high-risk decisions
☐ Limit or restrict specific duties temporarily
☐ Other: _____

9. Supervision Supports Provided

Support methods:

☐ Additional case review
☐ Documentation template
☐ Note audit
☐ Role-play/rehearsal
☐ Modeling by supervisor
☐ Live/recorded observation
☐ Increased supervision frequency
☐ Assigned reading/training
☐ Consultation with another professional
☐ Other: _____

Description of support plan:

10. Safety or Scope Adjustments

Are temporary restrictions or additional safeguards needed?

☐ No

☐ Yes

If yes, describe:

Examples:

☐ Supervisor review before closing notes

☐ Same-day consultation for elevated-risk cases

☐ No independent high-risk cases temporarily

☐ Additional observation required

☐ Documentation approval required

☐ Other: _____

11. Review Timeline

Remediation start date: _____

First review date: _____

Midpoint review date: _____

Final review date: _____

Criteria for successful remediation:

If sufficient progress is not demonstrated:

12. Supervisee Response

Supervisee response to evaluation/remediation plan:

Questions, concerns, or additional context offered by supervisee:

13. Outcome Review

Review outcome:

☐ Criteria met

☐ Criteria partially met

☐ Criteria not met

☐ Plan extended

☐ Duties restricted

☐ Formal escalation recommended

☐ Other: _____

Evidence supporting outcome:

_____

_____

Next steps:

_____

_____

_____

14. Signatures

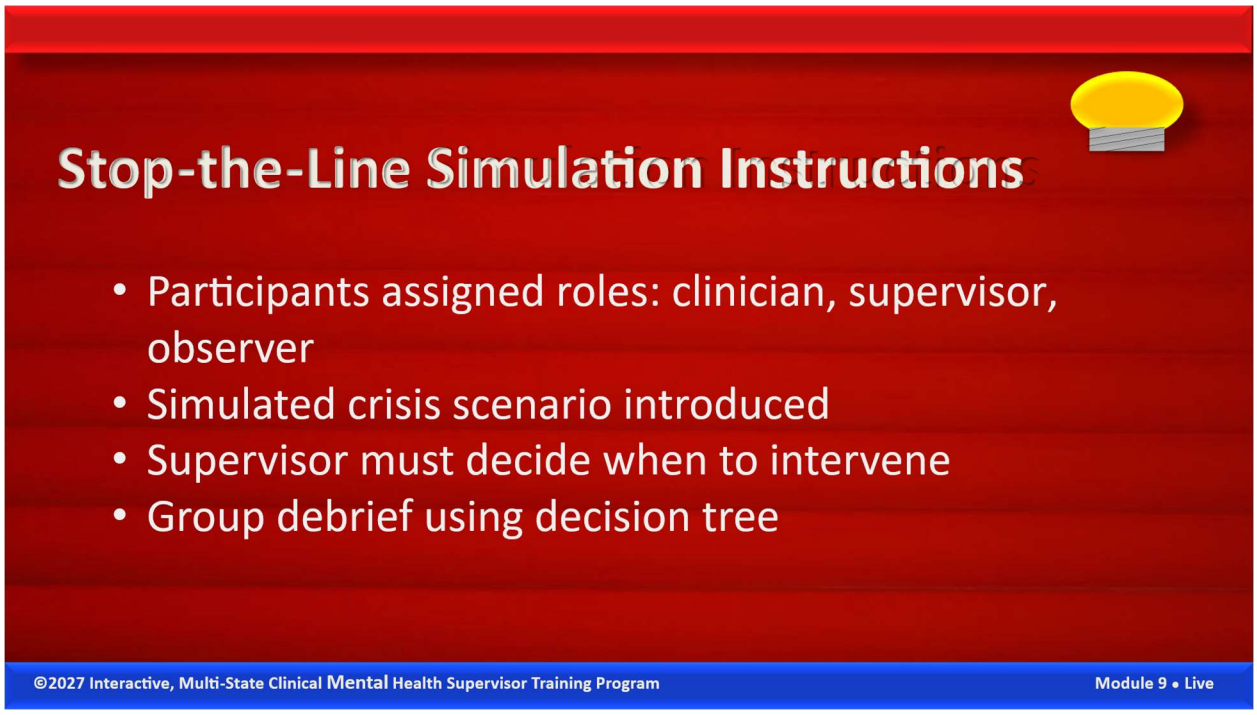
By signing below, the supervisor and supervisee acknowledge that this evaluation/remediation plan has been reviewed. Signature does not necessarily indicate agreement, but confirms receipt and discussion.

Supervisee Signature: _____ **Date:** _____
Supervisor Signature: _____ **Date:** _____
Additional Reviewer/Program Representative: _____ **Date:** _____

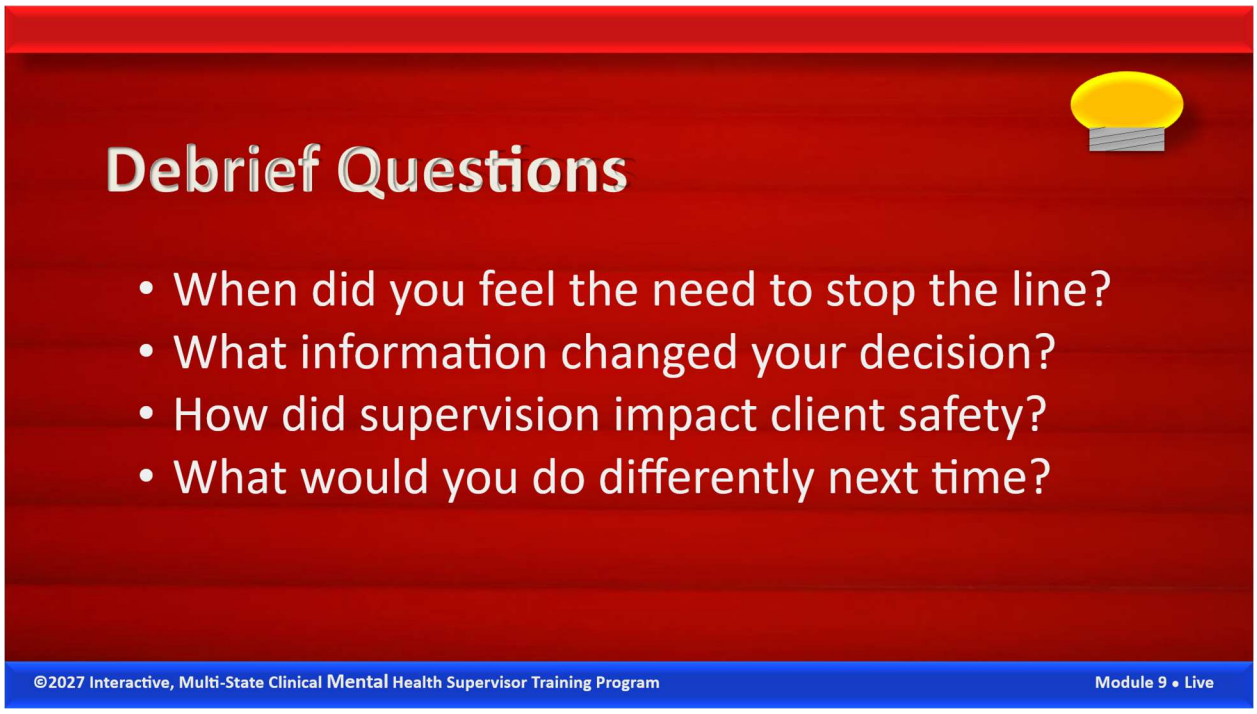
Module 9 Handouts/Instructions

Decision Tree: Safety Escalation

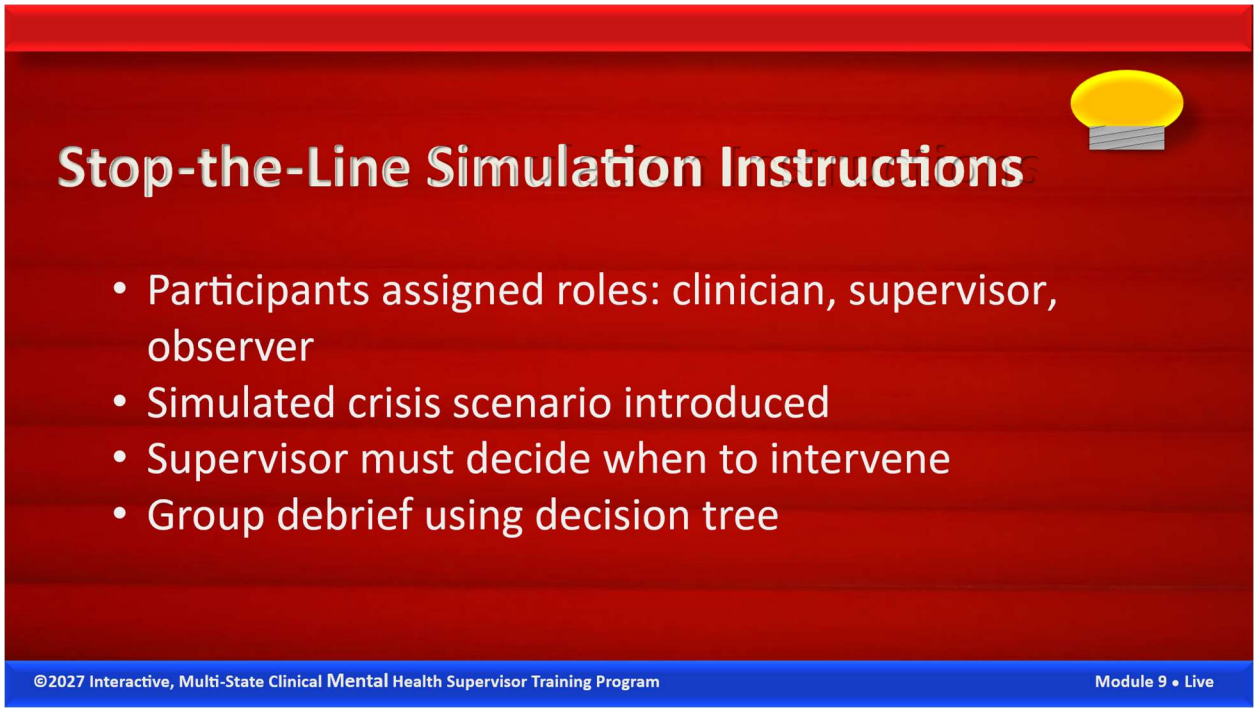
Stop-the-Line Simulation Instructions



Debrief Questions



Simulated Scenario



Stop-the-Line Simulation Scenario

Scenario Title

"I'm Not Sure I Can Stay Safe Tonight"

Purpose of Simulation
This simulation gives participants practice recognizing when routine supervision is no longer sufficient and when the supervisor must "stop the line" to protect client safety. The focus is on timing, supervisor authority, escalation, documentation, and debriefing.

Roles
Clinician/Supervisee: A pre-licensed counselor providing telehealth counseling.
Supervisor: The licensed clinical supervisor available for consultation.
Observer: Watches for risk cues, timing of consultation, clarity of supervisor direction, and use of the escalation pathway.

Background Information
The clinician is meeting by telehealth with a 28-year-old adult client named **Jordan**. Jordan has been in counseling for anxiety, depression, relationship stress, and recent job loss. In the past, Jordan has reported passive suicidal thoughts but denied intent or plan. The clinician has

discussed coping skills and support systems in previous sessions, but the safety plan has not been recently updated.
Today, Jordan appears tearful, withdrawn, and more hopeless than usual. Jordan reports that a partner ended the relationship two days ago and says, “I do not really see the point anymore.” Jordan is attending the session from home but recently moved to a neighboring state. The clinician has not yet confirmed Jordan’s exact current location or local emergency contact information.

Simulation Setup
The clinician begins the session alone with Jordan. After several minutes, the client begins making statements that raise safety concerns. The clinician must decide whether to continue managing the situation independently or contact the supervisor immediately.
The supervisor must decide when to intervene, whether to join the session, whether emergency resources are needed, and what documentation or follow-up is required.

Client Cues for the Role-Play
The person playing Jordan may use some of the following statements:
“I’m just tired of trying.”
“I do not think anyone would really miss me.”
“I thought about taking something tonight so I could sleep and not wake up.”
“I do not want you to call anyone. I should not have said anything.”
“I moved last week, so I’m not even in the same state anymore.”
“I have not told my sister how bad it is because I do not want to scare her.”
“I guess I can promise I will try, but I do not know.”
“I do have medication in the apartment.”
“I do not want to go to the hospital.”

Stop-the-Line Threshold
The supervisor should be contacted immediately when the clinician hears any of the following:
The client expresses possible intent or inability to commit to safety.
The client references access to means.
The client’s location is unclear during telehealth.
The client has moved to another state and emergency resources are not confirmed.
The clinician feels uncertain, overwhelmed, or outside safe independent scope.

Expected Supervisor Actions
The supervisor should move from routine consultation into active high-risk oversight.
Appropriate actions may include:
Confirm the client’s exact physical location.
Confirm whether the clinician has emergency contact information.
Ask the clinician for a brief risk summary: ideation, intent, plan, means/access, protective factors, current supports, and immediate safety concerns.
Decide whether to join the telehealth session directly.
Direct the clinician to keep the client engaged while safety steps are clarified.
Determine whether emergency services, mobile crisis, or a support person should be contacted.

Clarify whether the case remains within outpatient containment or requires emergency intervention.
Instruct the clinician on what to document in the client record and supervision record.
Schedule immediate follow-up and supervisory debrief.

Observer Checklist
The observer should watch for:
☐ Did the clinician recognize elevated risk early?
☐ Did the clinician contact the supervisor promptly?
☐ Did the supervisor clarify client location?
☐ Did the supervisor ask about means/access, intent, plan, protective factors, and supports?
☐ Did the supervisor decide whether to join the session?
☐ Did the supervisor give clear directives rather than vague suggestions?
☐ Did the team consider emergency services or mobile crisis?
☐ Did the supervisor clarify documentation requirements?
☐ Did the group debrief using the decision tree?

Documentation Requirements After Simulation
Participants should identify what must be documented:
Risk assessment summary:
What was disclosed, current risk level, protective factors, access to means, and clinical judgment.
Supervisor consultation note:
Who contacted whom, when, what information was shared, and what direction was given.
Actions taken and rationale:
Why the supervisor joined, why emergency services were or were not activated, and how client safety was addressed.
Follow-up safety plan:
Next contact, crisis resources, support person involvement, updated safety plan, supervision follow-up, and monitoring plan.

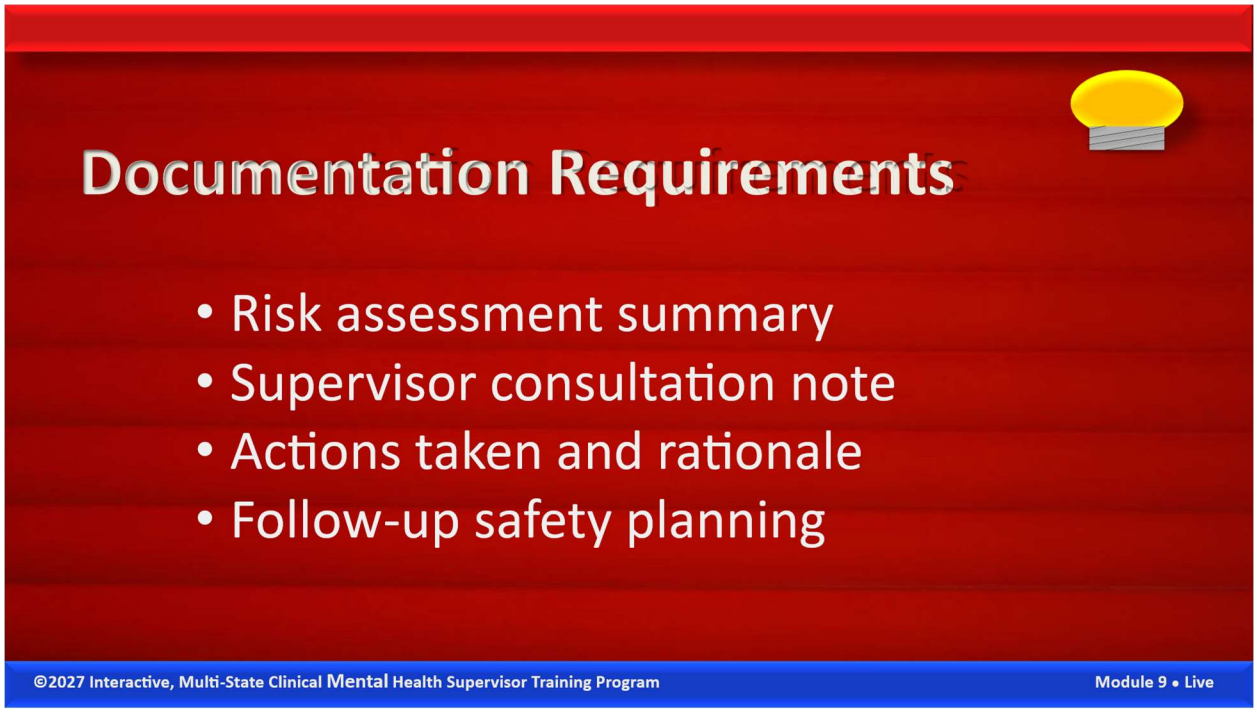
Debrief Questions
1. When did the situation become a stop-the-line moment?
2. What information changed the level of concern?
3. Did the clinician wait too long, act too quickly, or escalate appropriately?
4. What did the supervisor do that increased client safety?
5. What should be documented in the client record?
6. What should be documented in the supervision record?
7. What would you do differently next time?

Sample Supervisor Language
“Pause the clinical flow. This is now a safety consultation. I need you to confirm the client’s exact location, whether they have access to medication or other means, whether they are alone, and whether they can agree to immediate safety steps.”
“I am going to join the session now because risk, location, and access to means are unclear.”

“This is not optional consultation. Because safety is involved, we are moving up the escalation ladder.”
“After the immediate safety steps, we will document the risk assessment, consultation, rationale, actions taken, and follow-up plan.”

Learning Point
The goal is not for the clinician to manage the crisis alone. The goal is to recognize when the situation exceeds routine supervision and requires immediate supervisory oversight. A strong stop-the-line response protects the client, supports the supervisee, clarifies scope, and creates a defensible record of clinical reasoning and action.

Documentation Requirements



High-Risk Documentation Template

Client/Case ID: _____
Date of Event: _____
Time of Event: _____
Clinician/Supervisee: _____
Supervisor Consulted: _____
Modality: ☐ In person ☐ Telehealth ☐ Phone ☐ Other: _____
Client Location at Time of Contact: _____
Emergency Contact / Local Resource Confirmed: ☐ Yes ☐ No ☐ N/A

---

1. Risk Assessment Summary
Presenting risk concern:

Risk indicators observed or reported:
☐ Suicidal ideation
☐ Homicidal ideation
☐ Self-harm behavior
☐ Threat to others
☐ Abuse/neglect concern
☐ Psychosis / severe disorganization
☐ Substance-related impairment
☐ Medical instability
☐ Other: _____
Client statements or behaviors raising concern:

Intent / plan / means / access:

Protective factors:

Current risk level:
☐ Low ☐ Moderate ☐ High ☐ Imminent / emergency
Clinical rationale for risk level:

2. Supervisor Consultation Note
Time supervisor was contacted: _____
Reason for consultation:

Information provided to supervisor:

Supervisor guidance/directives:

Was supervisor direct entry needed?
☐ No
☐ Yes — supervisor joined: ☐ Session ☐ Phone call ☐ Crisis response ☐ Other

Additional consultation obtained, if any:

---

3. Actions Taken and Rationale
Actions taken:
☐ Continued session with safety monitoring
☐ Updated safety plan
☐ Contacted emergency contact/support person
☐ Contacted crisis line/mobile crisis
☐ Activated emergency services
☐ Mandated report made
☐ Increased supervision/monitoring
☐ Restricted supervisee autonomy or case responsibility
☐ Other: _____
Rationale for selected action(s):

If emergency services were not activated, explain why:

If mandated reporting was considered, document decision and rationale:

---

4. Follow-Up Safety Planning
Safety plan completed or updated: ☐ Yes ☐ No ☐ N/A
Safety steps reviewed with client:

Crisis resources provided:

Support persons involved or recommended:

Follow-up appointment/contact scheduled:
Date/Time: _____
Monitoring plan:

Supervision follow-up/debrief scheduled:
Date/Time: _____

---

5. Documentation Placement
Client record should include:
☐ Risk assessment summary

☐ Client statements/behavior
☐ Clinical rationale
☐ Safety plan
☐ Actions taken
☐ Follow-up plan

Supervision record should include:

☐ Time/date of consultation
☐ Supervisee concern/request
☐ Supervisor directives
☐ Escalation decision
☐ Learning/debrief plan
☐ Any supervisee performance or scope concerns

---

6. Supervisor Review / Sign-Off
Supervisor summary:

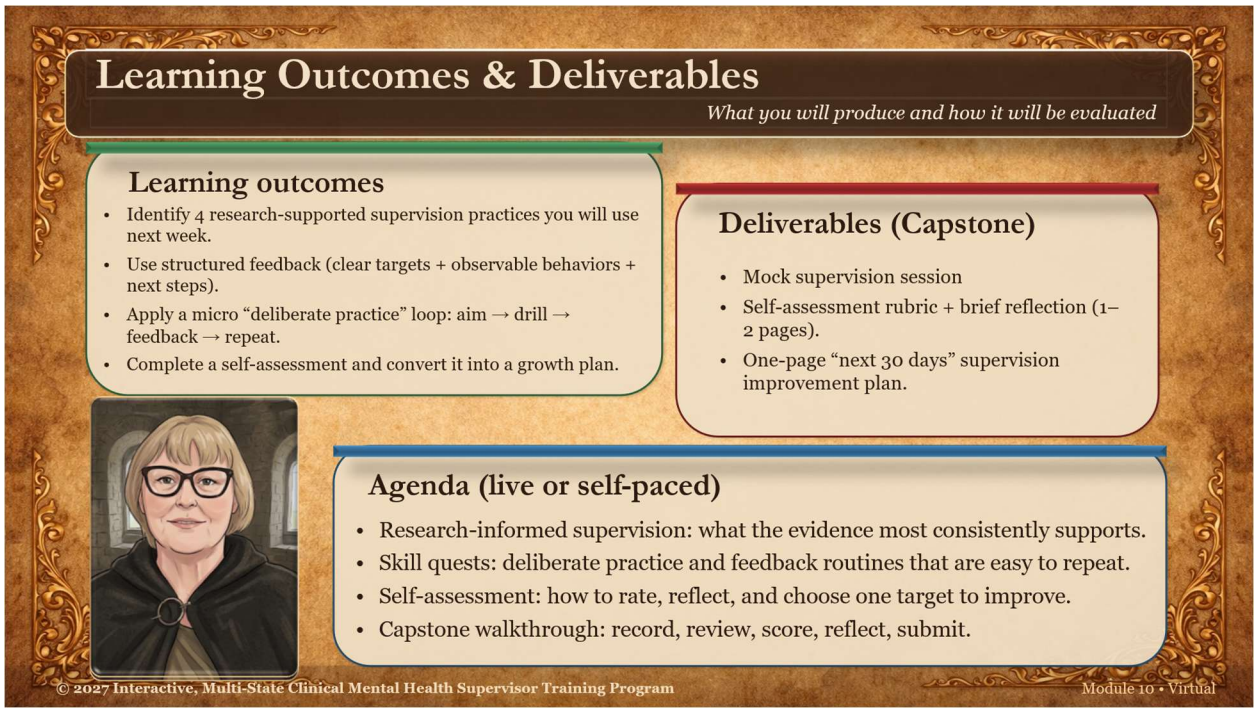
Additional required follow-up:

Supervisor Signature: _____ Date: _____
Clinician/Supervisee Signature: _____ Date: _____

Quick Reminder
Document clearly enough that another qualified reviewer can understand:
What was the risk? Who was consulted? What was decided? Why was that decision made? What happens next?

Module 10 Research-Informed Supervision + Capstone

Learning Outcomes, Deliverables, Agenda



Capstone Self-Assessment Template

Research-Informed Supervision + Self-Assessment
Deliverable: Recorded mock supervision + self-assessment
Participant Name: _____
Date: _____
Module: Research-Informed Supervision + Capstone
Recording Length: _____
Scenario / Supervision Focus: _____

---

1. Recording Information
Type of mock supervision:
☐ Case consultation
☐ Documentation review
☐ Feedback session
☐ Skill rehearsal
☐ High-risk oversight
☐ Cultural/process supervision
☐ Other: _____

Supervisee concern or learning need addressed:

Primary supervision model or framework used:

☐ Discrimination Model
☐ Developmental Model
☐ Reflective/Process Model
☐ Competency-Based Supervision
☐ Multicultural/Social Justice Framework
☐ Other: _____

Brief rationale for model choice:

2. Required Capstone Elements

Check each item included in the recording:

☐ Recording is 10–15 minutes.
☐ No client PHI is included.
☐ A supervision agenda is stated.
☐ Feedback is provided.
☐ Feedback is tied to evidence or observation.
☐ At least one practice repetition or skill rehearsal occurs.
☐ Supervisor role is clear.
☐ Next steps are identified.
☐ The session ends with a clear follow-up plan.

3. Evidence From the Recording

Identify one strong moment from the recording.

Time stamp: _____

What happened?

What supervision skill does this show?

Why was this effective?

4. Supervision Structure

How did I open the supervision session?

Was the agenda clear?

☐ Yes

☐ Partially

☐ No

How did I manage the flow of the session?

How did I close the session?

5. Feedback Self-Assessment

What feedback did I give?

Was the feedback specific and behavior-based?

☐ Yes

☐ Partially

☐ No

What evidence did I use to support the feedback?

What standard or expectation did I connect the feedback to?

What next step did I assign or co-create?

6. Practice / Skill Rehearsal

What skill was practiced or rehearsed?

How did I structure the practice repetition?

What did the supervisee do during the practice?

What would make the practice stronger next time?

7. Supervisory Alliance and Process

How did I build collaboration and trust?

How did I invite supervisee voice or reflection?

Did any tension, confusion, defensiveness, or stuck point appear?

☐ Yes

☐ No

If yes, how did I respond?

What could I have done to strengthen the supervisory alliance?

8. Ethical and Professional Awareness

What ethical or professional issues were relevant?

☐ Confidentiality

☐ Documentation

☐ Scope of practice

☐ Risk/safety

☐ Cultural responsiveness

☐ Boundaries

☐ Evaluation/gatekeeping

☐ Other: _____

How did I address these issues?

What should I document after this supervision session?

9. Research-Informed Practice

Identify at least one research-informed supervision principle demonstrated in the recording.

☐ Supervisory alliance

☐ Structured feedback

☐ Deliberate practice

☐ Competency-based evaluation

☐ Direct observation/evidence use

☐ Reflective practice

☐ Cultural responsiveness

☐ Rupture and repair
☐ Gatekeeping/client protection
Explain how this principle appeared in the recording:

---

10. Self-Rating

Area	Rating 1–4	Evidence
Supervision structure	____ / 4	_____
Alliance and collaboration	____ / 4	_____
Feedback quality	____ / 4	_____
Evidence use	____ / 4	_____
Practice repetition	____ / 4	_____
Ethical awareness	____ / 4	_____
Cultural/process awareness	____ / 4	_____
Clear next steps	____ / 4	_____

Total Score: _____ / 32
Rating Key:
1 = Needs significant revision
2 = Developing
3 = Meets standard
4 = Strong / ready to submit

---

11. Strengths and Growth Areas
My strongest supervision skill in this recording was:

Evidence from the recording:

One area I need to strengthen is:

Evidence from the recording:

One question I want feedback on is:

---

12. 30-Day Growth Plan
Skill I will strengthen over the next 30 days:

Why this skill matters for supervision:

Specific practice action I will complete:

Evidence I will collect:

☐ Recording
☐ Supervision note
☐ Feedback from supervisee
☐ Rubric score
☐ Self-reflection
☐ Consultation feedback
☐ Other: _____

Review date: _____

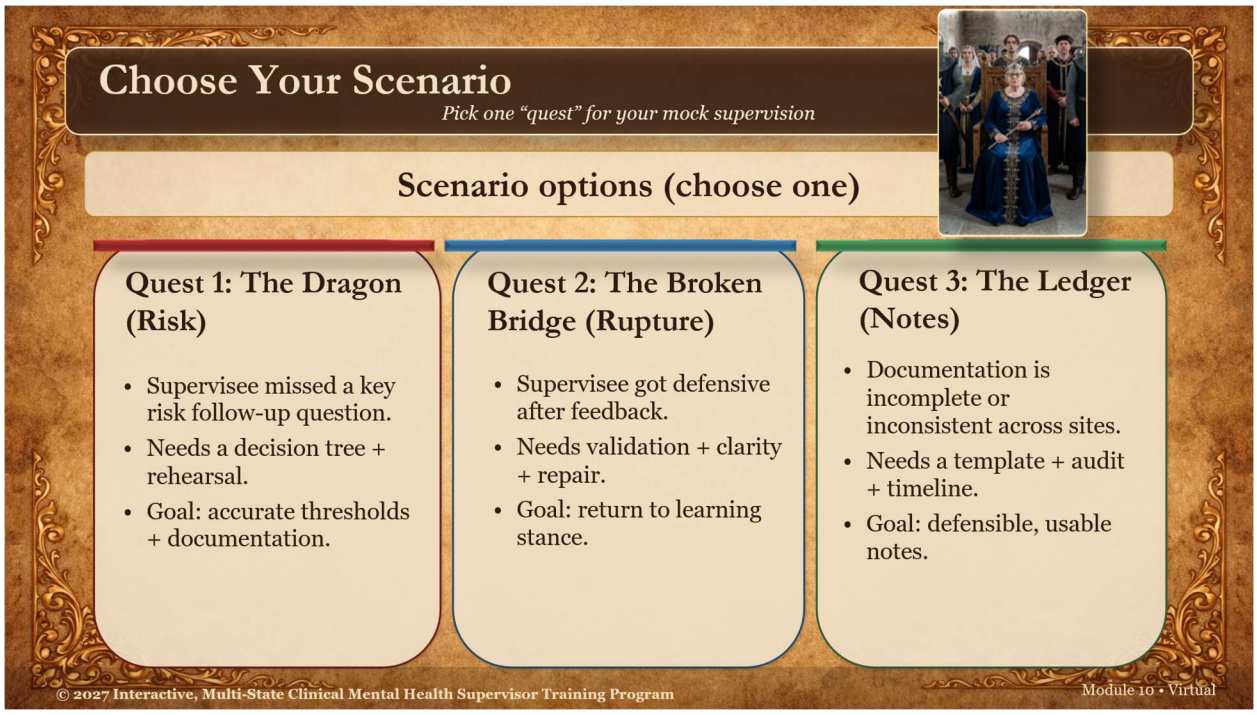
Success will look like:

Final Reflection

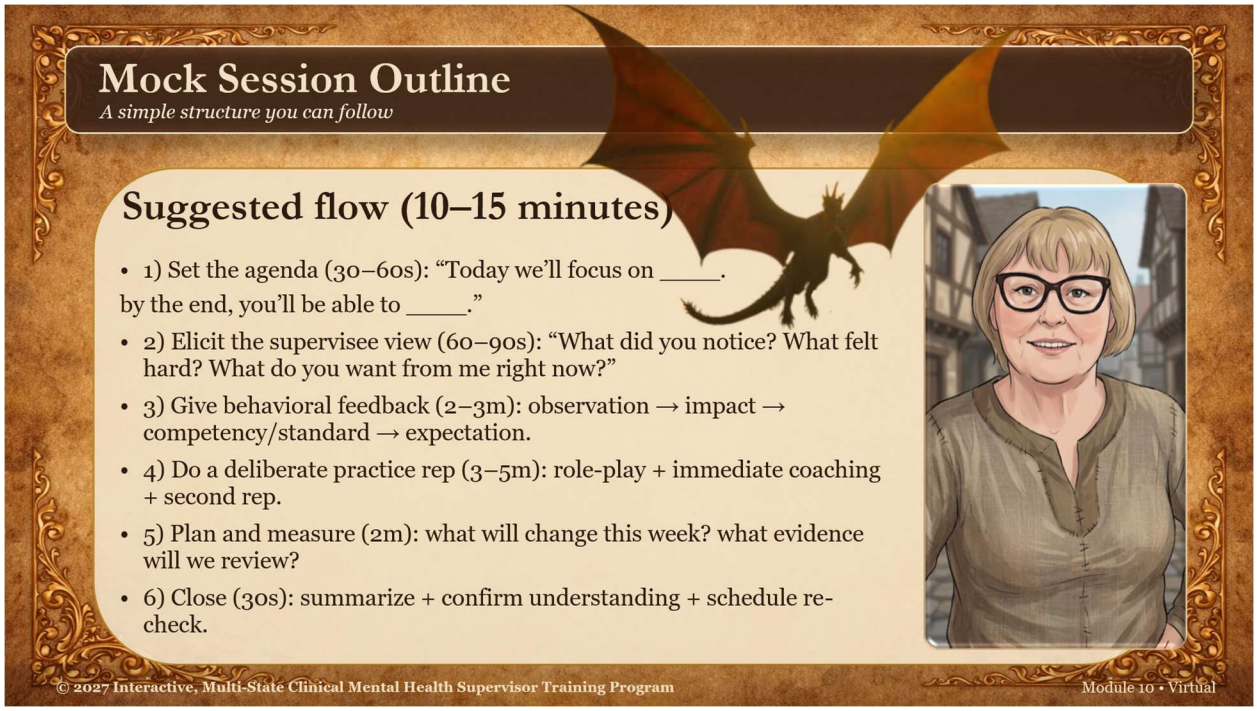
After reviewing my recording, I am learning that my supervision style is:

One commitment I will carry into future supervision is:

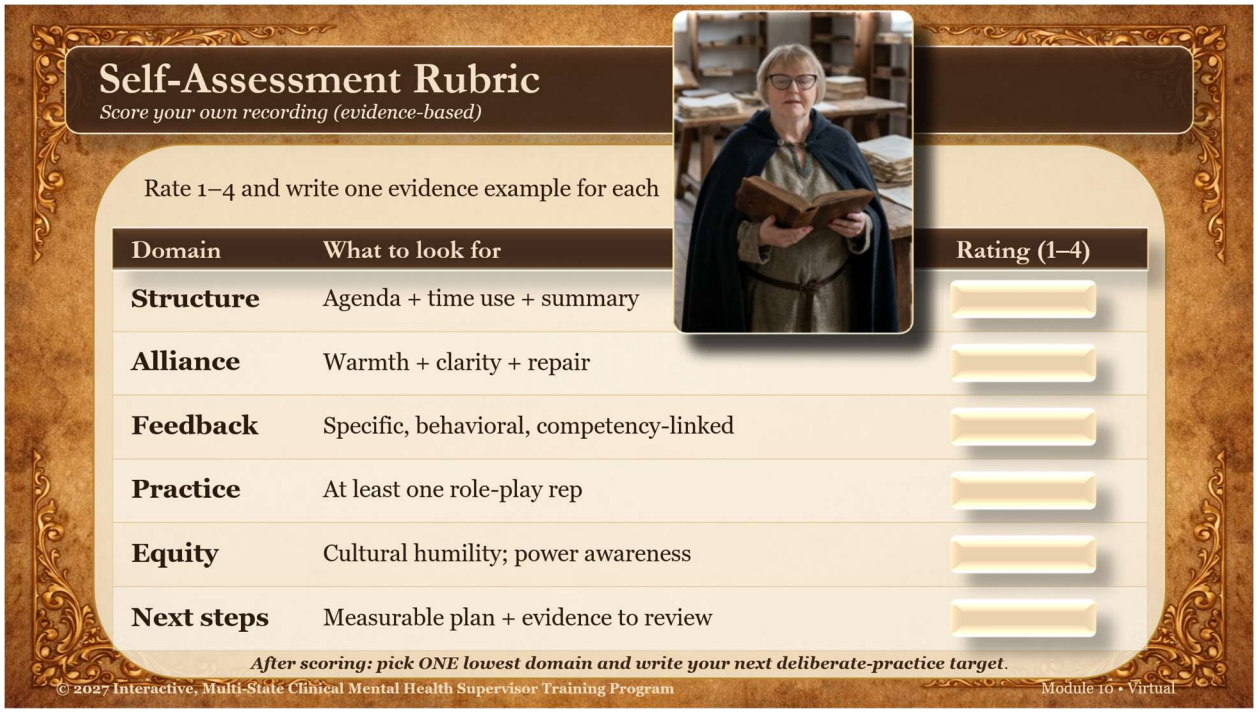
Choose Your Scenario (for mock supervision)



Mock Session outline



Self-Assessment Rubric



Mock Supervision Session Agreement Template

Non-Recorded Mock Session Assignment
For 2–3 Participants
This agreement is for participants completing a **non-recorded mock supervision session** as part of the *Interactive, Multi-State Clinical Mental Health Supervision Training Program*. The purpose of this assignment is to practice supervision structure, role clarity, feedback, skill rehearsal, ethical awareness, and self-reflection in a safe, educational, and non-clinical setting.

1. Purpose of the Mock Session
The mock session is a training exercise designed to help participants practice and demonstrate supervision skills. The session may include agenda-setting, case discussion, documentation review, ethical decision-making, cultural reflection, feedback, role-play, or skill rehearsal. This exercise is for educational purposes only. It is **not therapy, formal clinical supervision, clinical consultation, or treatment**.

2. Participants and Roles
Participants agree to take one or more of the following roles:
Supervisor: Practices leading the mock supervision session, setting an agenda, offering feedback, guiding reflection, and supporting skill rehearsal.
Supervisee: Participates in the mock supervision scenario, presents a fictional or fully de-identified training concern, and responds realistically for learning purposes.
Observer/Reviewer, if applicable: Observes the session, tracks required elements, and may offer feedback using the assignment rubric or checklist.

Participant Names and Roles:

1. Name: _____ Role: _____
2. Name: _____ Role: _____
3. Name: _____ Role: _____

3. No Recording Agreement

Participants agree that this mock supervision session **will not be audio recorded, video recorded, transcribed, photographed, or screen captured**.

Participants also agree not to use artificial intelligence tools, automated note-taking tools, transcription software, or meeting summaries during the mock session unless all participants and the instructor/facilitator have given permission in advance.

4. Use of Fictional or De-Identified Material

Participants agree that no real client protected health information will be used. Participants may use fictional scenarios, composite examples, or fully de-identified training material.

Participants will not include client names, initials, dates of birth, addresses, phone numbers, exact dates of service, agency identifiers, medical record numbers, employer names, school names, or other details that could reasonably identify a client.

5. Confidentiality of Training Material

Participants agree to treat the mock session, role-play content, feedback, and discussion as confidential training material. Participants will not share details from the session outside the assignment or training context.

Participants may discuss general learning takeaways, but they should not disclose personal comments, role-play content, peer feedback, or sensitive material shared by another participant.

6. Boundaries and Emotional Safety

Participants agree to keep the mock session professional, respectful, and appropriate for a training setting. The mock session should not be used to process personal trauma, provide therapy, evaluate another participant's personal life, or disclose sensitive personal information beyond what is necessary for the exercise.

Any participant may pause the mock session if the material becomes uncomfortable, unclear, or inappropriate for the assignment.

Pause phrase: **"Time out for training."**

7. Educational Feedback

Participants understand that feedback is part of the learning exercise. Feedback should be respectful, specific, behavior-based, and connected to the assignment objectives or rubric.

Feedback should focus on observable supervision skills, such as:

- Supervision structure
- Role clarity
- Supervisory alliance
- Feedback quality
- Ethical awareness
- Cultural responsiveness
- Skill rehearsal
- Next steps

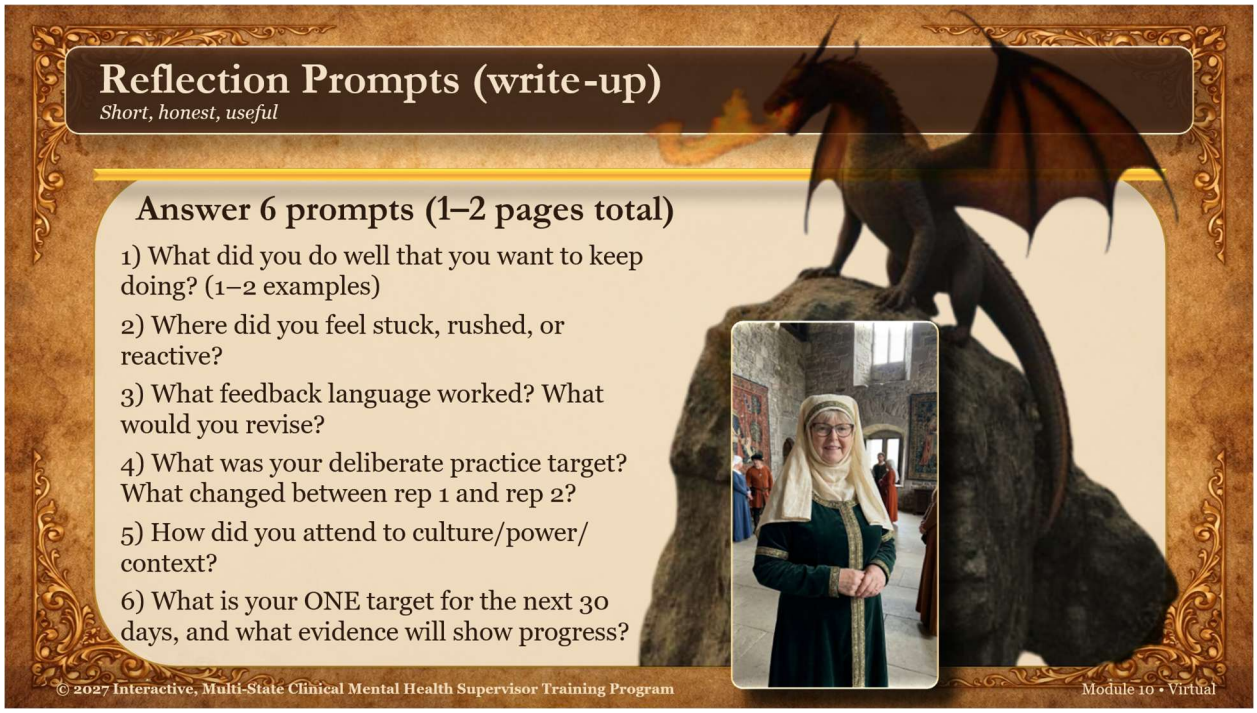
8. Assignment Requirements
Participants understand that the mock session should include the required assignment elements:

- Clear supervision agenda
- Defined participant roles
- No client PHI
- At least one feedback exchange
- At least one practice repetition, role-play, or skill rehearsal
- Clear next steps or follow-up plan
- Self-assessment or reflection completed after the session

9. Notes and Written Reflections
Participants may take brief personal notes for learning and self-assessment. Notes should avoid identifying client information or sensitive details about other participants.
Any written reflection submitted for the assignment should focus on the participant's own learning, supervision skills, and growth areas.
10. Voluntary Pause or Restart
Participants may pause or restart the mock session if there is a concern about privacy, emotional safety, unclear expectations, or accidental disclosure of identifying information.
If identifying information is accidentally shared, participants agree to stop, redirect, and continue using fictional or fully de-identified material.
11. Acknowledgment
By signing below, participants acknowledge that they understand the purpose of the mock session, agree that it will not be recorded, agree to protect confidentiality, and agree not to include real client protected health information.
Participant 1 Signature: _____ Date: _____
Participant 2 Signature: _____ Date: _____
Participant 3 Signature: _____ Date: _____
Instructor/Facilitator, if required: _____ Date: _____

Brief Non-Recorded Participation Statement
"I understand that this mock supervision session is for educational purposes only and will not be recorded. I agree not to include client protected health information and agree to treat the session content, peer feedback, and role-play material as confidential training information."

Reflection Prompts (write-up)



Wrap Up and Deliverables