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Executive Summary

The Santa Clara County Mental Health Department (SCCMHD) tasked a workgroup to focus on enhancing the quality and consistency of clinical supervision practice standards in the department. The goal of these practice standards recommendations is to ensure the appropriate skill level of supervisors, frequency and content of clinical supervision in the Santa Clara County Mental Health Department. Practicing to these standards can enhance the practitioner’s delivery of quality care from the first point of contact throughout the continuum of care by:

- Receiving regular, structured supervision grounded in best practices
- Enhancing the supervisee’s skills, knowledge and professional development
- Promoting recovery orientated services in culturally relevant, person-centered and family-driven ways
- Promoting healthy morale
- More effective client movement through levels of care
- Promoting fidelity to Evidenced Based Practices
- Adhering to agency, licensing, and accrediting requirements
- Monitoring legal and ethical issues to reduce liability
- Increasing staff retention
- Developing and promoting a learning culture

A workgroup, comprised of direct service providers, clinical supervisors and managers from county and contract agencies across the Family & Children’s (F&C) and Adult and Older Adult (AOA) Systems of Care, was convened in August of 2013. The workgroup has been meeting regularly since it was convened and has identified a number of goals, including:

- Conduct a needs assessment of staff to understand the system’s needs for clinical supervision
- Develop a core set of standards and skills for clinical supervisors
- Address training/support needs for clinical supervisors
These recommendations are intended for practitioners throughout the Santa Clara County Mental Health Department Systems of Care responsible for the provision of supervision, monitoring, evaluating and training of direct service staff. The recommendations are intended for the supervision of both professional and paraprofessional staff. Supervision needs to be adapted by the supervisors to match the needs and roles of the supervisees.

This document has been submitted to the System of Care Committees and Performance Quality Improvement Committee (PQIC) for final review and ratification. Implementation of the recommendations will begin following feedback and approval from the Systems of Care and PQIC Committees.
Background
In order to have a better understanding of current supervision practices, staff experience with supervision and to inform the tasks the workgroup was charged with, a survey and focus groups were conducted. In addition, the workgroup reviewed multiple documents and research regarding current best practices.

Survey
The workgroup developed 15 survey questions targeting direct service providers and clinical supervisors. The survey was distributed via e-mail to all county clinics and contract agencies. 106 responses were received. Here is a sample of the questions asked:

- Are you currently receiving Clinical Supervision?
- What makes your Clinical Supervision effective?
- What are the challenges you face in providing Clinical Supervision?
- What do you think could improve your Clinical Supervision?

The following summarizes results from the survey:
Focus Groups

Four focus groups were conducted in November 2013:

<table>
<thead>
<tr>
<th>Group</th>
<th>Number of Participants</th>
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<tr>
<td>F&amp;C Unlicensed staff</td>
<td>12</td>
</tr>
<tr>
<td>F&amp;C Licensed staff</td>
<td>5</td>
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<tr>
<td>AOA Unlicensed staff</td>
<td>4</td>
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<tr>
<td>AOA Licensed staff</td>
<td>6</td>
</tr>
</tbody>
</table>

The workgroup developed the following questions for discussion with the focus groups:

1. What Clinical Supervision/consultation/clinical support are you getting?
   a. Is it regular, scheduled, and formal?
2. What are the obstacles to regular, scheduled, and formal clinical supervision?
   a. How would you address these obstacles?
3. What are your needs for clinical supervision?
4. How much time in the clinical supervision that you receive is spent on clinical issues?
   a. On what is the remainder of the time spent?

Lessons Learned

- Supervision and clinical support appear to be highly valued and welcomed by practitioners
- Focus group participants indicated they would like to see clinical supervision become a higher priority in our system
- Unlicensed staff working toward licensure are generally getting clinical supervision more regularly
- Licensed staff are getting some informal consultation
- There was overall lack of consistent clinical support for licensed staff
There was overall lack of consistency in the structure, frequency and content of the supervision provided, no standardized practices were reported.

A high degree of variability in the quality of supervision was reported by participants.

Multiple challenges were identified to the provision of quality clinical supervision: time, documentation and administrative needs, differences in supervisees’ needs, personal.

Participants identified the following as strategies that could help them in supervision: more training on clinical supervision best practice models and a consultation group for supervisors; increased support at the management level for clinical supervision practices; standardized practices which speak to the regularity and structure of supervision.

Staff reported challenges with receiving and providing supervision both through the survey and the focus groups. Although supervision and clinical support were described to be highly valued in our system, demands of the work both for the supervisors and the practitioners were highlighted as obstacles to regular and consistent supervision across the focus groups. What commonly takes place is a brief review of casework, focus on problem solving, resolving crisis situations, “hallway consultations”, and, in some instances supervisees getting feedback via e-mail. Some additional obstacles included finding the time for supervision, carrying a large caseload, personal issues, availability of the supervisor, qualifications of supervisor, competing priorities, etc. In addition, the tension between clinical work and administrative supervision and finding a balance between the two further compounds the challenge of making regular, quality supervision the rule rather than the exception.

The majority of staff who indicated not receiving clinical supervision have been in practice for over 10 years and are likely to be licensed staff. Most licensed practitioners are not required by any governing body to receive supervision and reported getting consultation as needed. While the licensed staff acknowledged the benefits of ongoing supervision, there appeared to be some ambivalence about the need for it.

Staff who reported receiving supervision described that what made their supervision more effective was the experience and expertise of their clinical supervisor. The reflective capacities and relational approach of supervisors were also attributed to making supervision more effective. Additionally, practitioners expressed definite ideas about what may improve supervision. The majority of responses endorsed guidance, techniques, interventions, ideas, solutions, etc. A significant number of responses supported having regular and structured supervision in place.

The combination of all the obstacles identified can potentially lead to low staff morale and a feeling that the clinical work and its supervision are not valued by the system. Conversely, high quality supervision can potentially increase effectiveness of services, improve client outcomes and job satisfaction.
Review of documents
In addition to the survey, focus groups, the workgroup’s expertise and experience with clinical supervision, the following documents were reviewed:

- Best Practices in Clinical Supervision by The Association for Counselor Education and Supervision (ACES), a division of the American Counseling Association in 2011
- Practice Wise, Competence Model, Framework for Professional, version 5/10/2010
- Reviewed and adopted document format of Southern Counties Regional Partnership Core Competency Project, June 2014
- Guidelines for Competency-based Clinical Supervision in Health Service Psychology Education and Training Programs – APA, Board of Educational Affairs Task Force 2014
- Development of Clinical Supervision Practice Competencies – American Board of Examiners in Clinical Social Work
- Practical Applications in Supervision, CAMFT ‘s Supervision Manual, 2013
- Reviewed and adapted concepts from Arizona Department of Health Services Practice Protocol on Clinical Supervision, 2008
- Documents from multiple contract agencies regarding internal supervision practices: contracts, evaluation forms, case presentation formats, tips on supervision, coaching guides, etc.
- Materials and presentations from the 10th Annual International Interdisciplinary Conference on Clinical Supervision – Summer 2014
  - The Dynamics and Skills of Clinical Supervision: The Parallel Process and the Interactional Model, Lawrence Shulman, Ed.D.
  - Illustrating Distinct Approaches to Clinical Supervision Across Disciplines, Alex Gitterman, Ed.D.
  - Clinical Supervision in the World of Evidence-Based-Practice: Integrating Science and Art, Lawrence Shulman, Ed.D.
Clinical Supervision
Workgroup Recommendations
2014

- Dislikable Clients or Countertransference: An Interdisciplinary Perspective, Manoj Pardasani Ph.D.
- Supervisor Effects on Psychotherapy Outcome in Routine Practice, Tony Rousmaniere, Psy.D. and Robbie Babbins-Wagner, Ph.D.
- A Self-Psychology Perspective on Clinical Supervision: Ten Practical Tenets and Two Case Examples, Edward Watkins, Jr., Ph.D.
- Clinical Supervision In Ireland and the US: Similarities and Differences, Michael Ellis, Ph.D. and Mary Creaner, D.Psych
- Relational Depth In Supervision, Jodi Bartley, M.Ed.
- Supervisor Training: Implications of Common Factors and Deliberate Practice Research, Mark Cameron, Ph.D.
- Creative Supervisory Interventions for Theoretical Deconstruction and Development, Melissa Luke, Ph.D. et al
- Supervisor Effects on Psychotherapy Outcome in Routine Practice, Tony Rousmaniere, Psy.D. and Robbie Babbins-Wagner, Ph.D.
- Generational Characteristics and the Impact on the Working Alliance, Claudia Howell, M.Ed.
Clinical Supervision Defined:
Clinical supervision is a broad term which encompasses different principles, activities, disciplines and areas of practice. It involves regular, protected time for facilitated, in depth reflection on practice. Clinical supervision is applicable for all staff involved in the delivery of mental health services regardless of their experience or professional background. In this document the terms clinical supervision and supervision are used interchangeably to be inclusive of all practitioners practicing within the SCCMHD. The workgroup has elected to adopt clinical supervision leading experts’ Falender & Shafranske definition.

"Supervision” is a distinct professional activity:

- In which education and training aimed at developing science-informed practice are facilitated through a collaborative interpersonal process.
- That involves observation, evaluation, feedback, facilitation of supervisee self-assessment, and acquisition of knowledge and skills by instruction, modeling, and mutual problem-solving.
- That builds on the recognition of the strengths and talents of the supervisee and encourages self-efficacy.
- That is conducted in a competent manner in which ethical standards, legal prescriptions, and professional practices are used to promote and protect the welfare of the client, the profession, and society at large (Falender & Shafranske, 2004, p. 3).
Recommended core skills for Clinical Supervisors include but are not limited to:

**Core Clinical Knowledge Base**
Supervisor comprehends and applies a variety of individual and systemic therapeutic models and demonstrates their application in individual and/or group supervision, including but not limited to the following knowledge, skills and abilities:

1. Integrating into supervision evidence based and promising mental health practices (i.e. TFCBT, DBT, Child-Parent Psychotherapy, Seeking Safety, etc.)
2. Multiple treatment modalities within scope of practice
3. Awareness of supervisees learning styles (converger, diverger, assimilator, accommodator) and developmental level
4. Differing supervisee needs based on stage of professional development
5. Person-centered/ recovery, resilience and wellness oriented approaches
6. Relationship-based and family-centered approaches
7. Models of Supervision (i.e. Reflective Practice, Competency Based Supervision, Interactional Supervision, etc.)
8. Mental Health and Substance Use Co-Occurring Disorders
9. Typical development and life span
10. Neurodevelopmental disorders
11. Risk management including but not limited to:
   a. Danger to self
   b. Danger to others
12. The concepts of transference/countertransference and how to manage them in a clinical setting
13. Santa Clara County and agency’s Standards of Practice & Clinical Records Documentation
14. Use of tools and measures to support assessment, treatment planning and outcome measuring (i.e. CANS, MORS, etc.)

**Supervisory Relationship**
Supervisor develops and maintains a working alliance in order to enhance and maximize client care and professional development. Supervisor understands the importance of parallel processes including but not limited to the following knowledge, skills and abilities:

1. Ongoing agreement about clear roles and expectations for the supervisory relationship
2. Confidentiality, safety and transparency
3. Content and process of supervision changes with clinical and professional growth of the supervisee
4. Identifying and managing transference and counter transference issues
5. Establishing and maintaining professional boundaries
6. Awareness of the sociopolitical context within which the supervision is conducted
7. Creation of a climate in which honest feedback is the norm (both supportive and challenging)
8. Ability to provide formative and summative feedback
9. Power differentials and dual roles of the supervisor and supervisee
10. Working with challenging supervisees
11. Ability to inspire and motivate

**Contextual Factors**

Supervisor is knowledgeable of factors affecting the supervisee in the context of their clinical work with clients from diverse socio political backgrounds. Supervision addresses the sensitivity and skills supervisees need to implement adaptations to practice when issues of difference are present, including but not limited to the following knowledge, skills and abilities:

1. Clinical/cultural aspects of working with populations being supervised including AOA, F&C, First Five, TAY
2. Culture
3. Subcultures (i.e. foster care, gang, substance use, homelessness)
4. Family composition and structure
5. Age
6. Race
7. Socio-Economic
8. Gender
9. Language
10. Sexual Orientation
11. Education
12. Religion and Spirituality
13. Disabilities
14. Organizational Context (inter-phasing with systems)
15. Immigration status and acculturation issues
16. Legal issues

**Legal/Ethical/Regulatory Issues**

Supervisor understands and applies the respective professional, discipline, legal and ethical standards, standards of the agency of employment, and relevant mental health county, state and federal laws/mandates including but not limited to the following knowledge, skills, and abilities:

1. Legal and ethical issues specific to supervision
2. Confidentiality/HIPAA
   a. HIV/AIDS
   b. Substance abuse
3. Informed consent  
   a. Minor Consent  
   b. Caregiver affidavit  
4. Understands and supports Patient’s Rights  
   a. Conservatorship  
5. Follows the Code of Ethics and professional standards for one’s respective profession  
   a. Dual relationships  
   b. Use of self-disclosure  
   c. Conflict of interest  
   d. Gifts  
6. Follows agency and county of employment Ethics and Legal Codes  
7. Current on legal mandates and requirements  
   a. Child abuse reporting laws  
   b. Elder abuse reporting laws  
   c. Involuntary commitment (LPS 5150, and W&I Code and regulations)  
   d. Duty to Warn  
   e. Incident Reporting  
8. Use of technology and social media  
9. Commitment to knowing and utilizing available psychological science related to supervision  
10. Commitment to knowing one’s own limitations and scope of competency

**Standards & Work Management**

*Supervisors manage and model responsibilities and tasks of work assignment within an agency timelines and expectations including but not limited to the following knowledge, skills, abilities and values:*

1. Professional attributes critical to effective supervision such as commitment, respect, punctuality  
2. Personal attributes critical to effective supervision such as adaptability, dependability, self-awareness, cultural sensitivity and critical thinking  
3. Self-care, compassion fatigue, and vicarious traumatization/resiliency  
4. Providing consistent, scheduled, and structured supervision. Recommendations include the following minimum requirements:  
   a. Unlicensed staff on licensure track receive supervision in accordance to their licensure board requirements  
   b. Licensed staff receive one unit * of supervision 2 times/month  
   c. Paraprofessionals and other practitioners receive one unit * of supervision weekly  
5. Agencies are recommended to maintain a workflow that is manageable for supervisors by attending to the ratio of supervisors to supervisees
a. The numbers of supervisees assigned to a supervisor should be tied to licensure regulations, level of expertise and experience, years of professional practice, comfort level, complexity and intensity of services, qualifications, etc.
b. Best practice recommends a ratio of no more than 1:8

6. Supervisor structures supervision to address critical elements including**:
   a. Case Selection to review in supervision
   b. Preparation & Planning
   c. Goal-setting
   d. Instruction
   e. Monitoring
   f. Feedback & Support
   g. Reflection
   h. Balancing the clinical needs of the client and the training needs of the supervisee

7. Supervisor utilizes a combination of methods of supervision which may include but are not limited to:
   a. Live supervision
   b. Audio/video tapes
   c. Role play
   d. Documentation review
   e. Process recordings

* One unit of supervision = 1 hour of individual or 2 hours of group supervision

** The exact structure will depend on the practitioner’s needs. For practitioners with limited experience, for example, more structured sessions are common, whereas for more experienced practitioners, there is more scope of clinician-led consultations and discussion of relevant issues

8. Documentation standards in clinical supervision
   Minimum standards:
   a. A completed supervision agreement/contract signed by the supervisor and practitioner at the commencement of the supervisory relationship
   b. A continuing record maintained by the supervisor of the supervisee’s attendance at clinical supervision

   Best practice standards:
   a. Time and date of the session
   b. Name of the practitioner
c. Outline/summary of the cases/issues discussed with special attention to legal, ethical, and risk management
d. Outcomes and action plan
Recommendations for Training & Development of Supervision Skills*

1. Completion of coursework in supervision to meet minimum requirements for specific credentials i.e. social work, psychology, MFT, etc.
2. Supervisor receives or has received supervision of supervision which may include some form of observation (e.g. audiotape or videotape, sitting in, 2-way mirror, etc.) by an individual who has a high level of demonstrated competence in the provision of clinical supervision
3. Supervisor receives documented supervisee feedback
4. Regular self-assessment and awareness of need for consultation
5. 1-2 Professional Development days/year in clinical supervision advanced issues
6. Additional training recommended:
   - Santa Clara County Clinical Supervision Training Program (see appendix I)
   - CAMFT Sponsored Trainings on Clinical Supervision
   - National Association of Social Work sponsored trainings on Clinical Supervision
7. The workgroup has included a list of resources and a toolbox (see appendices) for supervisors’ use

*In programs or models where existing supervision standards are in place, those standards should be included.

Anticipated Outcomes

It is anticipated that by valuing clinical supervision at all levels within an organization:

1. Management will be more attentive to hiring practices of supervisors
2. Supervisors will be formally trained in the delivery of clinical supervision and participate in ongoing consultation groups
3. Supervisors will be assigned a manageable number of staff/supervisees

In addition, by maintaining consistent, high quality clinical supervision sessions with practitioners, implementing clinical supervision standards and training supervisors in advanced practices the following outcomes are anticipated:

4. Practitioners will experience professional growth and development
5. Practitioners will be trained on best practices in their respective areas of service
6. Practitioners will be aware of agency, licensing, ethical, and state requirements
7. Practitioners will provide more effective, high quality care to consumers
8. Practitioners will be regularly evaluated and given feedback on professional competency
Resources

Santa Clara County Clinical Supervision Training Program Proposal (see appendix I)


California Association of Marriage and Family Therapist (CAMFT): www.camft.org

CAMFT Supervisors’ Corner Website

National Association of Social Workers: www.socialworkers.org

American Psychological Association: www.apa.org

California Board of Psychology: www.psychology.ca.gov

California Board of Behavioral Sciences: www.bbs.ca.gov

Carol Falender’s Website: cfalender.com

Roth and Pilling Supervision Competencies, U.K. http://www.ucl.ac.uk/clinical-psychology/CORE/supervision_framework.htm

Supervision per Council on Accreditation (COA): http://coanet.org/standard/ts/

SCC Supervisors’ Toolbox (see appendices)*

Supervision Contracts (see appendix II)

Evaluation Forms (see appendix III)

Self –Assessment Forms (see appendix IV)

Case Presentation Forms (see appendix V)

Documenting Supervision (see appendix VI)

Tips on Supervision (see appendix VII)

*all materials are shared with permission from the sources
References


Ladany, N., Mori, Y. & Mehr, K. Effective and Ineffective Supervision. The Counseling Psychologist 2013 41: 28


Appendices

Appendix I

Santa Clara County Clinical Supervision Training Program Proposal
<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Topic</th>
<th>Presenter</th>
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<td>2/25/15</td>
<td>1pm - 1:30pm</td>
<td>Orientation</td>
<td>Zelia Faria-Costa</td>
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<td>1:30pm - 5pm</td>
<td>Models of Supervision</td>
<td>Angela Maldonado-Nunes, LMFT</td>
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<td>Lydia V. Flasher, Ph.D.</td>
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<td>Director, Psychology Training Programs</td>
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<td>Licensed Psychologist # 16024</td>
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<td>Maretta Juarez, LCSW</td>
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<td>IFECMH Specialist/RPF Mentor</td>
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<td>Senior Mental Health Program Manager</td>
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<td>Randall Ramirez, LCSW, LMFT</td>
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<td>Director of Behavioral Health &amp; Internship Program</td>
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<td>Clinical Supervision Law and Ethics</td>
<td>Mike Griffin, JD, LCSW</td>
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<td>6/10/14</td>
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<td>The Supervisory Relationship and</td>
<td>Nicholas Ladany, Ph.D.</td>
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| 8/12/15    | 9am - 4:30pm  | Supervising to the treatment of Co-Occurring Disorders                | Lorraine Williams-White, LCSW  
Addiction Medicine & Therapy Division  
Integrated Care Services |
| 9/9/15     | 2:30pm-4:30pm | Supervisors Consultation Group                                       | TBD                                                                       |
| 10/14/15   | 9am - 12:00pm | Evaluation and Next Steps in Practitioners Supervision                | Melanie Stern, LCSW  
Therapist, Consultant, Trainer  
Nia White Belt |
|            | 1:00pm - 4:00pm | Using measurement tools in supervision/ Supervising to multiple EBPs | TBD                                                                       |
| 11/11/15   | 2:30pm - 4:30pm | Supervisors Consultation Group                                       | TBD                                                                       |
| 12/9/15    | 9am - 12:00pm | Putting it all together                                                | Randall Ramirez, LCSW, LMFT  
Director of Behavioral Health & Internship Program  
Unity Care, San Jose, CA  
James Livingston, Ph.D.  
Senior Staff Psychologist  
Center for Survivors of Torture  
Asian Americans for Community Involvement  
San Jose, CA |
|            | 1pm - 4:00pm  | Compass Fatigue                                                       |                                                                            |
| 1/13/16    | 1:30pm - 3:30pm | Supervisors Consultation Group                                       | TBD                                                                       |
|            | 3:30pm - 4:30pm | Clinical Supervision Training Program Certificate Awards              |                                                                            |

*Dates, times, and presenters are subject to change

### Additional Trainings

The following 2 courses are to be completed before commencing the program or by July 31, 2015:

1) **Foundations of Clinical Supervision**  
(Required BBS course for Supervisors)  

2) **Facilitating the Reflective Process in Mental Health Work: An Inter-Disciplinary 2-Day Workshop for Mentors, Facilitators & Supervisors**  

For questions regarding the above training sessions and consultations groups contact Zelia Faria-Costa  
zelia.faria-costa@hhs.sccgov.org or Larry Powell @ larry.powell@hhs.sccgov.org
Appendix II

Supervision Contracts

- Carol Falender’s Basic Contract
- Carol Falender’s Sample Contract
- The Clinical Supervision Relationship (Alexis Horozan)
Defining supervision

- Collaborative and supportive
- Strength-based (identifying strengths of system, supervisees and supervisors)
- Developmental focus promoting lifelong learning
- Agreement that highest duty of supervisor and supervisee is protection of and working in the best interests of the client

This agreement serves to verify and describe the supervision provided by

______________________________ (supervisor name and degree) to ____________________________ supervisee.

Effective Date: __________________

Structure of sessions:
Frequency __________________
Duration __________________

Mutually determined goals and tasks by Supervisor and Supervisee to accomplish

Goal 1.

Task by Supervisor:

Task by Supervisee:

Goal 2.

Task by Supervisor:

Task by Supervisee:

Goal 3.

Task by Supervisor:

Task by Supervisee:

Strategies and methods to achieve these goals:

I agree to adhere to the ethical standards of my workplace and profession and to the regulations and personnel practices. I understand that personal factors are relevant to supervision and are valued.
I have read the above agreement and agree to operate in compliance with it.

Supervisor signature___________________________________________________

Date_________________________________

Supervisee Signature____________________________________________________

Date_________________________________
Sample Supervision Contract
Carol Falender, Ph.D.

Introduction to Supervision Contract

This document is intended to establish parameters of supervision, assist in supervisee professional development (whether licensure, post-licensure, or developmental supervision), provide clarity in supervisor responsibilities including the responsibility of the supervisor to protect the client.

This contract between _______________________(supervisor) and ______________________(supervisee) at ______________________________(site of supervision), signed on _______________(date) serves to verify supervision and establish its parameters.

I. Competencies Expectations

A. It is expected that supervision will occur in a competency-based framework.
B. Supervisees will self-assess clinical competencies (knowledge, skills, and values/attitudes)
C. Supervisors will compare supervisee self-assessments with their own assessments based on observation and report of clinical work, supervision, and competency-instruments.

II. Context of Supervision

A. _______hour(s) of individual supervision per week.
B. _______hour(s) of group supervision per week
C. Review of videotapes and/or audio tapes is part of supervision process
D. Treatment notes complete for all sessions for the past week and available in the supervision session for review
E. Supervision will consist of multiple modalities including review of tapes, progress notes, discussion of live observation, instruction, modeling, mutual problem-solving, and role-play.

III. Evaluation

A. Feedback will be provided in each supervision session. Feedback will be related to competency documents.
B. Summative evaluation will occur at ___(number) intervals per year:
_________________________(specify dates)
C. Forms used in summative evaluation are or available at ________.
D. Supervisor notes may be shared with the supervisee at the supervisor’s discretion and at the request of the supervisee.
E. In order to successfully complete the sequence, the supervisee must attain a
rating of ____ (on the evaluation Likert scales).
F. If the supervisee does not meet criteria for successful completion, the supervisee will be informed at the first indication of this, and supportive and emedial steps will be implemented to assist the supervisee.
G. If the supervisee continues not to meet criteria for successful completion, the steps in place and procedures laid out will be followed.

IV. Duties and Responsibilities of Supervisor
A. Oversees and monitors all aspects of client case conceptualization and treatment planning
B. Reviews video/audio tapes outside of supervision session
C. Develops supervisory relationship and establish emotional tone
D. Assists in development of goals and tasks to achieve in supervision specific to assessed competencies
E. Challenges and problem solves with supervisee
F. Provides interventions with clients and directives for clients at risk
G. Identifies theoretical orientation(s) used in supervision and in therapy and takes responsibility for integrating theory in supervision process, assessing supervisee theoretical understanding/training/orientation(s)
H. Identifies and builds upon supervisee strengths as defined in competency assessment
I. Introduces and models use of personal factors including belief structures, worldview, values, culture, transference, countertransference, parallel process, and isomorphism in therapy and supervision
J. Ensures a high level of professionalism in all interactions
K. Identifies and addresses strains or ruptures in the supervisory relationship
L. Establishes informed consent for all aspects of supervision
M. Signs off on all supervisee case notes
N. The supervisor distinguishes administrative supervision from clinical supervision and ensures the supervisee receives adequate clinical supervision
O. Clearly distinguishes and maintains the line between supervision and therapy.
P. Discusses and ensures understanding of all aspects of the supervisory process in this document and the underlying legal and ethical standards from the onset of supervision

V. Duties and Responsibilities of the Supervisee
A. Upholds and adheres to APA Ethical Principles of Psychologists and Code of Conduct
B. Reviews client video/audio tapes before supervision
C. Comes prepared to discuss client cases with files, completed case notes and prepared with conceptualization, questions, and literature on relevant evidence-based practices
D. Is prepared to present integrated case conceptualization that is culturally competent
E. Brings to supervision personal factors, transference, countertransference, and parallel process, and is open to discussion of these.
F. Identifies goals and tasks to achieve in supervision to attain specific competencies
G. Identifies specific needs relative to supervisor input
H. Identifies strengths and areas of future development
I. Understands the liability (direct and vicarious) of the supervisor with respect to supervisee practice and behavior
J. Identifies to clients his/her status as supervisee, the supervisory structure (including supervisor access to all aspects of case documentation and records), and name of the clinical supervisor
K. Discloses errors, concerns, and clinical issues as they arise
L. Raised issues or disagreements that arise in supervision process to move towards resolution
M. Provides feedback weekly to supervisor on supervision process
N. Responds non defensively to supervisor feedback
O. Consults with supervisor or delegated supervisor in all cases of emergency
P. Implements supervisor directives in subsequent sessions or before as indicated.

Procedural Aspects
A. Although only the information which relates to the client is strictly confidential in supervision, the supervisor will treat supervisee disclosures with discretion.
B. There are limits of confidentiality for supervisee disclosures. These include ethical and legal violations, indication of harm to self and others (and others as specific to the setting).
C. Progress reports will be submitted to __________ describing your development, strengths, and areas of concern.
D. If the supervisor or the supervisee must cancel or miss a supervision session, the session will be rescheduled.
E. The supervisee may contact the supervisor at (contact #) __________ or on-call supervisor at ________________. The supervisor must be contacted for all emergency situations.
Supervisor’s Scope of Competence:
Include supervisor’s training, licensure including number and state(s), areas of specialty and special expertise, previous supervision training and experience, and areas in which he/she has previously supervised.

The contract may be revised at the request of supervisee or supervisor. The contract will be formally reviewed at quarterly intervals and more frequently as indicated. Revisions will be made only with consent of supervisee and approval of supervisor. We, ___________ (supervisee) and ________________ (supervisor) to follow the directives laid out in this supervision contract and to conduct ourselves in keeping with our Ethical Principles and Code of Conduct, laws, and regulations.

__________________________________________________________
Supervisor                                                        Date

__________________________________________________________
Supervisee                                                        Date

Dates Contract is in effect:________________________________________
The Clinical Supervision Relationship

Supervisee Responsibilities
1. To provide service to clients in an ethical manner and adhere to ethical standards of profession.
2. To follow rules of confidentiality and protect clients from harm.
3. To avoid all harmful relationships with clients, especially sexual relationships.
4. To work always within the limits of competency, skill and training.
5. To seek supervision if there is any question of biases or problems working on a particular case.
6. To commit to making changes that will promote therapeutic effectiveness and professional growth.
7. To give honest self-report to supervisors of one’s weaknesses inability, biases and problems working with clients.
8. To be open to new and different clinical techniques and approaches.
9. To be open to feedback from supervisors and willing to follow advice and direction.
10. To accept referral to outside therapy if indicated.
11. To submit documentation of clerical work in timely and accurate form.
12. To maintain the confidentiality of group members (both client and personal issues).
13. To prepare for supervisory sessions and participate actively in the supervision process.
14. To provide supervisor with honest feedback about supervision and the supervisory process.
15. In situations of supervisor incompetence. (Substance abuse, sexual harassment, etc) seek consultation and guidance on how to proceed.
16. To want to become the best professional possible.

Supervisor Responsibilities
1. Protecting clients by insuring the quality of the care they receive.
2. Promotion and protection of the profession and community.
3. Be able and consistent in offering supervision.
4. Provide regular individual and/or group supervision.
5. Delineate roles, relationships, and expectations of supervision.
6. Be tolerant of different approaches and therapeutic models.
7. Provides fair evaluation and honest feedback.
8. Promote development of clinical skills and professional identity.
9. Protect clients and help supervisees avoid unethical decisions.
10. Avoid or limit scope of dual relationships and potential for harm.
11. Provide supervisee with means to give you feedback and resolve difficulties.
12. Maximize the use of techniques to protect and monitor client care.

We have read and discussed the supervisee/supervisor responsibilities:

Supervisee: _______________________________________________________________ Date:_______________

Supervisor: ______________________________ _____________________________ Date: ________________
Appendix III

Evaluation Forms

- Sample Supervisee Evaluation
- Sample Supervisor Evaluation
- FCS Intern/Trainee Evaluation
- CHC Intern Evaluation
- Supervision Outcomes Survey
Therapist Evaluation Checklist

Therapist:

Supervisor:

Date: Mid-year______ Final______

The present level of each skill should be rated as follows:

s  Strength
/  Ability commensurate with level of training
?  Insufficient data
n  Needs improvement (must specify)
na Not applicable

Any rating of “needs improvement” must be accompanied by specific recommendations in the comments section. Raters are encouraged to provide narrative commentary as opposed to ratings when possible.

I. CONTRIBUTES TO CLINICAL TEAM
   ___ conscientious; fulfills responsibilities without reminders, is productive
   ___ accepting and cooperative toward staff at all levels; forms positive relationships
   ___ establishes effective supervisory alliance
   ___ exercises good judgment in seeking help
   ___ exercises good judgment when acting independently
   ___ contributes to task completion and cohesion in meetings
   ___ exhibits increased autonomy over course of year
   ___ outside communications reflect positively on agency

II. CAPACITY FOR PROFESSIONAL DEVELOPMENT
   ___ approaches supervision in open and collaborative manner.
   ___ acknowledges impact of own feelings and cultural values on practice
   ___ appropriately self-critical; accurate assessing self
   ___ incorporates new ideas and critical feedback
   ___ motivated to learn (information and help-seeking)
   ___ actively participates in diagnostic teams and seminars
   ___ appropriately questions and challenges colleagues and supervisors
   ___ demonstrates improvement in skills over course of year
conduct consistently reflects knowledge of and conformance to APA ethical principles and state laws

III. GENERAL PSYCHOTHERAPY SKILLS

A. CASE MANAGEMENT SKILLS

documents services fully but concisely
assesses nonpsychological needs
initiates referrals as needed
completes work in a timely manner
able to network and coordinate services with external agencies and other service providers

B. ASSESSMENT SKILLS

1. Therapeutic Alliance:
conveys warmth, genuineness, empathy
conveys credibility
facilitates depth of self-disclosure
establishes alliance with all family members
respects client as whole person with strengths and needs
maintains objectivity
able to include cultural variables in alliance building

2. Data Gathering Skills:
aware of impact of own behavior and culture on client behavior
understands cultural background in client’s presentation
assesses dangerousness to self and others
handles child maltreatment issues appropriately
recognizes and understands nonverbal communication
recognizes and understands metaphorical communication
understands clinical process issues

3. Diagnostic-Analytic Skills:
conceptualizes and organizes data from definite theoretical view
recognizes impact of multicultural variables on psychological differences and response to treatment
incorporates empirical findings in literature in diagnostic formulation
generates accurate differential diagnosis
___ develops assessment plan to rule out differential diagnosis
___ generates accurate case formulation integrating development, self-report, interview-
   process, projective, and other data
___ communicates findings orally in case presentations
___ generates accurate and timely written reports

C. INTERVENTION SKILLS

1. Maintains Working Alliance:
___ tracks or reflects (particularly affect) client statements in session
___ maintains client’s motivation to work (without overwhelming or client becoming
   dependent)
___ balances tracking functions with guiding functions consistent with theoretical perspective
___ demonstrates multicultural competence
___ maintains appropriate case load

2. Focuses Therapy:
___ formulates realistic short and long-term behavioral goals
___ formulates methods (process goals) for achieving outcome
___ establishes shared sense of outcome and process goals with client
___ fosters positive expectations of hope
___ recognizes therapeutic impasses
___ realistic in assessing and re-assessing progress and revising formulation and diagnosis as
   indicated
___ interventions are consistent with theoretical formulation
___ interventions are culturally and ethically appropriate
___ interventions potentiate change
___ able to focus on process issues in session
___ interventions are prescriptive vs. generic
___ interventions reflect basic knowledge of cognitive-behavioral, dynamic, time limited,
   crisis intervention, and systemic interventions

3. Understands Interpersonal Process Issues:
___ uses personal response to client to aid assessment
___ selectively responds to accurate self-report, distortions, and client-therapist demands
___ responds appropriately to metaphoric and nonverbal content
___ recognizes and highlights underlying affect, cognition, or themes from content
___ accurately intuits culturally meaningful behavior

4. Psychological Assessment:
able to accurately administer cognitive tests
able to accurately score cognitive tests
able to accurately interpret cognitive tests
able to accurately administer personality tests
able to accurately score personality tests
able to accurately interpret personality tests
able to accurately integrate findings in a comprehensive report
able to formulate a dynamic conceptualization of personality functioning
is sensitive to cultural issues in terms of appropriateness of the instruments selected with the interpretation of data
able to generate appropriate treatment recommendations based on the results of the assessment

EVALUATOR COMMENTS:

Hall-Marley (2000) developed the Therapist Evaluation Checklist, an evaluation form used to give feedback to trainees. Sections include contributes to clinical team, capacity for professional development, general psychotherapy skills (case management, assessment, intervention), and evaluator comments.

©Susan Hall-Marley, 2000
SUPERVISOR EVALUATION FORM

Supervisee Name____________________________________

Supervision Period_____________________to____________________

Supervisor Name_____________________________ Date of Evaluation___________

Purpose: To provide the supervisor with an understanding of his/her job performance in relation to the supervisee, to suggest areas for improvement, to permit the student to offer feedback to the supervisor in a written form that is based on a set of clearly and previously-established criteria, and to increase the supervisor’s competence as a supervisor.

Performance Level Rating Scale: Based on current assessment and progress of supervision and expectations of supervisee:

3 – much more of this is needed
2 – it would be desirable to have somewhat more
1 – it would be desirable to have a little more
0 – this area is satisfactory

Directions: Utilizing the Rating Scale above, place the appropriate number on the line provided at the end of each item.

Evaluation Items

Supervisor is able to:

1. Be flexible and responsive to your changing needs
2. Establish an atmosphere of acceptance and psychological safety
3. Call attention to errors in a tactful manner & nbs;
4. Recognize and accommodate to your level of experience and style of learning
5. Refrain from indiscriminate use of praise
6. Provide opportunities for you to question, challenge or doubt
7. Encourage you to explore the implications of your interventions
8. Encourage you to formulate your understanding of the case material
9. Make specific suggestions when you need them
10. Not foster undue dependence on your part
11. When asked, present a clear, theoretical rationale for suggestions
12. Clearly inform you of legal issues
13. Clearly inform you of ethical issues
14. Be sensitive to the requirements placed on you by your agency
15. Admit errors and/or limitations without undue defensiveness
16. Be concrete and specific in comments
17. Facilitate your understanding of countertransference reactions to your clients
18. Seek consultation when it is needed
19. Summarize and/or highlight major points of supervisory session
20. Be reached in case of emergencies
21. Help you formulate the dynamics of the client
22. Listen sensitively to you
23. Help clarify and define the nature of problem(s) you are having in your work
24. Be clear about the limits of the supervisory relationship
25. Deal explicitly with the formal evaluation process
26. Through role-playing or other suitable techniques, to help you more effectively intervene with your client
27. Be straightforward with you regarding areas in which you need improvement
28. Be clear with you about the differences between supervision and psychotherapy
30. Maintain an appropriate focus in your sessions
31. “Be there” to meet your needs and not impose his/her issues on you
32. Be open to discussing any difficulties between the two of you which are hindering your learning
33. Clearly define the nature, structure, expectations, and limitations of the supervisory relationship
34. Make decisions and take responsibility when appropriate
35. Make you feel s/he genuinely want to help you learn
36. Be a good role model for you
37. Provide you with general knowledge about professional psychology
38. Be sensitive and adaptive to the stresses you are experiencing as a student
Summarize the supervisor’s strengths and weaknesses as you currently view them and make suggestions for ways in which your supervisor could further facilitate your learning.

________________________________________________________________________

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Hall-Marley (2001) developed this Supervisor Feedback form as an instrument to provide feedback to supervisors on the trainee’s experience of supervision. The form consists of sections including atmosphere for learning, supervision style, supervision conduct, and supervision impact. It is recommended a supervisor feedback form be used a minimum of four times during the training year and ideally, more frequently. It is a tool in establishing a dialogue and a feedback loop which should enhance the supervisory alliance.

© Susan Hall-Marley, 2001

Family and Children Services

Intern/Trainee Supervisor’s Clinical Evaluation Form

Intern/Trainee Name: __________________                                   Date: ____________
Supervisor’s Name: ___________________

Please indicate supervisee’s skill/performance levels in all areas using the following rating scale.

N= No opportunity to observe
0= Does not meet criteria for supervisee’s level of experience
1= Skill level inconsistent with supervisee’s level of experience
2= Skill level consistent with supervisee’s level of experience
3= Skill level exceeds supervisee’s level of experience

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<thead>
<tr>
<th>Criteria</th>
<th>Rating</th>
<th>N</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
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<tbody>
<tr>
<td>Documentation: (Progress notes, assessments, treatment plans, etc.)</td>
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<td>Comments:</td>
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<td>Therapeutic Skills: (creating safe environment, active listening, joining, interventions, etc.)</td>
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<td>Conceptualization: (hypothesizing, use of theory, client context considered, etc.)</td>
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<td>Diagnosis: (exploration of differentials, considers culture, gather’s relevant info, etc)</td>
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<td>Comments:</td>
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<td>Structuring: (boundaries, focusing session, controlling interactions, use of time, etc.)</td>
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<td>Use of Self: (aware of own belief system and impact on clinical work, disclosure, etc)</td>
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<td>Comments:</td>
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<td><strong>Professional Responsibility:</strong> (practices consistent with BBS and CAMFT legal/ethical standards, adheres to deadlines/policies, prompt and professional)</td>
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<tr>
<td><strong>Use of Supervision:</strong> (seeks supervision when appropriate, willing to disclose struggles/areas of weakness, ability to receive and utilize feedback, etc.)</td>
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<td><strong>Overall Intern/Trainee Rating:</strong></td>
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<td><strong>Additional Comments:</strong></td>
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Supervisor’s Signature

Intern/Trainee Signature
INTERN EVALUATION FORM

Today's Date: __________________________

Intern: ____________________________ Supervisor: ____________________________

Type of Evaluation:
Quarterly: ___________ Mid-Year: ___________ End of Year: ___________

Duration of Period Evaluated:
From: (month and year) ___________ To: (month and year) ___________

Describe type of supervision provided and hours per week:
Direct Observation ________ Group Observation ________ Individual Supervision ________

Please rate the intern’s level of competency using the descriptions below:

- **Competency area in need of attention:** Skills are below expectations; corrective action may be necessary.
- **Developing competency:** Skills emerging; performance may be inconsistent.
- **Competent:** Meets expectations, continues to acquire skill.
- **Fully competent:** Consistently strong performer.
- **Exceptional:** Demonstrates competency far exceeding expectations.

I. Assessment and Intake Evaluations:
   A. Please check the tests that the intern is able to administer competently, and comment on the level of expertise if desired:

<table>
<thead>
<tr>
<th>Test Name</th>
<th>Needs attention</th>
<th>Developing competency</th>
<th>Competent</th>
<th>Fully Competent</th>
<th>Exceptional</th>
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<tbody>
<tr>
<td>1. WISC-IV</td>
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<td>2. Stanford-Binet</td>
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<td>3. Cognitive Assessment System</td>
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<td>4. Children’s Depression Inventory</td>
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<td>5. MASC: Manifest Anxiety Scale for Children</td>
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<td>6. MMPI: Minnesota Multiphasic Personality Inventory</td>
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<td>7. Thematic Apperception Test</td>
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<td>8. Roberts Apperception Test</td>
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<td>9. Rey Osterreith Complex Figure Test</td>
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</table>
10. Conners’ Continuous Performance Test
11. Rorschach Inkblot Test: Exner Scoring System
12. Others

B. Please rate the intern’s assessment skills:

| 1. Professional Attitude/Style |   |   |   |
| 2. Interviewing Effectiveness |   |   |   |
| 3. Test Administration |   |   |   |
| 4. Interpretation of Test Results |   |   |   |
| 5. Diagnosis and Case Conceptualization |   |   |   |
| 6. Treatment Planning and Recommendations |   |   |   |
| 7. Report Writing |   |   |   |
| 8. Oral Communication (with patient and/or family) |   |   |   |

II. Treatment Principles:
A. Please rate the intern’s knowledge and expertise with the following treatment methods:

| 1. Maudsley Model Manualized Treatment |   |   |   |
| 2. Cognitive-Behavioral Therapy |   |   |   |
| 3. Play Therapy |   |   |   |
| 4. Family Systems Therapy |   |   |   |
| 5. Dyadic Parent-Child Attachment Therapy |   |   |   |
| 6. Group Therapy |   |   |   |
| 7. Other |   |   |   |

B. Please rate the intern’s knowledge and expertise with the following age groups:

| 1. Young Child | Need attention | Developing competency | Competent | Fully competent | Exceptional |
| 2. Latency Age |   |   |   |   |   |
| 3. Adolescents |   |   |   |   |   |

III. Therapeutic Skills:
Please rate the intern’s knowledge and expertise with the following aspects of therapeutic intervention skills:

| 1. Ability to build rapport and establish trust with patient / family |   |   |   |
| 2. Ability to understand process issues |   |   |   |
| 3. Ability to create a working relationship |   |   |   |
| 4. Ability to help the family move forward in treatment |   |   |   |
| 5. Ability to create a comprehensive case formulation that is clearly linked to the treatment plan |   |   |   |
| 6. Identify and utilize transference and countertransference issues |   |   |   |
7. Identify and understand family systems and broader systems issues relevant to client’s problem areas

8. Formulate realistic short and long term goals

9. Establishes shared sense of expectations and goals with client

10. Demonstrated flexibility, e.g. ability to adapt intervention techniques to developmental abilities of child and/or changes in client’s circumstances

11. Ability to identify and respond flexibly to therapeutic impasses

12. Writes concise and appropriate progress notes and treatment plans

13. Identifies and addresses case management needs, e.g., coordination of therapy components and communication with external service providers and professionals

14. Selects appropriate methods (i.e., both formal and informal outcome measures) to evaluate treatment and program efficacy

15. Creates and executes plan for evaluating treatment effectiveness

<table>
<thead>
<tr>
<th>IV. Consultation on Medical Services:</th>
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<tbody>
<tr>
<td>Please rate the intern’s knowledge and expertise with the following medical services activities:</td>
</tr>
</tbody>
</table>

1. Ability to collaborate with medical teams

2. Ability to provide psychological information to teams

3. Ability to work with the family in the medical setting

4. Ability to appreciate and exercise appropriate professional boundaries

5. Ability to write appropriate behavioral orders

6. Ability to write progress notes

7. Ability to work with teams and families in crisis

<table>
<thead>
<tr>
<th>V. Eating Disorder Treatment:</th>
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<tbody>
<tr>
<td>Please rate the intern’s knowledge and expertise with the following treatment steps:</td>
</tr>
</tbody>
</table>

1. Ability to perform intake interviews

2. Ability to make differential diagnosis and case conceptualization

3. Ability to provide appropriate treatments

4. Ability to provide treatment planning and referrals |
VI. Collaboration on Interdisciplinary Assessment Teams:
Please rate the intern’s knowledge and expertise with the following team responsibilities:

<table>
<thead>
<tr>
<th></th>
<th>Needs attention</th>
<th>Developing competency</th>
<th>Competent</th>
<th>Fully Competent</th>
<th>Exceptional</th>
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<tbody>
<tr>
<td>1. Ability to collaborate on interdisciplinary teams</td>
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<td>2. Ability to integrate assessment findings</td>
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<td>3. Ability to plan team interventions</td>
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VII. School Consultations:
Please rate the intern’s knowledge and expertise with school consultations:

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<tr>
<th></th>
<th>Needs attention</th>
<th>Developing competency</th>
<th>Competent</th>
<th>Fully Competent</th>
<th>Exceptional</th>
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<tbody>
<tr>
<td>1. Ability to use appropriate interview methods with school personnel</td>
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<tr>
<td>2. Ability to participate effectively with Individualized Educational Plans (IEP)</td>
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<td>3. Ability to integrate school observations, test data, and school interviews in child’s assessment and IEP’s</td>
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VIII. Professional Issues:
Please rate the intern’s knowledge and expertise with the following professional issues:

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<th></th>
<th>Needs attention</th>
<th>Developing competency</th>
<th>Competent</th>
<th>Fully Competent</th>
<th>Exceptional</th>
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<tbody>
<tr>
<td>1. Ability to understand and apply general ethical guidelines</td>
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<tr>
<td>2. Ability to relate child abuse reporting guidelines</td>
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<tr>
<td>3. Ability to understand and relate confidentiality guidelines</td>
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<td>4. Ability to appreciate patient diversity and cultural differences</td>
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<td>5. Ability to modify interviewing techniques and treatment practice to be compatible with ethnic/religious differences</td>
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<td>6. Dependability</td>
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<td>7. Leadership and initiative</td>
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<td>8. Timeliness</td>
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<td>9. Maintains appropriate professional boundaries</td>
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IX. Supervision and Education:
Please rate the intern’s knowledge and expertise with the following supervision and educational issues:

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<th></th>
<th>Needs attention</th>
<th>Developing competency</th>
<th>Competent</th>
<th>Fully Competent</th>
<th>Exceptional</th>
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<tbody>
<tr>
<td>1. Prepared and organized for supervision meetings</td>
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<td>2. Non-defensive and open response to feedback by supervisor</td>
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<td>3. Recognizes and readily brings problem areas to supervisor’s attention</td>
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<td>4. Appropriately reflective, e.g., considers personal contribution to process and effects of clinical decision making</td>
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<td>5. Willingness and motivation to learn</td>
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<td>6. Implements ideas discussed in supervision</td>
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<td>7. Interest and participation in seminars</td>
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<td>8. Interest and ability to teach staff</td>
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**NARRATIVE SUMMARY AND COMMENTS:**

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Intern’s Response to Evaluation:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Intern Signature  Date
Supervision Outcomes Survey

Supervisor's Name: ___________________________ Date: ________________

Please respond to the following questions in terms of your current supervisor. The terms "therapy" and "therapist" have been used as generic terms to apply to both counseling and psychotherapy. Use the following rating scale for all items:

1 Not at all ▄▄▄▄▄▄▄▄▄▄▄▄ ▄▄▄▄▄▄▄▄▄▄▄▄ ▄▄▄▄▄▄▄▄▄▄▄▄ ▄▄▄▄▄▄▄▄▄▄▄▄ ▄▄▄▄▄▄▄▄▄▄▄▄ ▄▄▄▄▄▄▄▄▄▄▄▄ ▄▄▄▄▄▄▄▄▄▄▄▄ ▄▄▄▄▄▄▄▄▄▄▄▄ ▄▄▄▄▄▄▄▄▄▄▄▄ ▄▄▄▄▄▄▄▄▄▄▄▄ ▄▄▄▄▄▄▄▄▄▄▄▄ ▄▄▄▄▄▄▄▄▄▄▄▄ ▄▄▄▄▄▄▄▄▄▄▄▄ ▄▄▄▄▄▄▄▄▄▄▄▄ ▄▄▄▄▄▄▄▄▄▄▄▄ ▄▄▄▄▄▄▄▄▄▄▄▄ ▄▄▄▄▄▄▄▄▄▄▄▄ ▄▄▄▄▄▄▄▄▄▄▄▄ ▄▄▄▄▄▄▄▄▄▄▄▄ ▄▄▄▄▄▄▄▄▄▄▄▄ ▄▄▄▄▄▄▄►Moderately ▄▄▄▄▄►Greatest degree possible

1. My supervisor helps me develop by providing both challenge and support.
2. The supervision I am receiving has helped me grow as a professional.
3. My supervisor helps me feel strengthened and affirmed in my efforts to become a professional.
4. My supervisor helps me identify development areas by identifying my strengths and weaknesses.
5. Supervision helps me better see the complexity in my cases.
6. Supervision helps me improve my ability to conceptualize my cases.
7. Supervision helps me examine, modify and refine my approaches to services provided.
8. Supervision helps me take risks that have led to professional growth and more effective services.
9. The relationship I have with my supervisor is characterized by acceptance, trust and respect.
10. My supervisor's feedback encourages me to keep trying to improve.
11. Supervision helps me see my mistakes as learning experiences.
12. The modeling of my supervisor helps me learn more about therapy.
13. Self disclosure by my supervisor helps to normalize my experience as a therapist.
14. My supervisor helps me to be open and receptive to supervision.
15. I feel comfortable sharing my perceived weaknesses

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</tbody>
</table>
and failures with my supervisor.

16. Supervision helps me to develop specific skills that have made me more effective as a therapist.

17. Supervision is helping me to better facilitate effective therapy with my clients.

18. As a result of supervision, I feel more confident in working with my therapy cases.

19. Overall, I am satisfied with my supervision.

20. I feel that supervision is contributing to my overall effectiveness in my therapy cases.

(Courtesy of Starlight Community Services)
Appendix IV

Self-Assessment Forms

- Christopher Ebbe’s Clinical Supervisors Self-assessment
- Falender’s Supervisors Self-assessment
- Supervision Session Bridging Form (Alexis Horozan)
Your self-evaluation of supervision-related skills, abilities, and attitudes may give you opportunities to recognize things you would like to improve as a supervisor and a chance to plan your next steps in development as a supervisor.

<table>
<thead>
<tr>
<th></th>
<th>GOOD</th>
<th>OK</th>
<th>COULD STAND</th>
<th>PLAN FOR NEXT SUP - SESSION</th>
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</thead>
<tbody>
<tr>
<td>my attitude about supervision</td>
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<tr>
<td>comfort with the responsibility of supervising</td>
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<tr>
<td>introduction of supervisee to supervision, and setting of goals</td>
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<tr>
<td>help supervisee to be candid and at ease?</td>
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<tr>
<td>establishing supervision &quot;contract&quot; -- agreeing on the basic</td>
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<tr>
<td>elements and goals of the supervision, in writing if needed or</td>
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<tr>
<td>desired</td>
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<tr>
<td>not supervising when interfering dual relationships exist</td>
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<tr>
<td>assessment of supervisee in order to plan specific learning</td>
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<tr>
<td>confidence in my abilities with regard to supervising</td>
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<tr>
<td>my authority in directing the actions of supervisees</td>
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<tr>
<td>my authority regarding caseload, case assignments, relative to</td>
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<tr>
<td>that of the system (clinic, etc.)</td>
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<tr>
<td>clarity about my model of supervision</td>
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<tr>
<td>clarity about the type of supervisory relationship I want to</td>
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<tr>
<td>have</td>
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<tr>
<td>ability to nurture supervisee's trust in me</td>
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<tr>
<td>providing appropriate support for supervisee</td>
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</table>
keeping supervision appointments and providing amounts of supervision promised

protecting supervision time (not answering phone, etc.)

protecting supervisee's privacy

balance of making supervisee feel safe versus reporting problems to training director or management

ability to quickly identify case issues in supervision

ability to teach/advise in response to case problems/difficulties

ability to supervise adequately all of the types of clinical activities that I am expected to supervise

ability to help supervisee connect theory with practice

demonstrating and modeling useful clinical skills

keeping up-to-date in knowledge about all of supervisee's cases

ability to identify supervisees'countertransference issues

ability to discuss countertransference issues comfortably and productively

ability to supervise with respect to client diversity

knowledge about ethical/legal matters for use in supervision

knowledge of licensing requirements for supervision (hours, clinical experiences, etc.)

encouraging professional identity development of supervisee

providing a good role model as a professional psychologist

encouraging high standards for mental health care
encouraging high ethical standards
ability to confront supervisee with needed feedback
ability to discuss my relationship with supervisee, when needed
ability to handle supervisees' transference feelings toward me
handling my own negative and positive feelings toward supervisees
ability to give useful oral feedback to supervisee
ability to give useful written feedback to supervisee
ability to separate my emotional reactions to supervisees from objective reality when evaluating supervisees
ability to evaluate supervisees on job requirements and professional consensus regarding desirable behaviors and traits, rather than with respect to my own values and preferences
comfort tolerating supervisee's inadequacies/problems during the learning process
comfort implementing remediation plan
comfort requiring tapes, process recording, etc. of supervisee
taking the time to use tapes, process recordings to create learning value for supervisees
comfort dealing with supervisees' ethical/professional criticisms of agency
plan for enhancing my supervision skills

sup\selfeval Christopher Ebbe, Ph.D. ABPP 12-99,4-09
### Falender’s Self-Assessment Supervisor Competencies

#### Supervisor Competencies Framework*

(rank present from 7 (superior) to 1 (absence of knowledge, skill, value); signify high priority to enhance competence items in column with “X”)

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>X</th>
<th>Present</th>
<th>Aspirational</th>
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<tbody>
<tr>
<td>Of area being supervised</td>
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<tr>
<td>Of models theories, modalities and research on supervision</td>
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<tr>
<td>Of professional/supervisee development</td>
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<tr>
<td>Of evaluation, process/ outcome</td>
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<tr>
<td>Awareness of diversity in all forms</td>
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<tr>
<td>Skills</td>
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<tr>
<td>Supervision modalities</td>
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<tr>
<td>Relationship skills</td>
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<tr>
<td>Sensitivity to multiple roles: Perform and balance</td>
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<tr>
<td>Provide effective formative and summative feedback</td>
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<tr>
<td>Promote growth and self-assessment in trainee</td>
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<tr>
<td>Promote growth and self-assessment in trainee</td>
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<tr>
<td>Assess learning needs and developmental level of supervisee</td>
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<tr>
<td>Encourage and use evaluative feedback from trainee</td>
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<tr>
<td>Teaching and didactic skills</td>
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<tr>
<td>Set appropriate boundaries and seek consultation when supervisory issues are outside domain of supervisor competence</td>
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<td>Flexibility</td>
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<td>Scientific thinking and translation of scientific finding to practice throughout professional development</td>
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<td>Values</td>
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<tr>
<td>Responsibility for client and supervisee</td>
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<td>Respectful</td>
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<td>Responsibility for sensitivity to diversity in all forms</td>
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<td>Balance between support and challenging</td>
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<td>Empowering</td>
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<td>Commitment to lifelong learning and professional growth</td>
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<td>Balance between clinical and training needs</td>
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<td>Value ethical principles</td>
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<tr>
<td>Commitment to knowing and utilizing available psychological science related to supervision</td>
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<td>Commitment to knowing one’s own limitations</td>
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**Social Context Overarching Issues**

| Diversity |
| Ethical and legal issues |
| Developmental process |

| Knowledge of immediate system and expectations within which the supervision is conducted |
| Creation of climate in which honest feedback is the norm (supportive and challenging) |

**Training of Supervision Competencies**

| Coursework in supervision including knowledge and skill areas listed |
| Has received supervision of supervision including some form of observation (video or audiotape) with critical feedback |

**Assessment of Supervision Competencies**

| Successful completion of course on supervision |
| Verification of previous supervision of supervision document readiness to supervise independently |
| Evidence of direct observation (e.g., audio or videotape) |
| Documentation of supervisory experience reflecting diversity |
| Documented supervisee feedback |
| Self-assessment and awareness of need for consultation when necessary |
| Assessment of supervision outcomes—both individual and group |

**Other to be defined by supervisor/setting**
SESSION BRIDGING FORM

Supervisee: __________________ Date: __________________

Part A (To be completed shortly after supervision session)

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

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

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<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Much</th>
<th>Very Much</th>
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   a) Helpfulness/effectiveness of supervisor: ________
      • What was helpful?
____________________________________________________________________
____________________________________________________________________

      • What was not helpful?
____________________________________________________________________
____________________________________________________________________

   b) How connected you felt to your supervisor: ________
   c) How engaged/involved you felt with the topics being discussed: ________
   d) How present you were in the supervision: ________

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

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

5. What risks did you take in supervision?
____________________________________________________________________
____________________________________________________________________

Part B (to be completed just prior to the next supervision session)
1. What were the high and low points of your clinical work this week? ____________________________________________________________
   ____________________________________________________________

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

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

4. Anything else you’d like to add? ____________________________________________________________
   ____________________________________________________________
Appendix V

Case Presentation Forms

- Unity Care’s Formal Case Presentation
- Case presentation format 0-5 population
CASE PRESENTATION

1. **Background Information**  (Relevant facts)
   a. **Fictional name**, age, sex, relationship status, ethnicity, education, occupation, residence.
   b. **Mental Status**: Cognitive functioning, appearance, dress, mood, orientation, contact with reality, affect.
   c. **Chief Complaint/Presenting Problem**: Conditions and situation precipitating admission/visit.
   d. **History of Presenting Problem & Treatment Episodes**: current condition, chemical use history.
   e. **Medical, Physical & Mental Health History**: Hospitalizations, emergency room visits, treatment, diseases, preventive health care, and high- risk potentials.
   f. **Social Assessment**
      1. Family of Origin: Description of family, functionality, generational issues.
      2. Primary Relationship: History, current, spouse’s chemical use and functionality.
      4. Trauma and Losses: Emotional, physical, and other.
      5. Social/Peer Relations: Support network, degree of social involvement and skills.
      7. Financial status: Problems, impact of chemical use and socioeconomic status.
   g. **Legal Problems**: History, current status and pending charges.
   h. **Vocation and/or Education**: Problems, performance, attitudes and plans.
   i. **Collateral Information**: information from sources other than the client and past treatment records.

2. **Diagnosis and Treatment**
   a. **Assessment and Diagnosis**: Summarize assessment and substantiate your diagnosis.
   
   b. **Treatment Planning**: Describe the plan and course of treatment. Describe how the treatment plan will address the client’s motivation for treatment, the client’s problems, strengths, weaknesses, and culture. How was the client involved in the development of the treatment plan?
   
   c. **Termination Plans**: Describe your plans for termination

3. **Transference/Countertransference**: Discuss possible reactions the client is having, and your emotional reactions to this client/case.
CASE CONSULTATION PRESENTATIONS

The following are suggestions as to how you might organize your presentations.

1. **PLEASE BEGIN WITH WHAT IT IS THAT YOU WOULD MOST LIKE THE GROUP TO HELP YOU WITH?**

2. **INTRODUCE FAMILY:** Names, ages of parents and target child, sibs, referral source and reason for referral, relevant cultural information (e.g., immigration status, country of origin, class status in country of origin and here, language), medical issues, living situation, support system. Relevant perinatal information (e.g., planned or unplanned pregnancy, perinatal complications, medical problems, developmental problems, special caretaking needs of child, etc.). Any important intergenerational relationships? If home visit, describe home and community, if relevant. Other support services currently involved? Describe parents and describe target child (what are they like?). Any notable stressors (e.g., health, financial, occupational, DV, substance or ETOH abuse, isolation, etc.)? How do they cope? Any other caregivers besides parents?

3. **FAMILY HISTORY:** Any information about parents’ families of origin, quality of relationship with their parents, role in family of origin if relevant. Stressors (as above), traumatic stress/events, any community stressors? What are the family’s cultural practices and beliefs?

4. **PARENTS’ RELATIONSHIP:** Relationship status, quality of relationship, involvement with children, etc. Who is primary caregiver? Level of involvement of partner? Describe their decision-making process, who is family spokesperson. Your countertransference to each parent.

5. **DESCRIBE CHILD:** Temperament, developmental level for age using Touchpoints, ability to engage, ability to be soothed, any regulatory issues, your countertransference (e.g., do you like the child?), diagnostic information using DC 0-3, etc.

6. **PARENTS’ RELATIONSHIP WITH CHILD:** Describe what you observe between caregivers and child. How are cues read? How does the parent soothe or redirect the child? How does the parent deal with the emotional states/needs of child? How does the parent meet the child’s physical and safety needs? How do they discipline the child? Your concerns? Parents’ perception of child? What does this child represent? Meaning of child to family?

7. **WHAT FEELINGS DO YOU HAVE ABOUT WORKING WITH THIS CASE?** Any part of the work been difficult, confusing, uncomfortable, frustrating, irritating, etc.?

8. **PLEASE SHARE SOME VERBATIM (OR AS close AS YOU CAN GET) NARRATIVE NOTES ABOUT EXCHANGES WITH THE FAMILY OR VIDEO CLIP. THIS CAN BE AN EXTREMELY HELPFUL PART OF YOUR PRESENTATION.** Specifically, give the group a sense of how you have intervened and how the parent and child respond to your interventions. I hope that this can be an opportunity where we can all talk openly about our work, and be able to benefit from the input of clinicians who come from a variety of disciplines, experiences, knowledge, and training.

(Adapted from the Harris Early Mental Health training Program, Oakland, CA)
Appendix VI

Documenting Supervision

- Case Review
- Clinical Supervision Record
- Administrative Supervision
<table>
<thead>
<tr>
<th>NAME:</th>
<th>DATE:</th>
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<tbody>
<tr>
<td><strong>Review of Case</strong></td>
<td><strong>Review of Case</strong></td>
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<tr>
<td>Name: dx:</td>
<td>Name: dx:</td>
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<tr>
<td>weekly, bimonthly, monthly Ind, Rehab, Meds, CM, Family, Group tx</td>
<td>weekly, bimonthly, monthly Ind, Rehab, Meds, CM, Family, Group tx</td>
</tr>
<tr>
<td>Current stressors or crisis</td>
<td>Current stressors or crisis</td>
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<tr>
<td>Intervention /Adherence to tx Plan</td>
<td>Intervention /Adherence to tx Plan</td>
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<td>Psychiatrist/ Med Adherence</td>
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<td>Counter transference/ Transference Plan</td>
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<td>Narrative summary / CANS/ MORS</td>
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<td>Tx Plan/ Goals Reflect Dx/Dates/ Signatures</td>
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<td>PN up to date/Proper Codes/ Legible</td>
</tr>
<tr>
<td>Intake assessment/ Cultural/ Medical Necessity</td>
<td>Intake assessment/ Cultural/ Medical Necessity</td>
</tr>
<tr>
<td>Annual Assessment/ UMDAP/ Transmittal</td>
<td>Annual Assessment/ UMDAP/ Transmittal</td>
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**Check in /Note**

Courtesy of GFC-Corp
### Agency Letterhead
#### Clinical Supervision Record

<table>
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<tr>
<th>Supervisee:</th>
<th></th>
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<tbody>
<tr>
<td>Supervisor:</td>
<td></td>
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<tr>
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#### Check all Topics Discussed:

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<th>Cases &amp; Assessment</th>
<th>Information &amp; referral</th>
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<tr>
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<td>High Risk issues</td>
<td>Evaluation issues</td>
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<td>Judgment</td>
<td>Decision making</td>
<td>Progress notes</td>
<td>Termination</td>
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<td>Communication skills</td>
<td>Problem solving</td>
<td>Goals &amp; objectives</td>
<td>Diversity issues</td>
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<td>Initiative</td>
<td>Treatment planning</td>
<td>Mezzo practice issues</td>
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<td>Flexibility</td>
<td>Crisis intervention</td>
<td>Macro practice issues</td>
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<td>Self-awareness</td>
<td>Practice/intervention skills</td>
<td>Ethical issues</td>
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<tr>
<td>Learning plan</td>
<td>Accountability</td>
<td>Specific EBP techniques</td>
<td>Other:</td>
</tr>
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</table>

**Comments:**


**Supervisee Strengths:**


**Challenges:**


**Tasks to be completed by the next supervision session or date specified:**


**Supervisee Signature:** ________________________________

**Supervisor Signature:** ________________________________

Adapted from SDSU, Kim Archuleta, LCSW
Administrative Supervision

Individual Supervision with __________________________ Date __________

Check-in:

- Treatment Plans/PFI/NARRATIVE Due and Completed this Month:

- Assessments due and Completed this Month

- Chart Audits to review

- Time Off Request/Scheduling:_____________________________________________

- Other i.e. Mileage due Monthly, Productivity, MD appointments, Open/Closed cases, issues?

- Pending Referrals:

- Concerns Discussed
Appendix VII

Tips on Supervision

- CANS Coaching guide for Supervision
- TCP Coaching guide for Supervision
- FCS Notice Regarding Treatment by an Intern
- Tips on How to Make Supervision a Priority
CANS Coaching guide for Supervision

1. The CANS is an interactive process versus a single event.

2. Early in the assessment process, the CANS tool is explained as part of the TCP engagement and assessment to the client and family.

3. The CANS is completed with the client and family.

4. The CANS results are shared with the client and family to celebrate successes or rethink strategies for needs that have not changed or increased.

5. During the process of completing the CANS, the client and family are asked to elaborate on the different scores of the CANS.

6. The relevant functional strengths identified by the CANS are to be reflected in the Action Steps by Individual/Family/Supporters to assist in accomplishing the specific Short-Term Goal; and the identified needs from the CANS are to be captured in the Obstacles and Short-Term Goals in the TCP Treatment Plan.

7. The staff administering the CANS ensures that the client and family see the relationship between the CANS and the TCP Treatment Plan process.

8. The rationale for the frequency of the CANS is explained to the client and family so that they are informed of the progress or lack of towards the TCP Treatment Plan goals.

9. The CANS administration drives the updating of the TCP Treatment Plan as the needs and strengths change over time.

10. The CANS needs to be administered before completing the Mental Health Assessment and should inform and guide the Narrative Summary and the TCP Treatment Plan.
TCP Coaching Guide for Person-Centered Supervision

1. During the first meeting, the TCP process (a Person-Centered, Family-Driven, strength-based collaborative approach) is fully explained to the individual and family.

2. All services are provided with utmost respect for the individual and family’s culture, values, beliefs and preferences, in the preferred language of the individual and family using common terminology.

3. Engaging the individual and family in talking about their strengths is critical.

4. The individual and family are asked to elaborate on their desired results or vision.

5. Early on in the process, the individual and family are given an opportunity to discuss what things have worked for them in the past.

6. A draft of the Narrative is presented to the individual and family for their feedback. This document is revised, as needed, to reflect an accurate shared understanding.

7. The individual and family are supported through a collaborative process in creating their own individualized written plan that describes their needs, desired results and strategies to address them.

8. Short-term goals and their timeframe are identified with the individual and family. They are based on what the individual and family feels they can successfully accomplish in the shortest amount of time (the purpose being to build hope and confidence and move to the next short-term goal toward their desired result).

9. The strengths of the individual and family are linked to the short-term goals and action steps in the treatment plan.

10. To keep the treatment plan a living document, progress towards short-term goals, related action steps and strategies used are discussed at each session.

11. Individuals and families are encouraged to access their own natural supports in the community.

12. A positive atmosphere around successes and accomplishments is created during review of the goals.

13. The desired transition is frequently discussed with the individual and family.
NOTICE REGARDING TREATMENT BY AN INTERN

Your assessment and treatment at Family and Children Services will be provided by Xxxx Xxxx, who is a Marriage and Family Therapist Trainee, and is working at Family and Children Services as part of her clinical training. When she completes her xxxx Ms. Xxxxx will be eligible to register as a ________________, and eventually apply for licensure as a Licensed Xxxxxx in the State of California.

During her internship at Family and Children Services, Mx Xxxxxx is being supervised by Xxxxxxxxx Xxxxxxxxxxx, a Licensed Marriage and Family Therapist in the State of California (License # MFC XXXXX). Your therapist will be consulting with Mx. Xxxxxxxx about your treatment.

If you have any questions about this process, please discuss these with your therapist.

_________________________        _________________
Client’s Signature            Date

_________________________        _________________
Parent/Guardian's Signature    Date

_________________________        _________________
Witness Signature              Date

(Courtesy of Family and Children Services)
Tips on How to Make Supervision a Priority

1. Hire qualified staff to do clinical supervision
2. Retain staff
3. Incentivize supervisors
   a. Higher pay
   b. Title
   c. Promotions
   d. Reduce other responsibilities to free up time for supervision
4. Manage the supervisor/supervisee ration
5. Endorse the balance between administrative and clinical supervision
6. Promote different levels of expertise within your organization (e.g. trainee, intern, licensed practitioner, senior practitioner, etc.)
7. Promote supervision in the language services are being provided
8. Promote professional development days for supervisors
9. Promote and encourage supervisors to attend the Supervisors’ Consultation groups or start your own at your organization
10. Offer on-going trainings in supervision on advanced issues in supervision

Key Elements to remember about supervision best practices

1. Clinical supervision and administrative supervision are distinct practices
2. High quality clinical supervision is often the exception rather than the norm
3. Clinical supervisors need to be highly skilled in the areas of practice of their supervisees
4. Clinical supervisors should update their knowledge and skills regularly
5. For best results clinical supervision needs to be consistent