Behavioral Health Services (BHS)

Guidelines for the Provision of Clinical Supervision

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Approvals	Signature	Date
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Purpose

Clinical supervision is a collaborative relationship between two clinical professionals; one having a greater degree of clinical knowledge and skill helping the other with the goal of enhancing professional competence and evidence informed practice to benefit clinical care to the individuals and families being served. There have been multiple definitions of supervision but most of them agree that supervision is evaluative and hierarchical, extends over time, and enhances the professional functioning of the more junior person. (1)

Falender and Shafranske (2004) proposed the following detailed definition of clinical supervision:

> A distinct professional activity in which education and training aimed at developing science-informed practice is facilitated through a collaborative interpersonal process. Supervision involves observation, evaluation, self-assessment and feedback, the acquisition of knowledge and skills by instruction, modeling and mutual problem solving, and encourages self-efficacy, building upon the recognition of the strengths and talents of the supervisee. Supervision ensures that clinical consultation is conducted in a competent manner in which ethical standards, legal prescriptions, and professional practices are employed to promote and protect the welfare of the client, the profession and society at large. (p. 3) (2)

Supervision is a distinct professional competency that requires on-going education, training and consultation. This Practice Guideline is intended to provide a framework to inform the development of supervisors, to encourage competent supervision and consultation, and to communicate to staff the Agency's value in skilled service delivery.

Intended Audience

Behavioral health professionals providing services to individuals and families we serve within HCA's County or county-contracted mental health and substance use disorder programs are the primary audience for these guidelines.

Definition of Terms

Supervisor is a departmentally designated staff member meeting educational and professional requirements who monitors, evaluates, mentors, and develops specific clinical competencies of the supervisee. They have received at least 15 hours of training in the theory, practice and modalities of clinical supervision from an accredited agency and enter into an agreement with their supervisee(s) to provide regular supervision of cases for the protection of the client, the public and for the training of the supervisee.

Supervisee is a pre-licensed volunteer or staff member who requires supervision to perform clinical activities per professional board, agency, and/or school regulations.

Clinical Trainee is an unlicensed individual who is enrolled in a post-secondary educational degree program that is required for the individual to obtain licensure as a Licensed Mental Health Professional or Licensed Practitioner of the Healing Arts; is participating in a practicum, clerkship or internship approved by the individual's program; and meets all relevant requirements of the program and/or applicable licensing board to participate in the practicum, clerkship, or internship and provides rehabilitative mental health services or substance use disorder treatment services, including, but not limited to, all coursework and supervised practice requirements.

Background

Development of Guideline

This Practice Guideline was developed by the Behavioral Health Services (BHS) Practice Guidelines Workgroup, which is a committee of clinicians, supervisors, psychiatrists, and BHS management who represent all BHS areas (i.e., Adult and Older Adult (AOA), Children and Youth Services (CYS), and Quality Management Services (QMS). The Guidelines were developed based on a review of the literature and other research sources (e.g. internet websites) in the field.

Selection of Evidence

Existing practice guidelines developed by national associations were used as resources in the development of this Practice Guideline. Journal articles referencing established guidelines were also included. All resources used were established in the year 2014 or later. Each of the guidelines used as evidence include academic and professional competencies that the supervisor should exhibit.

Documentation of Need

It is essential for less experienced behavioral health clinicians and alcohol and other drug (AOD) counselors to be trained properly to ensure that their practice is effective. Supervision protects the individuals and families being served, supports practitioners, and ensures that professional standards and quality services are delivered by competent clinicians. (3) It paves the way for greater accountability to the practice and profession while keeping the needs of the individuals and families we serve central during the supervision period. Supervision is a gateway for new clinicians to work toward their independent practice while having regular access to a more experienced clinician's expertise and experiences. The availability of supportive supervision is a valuable resource to supervisees and should be considered a necessity for maintaining high standards of service.

Supervision is particularly important when working in high acuity settings and with traumatized individuals. Supervision has been consistently recommended as a means of support and self-care for the therapist, with the aim of preventing secondary trauma. (4) Clinical supervision can aid in mitigating vicarious trauma responses in the supervisee when the supervisor brings awareness to the effects of working with trauma. (5)Trauma-informed supervision combines knowledge about trauma and supervision and focuses on the characteristics of the interrelationship between the trauma, the practitioner, the helping relationship, and the context in which the work is offered. (5)

Justification

Supervision can be a mutually beneficial process for all parties: the supervisor, the supervisee, and the individuals and families served. This will be achieved when there is application of ethical principles by both supervisor and supervisee. It is important that a positive learning environment is maintained during the supervision process that will maximize benefits for all concerned.

Inadequate supervision can result not only in poor professional development for the supervisee but also harm to individuals and families served. Cook & Ellis (2021) defined inadequate supervision as ineffective supervision that is characterized by one or more of the following: the supervisor's disinterest and lack of investment in supervision, the supervisor's failure to provide timely feedback or evaluation of the supervisee's skills, the supervisor's inattention to the supervisee's concerns or struggles, the supervisor's inconsistent work toward the supervisee's professional growth or training needs, or the supervisor not listening or being open to the supervisee's opinions or feedback. (6)

Although there is a widespread recognition of the need for supervision, there is much less clarity about how it should be provided. (7) These Guidelines, and the sources listed in the Reference section, are intended to be a resource for supervisors to guide their practice.

Consistency with Policies, Regulations, Laws, and Professional Standards

A Guideline differs from a Professional Standard, which is mandatory and, thus, may be accompanied by an enforcement mechanism. A Guideline is not mandatory, definitive, or exhaustive. This Practice Guideline is intended to be aspirational, with the intent to facilitate continued development of professional practices and to promote high quality services. This set of guidelines may not apply to every professional or clinical situation within the scope of the guideline. As a result, the guideline is not intended to take precedence over professional judgment.

Federal and state laws supersede Practice Guidelines. The supervisor and supervisee should familiarize themselves with and adhere to all Board of Behavioral Sciences (BBS), California Board of Psychology (BOP), and AOD counselor certification boards' regulations for clinical supervision. This Practice Guideline is to be used in conjunction with existing laws, regulations, policies, and procedures.

The American Psychological Association (APA) has guidelines for supervision, specifically in psychology. Professional associations such as Association of Social Work Boards (ASWB), the National Association of Social Workers (NASW), and Association of State and Provincial Psychology Boards all have guidelines for clinical supervision in their field and were reviewed to identify common elements in the area of clinical supervision (8).

Furthermore, a literature review was conducted in preparation for developing this Practice Guideline. References to the sources used are listed in the References section of this document.

The California Psychological Association's guidelines were based on the four principles for ethical supervision (respect for the Dignity of Persons, Responsible Caring, Integrity in Relationship, and Responsibility to Society), APA's guidelines fell into seven domains (Supervision Competence, Diversity, Supervisory Relationship, Professionalism, Assessment/Evaluation/Feedback, Professional Competence Problems, and Ethical, Legal and Regulatory Considerations). The NASW and ASWB's Best Practice Standards in Social Work Supervision outline standards for five areas relevant for supervision: Context in Supervision, Conduct of Supervision, Legal and Regulatory Issues, Ethical Issues, and Technology (3).

Guideline

Guideline Statement

This Practice Guideline highlights recommendations drawn from established practice guidelines from national associations. Its primary purpose is to educate professional staff and to identify well-supported practices to help guide the provision of high-quality services. These Guidelines are designed to educate about desirable professional practices, to suggest or recommend specific professional and personal behavior, and to guide performance. Applications for the use of this Practice Guideline are outlined and include the following common elements of clinical supervision: supervisor competence, supervisory relationship, professionalism, logistics, and ethical considerations/confidentiality.

Common Elements for Clinical Supervision

Supervisor Competence

Supervisors are expected to stay current in clinical, legal and ethical knowledge and skills in order to provide supervisees with the knowledge and skills necessary to gain self-competence. Supervisors are expected to familiarize themselves with and adhere to all Board of Behavioral Sciences (BBS), California Board of Psychology (BOP), or AOD Counselor certification boards' regulations for clinical supervisors, whichever applies to the supervisory relationship. This includes ensuring that all requirements are met for the provision of clinical supervision. Upon commencement of the role of clinical supervisor, new supervisors are to provide proof of completion of supervision requirements (i.e. training certificates, current license) to their direct supervisor. Further information can be found on the HCA website. .

Supervisors are expected to have knowledge of various theoretical orientations, evidence-based practices, cultural considerations, clinical specialty areas specific to the population the supervisee is serving, and relevant events that may impact the individuals and families being served (APA Council of Representatives, 2014). If a supervisee is working with a specific population, the supervisor should do his/her best to ensure they have specialized experience in the communities and/or specialty areas the supervisee is serving. Competency in these areas should be obtained and maintained through formal education, training, professional research, and experience. Supervisors are to be actively involved in ongoing professional development to ensure adherence to recommended best practices pertaining to the provision of clinical supervision.

Based upon the revised standards of clinical supervision effective January 1, 2022, as promulgated by the California Board of Behavioral Sciences, clinical supervisors who supervise Masters Level Associates are expected to:

- Ensure the extent, kind, and quality of counseling performed is consistent with the education, training, and experience of the supervisee.

- Monitor and evaluate the supervisee's assessment, diagnosis, and treatment decisions and providing regular feedback.
- Monitor and evaluate the supervisee's ability to provide services at the site or sites where he or she is practicing and to the particular clientele being served.
- Monitor and address clinical dynamics, including, but not limited to, countertransference, intrapsychic, interpersonal, or trauma related issues that may affect the supervisory or practitioner-patient relationship.
- Ensure the supervisee's compliance with laws and regulations governing the practice of marriage and family therapy, clinical social work, or professional clinical counseling.
- Review the supervisee's progress notes, process notes, and other patient treatment records, as deemed appropriate by the supervisor.
- With the client's written consent, provide direct observation or review of audio or video recordings of the supervisee's counseling or therapy, as deemed appropriate by the supervisor.

If a clinical supervisor is on vacation or administrative leave for a period not to exceed 30 days, a delegated supervisor may be appointed by the regular clinical supervisor. The delegated supervisor may sign off on the supervisee's hours. If the regular clinical supervisor is away for more than 30 days, a new supervision agreement must be completed between the supervisee and the delegated clinical supervisor. The delegated supervisor also needs to complete a new Clinical Supervision Reporting Form (CSRF) which must then be forward to QMS.

Supervisors must be prepared to handle and have experience with a wide range of clinical problems and populations. Supervisors are also encouraged to participate in regular consultation with other clinical supervisors to discuss and problem-solve issues that arise during clinical supervision and to continue to develop their skill set in facilitating clinical supervision. In order to gain competence in clinical supervision, both initial and on-going are required.

Training for Clinical Supervisors

Initial Training

The California State Board of Behavioral Science mandates that new clinical supervisors must receive 15 hours of training in various elements of clinical supervision to include:

- Law and Ethics of Clinical Supervision
- Supervisory Alliance

- Multi-Cultural Clinical Supervision

This training may be taken by any provider who is accepted by the California Board of Behavioral Sciences and California Board of Psychology. New clinical supervisors may begin to provide clinical supervision at any time after they have completed their initial training. New clinical supervisors need to complete all necessary county CSRF Clinical Supervisor Applications forms and forward them to QMS as soon as possible. They should also become familiar with the necessary Board of Behavioral Sciences Self-Assessment forms and complete all necessary self-assessments as soon as possible. The Self-Assessment can be forwarded to the BBS via email. Please see the BBS website for further information and for links to the appropriate form. This form is not yet required by the Board of Psychology.

BHS provides on-going support, training, and consultation to all clinical supervisors to assist them in managing their role. All new clinical supervisors are highly encouraged to contact Behavioral Health Training Services (BHTS) to meet with the Clinical Supervision Training Coordinators to be placed in a monthly Clinical Supervision Consultation Group during their first year of providing supervision. These groups will be further described below.

On-Going Training:

The clinical supervisor is required to accrue 6 hours of continuing education credits in clinical supervision from an accredited agency during each two-year renewal period.

Consultation Groups:

Monthly Consultation groups are provided through Behavioral Health Training Services to all clinical supervisors to support and provide on-going training in their supervision role. The Board of Behavioral Sciences allows each clinical supervisor to claim one (1) Continuing Education Credit, up to a maximum of (12) per year, for participating in supervision consultation. BHS provides one (1) CE for every hour of consultation attended. All new clinical supervisors have agreed to remain in consultation through clinical supervision groups for at least one year after completion of clinical supervision trainings. Please follow up with clinical supervision coordinator or BHTS if you need assistance being connected to a group. It is recommended that all clinical supervisors remain in clinical consultation continuously.

Multi-Cultural Clinical Supervision

Multi-cultural awareness is an important part of clinical supervision and should be a significant part of the training of pre-licensed associates. An important practice within multi-cultural supervision is cultural humility. Owen (2013) identified cultural humility as the core competence of multi-cultural clinical supervision (9). Cultural humility is the ability to maintain an interpersonal stance that is other-oriented in relation to aspects of cultural identity that are most important to the client (10). It is a lifelong process of self-reflection, self-critique, and commitment to understanding and respecting another's point of view. It involves engaging with others humbly, authentically, and from a place of learning.

Factors in Implementing and Maintaining a Multi-Cultural Framework in Clinical Supervision:

- Draw attention to differences and similarities within the triad of client/therapist/supervisor beliefs and values.
- Address values conflicts between supervisor and supervisee.
- Establish a robust supervisory alliance with supervisee.
- Recognize vulnerability of supervisees who disclose deeply held beliefs.

Supervisors need to be comfortable discussing such conflicts to avoid conflicts over personal values and to allow for individual differences. Supervisors who are culturally aware maintain an ongoing reflective practice building upon a base of self-awareness, empathy, compassion, and respect.

In summary, the practice of multi-cultural supervision is based on the following principles:

- Increasing supervisee cognitive flexibility & empathy for client.
- Adopting the perspective of the client.
- Discussing the continuum of experience from the most difficult client the supervisee has treated to the current client.
- Increasing the supervisee's awareness and knowledge of their own cultural background.
- Increasing supervisees' knowledge and skills in regard to the different ethnic and cultural groups among their supervisee and client populations.
- Engaging in respectful dialogue within supervision, with an understanding of one's cultural positioning and power.
- Developing their supervisees' cultural competence, through modeling and instruction in supervision.

Clinical supervisors and supervisees bring their cultural and ethnic identity, their past experiences, worldviews, physical appearance, and presence with them into the supervision relationship. The clinical supervisor must acknowledge that appropriate incorporation of cultural practices relies on the supervisee and the clinical supervisor acknowledging their differences and exploring how they might work together (11). By doing so, the clinical supervisor can support the desire of the supervisee to have their cultural worldview and professional practice incorporated into the supervision.

Supervisory Relationship

A quality supervisory relationship is built on trust, confidentiality, support, and empathic experiences. (3) Building a collaborative relationship is one of the key elements to successful clinical supervision. This type of relationship can be built through collaborative discussions of expectations, goals, and tasks of supervision (8). As supervisors initiate and engage the supervisee in these discussions, supervisors should acknowledge differences such as, values, culture, and biases. Discussion of the power differential inherent

in the supervisory relationship also helps to build a collaborative relationship. This type of discussion may be initiated by the supervisor verbally acknowledging the inherent power differential.

In order to maintain an effective supervisory relationship, clinical supervisors should consistently demonstrate respect toward a supervisee and model clear and consistent boundaries. Additionally, supervisors are encouraged to find opportunities to guide the supervisee to develop and implement self-care. In kind, clinical supervisors should have an established practice for self-care.

Supervision Agreement

Supervisors are required to establish a written agreement, or Supervision Agreement, with the supervisee at the onset of the supervisory relationship. Please see sample agreement required by the BBS in the attached Quick Guide. It is recommended that the Supervision Agreement include:

- Responsibilities and expectations of both parties and of that of the Service Chief or program director (when the Service Chief or program director is not the clinical supervisor)
- Program goals
- Availability of both the supervisor and supervisee for consultation, especially in crisis situations.
- Supervision structure, including frequency and duration
- Limits of supervision responsibility
- Learning objectives
- Measurable goals that are mutually agreed upon
- Specific guidelines to evaluate the supervisee's performance
- As the supervisee clinically and professionally progresses, the agreement may need to be updated to reflect new goals, responsibilities, and learning objectives.

For reference, please see the Behavioral Health Services Clinical Supervision Checklist for recommended elements required to initiate a new clinical supervision relationship.

Supervision Evaluation

To enhance learning and increase the effectiveness of supervision, a systematic procedure for ongoing supervisory feedback is necessary. Assessment, evaluation, and feedback are key to the supervisory process. Supervisors are expected to give feedback regularly to supervisees in a way that encourages professional growth. Supervisor's reflection on how their supervisees are progressing compared to their peers is essential to determining what skills still need to be developed.

Assembly Bill 93 codified the need for the clinical supervisor to provide a written evaluation to the supervisee at least once yearly and also at the termination of the supervision relationships. Behavioral Health Service has created an instrument for use in supervisory evaluations that may be found at the following link: https://ochca.sjc1.qualtrics.com/jfe/form/SV_1yQr4vn2pyGfFem

Best practice in clinical supervision encourages the supervisor to allow the supervisee to evaluate the clinical supervisor at the same time to balance the power differential between the supervisor and

supervisee. BHS utilizes several standardized instruments for this purpose. These instruments can be received from Behavioral Health Training Services (BHTS). The willingness of the supervisor to allow the supervisee to evaluate their performance demonstrates an attitude of humility by the supervisor while encouraging supervisor self-reflection about areas that may need their attention. When the supervisor utilizes this feedback for their own growth and development, it strengthens not only their abilities as a supervisor but also the morale of the supervisee and the longevity of both in the profession.

Termination of Supervision Upon Licensure:

Prior to termination and upon the submission of clinical hours to the Board of Behavioral Sciences and Board of Psychology, clinical supervision will continue until the license posts to their respective websites. Supervisees must receive one hour of either group or individual supervision per week pursuant to the Board of Behavioral Sciences, Board of Psychology and County policy. Supervisors should continue to keep supervision notes on supervisees until they are fully licensed and leave their supervision.

Upon licensure and subsequent termination of supervision, clinical supervisor will submit the CSRF showing date of termination as well as the master CSRF to QMS. All documentation of clinical supervision should be kept for a period of two renewal cycles (approximately three years) of the supervisee before the files can be shredded. This allows for the BBS and Board of Psychology to complete any auditing functions that it may deem necessary.

Professionalism:

Supervisors are expected to model professionalism and exemplary behavior. They are considered to be role models and should be mindful of their role and status as a supervisor. As supervisees grow professionally, they look to their supervisors for standards of how to act with peers, superiors, and individuals and families they serve. Supervisors should strive to model characteristics and interpersonal skills that are essential to the profession such as collaboration, objectivity, honesty, respectful interactions, straightforward communication, and openness to feedback.

Supervisors should be objective when handling any situations that may arise. This includes avoiding any possible dual/multiple relationships with the supervisee in which a possible conflict of interest may arise. All conflicts should be addressed in an open, honest, and explicit manner as soon as possible. Approaching conflict in this way promotes prompt conflict resolution and can aid in minimizing the impact on the supervisory relationship.

There should be a protocol established regarding how to handle differences in opinion when a clinical supervisor (who is not a Service Chief or program director) and a Service Chief or program director (who is not providing the clinical supervision) give different directions to the supervisee. Similarly, a protocol should be established when there are two clinical supervisors (e.g., an individual clinical supervisor and a group clinical supervisor). The Service Chief/Program Director and clinical supervisor(s) should decide on a protocol to address this, and the clinical supervisor should share the protocol with the supervisee at the start of supervision.

Logistics

The frequency and duration of the supervision should be established before the supervision process starts. In addition to regularly scheduled clinical supervision, supervisors should be accessible and provide timely response to clinical supervision requests from the supervisee (e.g., crisis situations, consultations on child or elder/dependent adult abuse reporting). The supervisor should discuss coverage plans with the supervisee when the supervisor is absent or otherwise unavailable.

Supervisees should maintain a record of supervision and remain current with their licensing or certifying board's requirements for clinical supervision.

Supervision via Videoconferencing

As of October 2024, the BBS recommended that the California State Legislature allow Supervision via Videoconferencing to become permanent as it increases access to supervision. The Legislature must vote on the legislation by January 1, 2026, when the provision is set to expire.

Ethical Considerations/Confidentiality

Ethical considerations are always included in supervision guidelines. Ethical standards should be considered shared responsibilities. The supervisor and supervisee need to be aware of their responsibility to promote the collective well-being of the people they serve. (12)

The supervisor has a primary, professional duty to monitor and to manage risk of emotional and/or physical harm to the individuals and families served, the supervisee, or to others that may arise within the sphere of supervisory responsibility. This includes identifying incompetent or unethical practice and taking appropriate steps to properly address the errors of the supervisee. (3)[2] Supervisees are expected to disclose their supervisory relationship to the individuals and families they serve and explain that ongoing consultation with the supervisor will occur.

The supervisor should handle supervisory material in a confidential manner. This may include privacy of the supervisee, for instance, when personal disclosures are made by the supervisee. Boundaries/parameters also need to be considered in order not to compromise the supervisory relationship. At all times, the supervisor should be aware of their status and not abuse their position.

Best Practices:

Specific Model of Clinical Supervision:

- Deliberate Practice
- Interpersonal Process Recall
- Multi-Cultural Clinical Supervision
- Chalkboard Case Conceptualization

Separation of Administrative and Clinical Supervision Functions:

It is also generally recognized that the clinical supervisor be different from administrative supervisor for the following reasons:

- Clinical factors often receive less attention than administrative factors during the supervision period.
- When the administrative supervisor also provides clinical supervision, the supervisee often does not reveal the full extent of potential client problems as they believe that it may impact their administrative performance evaluations.

When this cannot be avoided, it is recommended that administrative supervision and clinical supervision times be separated.

Standardized Forms for Supervision Notes:

Though not required, Health Care Agency recommends the use of a standardized supervision note template included in the appendix. The California Association of Marriage and Family Therapists recommend that clinical supervisors keep supervision notes for two renewal periods post licensure of the supervisee. Please review Quick Guide sample note template on the Practice Guidelines link (https://www.ochealthinfo.com/providers-partners/quality-management-services-qms/bhs-practice-guidelines).

References

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Quick Guide

Regulatory Board and Association Websites

American Association for Marriage and Family Therapy (AAMFT): https://www.aamft.org/iMIS15/AAMFT/

American Psychological Association (APA): http://www.apa.org/

Association of Social Work Boards (ASWB): https://www.aswb.org/

Association of State and Provincial Psychology Boards: http://www.asppb.net/

Board of Behavioral Health Sciences (BBS): http://www.bbs.ca.gov/

California Association of DUI Treatment Programs (CADTP): http://www.cadtp.org/

California Association of Marriage and Family Therapists (CAMFT): https://www.camft.org/

California Board of Psychology (BOP): http://www.psychology.ca.gov/

California Consortium of Addiction Programs and Professionals (CCAPP): https://www.ccapp.us/

National Association of Social Workers (NASW): https://www.socialworkers.org/

Sample Documents

Sample Supervisor Competency Assessment:

http://societyforpsychotherapy.org/wp-content/uploads/2016/10/Appendix-Special-Feature.pdf

Sample Supervision Contract from AAMFT:

https://www.aamft.org/Documents/Sample_Supervision_Contract.pdf

Sample Supervision Log from AAMFT:

https://www.aamft.org/Documents/Sample_Supervision_Log.pdf

Sample Supervision Observation Form:

https://www.aamft.org/Documents/Supervision_Observation_Form.pdf

Common Elements of Clinical Supervision

Supervisor Competence	Supervisory Relationship	Professionalism	Logistics	Ethical Considerations/ Confidentiality
Current in legal and ethical knowledge and skills. Adhere to all Board of Behavioral Sciences (BBS), California Board of Psychology (BOP), or AOD Counselor certification boards' regulations. Meet BBS, BOP, and AOD Counselor certification boards' requirements for the provision of clinical supervision. Provide proof of completion of requirements to Service Chief. Knowledge of various theoretical orientations, evidence-based practices, cultural considerations, clinical specialty areas, and relevant current events. [1] Competency obtained and maintained through formal education, training, professional research, and experience. Participate in regular consultation with other clinical supervisors.	Build collaborative relationship based on trust, confidentiality, support, and empathy. [2] Facilitate collaborative discussions of expectations, goals, and tasks. [3] Acknowledge differences such as, values, culture, and biases. Facilitate discussion of power differential. Establish a written agreement, or Supervision Contract, which includes: responsibilities, expectations, program goals, supervision structure, limits of supervision responsibility, learning objectives, measurable goals, and guidelines for evaluation.	Model characteristics and interpersonal skills that are essential to the profession such as, collaboration, objectivity, honesty, respectful interactions, straightforward communication, and openness to feedback. Maintain objectivity when handling situations. Avoid dual/multiple relationships. Address all conflicts in an open, honest, and explicit and timely manner. Establish and communicate protocol for how to handle differences in opinion between a clinical supervisor and the program's Service Chief, or between two clinical supervisors (i.e. individual supervisor and group supervisor).	Establish frequency and duration of supervision prior to the commencement of supervision. In addition to regularly scheduled supervision, be accessible and provide timely response to clinical supervision requests (e.g. crisis situations, consultations on child or elder/dependent adult abuse reporting). Discuss coverage plans for absences. Provide systematic, routine feedback and encourage reciprocal feedback. Provide regular feedback that encourages professional growth. Maintain consistent notes/record keeping.	Monitor and manage risk of emotional and/or physical harm to the individuals and families served, the supervisee, or to others that may arise within the sphere of supervisory responsibility. [4] Identify incompetent or unethical practice and take appropriate actions to address the errors of the supervisee. [2] Handle supervisory material in a confidential manner. Establish boundaries and at all times be aware of supervisory status and not abuse their position.

1. *APA Council of Representatives, 2014*
2. *NASW, 2013*
3. *APA, 2014*
4. *New Zealand Psychologists' Board, 2010*