CAMFT ACTCF

The Canadian Association for Marriage and Family Therapy
L'association Canadienne pour la thérapie conjugale et familiale

RMFT Supervisor Certification

Procedures and Competences Guidebook

Effective: October 2019

Table of Contents

		Page
CAMFT Welcome		3
A	Core Principles of RMFT Supervisor Certification	4
B	Key Terms	7
C	RMFT Supervisor Application Criteria	9
	Summary Table of Requirements	11
D	Maintaining your RMFT Supervisor Certification	12
E	Philosophy of Supervision Paper Guidelines	12
F	Responsibilities of the RMFT Supervisor	13
G	Responsibilities of the RMFT Supervisor Mentor	13
CAMFT Supervision Competences:		15

Supervisor Qualifying, Supervisor and Supervisor Mentor applications can be found on www.camft.ca under the 'Supervision' tab.

CAMFT Welcome

Welcome to the CAMFT Supervisors' Guidebook; thank you for your interest in becoming a Registered Marriage and Family Therapist Supervisor.
We believe that CAMFT recognition and support of supervision is one of the hallmarks of excellence in the field of Marriage and Family Therapy; it is one of the ways we promote the importance of systems thinking within the broader field of mental health.
Supervision is a backbone of the CAMFT community; it is how we maintain tradition and cultivate innovation. It honours the breadth of experience and perspective among our members; it celebrates diversity.
It is through supervision that we support those who are learning and growing in the profession; it is also how we ensure that our members continue to adhere to rigorous ethical standards.
We are grateful for your commitment to being part of this process.

Kathryn Guthrie
Supervision Coordinator CAMFT

THE RMFT SUPERVISOR CERTIFICATION PROCESS

A. CORE PRINCIPLES

CAMFT regards the following principles as forming the foundation of the RMFT Supervisory certification process:

1. A commitment to the essential concepts and values of the **systemic, relational and collaborative** philosophies that fundamentally inform both the practice and the supervision of marriage and family therapy.

2. The field of Marriage and Family therapy Supervision has a long history of **structured mentoring.** Mentoring or supervision of the supervisory process allows for enhanced learning and a structure for evaluation. CAMFT follows this tradition by requiring:
   a. a solid grounding in **clinical experience**
   b. formal **supervision mentoring**
   c. formal **didactic instruction** in clinical supervision

3. **CAMFT** embraces the core premises intrinsic to a **Competency-based clinical supervision**.
   A competency-based supervision model is isomorphic to the competency-based entry to practice models used by both professional and regulatory bodies in Canada. This model encourages professionals to supervise with competencies in mind. It allows **RMFT**s who meet the competencies to qualify for the **RMFT-Supervisor** designation via potentially diverse routes. This creates possibilities for becoming an RMFT supervisor for those who were trained internationally, in Indigenous or other cultures, or in other methodologies.

The above core principles are explained further below:

Systemic Supervision

CAMFT aligns itself with Todd and Storm's core premises of systemic supervision[1]: contextualization that invites multiple views and acknowledges complexity, responsiveness to a systemic web of relationships, a systemic foundation that promotes a relational change process, and accountability that balances safeguarding of clients, supervisee development and the supervisory relationship.

Systemic Supervision distinguishes itself by including systems thinking as foundational to understanding the therapeutic and the supervisory processes:

> "In a systems approach to supervision, conceptualizing the case and creating ideas for effecting therapeutic change will involve systems thinking on the part of the supervisor and the supervisee. Thus, the dialogue in a systems-oriented

[1] Todd, TC. & Storm CL. Core premises and a Framework for Sytemic Relational Supervision in Todd, TC. & Storm CL. (2014).*The Complete Systemic Supervisor: Context, Philosophy, and Pragmatics*. Wiley-Blackwell. p 1-16.

supervision session will likely include one or more of several key themes. In general, these themes portray a heightened attention to context. Specifically, the themes include the following concepts: (a) diagnosing the system, not symptoms; (b) viewing problems in context; and (c) focusing on systemic change." p. 307 [2]

Systems theory forms the bedrock of most of the couple and family therapy models developed during the last half century and thus strongly informs supervision for ***RMFT***s today.

Relational Theory

Closely connected to systems theory, **relational theory** is a framework used in physics and philosophy to understand reality or a physical system in such a way that the positions and other properties of objects are only meaningful relative to other objects. [3] In the social sciences, relational theorists posit that "all growth takes place within mutually empathic and mutually empowering relationships, and problems follow from the disconnections that occur in non-mutual relationships. …it is not a question of characterizing individuals as static entities but instead a focus on whether relationships are moving toward mutual empathy and mutual empowerment, and if not, what is preventing the movement." [4] These concepts have informed post-modern and feminist models of therapy which continue to be essential in the application of current models of couple and family therapy.

Collaboration Theory

Together with relational theories, collaboration theories have developed in multiple social sciences; management studies, education, psychology, social work, and information technology systems. In couple and family therapy, collaboration theories challenge traditional notions of hierarchical positioning, expert knowledge and acknowledge the negative impact of the abuse of power and systemic oppression. Collaboration theory promotes principles of client empowerment, enhancement of strengths, joint sharing and decision making. Collaborative theories invite a stance of humility and curiosity on the part of therapists and supervisors. [5] [6]

Clinical Experience

CAMFT deems clinical experience as a couple and family therapist to be fundamental to becoming a best practice ***RMFT*** supervisor. Clinical experience may include

---

[2] Montgomery, M & Hendricks, C & Bradley, L. (2001). Using Systems Perspectives in Supervision. The Family Journal. 9. 305-313. 10.1177/1066480701093011. Retrieved from: https://www.researchgate.net/publication/247763150_Using_Systems_Perspectives_in_Supervision

[3] https://en.wikipedia.org/wiki/Relational_theory

[4] Miller, JB, Jordan, JV, Kaplan, AG , Stiver, IP, Surrey, JL. (1991). – Some Misconceptions and Reconceptions of a Relational Approach. Jean Baker Miller Training Institute, Wellesley Centers for Women, Wellesley, MA. p 5. Retrieved from: **https://www.jbmti.org/vmfiles/49sc.pdf**

[5] Graham, J & Barter, K. (1999). Collaboration: A Social Work Practice Method. Families in society: the journal of contemporary human services. 80. 6–13. 10.1606/1044-3894.634.

[6] Anderson, H. (2007, October 5). The therapist and the postmodern therapy system: A way of being with others. Retrieved from http://www.europeanfamilytherapy.eu/wp-content/uploads/2012/10/anderson.pdf

supervised clinical hours during Master's level practica and internships, as well as supervised clinical hours as a therapist post graduation from a Master's program or equivalent. A total of 1500 clinical hours and 2 years as an ***RMFT*** is required to enter the qualifying process to become a supervisor. Only at this point can an ***RMFT*** apply to become an ***RMFT-SQ***. A total of 2000 hours of clinical experience and at least 3 years as an ***RMFT*** is required to attain the ***RMFT-S*** designation.

Supervision Mentoring

Supervision/mentoring is a formally contracted process designed to facilitate competency in supervision. It is paradoxically both hierarchical and collaborative. It is provided by a qualified **RMFT Supervisor Mentor** for an **RMFT-Supervisor (Qualifying)** whose goal is to attain the **RMFT-Supervisor** designation.

Supervision Mentoring can take the following formats:

Direct : live, audio or video recording of supervision provided
Indirect: case report or presentation of supervision provided
Group: (no more than 3 ***RMFT-SQ***s in a group)
Phone or secure media where distance prohibits regular face-to-face contact

Didactic Instruction

In order to gain sufficient understanding of the unique responsibilities involved in supervising and mentoring a **30 hour graduate level course** is required.
Proof of attendance will be required as evidence of completion.

In the near future, CAMFT will outline details for requesting approval of clinical supervision courses. Detailed syllabi for the proposed course will be required. CAMFT requires that the following text be a primary resource for supervision courses: Todd, TC. & Storm CL. (2014). *The Complete Systemic Supervisor: Context, Philosophy, and Pragmatics*. Wiley-Blackwell. Other texts and articles may also be included.

Courses will include an emphasis on the following:

- systemic supervision
- relational practice
- collaborative and reflective practices
- contextualization
- cultural awareness and humility
- diversity, power differentials, social justice and the effects of marginalization, and oppression on traumatized populations
- ethical and legal responsibilities
- the self of the therapist and self of the supervisor
- the supervisory relationship
- feedback, evaluation and gate-keeping

Competency based supervision

Competency-based supervision is a leading form of clinical supervision in Canada, Britain, the USA and Australia.[7] A competency-based supervision training model is

[7] Kaslow, N. J., Falender, C. A., & Grus, C. L. (2012). Valuing and practicing competency-based supervision: A transformational leadership perspective. *Training and Education in Professional Psychology, 6*(1), 47-54.

isomorphic to the competency-based entry-to-practice models used by both professional and regulatory bodies in Canada (such as FACT BC, College of Registered Psychotherapists of Ontario). [8] Other Canadian health-based professions utilize a competency focus in their education and practice. For example, The Royal College of Physicians and Surgeons delivers competency based medical education [9], and provincial Registered Nurses Associations practice standards are based on specific competencies.

The Canadian Counselling and Psychotherapy Association has a Supervision Competency Profile Project which offers a thorough discussion and research on competency-based supervision.[10]

The Psychology and Language Sciences Department of the University College of London, United Kingdom, has developed Competency Standards for Therapy as well as for Supervision.[11] **Dr. Tony Roth** of this department has been responsible for developing these competencies and has given **CAMFT** permission to use the framework developed and to adapt it to our Canadian context. **We are grateful!**

Demonstrating some of the competencies will require **direct supervision** by the supervisor mentor. Most of the competencies will require self reflection and self-evaluation by the qualifying supervisor. This process will be informed by dialogue with supervisor mentors, peers and supervisees. Case presentations and mentoring dialogues will also inform the evaluation of attaining competencies.

As CAMFT develops as an association, more resources and a guideline regarding the use of supervision competencies will be made available. Please refer to **Page 15** for the CAMFT Supervision Competencies.

B. KEY TERMS

RMFT Supervisor (Qualifying): *RMFT-SQ*

An ***RMFT-SQ*** is an RMFT who has met the application criteria and has been accepted to begin training toward the ***RMFT-S*** designation.

RMFT Supervisor: *RMFT-S*

An ***RMFT-S*** is an RMFT who has demonstrated generic and systemic supervision competencies (*see Appendix A*) and has met the application criteria to attain the ***RMFT-S*** designation.

RMFT Supervisor Mentor: *RMFT-SM*

An ***RMFT-SM*** provides consultation and mentors ***RMFT-SQ***s to enable them to attain the ***RMFT-S*** designation. An ***RMFT-SM*** is an ***RMFT-S*** who has supervised for at least 2 years and has provided at least 75 hours of supervision after attaining the ***RMFT-S*** designation.

---

[8] https://www.crpo.ca/wp-content/uploads/2017/08/RP-Competency-Profile.pdf

[9] http://www.royalcollege.ca/rcsite/cbd/rationale-why-cbd-e

[10] https://www.ccpa-accp.ca/wp-content/uploads/2016/10/Compilation-of-Competency-Profiles.pdf

[11] https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks-8

Types of Supervision

- Direct supervision: live observation, reflecting team, visual or audio recording
- Indirect supervision: case report, clinical notes, case presentation, case discussion in the supervisory context.
- Group supervision: any group of 3 to a maximum of 8, but preferably 6
- Dyadic supervision: two therapists receiving supervision together dyadic supervision hours count toward individual hours of supervision
- Individual supervision
- Supervision via phone or a secure media

Consultation is distinct from supervision. While the term supervision, has in the past often been the term used to describe the process between credentialed peers when consulting with each other or an already credentialed therapist consulting with a more experienced credentialed therapist, this process is now more commonly referred to as **consultation**. Consultation can be contracted or less formal. The consultant does not have legal accountability for the consultee's therapeutic decisions and interventions as a supervisor does for a qualifying intern or therapist. It is important that RMFTs begin to make this distinction in their work.

Clinical and Working Hours

Clinical hours are the face to face hours spent with a client or a group of clients, i.e. couples, families or groups are counted as ONE unit). Supervision, administration etc are NOT included when tallying clinical hours.

Working hours are all the hours, (including clinical) that you spend as a professional; supervision, consultation, continuing education, administration, etc.)

Supervision and Mentoring Hours

RMFT-SMs and ***RMFT-SQs*** are responsible for logging supervision and mentoring hours. For tracking purposes, please note the following:

- an hour of supervision in individual, dyads or groups of no more than 8, counts as one hour of **supervision** for each qualifying therapist and as **one** hour of **providing** supervision for the ***RMFT-SQ***
- an hour of **mentoring** to individuals, dyads, or groups of no more than 3, counts as one hour of mentoring received for each ***RMFT-SQ*** and one hour of mentoring provided for the ***RMFT-S***
- Supervision and mentoring hours do not include administrative matters. Supervision and mentoring must be the main activity in order for the time spent to be considered such.

C. RMFT SUPERVISOR APPLICATION CRITERIA

for the *RMFT-SQ* and, *RMFT-S* and *RMFT-SM* designations

ALL applicants must meet the following requirements:

1. Be an RMFT in good standing with the CAMFT
2. Indicate by signature a commitment to practice in accordance with the CAMFT Code of Ethics and the Standards of Practice and Ethics of the regulatory body (if any) in which they are registered
3. Be covered by professional liability insurance as an RMFT
4. Be able to attest by signature that they have:
   a. no active ethical complaints under investigation by a professional association, regulatory college or legal system;
   b. have never been the subject of any ethical complaint that resulted in disciplinary sanctions, or a defendant in, or respondent to investigation, civil litigation, arbitration, or proceeding in which professional conduct was at issue in which they were found guilty;
   c. have never been convicted of or pled guilty to any crime defined as a criminal offence.
   d. have never been denied membership in a professional body or registration in a regulatory college for psychotherapy, counselling or other relevant field.

   If unable to affirm all the above, applicants are required to attach a letter of explanation with the application that will be taken into account when reviewed.

RMFT Supervisor Qualifying (*RMFT-SQ)* Requirements

1. Be an ***RMFT*** in good standing for at least 2 years with a minimum of 750 total working (as distinct from clinical) hours per year.
2. Clear documentation of a minimum of 3 years of post-graduate experience with a minimum total of 1500 clinical hours (during and post-training).
3. Submission of a plan of supervision training that includes:
   a. courses in Supervision you have taken,
   b. the setting(s) in which you will be providing supervision for therapist supervisees,
   c. identification of at least one ***RMFT-SM*** who will be your mentor(s) as you work toward the required competencies.
4. Submit a completed application form.

RMFT Supervisor (*RMFT-S*) Requirements

1. Be an ***RMFT*** in good standing for at least 3 years with a minimum of 750 total working (as distinct from clinical) hours per year.
2. Clear documentation of five years of clinical experience with a minimum total of 2000 clinical hours (during and post training).
3. Completion of a 30 hour graduate level course (or equivalent) in clinical supervision.

4. Compilation of a list of articles / texts relevant to systemic supervision that have been read.
5. Completion of a paper that articulates a personal philosophy and framework of systemic supervision. *This should be completed toward the end of training.* The ***RMFT-SM*** and an external ***RMFT-SM*** will review and assess the paper and document satisfactory completion. (See Appendix 2 for details…to be developed.)
6. Documentation of having provided at least 150 hours of systemic supervision to those seeking credentialing. Supervisees do not necessarily need to be seeking RMFT credentials. The 150 supervision hours provided must be completed within 5 years of completing the supervision course.
7. Provided supervision to a minimum of four supervisees, two of whom were supervised for at least 6 months on a regular basis.
8. Completion of the Supervision Mentoring form, by all ***RMFT-SM***s who provided you a total minimum of 30 hours of supervision mentoring over a period of no less than 18 months. CAMFT recommends one or two mentors for continuity in mentoring. Under extenuating circumstances, detailed in writing to CAMFT, an exception may be approved for having one additional mentor.
9. Written confirmation from the last ***RMFT-SM*** that entry to supervision competencies have been reviewed, discussed and evaluated as attained *(form to be developed).*
10. Submit a completed application form. (See page…

RMFT Supervisor Mentor (*RMFT-SM)* Requirements

1. Be an ***RMFT*** in good standing for at least 5 years.
2. Be an ***RMFT Supervisor*** for at least 2 years in which a minimum of 75 hours of supervision was provided to a minimum of 5 supervisees
3. Demonstrate proficiency in practicing the supervision competencies required of an ***RMFT-S*** by documenting: reflection and personal review of these competencies; readings about supervision; evaluations by supervisees; and consultations with other RMFT-Supervisors; and other evidence of commitment to growing the profession.
4. Written confirmation from an ***RMFT-SM*** who has sufficient knowledge of the applicant to attest to the competency of the applicant to qualify as an ***RMFT-SM***.
5. Submit a completed application form (See page 40).

Summary of Requirements for RMFT Supervisor Designations

Designation	Years of Post-Graduate Clinical Experience	Years as RMFT	Clinical Hours * and Supervision/ Mentoring Hours	Working Hours**	Application Requirements
RMFT-SQ Supervisor (Qualifying)	Minimum **3** years	Minimum **2 years**	**1500** Clinical hours	750 per year minimum. In extenuating circumstances: illness, maternity leave, indicate this on application form.	Application process includes: - Plan for training - Setting in which supervision will be offered - Naming ***RMFT-SM***
RMFT-S Supervisor	Minimum **5** years	Minimum **3 years**	**2000** Clinical hours **AND** Provision of **150** hours of supervision to at least 4 supervisees - and for at least 6 months for 2 of these supervisees **AND 30** hours of mentoring for a period of at least 18 months and no more than 5 years by an ***RMFT-SM***	750 per year minimum. See above.	- Completion of pre-approved 30 hour graduate level course in supervision - Compilation of reading list - Philosophy of Supervision paper
RMFT-SM Supervisor Mentor	Minimum **5** years	Minimum **5 years** Minimum 2 years as ***RMFT-S***	75 additional hours of providing supervision to a minimum of 5 supervisees	750 per year minimum. See above.	Maintenance of "Living Document" - Competence Attestation from peer ***RMFT-SM***

***Clinical hours** are the face to face hours spent with a client OR a **group** of clients; i.e. couples, families or groups are counted as one unit. Supervision, administration etc are NOT included.

****Working hours** are **all** the hours that you spend as a professional; clinical, supervision, consultation, continuing education, administration, etc.

D. CONTINUING EDUCATION FOR SUPERVISORS AND SUPERVISOR MENTORS

1. As Systemic Supervisors in a profession inclusive of many cultures and social populations, best practice requires continuing education. At least one approved continuing education course (or 5 hours) in subjects relevant to supervision is required **every other year**. CAMFT may provide such courses and other courses that acquire pre-approval may qualify as well.
2. CAMFT strongly encourages all members and especially supervisors to become informed about the concepts of Cultural Humility, Intergenerational Trauma, and Intergenerational Trauma particularly in regards to Canada's Indigenous peoples, as well as refugee populations. A regular review of the recommendations of the Truth and Reconciliation Commission of Canada is strongly recommended. [12]
3. Supervisors are encouraged to document relevant reading or workshops completed throughout each year.
4. A summary of key points of learning can be added to the Living Document Philosophy of Supervision Paper regularly.
5. Documentation of continuing education and completed reading is required to be submitted every 5 years in order to maintain the ***RMFT-S*** or ***RMFT-SM*** credentials (form to be developed)
6. Every FIVE years, the Living Document Philosophy of Supervision paper will be peer-reviewed by an ***RMFT-S*** and a form submitted who can attest that documentation for continuing education, readings completed and a reflective addendum has been added. (form to be developed). Having a peer ***RMFT-S*** review this updated paper every 5 years facilitates supervisor accountability and connection in the ***RMFT*** supervision community.

E. PHILOSOPHY OF SUPERVISION PAPER GUIDELINES

CAMFT considers the Philosophy of Supervision paper to be **a living document** that is initially completed at the end of the ***RMFT-SQ*** training. After the initial completion, the paper becomes the foundation for a living document which will be one element of the renewal process for **RMFT Supervisors**. Revisiting this paper every five years and completing an addendum that briefly updates each category of the paper would produce a record of development over one's supervisory career.

While the beginnings of a paper about one's approach to supervision may be found in the 30 hour Supervision Course approved by CAMFT, CAMFT requires that the paper be completed toward the end of the mentoring process.

The 2000-3000 word paper will include these components in the following order:

1. A clear, concise formulation of the supervisor's approach to systemic supervision
2. Discussion of readings in which this approach is grounded

[12] http://www.trc.ca/websites/trcinstitution/index.php?p=905

3. Discussion of experience: (a or b)
    a. a supervisory case study as an example of the work
    b. personal reflection on use of self as supervisor
4. Goals for growth and learning based on Supervision Competencies

The paper will be reviewed by the last ***RMFT-SM*** as well as an external ***RMFT-SM*** reader for approval of the paper; the ***RMFT-SM*** and the ***RMFT-SQ*** will agree in their choice of an external reader. Having an external reader benefits the learning of the applicant and facilitates connection in the ***RMFT*** supervision community.

F. RESPONSIBILITIES OF THE RMFT SUPERVISOR

Supervising interns or qualifying therapists (supervisees) requires the following:

- a safe, viable and professional working relationship. Thus supervisors may not provide supervision to family or former family members, or other persons with whom a prior relationship would prevent a professional mentoring relationship.
- compliance with CAMFT Code of Ethics and applicable laws or regulations.
- a focus on client well-being and supervisee development
- awareness of the qualifications of each of your supervisees to ensure they are ready to practice under supervision.
- a dual focus on direct supervision (live, audio or video of the supervision) and indirect supervision (case report, case presentation).
- face-to-face meetings are preferred; however, under extenuating circumstances supervision may be provided via real-time technology assisted means that are compliant with PHIPA privacy laws and CAMFT ethics.
- maintenance of confidentiality except in limited circumstances mandated in law or by written consent.
- ensure that clients give written informed consent to their qualifying therapists that indicates from whom they receive supervision.
- availability to supervisees for emergencies and regular contact.
- a clearly written contract with each supervisee
- regular review of **CAMFT Supervision Competencies** to assess self
- regular verbal feedback of progress in couple and family therapy competencies and a written evaluation as necessary and at the end of the supervision contract
- a pre-determined process for addressing conflict in the supervisory relationship
- clear, dated, documentation of progress and concerns.

G. RESPONSIBILITIES OF THE RMFT SUPERVISOR MENTOR

Mentoring of ***RMFT-SQs*** requires the following:

- a safe, viable and professional working relationship
    - Thus mentors may not provide supervision to family or former family members, clients, or other persons with whom a prior relationship would prevent a professional mentoring relationship
- compliance with CAMFT Code of Ethics and applicable laws or regulations
- awareness of each of your ***RMFT-SQ'***s supervisees.

- a dual focus on direct mentoring (live, audio or video of the supervision) and indirect mentoring (case report, case presentation)
- face-to-face meetings are preferred; however, mentoring can be provided via real-time technology assisted means that are compliant with PHIPA privacy laws and CAMFT ethics.
- maintenance of confidentiality except in limited circumstances mandated in law or by written consent
- clients give written informed consent that supervision is occurring by an ***RMFT-SQ*** who is being mentored by an ***RMFT-SM***
- availability for ***RMFT-SQ***s for emergencies and regular contact
- a written contract
- regular review of **CAMFT Supervision Competencies** to assess self
- regular verbal feedback of progress in **CAMFT Supervision Competencies**
- a pre-determined process for addressing conflict in the relationship
- documentation of progress and concerns
- review of the philosophy of supervision paper written by the ***RMFT-SQ*** (relevant forms to be developed)
- the last ***RMFT-SM*** must determine that the ***RMFT-SQ*** meets the requirements to be a successful applicant, and if necessary extend the training should it be determined that the ***RMFT-SQ*** is not adequately prepared, or that there has not been adequate time or information on which to base a recommendation.
- submission of mentoring reports with the ***RMFT-SQ***'s application for the ***RMFT-S*** designation

CAMFT SUPERVISION COMPETENCES

Competence Frameworks for the delivery and Supervision of Psychological Therapies
CORE/ University College London, Great Britain

Permission for CAMFT to use and adapt these Supervision Competences was graciously given by Professor Tony Roth, of University College London. We are grateful for this opportunity to enhance the Supervision Certification process in CAMFT.
Original Documents of the Generic, Specific and Systemic Supervision Competences were retrieved on 22 April 2018 from: https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks-8
With the generous permission of Professor Roth, CAMFT has adapted the formatting, integrated the three documents, changed the order of competences, made minor edits, and added a few competences relevant to our Canadian context.

GENERIC and SPECIFIC SUPERVISION COMPETENCES

1. Ability to employ educational principles which enhance learning

A. Ability to apply the principles of adult learning

i. An ability to undertake supervision in a collaborative manner which assumes that learning is a two-way process (in which the supervisor can expect to learn from the supervisee)
ii. An ability to apply the principles of adult learning, incorporating active learning and promoting supervisee's reflection on their learning
iii. An ability to help supervisees identify their own strengths and weaknesses, and formulate learning objectives to address identified gaps
iv. An ability to take account of the supervisee's preferred approaches to learning, particularly with regard to any mismatches between their approach and the supervisor's usual preference

B. Knowledge

i. An ability to draw on knowledge of relevant educational models, and their implications for supervision practice, i.e.:
    a. that learning is best seen as part of a cycle of activities, rather than as a one-off event[13]
    b. that learning is enhanced by taking supervisees through an iterative cycle that
        (i) exposes them to new ideas
        (ii) gives them the opportunity to apply these ideas in practice
        (iii) reflect on what they learned from their experience
        (iv) apply their new learning to future work
    c. that supervisees are more likely to learn when they themselves perceive a gap between what they currently know and what they need to know[14]
    d. that learning is most likely to take place when supervisees experience an *optimal* level of discomfort, generated by a perception of a gap between the knowledge they currently have and the knowledge they need to make sense of their experiences
    e. that learning only takes place if the supervisee acknowledges this gap for themselves
    f. that it will be harder for learning to take place if this gap is too great

[13] (The Experiential Learning Cycle) Kolb, D.A. (1984) *Experiential Learning: Experience as the source of learning and development.* Prentice Hall, Englewood Cliffs, NJ
[14] Mezirow, J. (1994) Understanding transformation theory. *Adult Education Quarterly* 44 222-4

g. that supervises need to be able to make the connection between any new learning and their current knowledge[15]
h. that learning is most likely to take place if new information is presented in a way which links it to knowledge and experience already possessed by the supervisee
i. that learning is unlikely to take place if this connection is not made, or there is too great a gap between new information and the supervisee's current state of knowledge or experience

ii. An ability to draw on knowledge that supervisees learn best if the level of challenge they experience when performing clinical work or tasks within supervision is at an optimal level (neither too high nor too low), and that this 'optimal' level will vary from supervisee to supervisee

C. Transfer of learning

i. An ability to draw on knowledge of strategies for assuring the transfer of learning from the supervision context into clinical work, usually by agreeing on activities to be carried out between supervision sessions (such as role-play, practice–assignments or applying ideas to clinical work) and ensuring that these are reviewed in subsequent supervisions

D. Ability to use direct observation and contingent feedback to enhance learning in supervision

i. An ability to draw on knowledge of the benefits of behavioural techniques in supervision (i.e. linking observation with contingent feedback)
ii. An ability to identify and make use of contexts for observation best suited to desired learning outcomes – such as:
    a. direct observation of clinical work (including the use of taped material)
    b. role play within supervision
    c. observation and practice of specific therapeutic techniques within supervision
iii. An ability to draw on knowledge that feedback is most effective when it is:
    a. accurate (i.e. direct and avoiding dissimulation)
    b. focused on specifics (rather than general observations)
    c. offered contingently to specific actions (rather than as global feedback that could relate to many actions)
    d. as far as possible focuses on behaviours rather than on imputed personal characteristics (e.g. on a tendency for the supervisee to be too active, rather than on attempts to address an imputed need to take control)

E. Ability to link theory to practice, and relate practice to theory

i. An ability to help the supervisee use theoretical and conceptual ideas to guide and evaluate their practice, and use their clinical experiences to reflect and build on these ideas

2. Ability to enable ethical practice

A. Ability to identify and discuss ethical issues with the supervisee

i. An ability to draw on knowledge of relevant ethical and professional codes of practice
ii. An ability to identify and alert supervisees to common ethical issues that they are likely to encounter in their clinical work
iii. An ability to monitor supervisee's clinical practice in order to identify and discuss any emerging ethical dilemmas
iv. An ability to help the supervisee identify appropriate ways of resolving issues which reflect ethical dilemmas, including consideration of the consequences of such actions and (if relevant) the process of documenting the steps taken

[15] Chaiklin, S. (2003) The Zone of Proximal Development in Vygotsky's Analysis of Learning and Instruction. In Kozulin, A., Gindis, B., Ageyev, V. & Miller, S. (Eds.) *Vygotsky's Educational Theory and Practice in Cultural Context*. Cambridge: Cambridge University

B. **Ability to identify and discuss issues relating to confidentiality**

i. An ability to ensure that supervisees are aware of and understand relevant national, local and professional codes that set out the principles governing the maintenance of client confidentiality
ii. An ability to ensure that supervisees understand the conditions under which confidentiality can be breached (i.e. when there is substantive evidence of significant risk to the client or others) and are aware of the appropriate procedures for managing this
iii. An ability to ensure that supervisees can apply the principles of confidentiality to their clinical practice, in relation to:
    a. direct work with clients
    b. verbal and written communications with professional colleagues and relevant third parties
iv. An ability to ensure that supervisees can explicitly discuss the application of principles of confidentiality with their clients, and draw client's attention to the fact that:
    a. supervision itself may breach confidentiality (because it involves discussion with a third party),
    b. if working in a team, whether and how information about the client might be shared with professional colleagues,
    c. confidentiality can be breached if there is significant concern regarding risk

C. Dual role-relationships

i. An ability to draw on knowledge (and relevant professional codes) regarding the potential problems that can arise when the supervisor occupies more than one role in relation to the supervisee e.g.: when the supervisor has had or develops a relationship with the supervisee which could make it difficult for them to maintain a neutral supervisory stance (e.g. a close friendship, any family member closer than a cousin, or previous contact in which there were significant difficulties)
ii. An ability to draw on knowledge that certain dual relationships (such as intimate/ sexual relationships) are proscribed
iii. An ability to apply relevant professional codes which advise on the actions to be taken in relation to dual relationships
iv. An ability to be clear about the implications of any professional dual role-relationships, in particular when the supervisor also acts as a line manager to the supervisee

3. Ability to foster competence in working with difference

In this section the term "difference" is used to indicate the broad spectrum of cultural and demographic variations in client populations around which discrimination and disadvantage can and does occur. "Difference" therefore includes ethnicity, cultural background, religion, gender, sexuality, social class, disability, and age.

A. Ability to help supervisees consider the relevance of issues of difference

i. An ability to ensure that issues of difference (e.g. race, culture, religion, gender, sexuality, disability, age, etc.) are a routine part of discussion in supervision
ii. An ability to ensure that supervisees are aware of the rationale for a focus on culture and difference, largely:
    a. to maximize the effectiveness and/or relevance of interventions for all clients
    b. to maximize the effectiveness and confidence of the supervisee in working with difference
    c. to ensure that issues of difference which are relevant to the supervisor and supervisee themselves are included in supervision discussions
iii. An ability to help the supervisee explore cultural assumptions underlying their practice by:
    a. facilitating discussion which helps consider how the supervisor's and the supervisee's own background and experience of difference influences their outlook and assumptions

b. facilitating an awareness of cultural humility in the supervision process
c. acknowledge discrimination as a social and as a personal issue, both for clients and potentially for supervisors and supervisees

iv. An ability to draw the supervisee's attention to relevant national and local service policies relating to difference

B. Ability to help supervisees integrate issues of difference into their practice

i. An ability to help the supervisee identify and discuss relevant issues of difference including power differentials and intersectionality
ii. An ability to include consideration of the relevance of culture/ difference when assessing and formulating a client's presentation (including an ability to consider any assumptions which reflect the supervisor or supervisee's own culture or background)
iii. On the basis of assessment and formulation, an ability to help the supervisee identify ways in which practice with specific clients' needs to be adapted in order to be responsive to issues of difference
iv. An ability to help the supervisee implement adaptations to practice which are a response to issues of difference
v. An ability to help the supervisee develop a stance of cultural humility as well as cultural knowledge relevant to the client groups with whom they are working

C. Working with interpreters

i. An ability to ensure that supervisees are appropriately supported in working with interpreters, by:
   a. alerting them to procedures for ensuring best practice and identifying potential difficulties
   b. reviewing work undertaken with interpreters and identifying and discussing any issues which emerge

4. Ability to adapt supervision to the organizational and governance context

A. Knowledge

i. An ability to act on knowledge of the organizational context within which the supervisee is operating, and any implications this has for the ways in which supervision is conducted e.g.
   a. contractual relationships between training institutions and the clinical setting
   b. local arrangements for clinical governance
   c. local indemnity arrangements
   d. local arrangements for risk management

B. Ability to adapt supervision and supervisee's practice to the organizational context

i. An ability to help the supervisee understand the ways in which the organizational context shapes the pattern of clinical work, and to help them:
   a. work in a manner congruent with the context
   b. consider how their practice may need to be adapted
   c. reflect on the ways in which the context impacts on their practice

C. **Ability to adapt supervision to the clinical governance context**

i. An ability to ensure that the supervisee is aware of local governance arrangements (e.g. for record keeping, monitoring and audit)
ii. An ability to deliver supervision in a manner which is congruent with local governance arrangements
iii. An ability to help the supervisee understand and address the implications of local governance arrangements for the delivery of psychological interventions
iv. An ability to identify and discuss with the supervisee any breaches of the agreed governance arrangements, and to take appropriate action when required

5. Ability to foster and maintain a supervisory alliance

A. Knowledge of factors associated with a positive supervisory alliance

i. An ability to draw on knowledge that there are three domains to the supervisory alliance:
   a. the **bond** between supervisor and supervisee (a sense of mutual respect and engagement)
   b. agreement that **supervisory tasks** are relevant and appropriate
   c. agreement on the overall **goals and aims** of supervision

ii. An ability to draw on knowledge of therapist factors which increase the probability of forming a positive alliance:
   a. being flexible and allowing the supervisee to raise issues which are important to them
   b. being respectful
   c. being warm and affirming
   d. being open
   e. being alert and active
   f. being able to show honesty through self-reflection
   g. being trustworthy

iii. An ability to draw on knowledge of therapist factors which reduce the probability of forming a positive alliance:
   a. being rigid
   b. being critical
   c. making inappropriate self-disclosure
   d. being distant
   e. being aloof
   f. being distracted

B. Capacity to develop the supervisory alliance

i. An ability to gauge the degree of congruence in the aims of the supervisor and supervisee
ii. An ability to negotiate shared objectives for supervision
iii. An ability to ensure that the supervisee is clear about the rationale for usual structure and process of supervision sessions
iv. An ability to listen to the supervisee's concerns in a manner which is non-judgmental, supportive and sensitive
v. An ability to adjust interpersonal style in order to be congruent with the style of the supervisee
vi. An ability to invite the supervisee to give feedback about how they are experiencing supervision
vii. An ability to gauge whether the supervisee has questions, doubts or skepticism (etc) about the supervision relationship and supervisory process, and to respond to these concerns openly and non-defensively in order to resolve any ambiguities
viii. An ability to help the supervisee express any concerns or doubts they have about any aspect of the supervision process, especially where this relates to mistrust or skepticism

6. Capacity to manage threats to the supervisory alliance

i. Ability to recognize and to address strains in the supervisory alliance
ii. An ability to recognize when strains in the alliance threaten the efficacy of supervision
iii. An ability to deploy appropriate interventions in response to disagreements about tasks and goals
iv. An ability to check that the supervisee is clear about the structure and process of supervision and to review this with them and/or clarify any misunderstandings
v. An ability to deploy appropriate interventions in response to strains in the bond between supervisor and supervisee

vi. An ability for the supervisor to give and ask for feedback about what is happening in the here-and-now interaction, in a manner which invites exploration with the supervisee
vii. An ability for the supervisor to acknowledge and accept their responsibility for their contribution to any strains in the alliance
viii. An ability to help the supervisee to assert any negative feelings about the relationship between the supervisor and themselves
ix. An ability to recognize, and to take appropriate action, when the working alliance has broken down irretrievably

7. Ability to structure supervision sessions

A. Ability to establish a professional framework for supervision

i. An ability to conduct supervision in a manner which is congruent with relevant ethical, medical, legal, and professional frameworks
ii. An ability to draw on knowledge of the legal/ clinical responsibility for casework carried by both the supervisor and supervisee, and to ensure that this information is shared with the supervisee

B. Ability to establish and maintain boundaries

i. An ability to manage professional boundary issues
ii. An ability to ensure that the supervision does not become therapy, and to ensure that this boundary distinction is respected both by the supervisor and the supervisee
iii. An ability to ensure that personal disclosure by the supervisee is considered in the context of its contribution to the supervision process (rather than being responded to in a manner more appropriate to a therapeutic relationship)
iv. An ability to manage personal boundary issues:
    a. an ability to guard against the development of “dual” relationships (e.g. in which supervisor and supervisee become personal friends),
    b. an ability to guard against the development of proscribed dual relationships, such as an intimate/ sexual relationship
v. An ability to draw on knowledge of power differentials in supervision

C. Ability to negotiate a contract for supervision

i. An ability to negotiate a contract for supervision which specifies its aims and which identifies the expectations of both the supervisor and the supervisee regarding the areas which will be included in supervision
ii. An ability to ensure that supervisees are clear about procedures which will be followed should there be significant concerns about their practice
iii. An ability to conduct supervision in a manner congruent with the contract
iv. An ability to be open to feedback from the supervisee should any aspect of supervision content or structure deviate significantly from that which has been agreed

D. Ability to establish a structure for supervision sessions

i. An ability to impart information about the usual content and expected focus of supervision sessions
ii. An ability to negotiate and implement basic expectations regarding the pattern of supervision:
    a. frequency and duration of supervision sessions
    b. alternative supervision arrangements if the supervisor is on leave or unexpectedly unavailable
    c. supervision arrangements in the case of ‘emergencies’

E. Ability to agree to expectations about which cases will be presented

i. An ability to agree with the supervisee on a clear rationale for the selection of clinical work, aiming to ensure that:
   a. the supervisor is aware of progress with the supervisee's complete caseload
   b. there is explicit and mutual agreement about the basis for selecting which cases to discuss
   c. there is no systematic and/or undisclosed bias in selection of cases for discussion (e.g. supervisee only bringing cases which are progressing well)

8. Ability to help the supervisee present information about clinical work

A. Ability to help supervisee identify relevant content

i. An ability to ensure that the supervisee has a sense that it is legitimate to raise a broad range of concerns about their work (e.g. clinical or ethical dilemmas, personal feelings raised by the work, etc.)
ii. An ability to ensure that the supervisee feels able to bring examples of clinical work which have not proceeded well (i.e. to encourage a sense that such instances can be helpful for learning, and ensuring that concerns about evaluation do not lead to a reluctance to disclose difficulties or errors)
iii. An ability to help the supervisee present information about clinical work in a manner which is appropriately structured and organized

B. Ability to help the supervisee develop structured presentations

i. An ability explicitly to indicate expectations regarding the usual content of presentations, including a rationale for the inclusion (and exclusion) of material
ii. An ability to give clear and structured feedback about the supervisee's presentations, including comment on:
   a. clarity of presentation and relevance of material
   b. any significant content areas which have been omitted
   c. any included but less relevant content
iii. An ability to encourage feedback from the supervisee regarding comment on their presentational style
iv. an ability to reflect on and openly discuss any differences in supervisor/supervisee viewpoints regarding the relevance of content areas

9. Ability to help the supervisee practice clinical skills

A. An ability to identify areas of clinical technique which it would be helpful to practise in supervision sessions (usually through collaboration with the supervisee, and with reference to relevant training programmes or competence checklists)

i. An ability to identify and implement the most appropriate method for helping the supervisee practice clinical techniques, including:
   a. an ability to use modelling to aid learning
   b. an ability to use modelling in supervision sessions to demonstrate specific techniques
   c. an ability to use modelling in clinical sessions, usually by co-working with the supervisee
   d. an ability to clarify with the supervisee how sessions which include modelling will be run (for example, whether the supervisee will also practise techniques that the supervisor has modelled)
ii. An ability to set up and conduct exercises which allow the supervisee to practise/ rehearse implementing therapeutic procedures (e.g. exploring ways to phrase questions, implementing specific techniques etc)
iii. An ability to set up and conduct role play of therapeutic encounters

B. An ability to structure practice sessions in a manner which ensures that the supervisee:

i. is clear about the aim(s) of the practice session
ii. is appropriately prepared (e.g. through prior discussion or modelling of the skills by the supervisor)
iii. is clear about the skills they are expected to practise / demonstrate

C. An ability to give feedback about the practice session to the supervisee which is:

i. accurate and constructive,
ii. focuses on strengths and weaknesses,
iii. and is task-specific (rather than global)

D. An ability to help the supervisee reflect on feedback about the practice session

10. An ability to help the supervisee reflect on their work and on the usefulness of supervision

A. Knowledge

i. An ability to draw on knowledge that the accuracy of supervisee's self-appraisal tends to be lower when supervisors only give supportive feedback
ii. An ability to aid accurate self-reflection by giving feedback (in all areas of a supervisee's work) which is supportive but also accurate and appropriately challenging

B. Ability to establish expectations about reflection within supervision

i. An ability to communicate an expectation that the supervisee will undertake regular self-assessments within supervision (e.g. to reflect on specific clinical tasks or clinical activities)

C. Ability to facilitate reflection

i. An ability to implement educational models within which there are explicit opportunities for reflection and self-appraisal
ii. An ability to help the supervisee reflect on their experience (as gained both in clinical settings, in supervision and from academic input), with the aim of increasing the accuracy of their self-appraisal in the areas of:
    a. general and specific clinical skills
    b. current capacities and learning needs
    c. personal and professional development
    d. understanding of the application of ethics and values
iii. An ability to help the supervisee reflect on the perspective of the client, particularly as this relates to the client's experience of the therapeutic 'tasks' associated with therapy

D. Ability to gauge the supervisee's capacity to reflect

i. An ability to help supervisees use specific techniques to aid reflection, such as learning logs
ii. An ability to respond in a respectful manner to supervisee's reflections, so as not to inhibit future reflection
iii. An ability to gauge the supervisee's ability to engage in accurate self-appraisal
iv. An ability to gauge the supervisee's ability to respond to feedback in a manner that is consonant with the content of the feedback (i.e. in a manner which is neither dismissive nor over-reactive)
v. An ability directly to discuss difficulties in the supervisee's ability to reflect on feedback or to accurately self-appraise their work

E. Ability to monitor supervisee's capacity to apply the outcomes of reflection

i. An ability to monitor the extent to which the supervisee is able to apply their reflections to clinical work (i.e. to link reflection with changes in their clinical practice)

11. Ability to incorporate direct observation into supervision

A. Ability to use audio / video-recordings

i. Establishing a context for recording
ii. Knowledge of the potential advantages of using recordings in supervision (broadly, that supervisee report is not equivalent to actual behaviour, and that direct access to clinical material enhances the opportunity for feedback)
iii. Knowledge of the potential impacts of recording on the supervisee (e.g. self-consciousness) and on the client (e.g. anxiety regarding confidentiality)
iv. An ability to help the supervisee manage their concerns about recording
v. An ability to introduce recording in a manner which balances a concern for supervisee anxiety with the management of inappropriate reluctance or resistance to recording
vi. An ability to ensure that the supervisee understands the requirement to obtain informed consent in general, and is aware of the need to:
    a. discuss the purposes of recording with the client and give them the opportunity to discuss their thoughts and concerns about recording
    b. gain client consent in a manner which ensures that this is given without coercion, and that the client is aware of their entitlement to refuse consent at the outset or withdraw consent at any time throughout the therapy
    c. fully discuss the use of recorded material with the client, ensuring they know who will be listening to the recordings and the partial breach of confidentiality that this implies
    d. obtain formal written consent for recording
vii. An ability to ensure that the supervisee is aware of the requirement to assure that recorded material is kept securely, and can discuss this with the client
viii. An ability to ensure that the supervisee is aware of the requirement to destroy recordings after they have been used, and can discuss this with the client

B. Using recordings as a supervisory tool

i. An ability to discern and apply the evidence regarding the most effective use of recordings:
    a. stopping and starting the recording frequently, so as to focus on specific issues e.g. implementation of technique, maintenance of the therapeutic alliance (rather than using the recording to make general observations)
    b. employing appropriate question styles to help the supervisee reflect on their actions and those of the client
    c. helping the supervisee make links between theoretical ideas and their own practice
ii. An ability to decide on the most appropriate way of using recordings (e.g. whether to listen to recordings of complete sessions or to focus on discrete sections)
iii. An ability to negotiate with the supervisee in order to agree on the principles underlying the selection of recordings and the selection of extracts from recordings
iv. An ability to identify and focus on the supervisee's clinical concerns and queries
v. An ability to help the supervisee reflect on and review the recording in a way which is systematic and which helps explicate their understanding of their actions

C. Ability to use in-session direct observation

i. An ability to discern the potential impact of live supervision
    a. on the supervisee (e.g. self-consciousness and increased anxiety)
    b. on the client (e.g. anxiety regarding confidentiality, uncertainty over who is acting as the 'lead' therapist), and an ability to address these concerns
ii. An ability to negotiate with the supervisee so as to agree how the session will be run (e.g. whether the supervisor will observe rather than participate, who will make introductions, who will speak to the client, etc)
iii. An ability to observe the supervisee working with the client in their own (i.e. characteristic) style without intervening to point out 'errors' or concerns, unless these are so serious that immediate action is required

iv. An ability to track and note areas for feedback, and to give this after the session has ended
v. An ability, where relevant, to conduct live supervision from outside the therapy room (e.g. using one-way mirrors or video links)
vi. An ability to ensure that supervisees are appropriately prepared for methods which could be experienced as intrusive or anxiety-provoking (e.g. using earphones to communicate with supervisees while they are conducting the session)
vii. An ability to make judicious use of 'live' feedback so as not to undermine the supervisee's sense of autonomy
viii. An ability to help supervisees use specific techniques to aid reflection, such as learning logs
ix. An ability to respond in a respectful manner to supervisee's reflections, so as not to inhibit future reflection
x. An ability to gauge the supervisee's ability to engage in accurate self-appraisal
xi. An ability to gauge the supervisee's ability to respond to feedback in a manner that is consonant with the content of the feedback (i.e. in a manner which is neither dismissive nor over-reactive)
xii. An ability directly to discuss difficulties in the supervisee's ability to reflect on feedback or to accurately self-appraise their work

12. Ability to conduct supervision in group formats*

*When peer supervision is carried out in a group, group members can occupy the roles of supervisor and supervisee in turn. This means that although the competences in this section apply to this type of supervision, they would need some adaptation.

A. An ability to induct supervisees to group supervision

i. An ability to help supervisees prepare for group supervision by identifying issues which enhance their capacity to be effective participants, such as:
    a. expectations regarding attendance,
    b. considering in-group behaviours that tend to facilitate or to hinder the group's work,
    c. the identification of group 'norms' for appropriate behaviour
    d. the need to identify what they would like to gain from the group (e.g. considering in advance of a presentation what issues they would like feedback on)
    e. the need to prepare and present clinical material in a manner that enables their colleagues to engage with it
    f. how best to give feedback in a manner which is direct but also supportive
ii. An ability to model behaviour in the group which enhances the efficacy of the group (e.g. giving feedback which is direct but also respectful and supportive, and which displays appropriate empathy)

B. An ability to act as a group leader

i. An ability to take an active, assertive but non-authoritarian leadership role
ii. An ability to listen to, and act on, feedback about group functioning from group members

C. An ability to structure group sessions

i. An ability to clarify, and agree with group members, the way in which the group will function by identifying the mode of supervision most appropriate to the supervision task and to group membership:
    a. supervision of each member of the group in turn, with group members acting as an audience (supervision in a group)
    b. supervision of each member of the group in turn, with group members encouraged to act as active participants (supervision with a group)
    c. supervision which encourages all group members to act as supervisors, with the group leader facilitating this process (supervision by the group)
ii. An ability to ensure that there is a clear and transparent arrangement for allocating time to each supervisee

iii. An ability to identify and agree a consistent procedure for case presentations (e.g. who presents, how cases are chosen, length and format of presentation, etc.)

D. An ability to manage group process

i. An ability to support and monitor the engagement of supervisees with one another (e.g. by ensuring that supervisees have the opportunity to get to know and trust one another)
ii. An ability to ensure that supervisees feel supported for the work they are undertaking
iii. An ability to identify (and act on) problematic interpersonal issues, especially any tensions within the group (e.g. by addressing conflict or inappropriate competitiveness)
iv. An ability to address any problematic aspects of group process which reflect issues of difference and/or power (e.g. in relation to different levels of experience, or in relation to cultural issues)

13. Using measures to help the supervisee gauge client progress

In this section the term "measures" includes questionnaires, idiographic measures (i.e. measures tailored to the client themselves) or any systematic form of data collection (such as diary records).

A. Knowledge of measures

i. An ability to draw on knowledge of commonly used questionnaires and rating scales, and to use this to knowledge to help the supervisee select measures relevant to the client's presentation

B. Ability to help the supervisee interpret measures

i. An ability to draw on knowledge regarding the interpretation of measures (e.g. basic principles of test construction, norms and clinical cut-offs, reliability, validity, factors which could influence (and potentially invalidate) test results)
ii. An ability to convey the application of this knowledge to the work of the supervisee

C. Ability to help the supervisee administer measures

i. An ability to help the supervisee to:
    a. choose measures appropriate to each client's presentation
    b. identify both the strengths and limitations of the measures
    c. negotiate with the client both how and when measures will be completed
ii. An ability to help the supervisee discuss the use of (and rationale for) measures with clients
iii. An ability to help the supervisee to problem-solve any difficulties in obtaining self- report measures from the client

D. Ability to make use of information from objective measures to support supervision

i. An ability to use information from objective measures to help prioritize discussion of clients (e.g. to ensure that there is discussion of clients who are making little or no progress, or are deteriorating)
ii. An ability to integrate data from objective measures with an understanding of clinical material in order to hypothesize about the most appropriate clinical response, in particular:
    a. whether (or not) the supervisee needs to adapt or change their current approach
    b. whether there are any indications that the supervisee's competence is linked to poor response

14. Ability to gauge the supervisee's level of competence

A. Ability to develop criteria for gauging competence

i. An ability to develop criteria for appraising competence which are reliable and which are adapted to take account of the supervisee's level of experience, usually in the domains of the supervisee's:
    a. factual knowledge

b. generic clinical skills
c. model-specific clinical skills
d. ability to implement interventions in a way which demonstrates an understanding of the rationale for the intervention (i.e. to be able to make links between theory and practice)
e. capacity to reflect accurately on progress
f. interpersonal skills
g. ability to work effectively with professional colleagues
h. ability to apply ethical and professional standards in practice

ii. An ability to relate criteria for competence to relevant standards (e.g. those set by professional accreditation bodies, by relevant course curricula, by the competence frameworks for psychological therapy set by regulatory bodies *(e.g. in Ontario, CRPO, in Quebec, OPPQ)*

B. Ability to use a range of methods to gauge competence

i. An ability to use and draw together multiple methods of evaluation in order to gauge competence, including:
   a. observation
   b. supervisee self-report
   c. feedback from standardized ('objective') measures and client self-report
   d. feedback from professional colleagues who have worked with/ observed the supervisee

15. Ability to apply standards

A. Knowledge of expected standards of professional conduct

i. An ability to draw on knowledge of relevant professional and statutory codes of conduct which set out expected standards for pre-and post-qualification practice
ii. An ability to draw on knowledge of standards of clinical practice as defined both by relevant training organisations and local arrangements for clinical governance

B. Gate-keeping with supervisees who are at prequalification level*

*The notion of prequalification status, as applied here could refer either to: an individual who has not yet obtained a formal qualification which entitles them to practise clinically an individual who is entitled to practise clinically, but who is learning a specific therapeutic approach and whose training is being formally evaluated

i. An ability to apply knowledge of relevant criteria for passing or failing the work being undertaken by the supervisee
ii. an awareness of the degree to which the supervisor has authority to comment on whether the supervisee meets these criteria

C. Establishing a context for gate-keeping

i. An ability to ensure (from the outset) that the supervisee is aware of any relevant gate-keeping roles held by the supervisor

D. Identifying the significance of areas of poor performance

i. An ability to distinguish between different forms of unsatisfactory performance:
   a. clinical errors which reflect the supervisee's current level of experience
   b. poor practice (e.g. a failure to apply learning)
   c. reduced capacity to practice consequent on personal distress or mental health issues
   d. negligence or malpractice (i.e. practice which breaches acceptable standards)
ii. Where there are serious concerns about a supervisee's practice,
   a. an ability to ensure that these are specified in writing
   b. an ability to ensure that serious concerns are shared with the supervisee and any relevant third parties to training

E. Giving feedback about areas of concern

i. An ability to ensure that comments about areas of concern can be verified by specific information (i.e. that the evidence on which concerns are based can be shared with the supervisee)
ii. An ability to express concerns with the supervisee in a manner which is direct but non-confrontational, and which also clearly specifies areas of concern
iii. An ability to give feedback about areas of concern in a timely manner (i.e. reasonably contingent on their appearance)
iv. An ability to give feedback about areas of concern which includes clear (usually behaviourally specific) information about the adaptations the supervisee needs to make in order to address these concerns

F. Failing the supervisee

i. An ability to ensure that the supervisee has been alerted to areas which are likely to lead to failure, and been given an opportunity to rectify any relevant problems
ii. An ability to apply knowledge of any relevant criteria for failure, and to ensure that there is evidence which can be adduced to support such a judgment
iii. Where it is clear that failure is the appropriate option, an ability to hold to this judgment despite the personal and interpersonal difficulties that arise in such circumstances

16. Evaluation Bias

A. Ability to be aware of and act on potential sources of evaluation bias

i. An ability to discern when cultural interpretations of communication and behaviour are being made, and to apply cultural humility to the evaluation.
ii. An ability to draw on knowledge that judgments of competence may be influenced by the difficulty of the supervisee's caseload (i.e. that supervisees with more difficult clients may be judged as working less competently than those with more straightforward caseloads)
iii. An ability to draw on knowledge that supervisors tend to evaluate supervisees they like more positively than supervisees they dislike
iv. An ability for the supervisor to identify and act on any consistent evaluation biases they display (i.e. a tendency to rate more leniently or severely than is warranted)
v. An ability to draw on knowledge that a tendency towards more lenient evaluation than is warranted can reflect:
    a. a lack of clear criteria for assessing competence
    b. difficulty in 'benchmarking' criteria for competence due to a lack of supervision experience
    c. a fear of the interpersonal impact of negative evaluation (i.e. its potential to have an adverse impact on the supervisor-supervisee relationship, to 'upset' the supervisee, or concern over any implications for the supervisee's career prospects)
    d. anxiety about grievance procedures and about defending evaluation decisions
    e. anxiety about lack of institutional support for difficult decisions
vi. An ability to draw on knowledge that a tendency towards more severe evaluation than is warranted can reflect unrealistically high expectations and/ or displaced personal frustration

17. Ability to use a range of methods to give accurate and constructive feedback

A. Ability to create a context for giving feedback

i. An ability to ensure that the 'supervisory alliance' is good enough to allow summative and formative feedback[16] to be accepted (and reflected on) by the supervisee
ii. An ability to detect whether the supervisee is able to engage with feedback, and (if relevant) to identify and explore any factors which make this difficult for the supervisee.
iii. An ability to ensure that the supervisee is in a position to understand the feedback (i.e. that the feedback is congruent with their current level of understanding/ learning)
iv. An ability to detect when feedback may have a negative impact on the supervisee (e.g. supervisee withdrawal, shame, increased anxiety), and to manage any consequences in a supportive manner
v. An ability to take a stance of cultural humility when cultural differences affect the feedback process

B. Ability to give feedback in an appropriate manner

i. An ability to give feedback which:
    a. is balanced (i.e. identifies what the supervisee did well, as well as what was done less well)
    b. is clear and appropriately direct
    c. focuses on specific aspects of the supervisee's work (rather than making general or global observations)
ii. When commenting on perceived problems in clinical work, an ability to suggest alternative actions the supervisee could take
iii. An ability to phrase feedback in a manner which avoids the imputation of personal failure:
    a. by focusing on examples of behaviour (as opposed to attributing problems to the supervisee's personal qualities)
    b. by phrasing comments in a manner which directs attention to the issues rather than to characteristics of the supervisee
iv. An ability to give feedback in a manner which makes it clear when this reflects the supervisor's opinion rather than a fact, or the 'truth'
v. An ability, after giving feedback, to be receptive to (and to engage with) feedback from the supervisee

18. Maintenance of standards with supervisees who are qualified practitioners*

(Typically, **supervision** is provided to those who are not yet qualified and **consultation** to those who are qualified, however, at times supervision may be mandated to address specific issues with a qualified practitioner.)

i. An ability to identify practice which falls below the standards expected of a qualified practitioner, in particular unethical or incompetent practice, or poor practice which reflects personal difficulties impinging on the supervisee's capacity to work effectively
ii. An ability to generate and negotiate a suitable plan of action to respond to deficiencies in practice (which reflects and responds to the nature of the supervisee's difficulties)
iii. An ability (where justified by serious concerns about the supervisee's practice) to take action independent of the supervisee's consent

[16] "Summative feedback" is feedback about an outcome (such as passing or failing an aspect of clinical work). "Formative feedback" is feedback about *how* something has been done, and is intended to modify the supervisee's thinking or behaviour for the purpose of improving learning

19. Ability for supervisor to reflect (and act on) on limitations in own knowledge and experience

i. An ability for the supervisor to reflect on and recognize the limitations of their training and/or experience
ii. An ability to limit supervision to those approaches in which the supervisor has sufficient training and/or supervised experience
iii. An ability to act on any limitations in training and/or experience which could impact on supervision quality (e.g. by undertaking further training, arranging for supervision of own work etc)

Supervising Systemic Therapies

This section describes the knowledge and skills needed for the supervision of systemic therapies. It is not a 'stand-alone' description of competences and should be read: 1) As part of the supervision competence framework. Effective supervision of systemic psychological therapies depends on the integration of modality-specific supervision competences with the knowledge and skills set out in the other domains of the supervision competence framework. and 2) With reference to the competence framework for systemic psychological therapies, which describes the generic, basic, specific and problem-specific competences which contribute to the effective delivery of systemic therapies. (See: https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks)

A Supervisor's expertise in systemic psychological therapies

i. An ability for the supervisor to draw on knowledge of the principles underpinning a broad range of systemic psychological therapies
ii. An ability for the supervisor to draw on personal experience of the clinical applications of
iii. systemic psychological therapies
iv. An ability for the supervisor to recognize systemic information in cultures that are systemic in nature and in practice, as in Indigenous and African, and other cultures in recent immigrant families.
v. An ability to enable supervisees to make a relationship between theory and personal and
vi. professional identities
vii. An ability to recognise (and to remedy) any limitations in knowledge and/or experience which have implications for the supervisor's capacity to offer effective supervision
viii. An ability to hold in mind the multiple levels involved in supervision:
    a. family relationships
    b. the relationship between the family and the therapist
    c. the therapist's personal and professional contexts
    d. the relationship between the therapist and the supervisor
    e. the supervisor's personal and professional contexts
    f. the context in which the supervision takes place.
ix. An ability to ensure that supervision integrates attention to generic therapeutic skills (such as the ability to maintain a positive therapeutic alliance or an ability to respond appropriately to client's distress) while also focusing on the development and /or maintenance of skills specifically associated with systemic psychological therapies

B Supervisory stance

i. An ability consistently to apply the principles of systemic therapy to the conduct of supervision
ii. An ability to be self-reflective and reflexive, and so monitor the emotional and interpersonal processes associated with supervisor-supervisee interactions
iii. An ability to adapt supervision in relation to:
    a. the supervisee's stage of learning and development as a therapist

b. the supervisee's learning and therapy styles
c. the organisational context within which supervisees are working
d. the cultural context within which supervisees are working

iv. An ability to demonstrate flexibility in the application of theory and technical principles
v. An ability to take a respectful attitude to the supervisee, including an ability to be supportive and nonjudgmental, especially in relation to the supervisee's discussion of clinical errors or mistakes
vi. An ability to demonstrate a willingness to give an account of the thinking which lies behind supervisory interventions
vii. An ability to maintain a relationship that is supportive of training but does not become "therapy"
viii. An ability to maintain a primary focus on the educational and developmental goals of supervision
ix. An ability to maintain an appropriate balance between a collaborative and an authoritative stance
x. An ability to recognise and help the supervisee reflect on parallels in the relationships between the therapist and the family(or system with which they are working), and that between the therapist and the supervisor and/or the team

C Adapting supervision to the supervisee's training needs and their developmental stage

i. An ability to identify the supervisee's knowledge and experience of systemic therapies
ii. An ability to monitor the supervisee's ability to make use of a systemic perspective to understand the client's presentation and the evolution of therapy
iii. An ability to help the supervisee reflect on their development as a systemic practitioner in order to identify specific learning goals
iv. An ability to help the supervisee consider what will be needed in order to maintain a systemic stance outside of supervision
v. An ability to link material covered in specific supervision sessions to the supervisee's learning needs and personal development
vi. An ability to negotiate learning agreements which reflect the supervisee's learning needs

D Specific content areas for supervision of systemic psychological therapies

i. An ability to help the supervisee to review and apply knowledge about systemic ideas and techniques
ii. An ability to help the supervisee maintain a therapeutic stance appropriate to the systemic approach they are employing
iii. An ability to help supervisees to make connections between systemic theory and their personal and professional lives, and hence apply the approach to themselves
iv. An ability to link systemic concepts and principles to therapeutic strategies and techniques, developing a reflexive relationship between the levels of approach, method and technique
v. An ability to link systemic concepts and principles to cultural behaviours, beliefs and values, and family relationships outside of the supervisees own personal cultural experience.
vi. An ability to help therapists to develop systemic rapport (i.e. to align with one family member without compromising the ability to align with others at a later time)
vii. An ability to adapt and apply systemic therapy techniques within supervision so that supervisees can gain direct experience of them (for example, applying action techniques to their own work, 'internalised other' interviewing, receiving a therapeutic letter from the supervisor).
viii. An ability to recognise when the clinical material generates significant concerns, feelings or difficulties in supervisees, and to help them consider how these reactions can be used in the therapy
ix. An ability to help the supervisee reflect on ways in which their experience of the supervision process may contribute to an understanding of the therapy they are undertaking
x. An ability to help the supervisee to recognise the role of their own family history and current circumstances as a resource and possible constraint in relation to each case

xi. An ability to help supervisees to present clinical material in a variety of formats, including:
    a. discussion and exploration of verbal reports
    b. written reports
    c. review of audio and/or video recordings
xii. An ability to foster the supervisee's competence in working with difference, including real or perceived power differences:
    a. an ability to attend to the relevance/impact of a broad range of social differences (e.g. gender, race, religion, age, ability, class, culture, ethnicity, spirituality and sexuality) in interactions with supervisees and in the supervisee's interactions with clients
    b. an ability to explore the issues of difference and power within the supervisory relationship
xiii. An ability to help supervisees focus on the fact that by participating as a therapist with any system they become part of that system, and to help them consider the potential implications of this for the meaning of their actions

E Live supervision and supervision in and through teams

i. Ability to intervene live in an ongoing session, taking into account the family's well being, the therapeutic relationship and the therapist's development and (if involved) the team behind the screen
ii. An ability to consider the effects of live supervision on the family and on the therapist, particularly if the supervisor has intervened in a way that differs significantly from the approach taken by the therapist
iii. An ability to utilise reflecting team interventions both as an intervention in clinical work and as part of a therapist's own development
iv. An ability to engage a reflecting team in maintaining a reflexive systemic position in their manner of interacting with each other and while intervening in clinical work and in each other's development
v. An ability, when undertaking supervision of a team, to make explicit the multiple positions of team members and hence to ensure that relevant group processes are included in supervision
vi. An ability to use live supervision to help therapists to develop their knowledge and skills and adapt interventions to particular client needs
vii. An ability to observe and discuss the supervisee's clinical work through the use of one-way screen, video link, in room observation or joint working

F Monitoring the supervisee's work

i. An ability to make use of recordings/ direct observation and live supervision techniques to monitor the supervisee's ability to use strategies and techniques appropriate to the systemic approach being adopted
ii. An ability to use systemic techniques to constructively challenge problematic performance of a supervisee