Clinical Supervision and Risk Management

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The past decade has brought a major shift in supervision practice with increased research and evolving best practices. An unanticipated result has been trepidation by some practitioners leading them to not engage in as much supervision as they may otherwise have done in the past. There are also concerns of liability arising from risks in overseeing and being responsible for the clinical work of others, especially supervisees in training. In this article we will describe the shift and specific steps to manage risk in supervision.

Consider the following vignette. An advanced post-internship, doctoral student ("supervisee") has approached a psychologist requesting to become her Psychological Assistant to accrue post-doctoral supervised hours for licensure under supervision ("supervisor"). The supervisor has a thriving practice and thinks the supervisee will be an excellent addition but is concerned about not having supervised for several years. What should this potential supervisor consider in making her decision and factoring in risk management?

First, the supervisor should ensure that she knows the most current regulations for supervision of Psychological Assistants (http://www.psychboard.ca.gov/licensee/sup-psych-assist.shtml) including the necessity of completing a supervision agreement and obtaining approval by the California Board of Psychology prior to beginning any client contact or supervision. The agreement must contain:

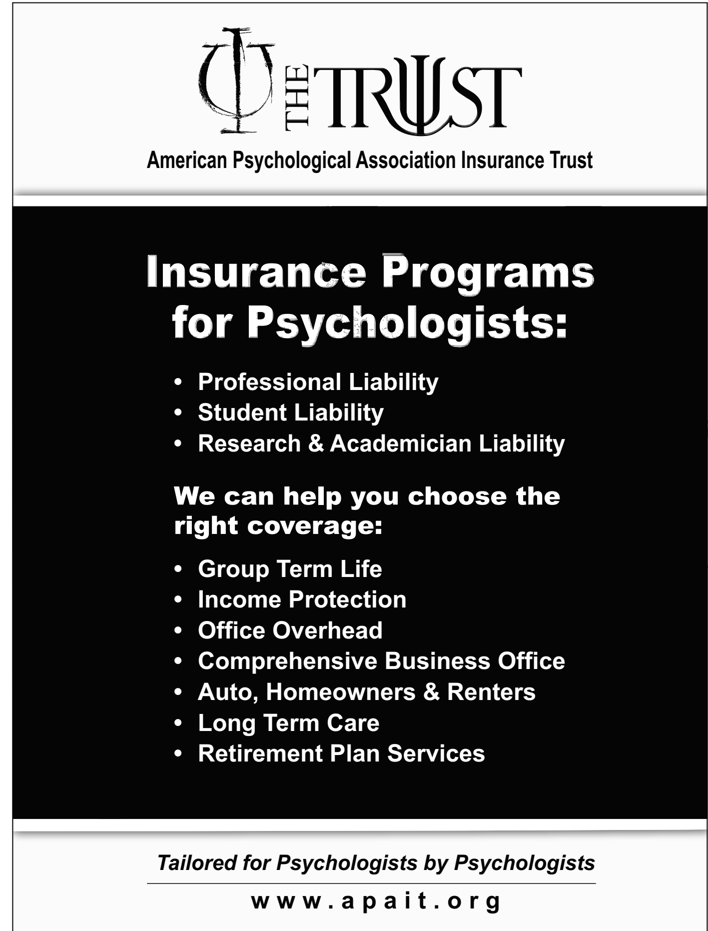
(1.) a description of the specific duties the supervisee will perform as they engage in psychological activities that directly serve to prepare the supervisee for the independent practice of psychology once licensed: and

(2.) a summary of the goals and objectives of this plan for supervised professional experience (SPE), including how socialization into the profession will be achieved.

The plan includes an "organized program that consists of a planned, structured and administered sequence of professionally supervised comprehensive clinical training experiences. SPE shall have a logical training sequence that builds upon the skills and competencies of the trainee to prepare him or her for the independent practice of psychology once he or she becomes licensed" (http://www.psychboard.ca.gov/applicants/sup-agreement.pdf).

Next, the supervisor should actively assess the supervisee's competence. One way to do this would be to collaboratively review competency documents from her internship and/or graduate school, probably derived from Competency Benchmarks (http://www.apa.org/ed/graduate/competency.aspx) and consider her competence specific to the supervisor's own areas of competence. They could discuss cases, conceptualizations and interventions for the supervisor to understand the strength of her training and skills and the match for her clients and practice.

The supervisor may refer back to the California Board of Psychology website and collaboratively develop the downloaded supervision agreement with the supervisee to be submitted it to the Board of Psychology for approval. In the process, the supervisee identifies areas she views as in development (e.g., ongoing interest in adolescent treatment and the issues of confidentiality and the rights of the parents). An important area is to be conversant in legal and regulatory standards in California. The supervisee delineates her special areas of strength, (e.g., in establishing strong relationships with families with diverse socioeconomic, ethnic, and racial makeup and with interventions for



anxiety and depression, suicidality, and treatment of eating disorders).

Next the supervisor carefully considers strategies to minimize the risk involved in supervision. She reviews the two general liability doctrines that govern clinical supervision: direct liability and vicarious liability. *Direct liability* or *negligent supervision* refers to responsibility for her own negligent acts. To satisfy the standards of performance, the supervisor must pay attention to critical aspects including proper monitoring and ascertaining the level of competence of the supervisee and ensuring supervision meets the standard of care. A supervisor who is unaware of cases the supervisee is carrying, progress or lack of such in cases, or is not competent to treat the client or intervention being implemented is not meeting the standard of care. *Vicarious liability* or *respondeat superior* refers to the fact that the supervisor may be held liable even if the supervisor's conduct is not deficient, negligent, or careless and even though the supervisor engages in no direct negligence or carelessness. Such liability arises under the doctrine that one who occupies a position of authority or control over another may be held liable for damages caused by the negligence of the person under his/her control even if the person in authority has done nothing wrong and has satisfied his or her direct obligations of care. In clinical supervision then, the supervisor may be legally liable for injuries caused by negligence of supervisees.

To prove liability and recover against the supervisor, a client must satisfy a number of factors. First, the supervisor must have an employer/employee relationship by virtue of selection of the employee and power of dismissal. The supervisor may only be held liable for negligent acts if those acts have been performed in the course and scope of the supervisory relationship. In this regard, the courts may consider the following regarding the scope of employment: 1) the supervisor's power to control the supervisee; 2) the supervisee's duty to perform the act; 3) the time, place, and purpose of the act; 4) motivation of the supervisee for performing the act; and 5) whether the supervisor could have reasonably expected the supervisee would commit the act (Disney & Stephens, 1994). Also the supervisee's client must prove he/she was injured. To be more specific, the supervisee who was motivated to help the client is functioning more within the scope than one who is simply acting in personal self-interest or for financial gain.

How can a supervisor minimize risk? First, the supervisor is presumed to (and should) be competent in clinical practice being carried out by the supervisee (e.g., interventions, diversity statuses of client, theoretical orientation) and in the practice of supervision. To supervise, as to practice psychology, the supervisor should engage in ongoing continuing education and professional development to stay abreast of the profession.

The supervisor is required to enroll in a six hour supervision continuing education course to meet the regulation for supervision (1387.1(b)CCR) http://www.psychboard.ca.gov/lawsregs/archive/supervision-regs.shtml. A number of best practices are prescribed in the typical course in key areas: 1) establishing a supervisory relationship; 2) implementing supervisee self-assessment to identify strengths and areas needing improvement and building upon strengths; 3) directly addressing the power differential between supervisor and supervisee and promising the supervisor will inform the supervisee of concerns in performance as they arise including responsibility to report to the Board of Psychology; 4) identifying supervisor expectations for supervision in the form of a supervision contract; 5) infusing diversity and consideration of the multiple diversity identities of client(s), supervisee, and supervisor and their relation to worldview as well as in assessment and treatment planning; 6) ensuring processes are in place for ongoing feedback to the supervisee and from supervisee to supervisor; 7) ensuring competence in ethical and legal issues; 8) attending to and managing supervisee personal reactivity or countertransference; and 9) identifying and balancing multiple relationships (Falender & Shafranske, 2004, 2007, 2008, 2012; California Board of Psychology, http://www.psychboard.ca.gov/applicants/supervision-best.shtml).

The supervisor identifies a time to meet with the supervisee weekly to ensure the requisite supervision hours will accrue. The supervisee could be encouraged to make client audio or video recordings (with client consent) for review in supervision to maximize the supervisee's learning. The supervisor instructs the supervisee in emergency procedures and how to contact the supervisor via cellphone or other electronic means. The supervisor reviews with the supervisee the APA Ethical Principles of Psychologists and Code of Conduct (2010) and highlights several sections including informed consent (10.01), therapy involving couples or families (10.02), confidentiality (4.) and describes the importance for the supervisee to think of ethical principles as she conducts therapy and to bring these to supervision for discussion. The supervisor emphasizes that feedback is a critical component of clinical supervision — that she will be providing specific feedback

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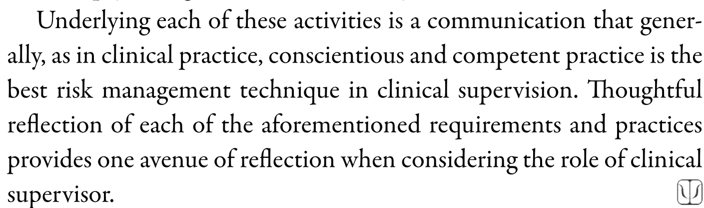
based on the supervisee's own self-assessment of competence and the supervisor's observations.

The supervisor identifies special interests of the supervisee (e.g., interest in legal standards for treatment and supervision as she wrote her dissertation on duty to protect with adolescents) and suggests ways to further that interest. The supervisor may likely encourage the supervisee to become involved in professional organizations, perhaps to attend the California Psychological Association convention where she or colleagues might be presenting and could introduce the supervisee to other psychologists in the community.



Underlying each of these activities is a communication that generally, as in clinical practice, conscientious and competent practice is the best risk management technique in clinical supervision. Thoughtful reflection of each of the aforementioned requirements and practices provides one avenue of reflection when considering the role of clinical supervisor.

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