The Psychotherapists Board of Aotearoa New Zealand

Te Poari o nga Kaihaumanu Hinengaro o Aotearoa

Policy Statement on Psychotherapist Clinical Supervision	
Purpose	To state the Psychotherapists Board of Aotearoa New Zealand's requirements and recommendations for clinical supervision of psychotherapists.
Policy Statement	All Psychotherapists will undertake regular clinical psychotherapy supervision. Additional supervision, such as work-place, cultural and other specialist supervision may be undertaken as well as clinical supervision. Psychotherapist clinical supervision contributes to improved competence in clinical practice and professional development. For further information and guidelines refer to Psychotherapist Core Clinical Competencies: "Reflective Practice and Continuing Professional Development." In this policy the term 'clinical supervision' takes the meaning understood in the profession of psychotherapy, rather than the meaning attached to the term "supervision" in the HPCAA[1]. That is, a psychotherapist is expected to consult regularly with a person skilled in psychotherapy for the purpose of professional support, assistance and professional development.
Supervision	**Clinical psychotherapist supervision is to be provided by either:** 1. A registered psychotherapist with a current APC; or 2. A health practitioner registered under the HPCAA with a current APC; approved by the Board as having sufficient psychotherapy training, knowledge, skills, professional development. *Note: those registered in the Interim Psychotherapist Scope of Practice must have a supervisor from category 1 above.* It is expected that clinical supervisors will be actively engaged in clinical supervision of their supervisory practice. It is expected the clinical supervision should not be provided by a person in a managerial or line-responsibility position.
Frequency of Psychotherapy Clinical Supervision	Psychotherapists registered in the Psychotherapist Scope of Practice or Psychotherapist Scope of Practice with Child and Adolescent Psychotherapist Specialism are expected to undertake clinical supervision of a frequency and duration commensurate with the psychotherapist's experience, case load and intensity of clinical work.

[1] ~~In the HPCAA (2003) supervision (Part 1, S5(1)) is defined as 'the monitoring of, and reporting on, the~~ performance of health practitioner by a professional peer'. In the context of this policy clinical supervision is regarded as more akin to consultation.

	It is generally accepted that clinical supervision should occur at a minimum fortnightly.
Psychotherapists registered in the Interim Psychotherapists Scope of Practice	**Psychotherapists registered in the Interim Psychotherapists Scope of Practice** are expected to undertake clinical supervision which will normally be at least one hour every two weeks, regardless of caseload since it has a partial training function. Newly qualified practitioners with less than two years post-graduation experience are expected to participate in weekly clinical supervision for the first two years of post-graduation practice regardless of caseload. Psychotherapists registered in the Interim Psychotherapists Scope of Practice wanting to be registered in the Psychotherapist Scope of Practice ***must*** have clinical supervision from a psychotherapist registered in the Psychotherapist Scope of Practice. Psychotherapists registered in the Interim Psychotherapists Scope of Practice wanting to be registered in the Psychotherapist Scope of Practice with Child and Adolescent Psychotherapist Specialism ***must*** have clinical supervision from a psychotherapist registered in the Psychotherapist Scope of Practice with Child and Adolescent Psychotherapist Specialism.
Peer Clinical Supervision (2 or more people)	It is expected that practitioners engaging in peer clinical supervision will be experienced psychotherapists. **Note:** Peer clinical supervision is not adequate for those in the Interim Psychotherapist Scope of Practice.
Group Supervision	Where clinical supervision is in a group with a supervisor, care must be taken to provide time equivalent to at least 30 minutes per person, per fortnight.
Mode of clinical supervision	Where possible clinical supervision should be conducted face to face and participants should be physically present. When this is not possible other methods may be used with preference to spoken methods (such as phone or Skype). Use of just phone clinical supervision with no face to face meetings is a concern and is not encouraged. *Due consideration must be given to confidentiality (see note on electronic means below*).*
Cultural Supervision	In situations specific cultural supervision may be needed; refer to the Board's Cultural Competencies requirements.
Additional Supervision	The Board acknowledges that some psychotherapists receive additional clinical supervision from: • practitioners overseas; and • practitioners in New Zealand who do not meet the Board's criteria for clinical supervision. The Board does not wish to limit such supervision. In such cases there is a requirement that the practitioner *must also* have clinical supervision from a person who meets the Board's criteria.
Clinical Supervision Contracts	A clinical supervision contract, indicating the session length and frequency of clinical supervision agreed to by the supervisor and supervisee should be completed, signed and held by both the supervisor and supervisee. Other issues may be addressed in this contract. This contract must be presented to the Board if requested.

(i)Note on email security: Quote from Health Information Privacy Code (1994) (Amended).
Rule 5 Commentary (p. 33) http://www.privacy.org.nz/assets/Files/Codes-of-Practice-materials/HIPC-1994-2008-revised-edition.pdf

Electronic means

Electronic means including email pose special problems in privacy. Use of email to transmit health information may result in the information being stored on several hard drives, not all of which may be secure from unauthorised access. There is also a risk of interception during the transmission as email commonly passes through a number of computers on the way to its final destination. Some practitioners may, for such reasons, entirely avoid its use. Others may use it only for less sensitive purposes, such as arranging appointments.

An email security policy for a health agency might include:

• establishing guidelines on the nature of information which may be transmitted by email;
• encryption and virtual private networks;
• enforcing security of access;
• using addresses received electronically where possible to minimise the risk of key-entry errors where information is sent to the wrong person;
• using addresses based upon roles rather than people's names;
• producing and distributing an official and regularly updated list of email addresses (with a clear expiry date for each edition) to ensure that the addresses are current and accurate; and
• discouraging the inclusion of lengthy 'chains' of responses in emails, as sensitive information may be unwittingly included in an early response."