Queensland Centre for Mental Health Learning

Response to the Psychology Board of Australia

Consultation Paper 12
Exposure Draft: Guideline for Supervisors
and Supervisor Training Providers

Thank you for the opportunity to read your Consultation Paper 12 and to offer you feedback on the development of your application process to become a provider of competency-based supervisor training programs.

Introduction:

I do wish to acknowledge the Board's timely development of these Guidelines. Internationally, researchers and theorists have been advocating for the formalising of such frameworks for decades. As Hawkins & Shohet (2006) point out, 'in the 1980s there was no formal accreditation for being a supervisor and little in the way of formal training. Most practitioners became supervisors as a result of having been in the profession long enough'. Bernard & Goodyear (2004), writing within the field of Mental Health, add that:

> *"Hoffman (1994) characterized the traditional lack of formal training for supervisors as the mental health professions' "dirty little secret" (p.25). Like others (e.g. Pope & Vasquez, 1991; Stoltenberg & Delworth, 1987), she suggested that supervisors who practise without having been trained as supervisors are doing so unethically".*

Bernard and Goodyear go on to write that 'fortunately, practitioners in the several mental health professions now increasingly acknowledge how important it is for supervisors to receive formal training'.

And so, there is much to celebrate in your Board formalising this next step in the development of the discipline of Supervision within this country.

However, as well as the positive acknowledgement, I do have a few concerns regarding your draft document.

Background Information:

In order to give you the context from which these comments arise:

(a) firstly, I write this response as an individual who has been actively involved in the field of Clinical Supervision for over thirty years, as a Supervisor and as an Educator;

(b) also, they are offered on behalf of my current employing body, The Queensland Centre for Mental Health Learning. The Centre, one of Queensland Health's educational initiatives, is a State-wide service, which aims to be a leader in mental health education and training in Australia. My role within the Centre is to design and facilitate an ever-increasing range of Clinical Supervision workshops across Queensland. Given the geographical challenges of this State, I and other facilitators regularly travel to rural and remote areas to ensure that supervision education is available beyond the city boundaries;

(c) thirdly, I acknowledge the generous collaboration that Nick Rayner, the Acting State-wide Psychology Leader for Queensland Health's Mental Health Services, has offered in the drafting of this response;

(d) fourthly, the following is a brief sketch of Queensland Health's recent history regarding supervision. In 2001, Queensland Health commenced its Clinical Supervision Educational program.

> "*This began as a joint collaboration with the University of Queensland. The original impetus for the project was an Enterprise Bargaining Agreement, which aimed to address the concerns of Allied Health staff regarding limited access to supervision and limited career structure opportunities in the mental health workforce. A consortium of Allied Health departments from the University of Queensland was approached to undertake a research evaluation of clinical supervision and mentoring of Allied Health professionals in the Mental Health Service.*
> *The project identified:*
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> - *International best practice in supervision*
> - *Current practice and problems in supervision for Allied Health*
> - *Organisational, attitudinal and incentive blocks to supervision delivery*
> - *A model of supervision which was relevant and sustainable*
> - *A Queensland Health policy for Clinical Supervision in Allied Health Mental Health Services.*
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> *Over the years, building on this earlier research, the Queensland Centre for Mental Health Learning, under the governance of the Mental Health State-wide Steering Committee on Clinical Supervision, has been developing, implementing and evaluating a comprehensive supervision education program"(Supervisor Workbook, Queensland Centre for Mental* Health *Learning, 2009)*; and, finally, in terms of background,

(e) in October 2009, thanks to the work of the Mental Health State-wide Steering Committee on Clinical Supervision, the Queensland Health Mental Health Directorate ratified its 'Clinical Supervision Guidelines for Mental Health Services'. I attach a copy of these, for your information. These Guidelines provide:

> *'a standardised, generic and flexible state-wide approach to clinical supervision for all mental health clinicians. The principles outlined will assist clinicians, clinical supervisors and managers to understand the purpose of clinical supervision and to clarify their respective responsibilities. Queensland Health supports and provides access to clinical supervision for all mental health professionals involved in the direct delivery of mental health services. The following groups of clinicians in mental health services are expected to participate in clinical supervision -*
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> - *medical staff*
> - *mental health nursing staff*
> - *allied health staff*
> - *indigenous mental health staff*
> - *consumer and carer workforce*
> - *other clinical staff'.*

Queensland Health Mental Health Services have worked collaboratively over many years to create structures and models of Supervision that I am proud to be a part of and it is arising from these experiences that I offer the following comments.

1. Is the new profession of Clinical Supervision to be trans-disciplinary or is it discipline-specific?

Our experience, here in Queensland, is that there is much to be gained by allowing a generic, trans-disciplinary approach to the field of Clinical Supervision. Rural and remote staff, in particular, benefit from such provisions. We, like other States and Territories with a number of rural and remote locations, continue to address the challenge of educating practitioners who work outside the Capital city yet who wish to become Clinical Supervisors.

Of course, when someone is a new clinician, there are clear developmental advantages in being supervised primarily by a colleague from within the same discipline. However, given that Clinical Supervision is similar to and yet different from Professional Supervision, it may well be that even a new Clinician might have as a principal Professional Supervisor one who is a Psychologist, who can take on the gate-keeping role with regard to Board requirements and a secondary Clinical Supervisor, from a different discipline, who would facilitate the Supervisee to reflect not only the formative but also more fully on the restorative and normative functions of supervision. It seems that this differentiation of tasks, between gate-keeping and critical reflection, between the Professional and the Clinical Supervision is not sufficiently articulated in your draft, with your Guidelines blurring rather than clarifying the boundary between the two forms. This clarification seems crucial given the different parameters of power and confidentiality.

Within the Queensland Health Clinical Supervision Guidelines for Mental Health Services, the following is offered to clarify such distinctions:

> **"*Clinical supervision*** *is a clinician-led activity. This means the clinician chooses their clinical supervisor, in conjunction with the Team Leader/Unit Manager and Discipline Leader, and in collaboration with their supervisor; determines the frequency of clinical supervision (within the specified standards), the purpose of clinical supervision, the focus of each session and their own learning goals….* ***Professional*** *(intra-professional)* ***supervision*** *is distinct from clinical supervision and refers to the relationship between a clinician and their discipline leader where the focus is primarily on discipline or profession specific practice skills.*
>
> ***Clinical supervision*** *is a distinct intervention and specialisation that involves a specific set of generic competencies irrespective of professional discipline, practice setting, consumer focus and service delivery model…Such competency base clinical supervision is central to the successful implementation of evidence based practices and for promoting quality assurance in mental health practice'.*

Thus, the contemporary issue is no longer the lack of clarity regarding what Clinical Supervision is when contrasted with Line Management, although historically these mutually exclusive tasks were often blurred into one. What now seems to be emerging is a growing confusion between Clinical Supervision and what is becoming known as Professional Supervision. Often these two separate and mutually exclusive functions are merged into one,

to the confusion of both.

Creating a trans-disciplinary, rather than a discipline-specific model, would allow Clinical Supervision to be easily adapted not only for Psychologists but also for Social Workers, Occupational Therapists, other Allied Health Clinicians as well as for staff from a wider range of professions.

In the Queensland Centre for Mental Health Learning Clinical Supervision workshops, we differentiate Line Management as operational responsibility and its purpose is to ensure competent, safe management; Professional Supervision is a discipline specific intervention that serves the requirements of the Profession and its Professional Registration Board and Clinical Supervision is a 'clinician-led activity'. The task of the Clinical Supervisor is to create a safe, competent and confidential alliance in order to facilitate the supervisee to reflect on his/her objectives and blind-spots for the benefit of the service to clients/patients/consumers. Practitioners and, therefore, clients/patients/consumers as a consequence, are clearly better served and less confused if they have access to each distinct form of supervision.

<u>Recommendation 1:</u> that the Board consider offering a set of Guidelines for Professional Supervisors distinct from Clinical Supervision provisions.

Returning to the matter of trans-disciplinary or discipline-specific education for Clinical Supervisors, internationally, and most obviously in the U.S. and the U.K. where the bulk of the writing on Supervision has emerged, there seems to be a crossroads that the discipline of Supervision or Clinical Supervision has reached. The Board, as evidenced in this draft document, seems to have side-stepped this crucial conversation by advocating that the education for this emerging profession be primarily discipline specific. In the late 1970s, theorists, researchers and educationalists began to look beyond the specifics of the separate disciplines within which supervisees were practising and, instead, focussed attention on what is common. This led to the development of Clinical Supervision as an intervention, a discipline and even a profession in its own right. As a consequence, those actively involved in the education of Clinical Supervisors over these past thirty years have been making a choice whether to restrict the courses to a specific discipline focus or to recognise the trans-disciplinary nature of Clinical Supervision based on generic process and developmental models and ratify educational programs as such.

> *'Although there would appear to be a good deal of diversity in the ways in which clinical supervision is conceptualised the evidence suggests that supervisors from a range of allied health professions actually engage in very similar supervisory processes, regardless of their practice setting and professional and theoretical backgrounds (Ladany et al., 1999). Indeed, there are far more similarities than differences in the aims, processes and methods of supervision across the professions of social work, psychology, speech pathology and occupational therapy (Hart,1982). Furthermore, difficulties and practical issues relating to supervision are very similar across mental health disciplines'* (Supervisor Workbook, Queensland Centre for Mental Health Learning, 2009).

Six of the seven Board-approved supervisor competencies appear to be generic to Clinical Supervision rather than specific to the discipline of Psychology.

<u>Recommendation 2:</u> that the Board consider, as Queensland Health has done,

acknowledging and even allowing much more provision for a generic understanding of Clinical Supervision rather than restricting it, as in your draft Guidelines, to a Psychology discipline-specific activity or specialisation.

By considering this recommendation favourably, the Board would be keeping the door open to a wider trans-disciplinary conversation about Clinical Supervision, especially regarding the minimum standards required for an appropriate generic accreditation process. This would attend not only nor primarily to the formative function of clinical Supervision but also equally to the restorative and normative functions.

2. The matter of Cultural Supervision:

In this country in the twenty first century, a growing number of practitioners are recognising, as well as Clinical and Professional Supervision, the crucial importance of Cultural Supervision. Rather than subsuming this under either of the two previous categories, it may be that this area warrants its own guidelines.

Recommendation 3: that the Board, in consultation with Aboriginal and Torres Strait Island Cultural Supervisors and Educators, draft a third set of Guidelines for Cultural Supervision.

3. The Supervision of Supervisors:

Although reference is made to the importance of Supervisors receiving supervision of their supervision 'including observation and critical feedback', no attention is given in your draft Guidelines as to how such Supervising Supervisors are themselves to be educated, assessed and accredited. This, in my view, is a significant omission, particularly given that you offer comprehensive guidance on the standards needed for Supervisors who supervise Interns and Provisional Psychologists and how these Supervisors are to be educated, assessed and accredited. Does not this oversight perpetuate what Watkins (1997) pointed out and what you quoted in your own document that:

> *"We would never dream of turning untrained therapists loose on needy patients, so why would we turn those untrained supervisors loose on those untrained therapists who help those needy patients?'.*

Surely this applies even more so to those senior practitioners charged with this greater responsibility, given that research indicates that many senior Supervisors have themselves not received adequate training for their task?

It may assist you to know that here, at the Queensland Centre for Mental Health Learning, we have begun offering senior Supervisors the opportunity to attend 'Supervising Supervisor' workshops. These incorporate live supervising supervisor sessions, which are both observed as well as videotaped and then reflected upon and critiqued by the supervising supervisor, other participants and the facilitators.

Recommendation 4: that the Board consider addressing in the Guidelines what are to be the minimum standards for those wishing to become the Supervisors of other Clinical Supervisors.

There may also be some value in differentiating between those who wish to provide supervision to students seeking college endorsement (Post-Graduate, Masters or Doctorate), those supervising colleagues who are completing a Psychology internship

program (4 + 2 or 5+1 pathways) and those supervising colleagues who are already Board-ratified.

One of the central skills that the Queensland Centre for Mental Health Learning Supervision Workshops offers participants is the ability to give and to receive effective feedback. The Board may consider including the giving and receiving of effective feedback to be a core component not only in assessment of a person's suitability to be the Supervisor of other Supervisors but may also be a crucial competency even at the first level of any supervision education.

4. Accreditation:

As indicated earlier, the Board's accreditation process appears to be more a process for accrediting Professional Supervisors and Educators rather than for accrediting Clinical Supervisors and Educators.

Recommendation 5: that, in consultation with Clinical Supervisors and Educators from across the range of disciplines, the Board may consider creating a generic pathway for the accreditation of Clinical Supervisors as well as a generic pathway for the accreditation of Supervising Supervisors.

Conclusion:

In the early days of Psychology, things were much simpler, just as they were in the field of Clinical Supervision. However, as the historian A.J.P. Taylor pointed out, 'history gets thicker as it approaches recent time'. In recent time, in this country as it is internationally, there has been a growing richness both in the research into and the writing about Psychology in all its manifestations and about Supervision, whether Clinical, Professional or Cultural. These findings create not only greater complexity but also give the opportunity for more choice and, therefore, more conflict. The matter of whether Clinical Supervision is a profession in its own right, with its own generic history, models and accreditation processes or is it a specialist area of already existing professions still remains an open question. Falender & Shafranske (2007) advocate that Supervisors emphasise 'the portability of competencies rather than orienting training in a parochial manner, which focuses learning exclusively on how to conduct a particular form of treatment'. This is congruent with Norcross & Halgin (1997) when ' presenting an approach to integrative approaches to supervision, opined, "The emphasis should be placed squarely on 'how to think' rather than on 'what to think'.' Our hope is that the Psychology Board of Australia not only ensures that it actively joins in with the trans-disciplinary conversation regarding the future of Clinical Supervision but also that it may consider leading the way in creating a solid foundation for life-long safe and competent Clinical Supervision for all practitioners, seniors as well as beginners.

Written by Paul Bailey
11th January, 2012.

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