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Clinical supervisor training in Australia: A review of current problems and possible solutions

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Abstract

Clinical supervision cuts to the heart of professional psychology training. It is the most expensive single investment of staff time in the training of the psychology practitioner, and it appears to be the single most important contributor to training effectiveness, repaying that investment. Now there are changes afoot internationally which may change its pivotal role. For example, the Psychology Board of Australia has recently proposed that supervisors undergo approved supervisor training; in the USA, a competence-based emphasis is gaining ground; while in the UK, supervisors within the Improving Access to Psychological Therapies initiative are receiving unprecedented training and support. It is therefore timely to clarify the need for such training and to consider promising options for its effective delivery. Following a summary of the changes within Australia, we next address these emergent problems and promising solutions by examining the available scientific evidence and by considering professional consensus statements.

Key words: *Clinical supervisor training, professional supervision, psychologist registration.*

The future of professional psychology training in Australia may be in for a bumpy ride over the question of who should be allowed to practice as a clinical supervisor. The change from a state/territory-based registration system to a national registration system comes into effect from July 1, 2010. As we write this paper, Australian psychologists across the country are engaged in debates, e-blogs, and over-tea chats about professional issues, including registration, specialist registration, and clinical supervision. We have not witnessed a similar preoccupation with professional issues for several decades. This is in response to a series of recent documents released by the Psychology Board of Australia (PBA): first, a draft discussion paper in October 2009 that managed to provoke the typically placid community of psychologists into a vigorous debate (PBA, 2009a), generating 115 submissions (PBA, 2009b). Second, following these two publications, the PBA has just submitted their recommendations (PBA, 2009c) to the Australian Health Workforce Ministerial Council for their final approval. Among other matters surrounding registration and required endorsements for specialisations in psychology, this PBA paper deals with new regulations about the eligibility of psychologists to provide clinical supervision,[1] a topic that is the focus of the current paper.

The PBA's proposal on clinical supervision comprises an important change to the world of the Australian clinical supervisor: it recommends that in addition to 3 years of post-Registration psychology experience, a psychologist must "have completed a Board-approved training programme in psychology supervision prior to applying to act as a Board-approved supervisor" (PBA, 2009b, p. 14).

It is of note that the suggestion regarding the introduction of mandatory clinical supervisor training initially flagged by the PBA's discussion paper (PBA, 2009a) was met with general but not unqualified support (PBA, 2009b). There were concerns raised from several influential quarters. Two of the Australian Psychological Society (APS) Colleges were keen to see more evidence of the effectiveness of supervisor training before the changes became mandatory. The College of Educational and Developmental Psychologists (2009) required

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more compelling evidence to indicate that supervision had a substantive impact on practice, and the College of Organisational Psychologists wanted to see evidence of the effectiveness of supervisor training programmes implemented in Queensland and New South Wales before the Board proceeded with endorsement of supervision as an area of practice (APS College of Organisational Psychologists, 2009). Further, the APS (Australian Psychological Society, 2009) and a submission from Curtin University of Technology (2009) supported training for supervisors of psychologists undertaking the 2-year supervised practice following 4 years of undergraduate training in psychology (4 + 2 internship pathway), but suggested that similar implementation for the integrated 6-year Masters training (conducted through universities route) should be deferred. Regardless of whether the PBA's recommendations about clinical supervision will be passed by the Ministerial Council, clinical supervision and supervisor training are ''hot'' issues for the Australian psychologist. We are undoubtedly at a critical point in the history of professional training in Australia, and so we believe it is timely to step back from the heat of the debate and examine the evidence that can help to answer some key questions: Is supervisor training essential for supervisory competence? If it is, what should be the nature and format of supervisor training? To what extent is supervisor training being implemented, internationally? Should it be regulated by bodies such as Registration Boards? We hope that our paper will contribute to the debate, and facilitate informed decisions for the future.

Is supervisor training essential for supervisory competence?

Expert consensus

Unlike the diversity of expert opinions on several other hotly debated issues in psychology, expert opinion is unanimous in identifying the need for supervisor training, often in forceful terms. While clinical supervision is readily acknowledged as ''perhaps the most important mechanism for enabling the acquisition of competencies'' (Stoltenberg, 2005; p. 858), there is collective amazement, angst, and alarm about the concomitant neglect of supervisor training (e.g. Falender et al., 2004; Russell & Petrie, 1994; Stoltenberg, 2005). Most textbooks on clinical supervision mirror the position described above (e.g. Bernard & Goodyear, 2004; Borders & Brown, 2005; Milne, 2009; Watkins, 1997). In fact, inadequate attention to supervision outcomes, training, and research has raised serious concern in other non-psychology disciplines, including psychiatry (Whitman, Ryan, & Rubenstein, 2001), occupational therapy (Gaitskell & Morley, 2008), and other allied health disciplines (Kavanagh, et al., 2003; McMahon & Simons, 2004). Possible consequences of poor or absent supervisor training include a reduced readiness to supervise and unhelpful supervisory styles ranging from extreme passivity to excessive authoritarianism (Hoffman, 1994). In turn, this may adversely impact on the practitioner–client working alliance, and on client progress (Lambert, 2006). This alarming perspective is best summarised by Watkins (1997), who reasoned:

> The facts are staggering: a) psychotherapists-in-training typically are closely scrutinized and supervised because becoming a therapist is considered to be a labor-intensive endeavour for which much training and supervision are needed; (b) supervisors have the charge of facilitating the growth and development of their supervisees and, in turn, helping those supervisees facilitate the growth and development of their patients, and (c) though being the ultimately responsible party in the supervisor-supervisee–patient triad, supervisors typically receive little to no training in how to supervise and do supervision. Something does not compute. (p. 604)

This stance by experts is based on or further bolstered by the following arguments.

The experience-begets-expertise assumption is flawed

The widespread practice of not requiring supervisor training rests on the assumption that experience as a therapist or as a supervisee will seamlessly transfer into effective supervision. However, the professional literature does not endorse such a position (e.g. Whitman, et al., 2001). Although many authors acknowledge that some competencies required to practice psychology may overlap with and/or have similar elements to supervisor competencies (Milne, 2006), a careful scrutiny of the necessary competencies and capabilities suggests that additional training is required, specific to supervisors' roles and responsibilities (Milne, 2009; Roth & Pilling, 2008a). To illustrate, an influential supervision model (Bernard & Goodyear, 2004) proposes that effective supervisors should be capable of discriminating and competently switching between three different roles (teacher, counsellor, and consultant). This implies that training should encompass a specialised body of knowledge and skills for supervision with its own curriculum (Borders et al., 1991). Other authors even see supervision as a profession in its own right (Carroll, 2007; Getz, 1999). There is evidence to support these expert opinions, supporting the view that experience by itself may not confer effectiveness as a supervisor. The evaluation of

supervisor training in Queensland indicated that the majority of participants who failed at least one of the four components of the assessment had held registration for more than 3 years (Griffiths University Consortium, 2009).

Unsound and inefficient supervisory practices are widespread

Surveys of supervisory practices indicate that practice guidelines are often not adhered to, and that poor supervisory practices are relatively widespread (Gonsalvez, Oades, & Freestone, 2002; Kavanagh et al., 2003; Townend, Iannetta, & Freeston, 2002). This impression is shared by others, including those who train supervisors (Binder, 1993; Milne & James, 2002). Examples include the over-reliance on supervisees' reports of their casework, at the expense of direct observation and skills-development within supervision, yet supervisee case reports are known to miss substantive and important information (Campbell, 1994). And case presentation without concurrent direct observation of therapist–client interactions is incapable of capturing higher order competencies, including accurate diagnostic formulations and psychological conceptualisation (Gonsalvez & McLeod, 2008; Holloway, 1988; Padesky, 1996). The neglect of observational methods is common among CBT supervisors (Townend et al., 2002), despite recommendations to the contrary by prominent CBT authors (Liese & Beck, 1997; Padesky, 1996), and supervisee preferences (Gonsalvez et al., 2002; Kavanagh et al., 2003). Finally, there is a fairly compelling literature across disciplines that suggests that systematic biases affect self-report and self-assessment (for more systematic reviews, see Gordon, 1991; Ward, Gruppen, & Regehr, 2002).

Provision of supervision without training might be unethical

Critics also point out that untrained supervisors who are providing supervision may be practising outside the limits of their training and competencies, potentially placing them in breach of the profession's ethical guidelines (Cormier & Bernard, 1982; Wheeler & King, 2000). This has been termed Psychology's ''dirty little secret.'' (Hoffman, 1994, p. 25).

Empirical evidence to support supervisor training programmes

Finally, the available research is fairly consistent in finding positive effects of supervisor training. Illustrative examples include Barrow and Domingo (1997), who evaluated the training in supervision for 15 fairly experienced supervisors in relation to their 43 students, using control and experimental groups. Effectiveness evaluation was based on the Individual Supervisory Conference Rating Scale, an observational tool tapping key supervision interactions (e.g. the supervisor stating the objectives of the meeting). They found that training was associated with supervisors becoming more facilitating (e.g. a more active listener). Similarly, McMahon and Simons (2004) developed the Clinical Supervision Questionnaire to evaluate the success of their 4-day supervisors' workshop, designed to measure confidence and practical skills. Only the experimental group improved significantly on this questionnaire following training. The two studies above were among 11 such controlled evaluations that were reviewed systematically by Milne, Sheikh, Pattison, and Wilkinson (in press), who concluded that these studies provided clear empirical support for supervisor training (e.g. 15 specific elements of training had empirical support: primarily corrective feedback, educational role-play and observational learning). A twelfth controlled evaluation was reported by Kavanagh et al. (2008). Within a randomised controlled design, they trained 46 allied health practitioners in Australia in supervision over a 2-day period, reporting only limited benefits. These improvements were restricted to more complete supervision contracts and fewer reported problems: no significant training effect was obtained on the measure of supervision methods or self-efficacy. Kavanagh et al. (2008) concluded that making relevant improvements in supervision practice may be more challenging than originally anticipated. As they noted, this might be due to the brevity of their training programme, and although they utilised multiple measures, all relied on self-report questionnaires. Where accompanying self-report data have been inconclusive, direct observation within intensive, rigorous $N=1$ studies have generated more compelling data for the effectiveness of training (e.g. Milne & James, 2002; Milne & Westerman, 2001).

In addition to these 12 controlled evaluations are some large-scale supervisor training studies with less rigorous but affirmative evaluations. Milne (in press) described a national pilot study in which a training manual for his ''evidence-based clinical supervision'' approach was used by 25 trainers within 11 Doctorate in Clinical Psychology programmes throughout the UK, yielding positive reaction evaluations from the trainers and the participating supervisors ($N=256$). In Australia, the Supervisor Training and Accreditation Program (O'Donovan, Dooley, Kavanagh, & Melville, 2009) has resulted in over 1000 psychologist supervisors receiving a 2-day

workshop since 2004, with evidence that it is associated with high levels of participant satisfaction (86% endorsement of the workshop, overall) and significant increases in evaluations of knowledge about supervision and the use of a range of supervision methods. From Sweden, Sundin, Ogren, and Boethius (2008) reported on a psychotherapy supervisors' training programme. Although the numbers involved are more modest (e.g. 21 supervisors), an intensive 2-year (part-time) small-group training format was described, and the evaluation was also relatively sophisticated: five self-report questionnaires were completed by these supervisors and/or their supervisees (e.g. development of psychotherapy skills in the supervisee), within a regression design. The authors concluded from the significant effects obtained that the training was effective in developing the supervisors' competence.

Moderating such claims for the effectiveness of supervisor training are the conclusions of a few other, mostly narrative reviews. Some of these have been more guarded, but it should be stressed that this is largely because of the paucity of training evaluations, rather than the rigor of the extant literature. For instance, Whitman et al. (2001) noted that there was little empirically based research, and in relation to medical education, Kilminster and Jolly (2000) guardedly concluded that there was no more than modest evidence that training had a positive effect on supervisors. In Australia, Spence et al. (2001) reviewed the evidence from occupational therapy, social work, speech pathology, and clinical psychology, concluding that ''although there is some tentative evidence to suggest the training supervisors can produce a change in supervisor practices and supervisee subjective ratings of the benefits of training, it remains to be demonstrated conclusively that such training achieves long-term impact on supervisee clinical practice and client outcomes'' (p. 149). This echoes an earlier review (Russell & Petrie, 1994).

However, demonstrating conclusive impacts on professional practice and on clinical outcomes is an exacting yardstick (consider, for example, the difficulty in showing a causal relationship between supervision and subsequent therapy outcomes: see Wampold and Holloway, 1997). Similarly, the paucity of research does not necessarily mean that we lack sufficient empirical evidence to guide the training of supervisors, as is indicated by the success of the large-scale training studies noted above. A further reason to be sanguine is that these more cautious opinions are based on traditional, narrative reviews, lacking the objectivity and precision of the systematic review (Petticrew & Roberts, 2006).

In summary, rigorous research and expert consensus have generally indicated that training in supervision can be effective (Milne et al., in press), but there are clearly many fundamental issues to resolve, such as the appropriate form of measurement (e.g. whether to require client benefit as the acid test of effective training, or to prize intermediate outcomes in a stepwise manner, such as the supervisors' learning). Hopefully a new burst of supervisor training in Australia (as elsewhere) will help researchers to address these issues.

What should be the nature and format of supervisor training?

If the PBA's decision to require training of all clinical supervisors is consistent with the scientific evidence and professional consensus statements in both the USA and the UK, the obvious question that follows is: What should be the nature and format of supervisor training? In the USA, Falender et al. (2004) designed a competencies framework as part of a concerted effort to upgrade supervision to a core professional activity. This framework consisted of knowledge (e.g. understand supervision models & research), skills (e.g. ability to give feedback effectively), and values (e.g. a respectful and empowering relationship). These were supported by attention to the social context of supervision (e.g. ethical and legal issues), to training in developing these competencies, and to the related competence assessment options (e.g. supervisee feedback). The consensus of Falender et al. (2004) defined the competencies of effective supervision as a basis for training supervisors, adding suggestions on how best to design this training. This featured coursework, supervision of supervision, and experiential methods that played an important role in supervisory skills training to be organised within a developmental sequence. Also from the USA, Borders' (2009) narrative review of the scientific literature outlined five best-practice principles for training programmes. She concluded that supervisor training programmes should: (i) address all the core content areas identified in professional standards and the literature; (ii) include both didactic instruction and supervised practice, concurrently and/or sequentially (experiential activities should involve direct observation of supervision practice with feedback); (iii) reflect a developmental approach in their content and sequencing; (iv) include instruction of a wide range of supervision methods, techniques, and approaches, with an emphasis on the intentional and flexible use of these approaches; and (v), include instruction in basic principles of learning theory. Somewhat similar recommendations including the application of a developmental model, applying experiential training methods, and adopting a science-informed approach (e.g. by evaluating whether such training fosters

competence) were recommended by Kaslow et al. (2004) following an exceptionally thorough consensus-building meeting among experts within the USA.

In the UK, a comparably thorough but more explicitly evidence-based approach has been taken to building an expert consensus concerning supervisor training within the IAPT initiative (Roth & Pilling, 2008a). This approach is described in Roth and Pilling (2008b) and is based on the procedure followed in developing the cognitive-behaviour therapy (CBT) competence statement, designed to ensure utility and applicability. As a result of this work, a supervision competence framework was generated, consisting of 11 ''generic'' supervision competences (e.g. ability to structure supervision sessions), four ''specific'' competences (e.g. ability to incorporate direct observation into supervision), six competences related to the different models (e.g. supervision of CBT), and finally, ''metacompetences'' (e.g. making appropriate adaptations to maximise the supervisees' learning). As Roth and Pilling (2008b) note, this carefully structured competence statement provides a curriculum for supervisor training, which they estimate would take up to 7 days to deliver. The related IAPT supervisor training is currently underway in England, with these days spaced out over several weeks to encourage the participants to transfer their learning to the workplace. Like Kaslow et al. (2004), they advocate an appropriate mix of didactic and experiential training methods, supported by e-learning materials.

These consensus statements also concur with the key professional organisations in the UK, which are increasingly requiring that supervisors receive training in order to practice within pre-qualification training programmes. To illustrate, the British Psychological Society (2007) states that training programmes in clinical psychology ''must organise regular supervision workshops to train supervisors in methods of supervision'' (p. 65). Similarly, a review of nine other National Health Service professions indicated that they expected their supervisors to attend some form of training in supervision, with workshops lasting between 1 and 5 days (Milne, 1998). A further support from the UK for this international consensus comes from that systematic review of 11 controlled evaluations of supervisor training (Milne et al., in press). Taken together, these 11 studies provided an informative account of clinical supervision training, suggesting that it consisted of up to 20 related variables. These were primarily based on conducting an assessment of educational needs, leading to various developmental activities designed to achieve these objectives (e.g. modelling, prompting, and direct observation), and concluding with the provision of feedback. These 11 studies utilised a blend of such methods, on average 4.5 per study.

In summary of this section, it is clear that there is a remarkable level of consensus among international experts about the nature of supervisor training. It also seems clear that the identified competencies required of supervisors are sufficiently advanced and complex to require more than an isolated and short (e.g. 1-day) workshop on its own to be effective. Not surprisingly, these sentiments are echoed in Australia. For instance, Hewson who conducted a large number of workshops for the NSW Registration Board indicated that the standard 2-day workshop may not be adequate to equip psychologists with even basic supervisory skills (Hewson, 2009). This agrees with preliminary empirical evidence (e.g. Kavanagh et al., 2008) that shorter term training programmes may be less effective than either more intensive training programmes (e.g. McMahon & Simons, 2004), or those where initial workshops are followed up by updates and more systematic assessment requirements (e.g. Griffiths University Consortium, 2009). This is important information for the PBA and for Australian universities that are mandated to offer clinical supervision training as part of their Doctor of Psychology programmes to absorb, particularly given the responses from an email poll of Directors of Psychology Training (C. Gonsalvez, personal communication, Sept 14, 2009). These suggested that brief (half- or 1-day) workshops are actually the most common format for supervisor training. The greater awareness of the need for supervisor training within the PBA and among training programmes is therefore an important positive step, but the evidence indicates that a brief workshop will be an inadequate solution.

To what extent is supervisor training being implemented internationally?

We are unaware of the existence of recent data that systematically assess the extent and nature of the need for supervisor training among Australian psychologists. The best information available is contained in a series of reports emanating from a project funded by Queensland Health on the perceptions, practices, problems, and outcomes of supervision. Although not a specific objective of the investigation, the reports also address clinical supervisor training (Kavanagh et al., 2003; Spence et al., 2001; Strong et al., 2003). Four allied health professions involved in delivering mental health services including psychology, occupational therapy, social work, and speech pathology were studied. Following seven focus-group interviews, conducted with 58 allied health professionals, semi-structured

telephone interviews were designed and conducted with Directors of mental health services (Strong et al., 2003). The involvement of Queensland Health in the project ensured that all 21 regions of the state were covered, employing 486 allied health professionals, with a 100% participation rate. Further good inter-rater reliability of coding and classification of responses from focus-groups and interviews lends credibility to the findings (Strong et al., 2003). The report concluded that, ''the data suggest that most allied mental health supervisors currently receive minimal training in supervision skills, irrespective of their discipline'' (Spence et al., 2001, p. 151), and that ''current practice in supervision was seen as ad hoc and of variable standard; the need for training in supervision was seen as critical'' (Strong et al., 2003, p. 191). Although these findings apply to Queensland, the other states do not have the data to argue that they fare any better. The conclusions from the Queensland studies are far from surprising because, until recently, in most states and territories in Australia, the only eligibility criterion required of qualified psychologists to undertake supervision was professional experience as a fully registered psychologist, with the prescribed level of experience varying from 2- to 5 years (Gonsalvez & McLeod, 2008). Admittedly, these reports represent supervisory practices prevalent close to a decade ago in Queensland and, very likely, in the rest of the country, and have not taken into consideration the commendable recent developments in supervision training detailed later.

Survey data from other countries suggest a similar pattern of need for supervisor training. In the UK, 108 of the 170 respondents (64%) drawn from the multi-disciplinary members of the British Association for Behavioural and Cognitive Psychotherapy reported having received some form of supervisor training (Townend et al., 2002), and a survey of 10 mental health professions indicated that all of them agreed that supervisors should receive training (Milne, 1998). In the USA, Falender et al. (2004) lament that a majority of psychologists have not actually had any formal training in supervision. Scott, Ingram, Vitanza, & Smith (2000) surveyed 123 counselling or clinical psychology training programmes accredited by the American Psychological Association, finding that 84% of them offered some form of training in supervision. A subsequent USA survey addressed the proportion of supervisors who actually attended such workshops, reporting much more alarming data (Lyon, Heppler, Leavitt, & Fisher, 2008). Just over a third of their sample of 233 pre-Doctoral interns in counselling & clinical psychology had completed any formal supervisor training (39%).

Recent developments

In Australia, state-based Registration Boards, notably Queensland and NSW, have recently introduced supervisor-accreditation systems for supervisors (see Gonsalvez & McLeod, 2008), making supervisor training mandatory. The supervisor training and accreditation programme in Queensland that commenced in 2004 has provided training to 1017 supervisors, of whom 727 have gained accreditation after meeting assessment requirements (Griffiths University Consortium, 2009). A further strength of the programme is that its effectiveness has been empirically demonstrated (Charman, 2007; Griffiths University Consortium, 2009). In a similarly commendable manner, the NSW Registration Board commenced a state-wide programme of supervisor training in January 2006 with standardised 1- and 2-day workshops offered to supervisors. The assessment of supervisor competence following these training workshops in NSW have been less than rigorous and an empirical evaluation of enduring outcomes is yet to be reported.

These initiatives are indeed commendable and demonstrate that this major problem in professional training in psychology is beginning to be addressed in a systematic fashion, at least in some quarters. However, decades of neglect have ensured that the problem is too large to be remedied within a short period. The NSW and Queensland training programmes were directed specifically to certain categories of supervisors, namely psychologists providing supervision for trainees undertaking the 2-year supervised practice route (the $4+2$ pathway in a non-university set up) to generalist Registration. Also, there is a continued demand for supervisor training even in Queensland and NSW, states that provided regular workshops during the past few years (Griffiths University Consortium, 2009; Hewson, 2009). Thus, in addition to significant numbers of psychologists and specialist psychologists who may not have received any training to supervise, there will also be substantial numbers who may have received initial input but now require additional training. Further, international trends suggest a movement from clinical supervision being an optional competency reserved for a subgroup of interested psychologists, to it being essential for most professionals. For instance, the consensus statement from the USA argued that supervision should constitute a core competency for all psychologists (Falender et al., 2004). The PBA (2009c) proposal, recommending that peer-consultation becomes a mandatory component of continuing professional development activities, strengthens the argument for training

to be dispersed to a wider group of Australian psychologists. Thus, the initial roll-out of supervisor training undertaken by selective Registration Boards in recent years is best considered a valuable first step to redress a widespread and urgent need. What is required is nothing short of a long-term, step-wise programme of training and evaluation, engaging all supervisors and supporting their continuing professional development across basic and advanced levels of supervision expertise.

Should clinical supervision training be regulated by the registration system?

Given the importance and the centrality of clinical supervision to the training of the psychology practitioner, it does seem reasonable that supervisor eligibility be monitored and regulated in some manner. There are a few reasons why at least minimal requirements should be included within the Registration system. These include the fact that membership within the Registration body is mandatory, whereas membership in a professional society is optional; and that the Registration system has more legislative clout than professional societies. The PBA also argues that it is in the public interest that supervisory competence be regulated by the Registration authority.

> Because supervision is critical to safe psychology practice, it is in the public interest for supervisors to meet additional requirements to be identified on the register as being competent to provide their services within this scope of practice. (PBA, 2009a, p. 46)

and,

> The Board has formed the view that a serious risk to the public exists in the profession because there is insufficient regulatory control of psychology supervisors. (PBA, 2009a, p. 46)

Although it is clear that the PBA is keen to play a role in the monitoring and regulation of supervision training, the finer operational details are yet to be articulated. The decisions that provisional psychologists must be supervised by Board-approved supervisors during their internship programme, and that supervisors must undertake a Board-approved supervisor training programmes, have already been made, and are to come into effect from July 1, 2010 (PBA, 2009c). In addition to generalist registration as a psychologist, the PBA has now approved seven ''area of practice'' endorsements (PBA, 2010). This creates the need for two categories of supervisors: (i) Board-approved supervisors for trainees seeking generalist registration and (ii) Board-approved supervisors who supervise psychologists seeking area-of-practice (specialist) endorsements. Because supervisors in the first category may not hold ''specialist'' qualifications, it appears clear that they will be ineligible to provide supervision for psychologists in Category 2. However, there is no mention as yet as to whether supervisor training programmes for the two supervisor categories will remain the same or different. There is a striking level of overlap between the theory, processes, methods, assessment, and evaluation components of supervision across different psychology specialisations and, in fact, across disciplines (Spence et al., 2001). Hence, initial, basic supervisor training programmes should be capable of meeting requirements for both supervisor categories. Follow-up advanced training programmes could be tailored to meet specific area-of-practice endorsements. This kind of integrated approach has proved popular within the IAPT model of supervisor training in England, in that the supervisors of both the ''high-intensity'' and the ''low intensity'' psychological therapists are trained together for most of the 7-day supervision workshop. The implication of the supervisor categories is that the PBA will have to maintain directories for each supervisor category, and monitor both inclusion and maintenance of eligibility status over a supervisor's career. The process by which supervisor training programmes will receive Board approval remains unclear at this stage. Registration Boards and professional bodies such as the APS have effectively collaborated in the past in formulating accreditation policies and monitoring accreditation processes and outcomes for undergraduate and graduate training programmes. In effect, although it is appropriate for the PBA to have a role in the regulation of supervisor eligibility, adequate representation from and active engagement with relevant professional bodies is viable and critical to the best interests of the community and Australian psychology.

In the UK, there is a more cautious approach to regulation of clinical supervisors. A voluntary register of accredited clinical psychology supervisors was introduced by The British Psychological Society in 2009, and the supervisors of a range of professional groups are similarly encouraged to join a register by The British Association for Behavioural and Cognitive Psychotherapy. However, these bodies (and others in the UK) do require that appropriate arrangements for supervisor training are in place, as a condition of programme accreditation. Therefore, both the UK and Australia share a requirement that

supervisors receive training within professional Clinical Psychology programmes, but the UK does not yet require that these individual supervisors are registered.

Conclusions

Supervision appears to play a significant role in developing clinical competence in supervisees and in promoting clinical outcomes, whether assessed empirically (Bower, Gilbody, Richards, Fletcher, & Sutton, 2006; Milne, 2009), judged in terms of its influence by the participants (Lucock, Hall, & Noble, 2006), or considered by experts (Falender et al., 2004). Paradoxically, the development of supervisors' competencies has been sorely neglected. The current paper uses the available scientific literature and expert consensus in the USA and UK to clarify for the Australian psychologist and supervisor some key questions and promising answers about the development of systematic training in clinical supervision, supported by better regulation.

Professional bodies, including those that represent psychology, have often justifiably argued that they uphold and promote high standards of professional competence for their members and ensure quality of care to the public. In the case of clinical supervision we may have failed to live up to this expectation. More than 15 years have elapsed since Watkins decried the mismatch between the importance of clinical supervision and the attention to supervisor training, in his memorable quote, ''something does not compute'' (Watkins, 1997, p. 604). A similar period has elapsed since Hoffman talked about ''psychology's dirty little secret'' (Hoffmann, 1994), and close to a decade has elapsed since Whitman et al. (2001) described the state of clinical supervision as ''the persistent paradox.'' In the case of standards for clinical supervision, we may have forfeited the right to take the high moral ground. It is time for action. It is probably time for all stakeholders (professional bodies and disciplines, private and public health agencies, universities and other training clinics) to pool resources and address in a concerted and systematic manner what is undoubtedly a huge gap in continuing professional development: clinical supervisor training and evaluation. Finally, for the impetus towards better regulation of supervisory practice to become successful, it should be complemented with a parallel, pro-active endeavour to facilitate and support supervisory practice with enhanced development of resources, including manuals, work-books and better psychometric tools to evaluate supervisory processes. Collaborative initiatives by the PBA, APS, and other training institutions (such as universities) will be required for such initiatives to gain and sustain momentum.

Note

1. The current paper uses the term clinical supervision to designate professional or practitioner-based supervision across specialisations in psychology and other health disciplines.

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