Developing supervisory competence: preliminary data on the impact of CBT supervision training

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Abstract. Clinical supervision is key to the delivery and governance of effective psychological work. We place increasing emphasis on the evidence base in our clinical decision making, and yet there is no comparable body of information to inform our supervisory practice. This is a serious problem for psychological therapists; there is an urgent need for theoretically driven and empirically evaluated approaches to supervision, and the training of such skills. This preliminary evaluation examined the impact of a 5-day training designed for Improving Access to Psychological Therapies (IAPT) supervisors new to the role. A within-subject, repeated-measures design was used to compare self-assessed supervision competencies over the course of training. Twenty-eight IAPT supervisors completed 5 days' training based on the Supervision Competencies Framework and IAPT Supervision Guidance. Significant improvements were found in ratings of generic, specific, applied and meta-supervision competencies, as well as overall competency. This evaluation gives preliminary support for the impact of training on supervisory competencies. There are clear limitations, particularly the lack of objective measures and comparison training. Nevertheless, in the context of a very limited evidence base to date, the study contributes to a more robust approach to developing supervisory competence in clinical practice.

Key words: Competence, IAPT, supervision, training.

Introduction

The role of clinical supervision in the delivery of safe and effective therapeutic work is widely accepted. While this is recognized in our professional standards (e.g. DCP, 2005; DoH, 2008; BABCP, 2010) and by experts in the field (e.g. Butler, 2001; Padesky, 2006; Scaife, 2008; Lewis, 2012), the evidence base for the value of supervision and the impact of training remains scarce (Milne & Dunkerley, 2010; Milne *et al*. 2011). It is of note that in times of increased attention to the evidence in our clinical work, the practice of supervision remains highly valued but poorly evaluated (Milne & Dunkerley, 2010).

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There are numerous definitions of clinical supervision which differ in emphasis and according to therapeutic context (Turpin & Wheeler, 2011). A useful definition by Roth & Pilling (2007) describes supervision as:

> a formal but collaborative relationship . . . guided by some form of contract between a supervisor and supervisee. The expectation is that the supervisee offers an honest and open account of their work, and that the supervisor offers feedback and guidance which has the primary aim of facilitating the development of the supervisee's therapeutic competencies, but also ensures that they practise in a manner which conforms to ethical and professional standards (p. 4).

In their systematic reviews of the impact of supervision and supervision training, Milne, James and colleagues found a large body of literature but few empirical studies, and methodological problems with many of these. Overall, they found reason for cautious optimism, with some evidence that supervision and training can increase competence. These authors argue persuasively that the lack of rigorous evaluation in this area must be addressed if we are to remain credible healthcare professionals, and that a 'softening' of the notion of evidence-based practice to include both empirical evidence and professional consensus (following Parry, 2000) may be significant in addressing some clinicians' continued ambivalence about working to the evidence base (Milne & James, 2000; Milne & Dunkerley, 2010; Milne *et al.* 2011).

In this context, Milne & Dunkerley (2010) developed a series of guidelines for clinical supervision drawn from the (albeit limited) evidence available. The guidelines focus on: (i) needs assessment and the learning contract; (ii) methods of facilitating learning in supervision; (iii) enhancing the supervisory relationship; and (iv) evaluation in clinical supervision.

The national Improving Access to Psychological Therapies (IAPT) programme has also influenced this debate; 'supervision is key activity, which will determine the success of the IAPT programme' (Turpin & Wheeler, 2011). Supervision training is identified as an essential component of the programme, and a requirement for all IAPT clinicians who supervise others. Roth & Pilling (2007) have defined generic, specific, applied and meta-supervision competencies for psychological therapists, and Turpin & Wheeler (2011) give guidance on the delivery and training of supervision in IAPT settings. These competencies and supervision training guidelines are also likely to be relevant to psychological therapists in secondary and other healthcare settings. To our knowledge, IAPT supervisor training has not been evaluated to date.

This preliminary evaluation examined the impact of a 5-day training designed for IAPT supervisors in the South of England. We aimed to improve participants' supervisory practice based on the competencies defined by Roth & Pilling (2007). In the context of limited evidence for supervisory training, and no previous studies of training designed for IAPT supervisors specifically, this is likely to be a valuable first step towards understanding the impact of these courses.

Method

Design

A within-subject, repeated-measures design was used. The training ran over 5 days consisting of three blocks – two blocks of 2 days and a final single day. The three blocks ran

approximately 6 weeks apart. Competency self-assessments were completed at each of the three blocks of training. The first assessment was conducted as a baseline, at the start of the first workshop. The second and third assessments were completed at the end of the second and third blocks of training, respectively. The predictor variable was time and the dependent variable was the self-reported assessment of competencies. Ethical guidance was sought from the chair of our faculty ethics committee.

Participants

Twenty-eight people completed the 5-day IAPT supervision training for high-intensity (HI) and psychological wellbeing practitioners (PWPs). The supervisors worked across a number of NHS bases and had a wide range of supervision experience. All were new to IAPT supervision.

Training

The training was commissioned by the Strategic Health Authority to support the IAPT programme locally. The 5-day course was developed following the IAPT Supervision Guidance (Turpin & Wheeler, 2011) and in line with the Supervision Competencies Framework (Roth & Pilling, 2007). We combined joint HI and PWP sessions on the theory and complexities of supervision, and ran separate sessions for role-specific tasks such as use of the Cognitive Therapy Scale – Revised (CTS-R; Blackburn *et al.* 2001) for HI supervisors, and IAPT case management for PWPs. Much of the content of the training was based on the 'Guidelines for Evidence-Based Clinical Supervision' (Milne & Dunkerley, 2010) and the 'Ten Step Model for Supervision' (Gordon, 2012). Experiential approaches to learning were emphasized. Table 1 outlines the content and learning outcomes for each of the sessions, along with examples of experiential exercises used.

Materials

Participants completed a self-assessment of supervisory competence, developed for the purpose of the study. The measure consisted of the 18 competencies defined by Roth & Pilling (2007), yielding four sub-scales (generic, specific, applied, and meta-supervision competencies) which are totalled to give an overall score. Participants rated themselves on a three-point 'traffic light' scale from 'not/barely achieved' (red), 'partially achieved' (amber) to 'well/fully achieved' (green), as shown in Figure 1.

Procedure

The participants were verbally informed of the trainers' intention to evaluate the course for two purposes – first, to improve the training for future cohorts, and second, for potential publication. It was made clear that submitting their self-assessments was entirely optional and that all material would be treated confidentially. Submission of the assessments was assumed to indicate consent to the use of data for the purposes stated. Participants were asked to complete the measure at each of the three blocks of training.

Table 1. *Summary of training*

Day	Content	Learning outcomes*	Example of experiential learning

1	**Theory & key principles**
	Definitions of supervision and role in IAPT
	Functions – normative, restorative, formative
	Clinical governance and ethical issues
	Therapeutic alliance
	Learning/educational principles
		1. To be familiar with supervision competences framework (Roth & Pilling, 2007)
		2. To critically evaluate own supervision skills
		3. To develop 'generic supervision skills':
		  • Critically evaluate clinical governance issues
		  • Demonstrate supervisory alliance skills
		  • Demonstrate application of educational principles
			Individually – identify own beliefs as supervisors or supervisees
			In small groups – what are the emotional and behavioural consequences of these? Devise a behavioural experiment to shed further light on the value of these beliefs

2	**Managing supervision – structuring sessions**
	Use of supervision contracts and goal setting
	Record keeping
	Within session structure
	Supervision '10 step model' (Gordon, 2012) (HI)
	Clinical case management supervision (PWP)
	Clinical supervision (PWP)
		1. To develop 'generic supervision skills':
		  • Demonstrate ability to structure supervision
		  • Demonstrate ability to facilitate supervisees to present and reflect on their work (HI)
		  • Critically evaluate own limitations and implications
		  • Demonstrate understanding of PWP supervision models, and use of generic skills in supervision (PWP)
			In small groups – role play contracting for supervision and collaborative goal setting

3 & 4	**Supervision in practice – HI/PWP specific methods**
	Evidence-based framework for clinical supervision (Milne & Dunkerley, 2010) (HI)
	Use of CTS-R (HI)
	Feedback and evaluation (HI)
	Active supervision methods (HI)
	Further practice of clinical case management supervision skills (PWP)
	Further practice of clinical supervision skills (PWP)
		1. To develop 'generic supervision skills':
		  • Demonstrate ability to assess supervisees' competence (HI)
		  • Demonstrate ability to help supervisees reflect on work (HI)
		  • Demonstrate ability to give accurate and constructive feedback (HI)
		  • Demonstrate understanding of PWP supervision models, and use of generic skills in supervision (PWP)
		2. To develop 'specific supervision skills': (HI)
		  • Demonstrate ability to help supervisees practise skills
		  • Demonstrate ability to apply standards using CTS-R
			Individually – score full therapy recording using CTS-R
			In small groups – compare scores and use manual to attempt to resolve discrepancies

Table 1 *(cont.)*

Day	Content	Learning outcomes*	Example of experiential learning
		3. To develop 'skills in supervising in specific modalities' (HI) ● Abilities applied to CBT supervision	
5	**Supervision complexities** Application of cognitive interpersonal model (Safran & Segal, 1990) to formulate and address ruptures in supervision (following Kennerley, 2006) Application of professional standards regarding failure Review of clinical case management Group process in practice using 'forum theatre'	1. To be able to formulate process issues, and respond to ruptures using the cognitive model 2. To be able to apply procedures relevant to assessment of poor performance and failure 3. To be able to maintain an overview of supervisees' overall caseloads 4. To be able to apply skills in structuring group supervision and managing group process 5. To be able to reflect on limitations of training and experience, and implications for practice	'Forum theatre' exercise with whole group to illustrate common problems in group supervision, and facilitate means of addressing these in supervisor role

IAPT, Improving Access to Psychological Therapies; HI, high intensity; PWP, psychological wellbeing practitioner; CTS-R, Cognitive Therapy Scale – Revised.

* Learning outcomes apply to both HI and PWP supervisors, unless otherwise stated.

Name (or initials if preferred): _____   Date: _____

Review the supervision competencies and guidance then assess yourself as follows:

🔴 Not/barely achieved   🟡 Partially achieved   🟢 Well/fully achieved

Item	Competency	Rating (circle traffic light that best applies)		
1.	Ability to employ educational principles which enhance learning	🔴	🟡	🟢
2.	Ability to enable ethical practice	🔴	🟡	🟢
3.	Ability to foster competence in working with difference	🔴	🟡	🟢
4.	Ability to take into account the organisational context for supervision	🔴	🟡	🟢
5.	Ability to form and maintain a supervisory alliance	🔴	🟡	🟢
6.	Ability to structure supervision sessions	🔴	🟡	🟢
7.	Ability to help the supervisee present information about clinical work	🔴	🟡	🟢
8.	Ability to help supervisee's ability to reflect on their work and on the usefulness of supervision	🔴	🟡	🟢
9.	Ability to use a range of methods to give accurate and constructive feedback	🔴	🟡	🟢
10.	Ability to gauge supervisee's level of competence	🔴	🟡	🟢
11.	Ability for supervisor to reflect (and act on) on limitations in own knowledge and experience	🔴	🟡	🟢
12.	Ability to help the supervisee practice specific clinical skills	🔴	🟡	🟢
13.	Ability to incorporate direct observation into supervision	🔴	🟡	🟢
14.	Ability to conduct supervision in group formats	🔴	🟡	🟢
15.	Ability to apply standards	🔴	🟡	🟢
16.	Supervision of overall caseload	🔴	🟡	🟢
17a. *or*	Supervision of Low Intensity interventions	🔴	🟡	🟢
17b.	Supervision of High Intensity Cognitive and Behavioural Therapy	🔴	🟡	🟢
18.	Supervision meta-competences	🔴	🟡	🟢

Fig. 1. Supervision competency self-assessment for psychological wellbeing practitioner & high-intensity CBT supervision. Based on Roth & Pilling (2007). A competence framework for the supervision of psychological therapies (http://www.ucl.ac.uk/CORE/).

Results

Descriptive statistics for each of the four subscales and overall competency suggested improvements over time (see Table 2). Repeated-measures ANOVAs and Bonferroni corrected *post-hoc* tests were then used to examine these changes in more detail. Greenhouse–Geisser corrections were used when sphericity assumptions were violated.

A repeated-measures ANOVA with Greenhouse–Geisser correction showed that mean generic competency differed significantly between time points ($F_{2,43} = 25.77$, $p < 0.001$,

Table 2. *Descriptive statistics for supervisory competencies over time*

	Competency				
	Generic ($n = 28$)	Specific ($n = 28$)	Applied ($n = 28$)	Meta ($n = 26$)	Overall ($n = 28$)
Time 1	14.50 (3.46)	4.04 (1.60)	2.07 (1.12)	0.88 (0.52)	21.46 (5.68)
Time 2	18.07 (2.09)	6.14 (1.18)	3.14 (1.01)	1.19 (0.49)	28.54 (3.42)
Time 3	19.61 (2.59)	6.86 (1.18)	3.54 (0.74)	1.50 (0.51)	31.43 (4.35)

Values given are mean (standard deviation).
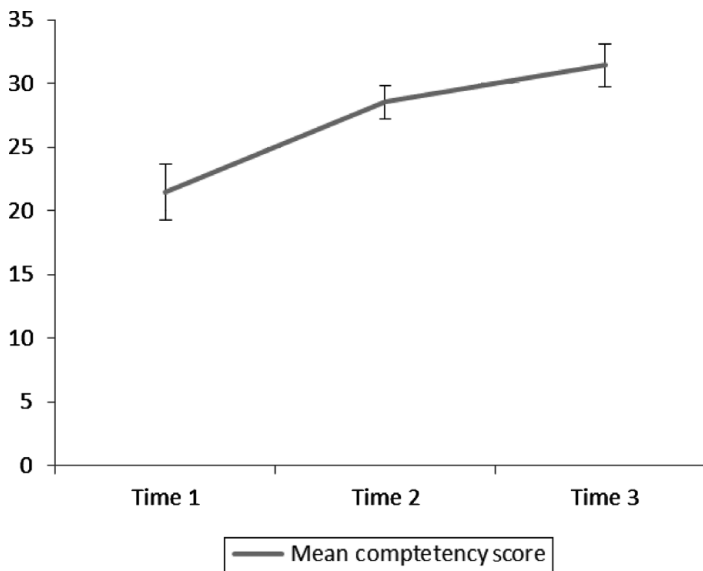
Fig. 2. Mean overall competency over time. Error bars show confidence intervals.

$\omega^2 = 0.38$). *Post-hoc* tests showed significant increases between times 1 and 2 ($p < 0.001$), and times 1 and 3 ($p < 0.001$). Mean specific competency differed significantly over time ($F_{2,54} = 31.85$, $p < 0.001$, $\omega^2 = 0.44$), with significant differences between times 1 and 2 ($p < 0.001$), and between times 1 and 3 ($p < 0.001$). Mean applied competency differed over time ($F_{2,54} = 25.17$, $p < 0.001$, $\omega^2 = 0.28$), and *post-hoc* tests indicated significant changes between times 1 and 2 ($p < 0.001$), and times 1 and 3 ($p < 0.001$). Repeated-measures ANOVA with Greenhouse–Geisser correction showed that mean meta-competency differed significantly between time points ($F_{2,39} = 10.48$, $p < 0.005$, $\omega^2 = 0.20$), with significant increases between times 2 and 3 ($p < 0.005$) and times 1 and 3 ($p < 0.005$). Finally, mean overall competency differed significantly between time points ($F_{2,54} = 36.88$, $p < 0.001$, $\omega^2 = 0.45$), and *post-hoc* tests showed significant increases between times 1 and 2 ($p < 0.001$), times 2 and 3 ($p = 0.01$) and times 1 and 3 ($p < 0.001$). Overall competency changes are shown in Figure 2.

Discussion

Self-rated supervisory competence improved over time for the people participating in the 5-day training course. Improvements were found in generic, specific, applied, and meta-supervision competencies, and reflected in overall competency.

As a preliminary and naturalistic study, there are significant limitations to the methodology. Most importantly, our design does not allow causal inferences to be drawn concerning the effect of the training on the competency ratings. The study also lacked any objective measure of supervisory skill. Although the self-assessment tool was based on best practice guidelines, it is not established as a valid and reliable measure. This is a serious weakness. The scale now requires validation with novice and established supervisors. In addition, reliance on self-ratings of competence may have resulted in inflated reports due to demand effects – it may be that participants reported improved competencies assuming that this was what was expected of them. In hindsight, it would also have been helpful to record the range of participants' CBT supervision experience and the effect of training on novice, experienced and highly experienced supervisors. Unfortunately this information was not collected in the present study.

Within these limits, the evaluation provides interesting initial data. The findings are consistent with the possibility that the training led to improved supervision competencies, although the design means that these changes cannot be attributed to the training. The results are nevertheless relevant in the context of a very limited evidence base to date. The impact of training now needs to be examined more rigorously with methodologies that allow causality to be attributed, for example using a comparison control training.

Milne & Dunkerley (2010) argue that the lack of an evidence base for the development of supervisory skills is a serious problem for psychological therapists. How can we claim to adopt an evidence-based approach to our work, which increasingly involves the supervision of others, and yet fail to approach this area with a rigour comparable to that expected in direct clinical work? In short, we need to extend the emphasis on evidence-based care to our supervisory practice. This study provides preliminary data contributing to what we hope will be a more robust approach to supervision in the future.

Summary of the main points

(1) Clinical supervision is essential to effective psychological work; the dearth of an evidence base in this area is a serious problem for practitioners.
(2) This preliminary evaluation examined the impact of a 5-day training course designed for IAPT supervisors.
(3) Improvements in self-rated supervision competencies over the course of the training are consistent with the possibility that the training led to these outcomes. However, our design means that these changes cannot be attributed to the training.

Acknowledgements

Declaration of Interest

None.

Recommended follow-up reading

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Learning objectives

(1) To recognize the urgent need for an evidence base in clinical supervision training.
(2) To be familiar with a training programme (overview) designed to meet learning outcomes in line with the Supervision Competencies Framework (Roth & Pilling, 2007).
(3) To understand how initial data were gathered over the course of the 5-day training course, and the value and limitations of this information.