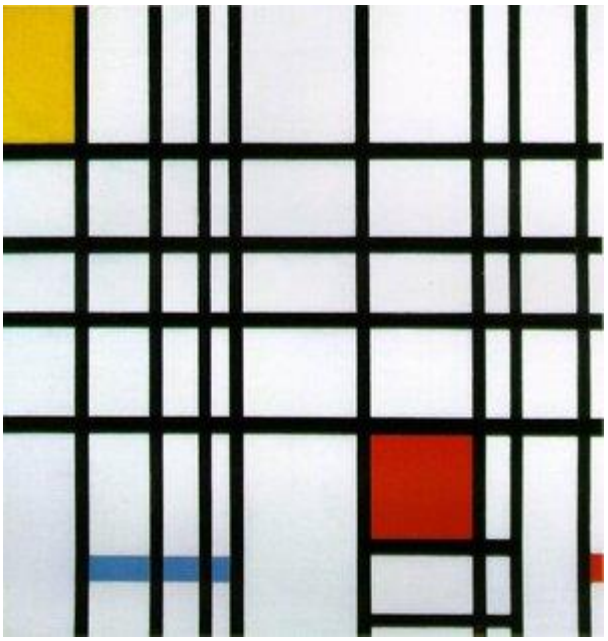

A competence framework for the supervision of psychological therapies[1]

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The full set of competences referred to in this document are available for downloading from the CORE website:

www.ucl.ac.uk/CORE/

[1] This document was partially revised in July 2015

Acknowledgments and Background

This work was originally commissioned in 2007 by the Care Services Improvement Partnership (CSIP), Skills for Health and NHS Education for Scotland. The brief from these organisations focused on the competences needed to supervise the high and low intensity interventions described in the Improving Access to Psychological Therapies (IAPT) programme. Since this time the framework has been broadened to include supervision of the range of therapy modalities and clinical contexts included in the 'suite' of competence frameworks published on the CORE website (accessed at www.ucl.ac.uk/CORE/competence-frameworks).

Introduction

Supervision is a critical element of clinical training and clinical practice, since it links academic input to the realities of clinical work, and is the means by which theory becomes linked to practice (e.g. Scaife 2001, Bernard and Goodyear 2004). However, the ways in which supervision is delivered varies widely in different settings, between professions and across therapeutic modalities. In addition, there are many different forms of supervisor training, most of which (at least for now) is essentially elective. While some organisations have systems for formally accrediting supervisors, few practitioners seem to take up this option. By way of example, currently the British Association for Behavioural and Cognitive Psychotherapies (BABCP) has only 46 accredited supervisors compared to around 1300 accredited practitioners (Holland, personal communication, April 2008), indicating a significant gap between the numbers of clinicians who practice supervision and those who have obtained formal accreditation to do so. This does not imply that the quality of supervision offered by unaccredited individuals is poor but it does contribute to a situation where clinical services, aiming to employ individuals who can deliver effective supervision, have little external guidance which they can use to delineate the competences their workforce will need, to operate as effective supervisors. The competence framework is intended to redress this state of affairs.

What is supervision?

Defining supervision is challenging, largely because the content and structure of supervision varies with professional grouping, therapeutic orientation and clinical context. As a consequence there are many definitions, each with their own nuances of emphasis and tone. Drawing on a number of sources (e.g. Falender and Shafranske, 2004, p3; Bernard and Goodyear 2004 p 7; Scaife 2001, pp 2-3)) this framework conceives of supervision as a formal but collaborative relationship which takes place in an organisational context, which is part of the overall training of practitioners, and which is guided by some form of contract between a supervisor and a 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 competences, but also ensures that they practices in a manner which conforms to current ethical and professional standards.

Although supervision is strongly associated with training at a prequalification level, it is just as relevant to qualified practitioners, where it has an important role in maintaining and developing their skills. This means that although the supervisory role will often be taken by a more senior practitioner, this is not always the case - for example, both parties could be equally experienced, and here terms such as 'peer supervision' or 'consultation' tend to be preferred.

Evidence for the benefits of supervision

What follows is a synoptic (rather than a systematic) overview of research and research issues in this area. Given the timescale for development of this framework we have not undertaken a systematic review of the supervision literature. However, we have been able to draw on several relevant and recent systematic reviews (Lambert and Ogles, 1997; Ellis and Ladany, 1997; Milne and James, 2000;, Kilminster and Jolly, 2000, Freitas, 2002; Wheeler and Richards, 2007; Milne, Aylott, Dunkerley, Fitzpatrick and Wharton (unpublished)) as well as individual research studies.

Although there is a considerable literature on supervision, there is only a limited literature on the *outcomes* associated with supervision – either in terms of the impact of supervision on the supervisee's competence, or in relation to the benefit of supervision on client outcomes – the ultimate test, and also in a sense the acid test (Ellis and Ladany 1997). The absence of such research is not a matter of simple neglect or indifference; it is rather that most studies of supervision reflect an interest in the *process* of supervision. This probably reflects widespread professional assumptions that there is an inherent (and hence unquestioned) virtue to supervision, despite the weakness of the evidence base in support of this contention (e.g. Cape and Barkham, 2002). Certainly, all trainings in psychological therapy require students to undertake supervised practice as a condition of accreditation, and post-qualification supervision is seen as important to the maintenance and development of skills and knowledge. The professional ubiquity of supervision does not, in itself, create an argument for its value, but it clearly does create a context in which learning and development are seen as inherently linked to clinical practice.

In seeking evidence regarding the value of supervision, it is worth starting by noting that supervision is an implicit – and often under-recognised - component of the treatment packages used to research the efficacy of psychological therapies. Current editorial standards mean that published reports of well-conducted clinical trials always contain a detailed description of the intervention used, but not all these accounts include a clear account of the pre-trial qualifications of therapists, any additional training and the amount of supervision received. While few researchers would countenance conducting a trial without training and supervision, these elements are often lost from view once the study is published. For example, in order to identify the training and supervision associated with the clinical trials contributing to the evidence-base for the CBT competence framework, we needed to contact the original researchers in order to obtain some of the relevant information (Roth, Pilling and Turner, 2010). This lack of explicit detail risks rendering supervision and training invisible, when in fact it could be argued that training and supervision form an important component to the treatment 'package' received by clients in research trials. As there are no trials in which training and supervision have been systematically manipulated, we do not know if supervised and unsupervised clinicians would achieve equivalent results. Nonetheless, most of our evidence for the efficacy of psychological therapies has been created in the context of supervised practice, making this a factor which it would be unwise to ignore.

Problems conducting research into supervision

Ultimately, the purpose of supervision should be to enhance client outcomes, but detecting a casual link is challenging, requiring that there is evidence that supervision impacts in some way on the supervisee, that this is translated into a change in their behaviours as therapists, and that this change improves outcomes. As noted by Milne and James (2000) there is a 'pyramid' of potential influence (which also includes the support received by supervisors themselves). In any naturalistic setting this hierarchy of influence mitigates against detecting any causal links – there are simply too many potential sources of variance. Implementing the usual methods for overcoming this problem – for example the randomised trial – would be challenging, not only scientifically but also pragmatically, because funding for such a project would be hard to obtain. On this basis, most research is conducted post hoc (in other words by reanalysis of data from trials whose primary hypotheses related to a different question, such as the efficacy of a particular therapy), or is rather small scale (and hence statistically 'underpowered' and unlikely to detect any influences even if they were present).

Overview of research evidence

There are several good quality systematic reviews of supervision (as cited above). Most of these highlight the lack of studies linking supervision to outcome. In a review focused specifically on this issue, Freitas (2002) identified just 10 relevant studies, many of which had significant methodological flaws, making it hard to draw any clear conclusions from them. Asking a slightly different question, there is evidence of modest links between training and outcome, and some evidence of specific benefits for particular techniques. Lambert and Ogles (1997) make several recommendations for future research, not least

the need for some consistency in identifying supervisory and training outcome criteria. In their review, they focused on evidence for change in supervisee interviewing skills, interpersonal skills and technical skills, and recognised that supervision would also be directed to changing supervisee values and attitudes, and promoting their personal growth. However, studies employed a wide range of measures with differing aims, and measures with the same purpose were structured and administered in ways which made them non-comparable.

If the evidence for the specific benefits of supervision is somewhat sparse, then it follows that it will not be easy to identify the specific competences required of supervisors on empirical grounds alone. For example, Milne and James (2000) identified 28 trials of supervision in which learning outcomes were evaluated empirically in routine clinical settings. All bar 5 of these studies focused on the application of CBT to people with of learning disabilities (with 3 studies of supervision in adult mental health, 1 in psychiatric rehabilitation and 1 in children and families). This review identified some successful activities – close monitoring of the supervisee in order to provide contingent feedback, modelling of specific competences, providing specific instructions and goal setting. Although helpful as a starting point, reliance on this set alone would lead to a fairly limited competence list. Realistically – or perhaps more accurately, pragmatically - it seems clear that any competence framework would need to be developed, by integrating empirical findings with professional consensus, in this way articulating the sets of activities usually assumed to be associated with better learning outcomes.

Many studies of supervision address themselves to process issues, and one strand of this work attempts to identify supervisory actions which enhance learning, in particular the impact of the "supervisory alliance" (a phrasing deliberately chosen to echo the notion of the therapeutic alliance). This is taken to be a basic building block for successful supervision, and Ladany (2004) emphasises the role of a sound supervisory alliance in order to conduct the tasks of supervision, and to reduce unhelpful supervisee behaviours, especially nondisclosure of important clinical information. Ladany et al. (1996) surveyed 108 supervisees, finding that nearly all admitted to non-disclosure of varying sorts. Worryingly a substantial amount of this nondisclosure related to material which could be seen as central to learning – for example personal issues raised by the work, perceived clinical mistakes and negative reactions to client. This work also gives some indication of supervisor behaviours which makes nondisclosure more likely – for example, being unaffirming, unsupportive, unstructured and less interpersonally sensitive.

Conducting psychological therapy is potentially exposing at a personal as well as a professional level, and it makes sense that supervision should create a learning environment where supervisees feel able to identify their errors or anxieties without feeling shamed. However, this entirely appropriate emphasis on fostering personal and professional development means that interpersonal issues can become entangled in the assessment process, especially when outcomes are poorly defined. A number of studies provide evidence in support of this. For example, both Dodenhoff (1981) and Carey et al. (1988) found evidence of a 'halo' effect whereby the fit between supervisee and supervisor seemed to play a major part in the supervisor's evaluation of supervisee

competence, and also in the supervisee's evaluation of the quality of supervision. This result is not very surprising, but it is worrying; concurrent client ratings of effectiveness suggested that the bias described in this study led supervisors to judge supervisees as more effective than they actually were. Accurate evaluation is clearly not a straightforward process, not only because of interpersonal biases, but also because supervisors need to be able to separate out the influence of context and complexity from the capacity of the trainee. For example, Rounsaville et al. (1988) found that supervisors' assessment of competence correlated with client difficulty, suggesting that it was hard for supervisors to disentangle one factor from the other.

Finally there are some studies which indicate the sort of behaviours associated with good supervision. Two frequently cited papers are worth highlighting and both come to similar conclusions. Shanfield and colleagues (Shanfield et al. 1993; Shanfield et al. 2001) asked experienced supervisors to listen to tapes of supervision sessions and to rate them as good, mid/low or poor quality. Subsequent analysis of the tapes converted these global impressions into lists of supervisor actions. 'Good' supervisors tended to allow the supervisee's story to develop, track the most immediate concerns/queries of the supervisee, and make comments that were specific to the material being presented. In contrast, poorer supervision seemed to occur when supervisors were less disciplined in maintaining a focus on supervisee's concerns, were less structured and paid little or no attention to supervisee's concerns/queries. A similar pattern emerged from Henry et al.'s (1993) study of trainees learning to apply psychodynamic therapy. This found an association between client outcomes and the type of supervision received, with better outcomes when supervisor behaviours were similar to those described by Shanfield's group.

Developing the competence framework for supervision

Method

The CBT competence framework (described in detail in Roth and Pilling (2007) and Roth and Pilling (2008)) was the methodological 'prototype' for the development of the supervision competence framework. As such, it is appropriate briefly to review the principles which guided this work.

Developing the CBT competence framework: A central objective in the development of the framework was to restrict the list of competences to those for which there is evidence of benefit or a clear professional consensus regarding their value. To do this, the framework identified those CBT approaches for which there was substantive evidence of patient benefit, located the manuals (or equivalent) which described the procedures used in the trials demonstrating efficacy, and from these "extracted" competences.

Because it was important to ensure that the CBT framework had utility and applicability, the competence lists were clustered in a manner which reflects the way that clinicians use them. This 'architecture' is important, because it helps clinicians to see how the many activities that comprise therapy fit together holistically. This means that the CBT framework is outlined in a 'map' of activities which, taken together, represent the practice of effective CBT. The underpinning to this map is a model of competences which potentially works well across most therapy modalities, and is shown in Figure 1.

The model sets out 5 domains into which different areas of clinical activity can be fitted, and into which the competences extracted from manuals were located (hence populating the map).

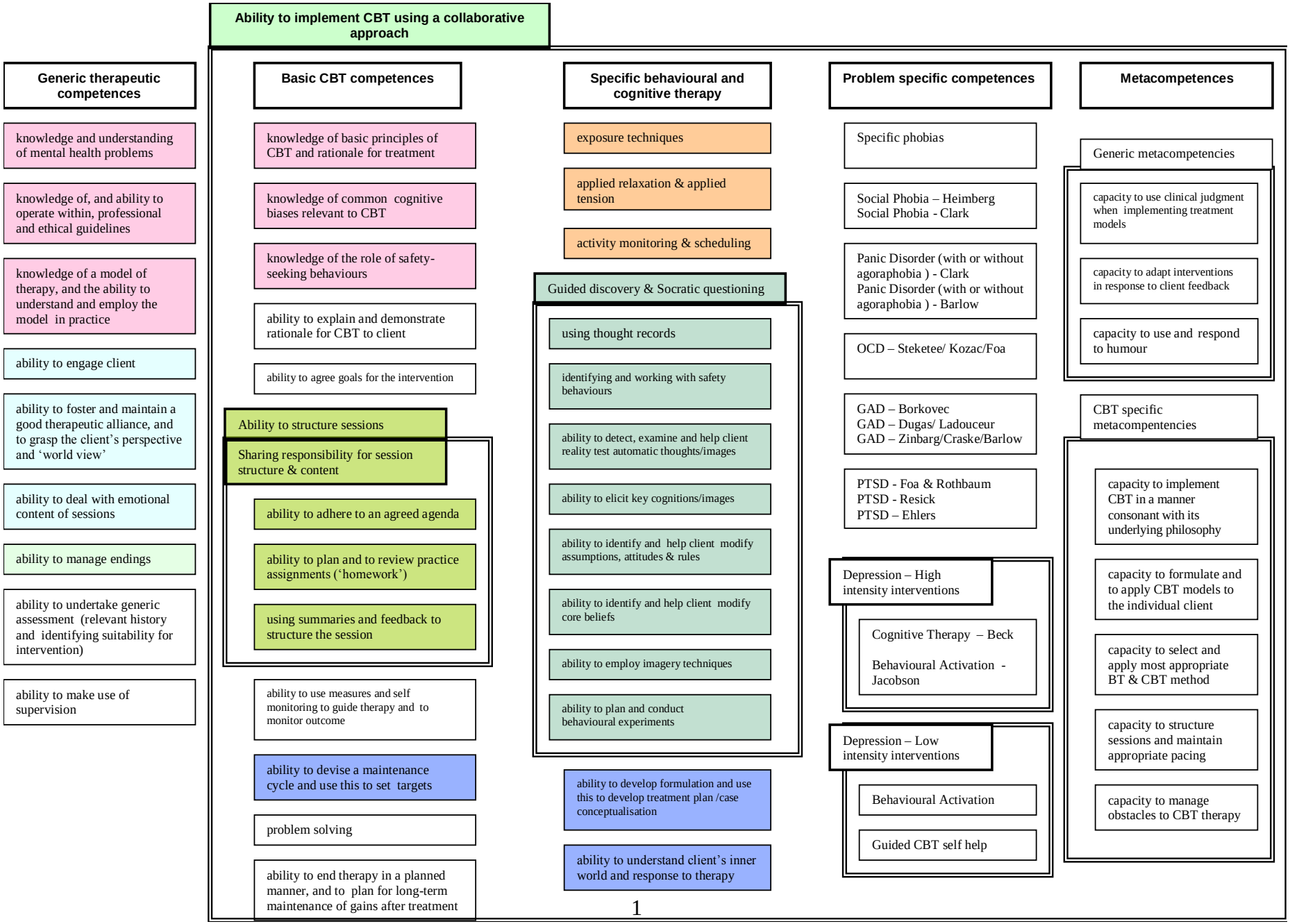
To ensure that the right trials and manuals have been identified and that the process of extracting competences was appropriate and systematic, an Expert Reference Group (ERG) oversaw the project, and peer reviewed the emerging work. Additional peer review was provided by the researchers and clinicians who had developed the therapies contained in the framework. All this assured the fidelity of the framework in relation to the therapy it claimed to represent.

The same procedure is being used, with minor adaptations, to describe other therapy modalities (psychoanalytic/psychodynamic, systemic and humanistic-person centred/experiential).

Applying the methodology to the supervision competence framework

As far as possible, the development of the competence framework for supervision followed the principles described immediately above.

Figure 1 CBT competence framework



Identification of sources for competence descriptors

As already noted, the quality and depth of evidence for supervision is poor, in contrast to the evidence for therapy modalities. There are relatively few substantive findings, and many studies are suggestive rather than conclusive because of their relatively weak methodology. This means that there is no equivalent of an evidence-based therapy manual, in the sense of an outline of procedures whose efficacy has been tested in a research context. The many books and papers which describe how supervision and educational models should be implemented have an uncertain link to evidence for the positions they espouse. In the face of this, it makes sense to balance a demand for evidence against clear professional consensus, particularly where the consensus relates to common supervisory practice, and hence speaks to the way that the majority of supervisors are trained and are expected to act. On this basis, the framework is based both on best available evidence as well as those books and papers viewed as authoritative by professional groups. These sources were reviewed on the basis that:

- they contain a clear description of supervision techniques or process issues
- they are widely used by more than one professional group
- their authority as 'basic' texts is confirmed by members of the ERG

We also located relevant "consensus" statements from various professional bodies and academic groups which set out supervision competences, usually based on a mix of research evidence and professional consensus. Our main sources of evidence are identified in the reference list and Appendix 1.

Role of the Expert Reference Group (ERG)

Members of the ERG were selected to represent professional groups, professional training programmes and researchers into supervision (a list of members can be found in Appendix 2). In addition, there was representation from commissioners of training in the UK (through the IAPT programme) and Scotland (through NESS). The ERG met twice (on 24th January and 10th April 2008). The first meeting agreed the scope for the framework and potential sources of information on which it could draw. Between meetings the draft framework was circulated for peer-review, with further discussion at the second meeting focusing on finalising the framework and considering the ways in which it could be used to define a curriculum for training and to monitor the quality of supervision.

A guide to the map of supervisor competences

The map of supervisor competences retains a similar structure to that employed for the therapy modalities, with one small change. It does not contain a domain of 'basic' supervision competences because it became clear that this domain was not required. Most of what is 'basic' to supervision is best contained in the domain of 'generic' supervision competences. Consequently the map has four domains, as shown in Figure 2.

The map shows the sets of activities to which supervisors need to attend. The competences which constitute each area of activity are not published here, but are available to download from **www.ucl.ac.uk/CORE/.**

Generic supervision competences

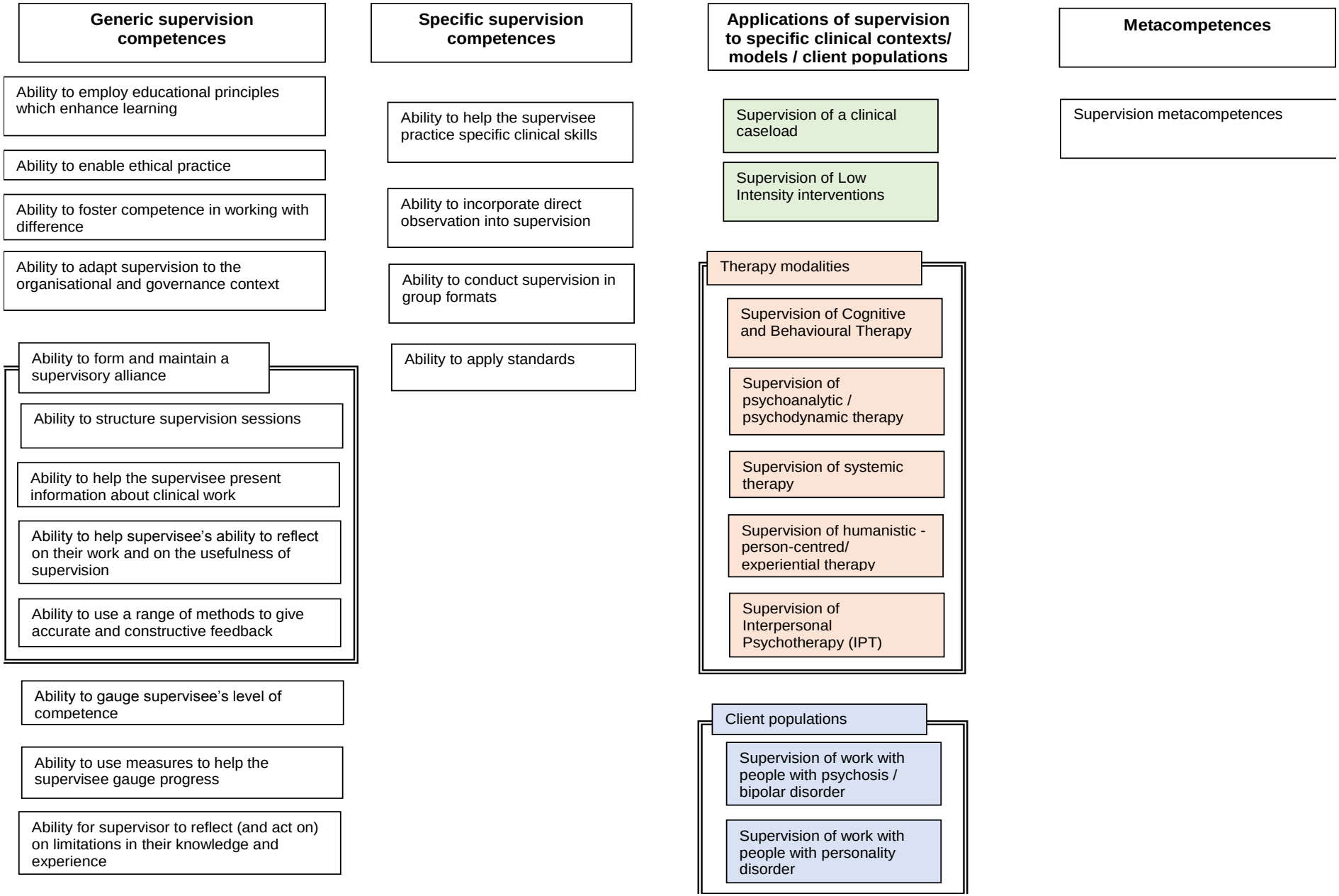
This domain includes the competences that underpin the supervision of all therapy modalities, whether this is configured (in IAPT terms) as a high or low intensity intervention.

The first area of activity is the **ability to employ educational principles** which enhance learning and which can be employed in supervision. This recognises that supervision is an educational process and that there is benefit to employing well-established principles which enhance learning.

The **ability to enable ethical practice** is also critical. Supervisors need to be able to ensure that supervisees are aware of a broad range of ethical principles and professional codes of conduct, and to ensure that these are embodied in their clinical practice. A distinct area of ethical practice is an understanding of the principles which underpin the management of confidentiality, both in relation to clinical practice but also in relation to supervision itself. Finally, ethical practice in the context of the supervision relationship itself requires some understanding of the risks inherent in 'dual role-relationships' (where the supervisor has or develops a relationship with the supervisee which could lead to a conflict of interests or to the risk of creating an abusive relationship).

One area of ethical and professional practice is the **ability to work with 'difference'**, a term which is used to indicate the broad spectrum of cultural and demographic variations in client populations around which discrimination and disadvantage can and does occur. "Difference" therefore includes ethnicity, cultural background, religion, gender, sexuality, social class, disability, and age. The main aim of considering issues of difference is maximise the efficacy of clinical practice for all clients. This is done by helping supervisees to see the potential relevance of difference and to integrate this thinking into their work. This includes – indeed often starts from - reflection on the assumptions introduced by the supervisor and supervisee's own experience of difference, whether this be from a 'majority' or a 'minority' cultural perspective. Issues of difference make themselves felt particularly strongly when client's language skills make it difficult

Figure 2 Supervision competences framework



to be understood, or to understand the therapist, and preparing supervisees to work with interpreters is an important skill.

The clinical setting will influence the way in which supervisees work, and also the way in which supervision is delivered. For this reason the process of supervision needs to be adapted to the **organisational and governance context** within which the supervisee is practising and within which supervision takes place.

Forming a good supervisory alliance is widely seen as crucial to the development of a good training relationship, and there is evidence that poor alliances can prejudice the effectiveness of supervision. For this reason, the factors which foster or hinder the development of an alliance are explicated clearly, as are the skills associated with recognising and remediating any threats to the working relationship between supervisor and supervisee.

Although the quality of the alliance will impact across all areas of supervision, there are four areas where this forms a particularly important context, as highlighted in the map. This is because each of these areas is dependent on the presence of a collaborative working relationship:

The **ability to structure supervision** involves establishing the professional framework for supervision, establishing and maintaining appropriate personal and professional boundaries and ensuring that there is a contract for supervision which covers both concrete issues (such as timing and duration) as well agreements about supervision content.

It is all too easy to assume that supervisees know how best to **present clinical information**. In fact this is an important skill in its own right, and it is important that supervisors can help supervisees to think about how to identify content that is relevant (and by implication, to identify that which is less pertinent), and also to consider how best to present this information.

The **ability to 'reflect'** and to undertake accurate self-appraisal is a critical part of adult learning. This implies a capacity both to be open to experience while it is happening, and to review – and hence learn - from experience after it has occurred. This is critical because reflection is one of the ways in which learners learn for themselves; without this skill they will find it hard to shift from a position of being dependent on others. Enhancing the supervisee's ability to reflect is therefore an important competence.

Giving accurate and constructive feedback is one of the more challenging aspects of supervision since it requires considerable skill to detect what should be focussed on and how the feedback should be delivered. Although supervisors can often detect aspects of the supervisee's behaviour that need improving, unless feedback is delivered in a positive way which can be utilised by the supervisee it will not be 'heard', and hence it will not be acted on.

The next area of activity relates to evaluation, perhaps best considered as two components. The first considers how supervisors can **gauge the supervisee's current level of competence**. This is far from straightforward, because doing this requires the supervisor to be aware of potential sources of bias in evaluation. Supervisors are more vulnerable to bias if their criteria for competence are poorly thought through, in which case they will be inherently unreliable. Usually they will need to appraise competence using a range of methods, partly because detecting progress in different areas of skills requires this, but also because this is a good way to 'triangulate' information.

The second area of evaluation is the **capacity to use objective "measures" to gauge progress** (defining 'measures' rather broadly as any systematic form of data collection). This requires the supervisor to have and to convey knowledge of measures and their interpretation, to help the supervisee administer them, and to make use of information from these measures within supervision. This is potentially complex – information about the case as a whole needs to be integrated with quantitative data and it would not be helpful to use indications that a client is not doing well to assume that this means that the supervisee is performing poorly. It is worth observing that supervisors probably make less use of objective measures than might be expected, despite the fact that these are one of the few ways of reliably gauging the supervisee's clinical impact.

The final generic competence relates to the **supervisors' capacity to to reflect (and act on) on limitations in their knowledge and experience.** All supervisors have limits to their expertise and competence; being able to acknowledge where these limits lie is an important aspect of good practice.

Specific supervision competences

The **ability to help the supervisee practice specific clinical skills** is critical, since this forms a direct bridge between theory and practice. Probably one of the most effective ways of doing this is for the supervisor to model skills, providing a behavioural demonstration for the supervisee. This can be done in the supervision session, and also in-vivo with clients; in both instances the expectation is that the supervisee is then given the opportunity to implement the skills themselves. In order to maximise learning, it is important that sessions are structured in a way which means that the supervisee is clear about the aims and the basis for the skills they are practising, can gain feedback on their performance, and will have time explicitly to reflect on this.

Direct observation of the supervisee is important, especially because there is good evidence that it is very difficult to gauge the accuracy of a supervisee's clinical work without doing this – reliance only on self-report is potentially misleading. Direct observation can be carried out using audio or videotapes, or by being present in the therapy room. Video has considerable advantages over audio recording, but is not available in many settings. Whichever form of taping is used, clients will need to give

fully informed consent for taping, and supervisees will need some preparation to support them in undertaking a task that many find quite stressful. Using tapes in supervision requires careful thought, since supervisors need to impose some structure on the process of listening or watching. In general, evidence suggests that tapes should be listened to in an active manner, stopping and starting the tape and asking supervisees to reflect on the reasons for their actions (a process which is formalised in techniques such as Interpersonal Process Recall). An alternative way of directly observing supervisees is to co-work with them. This can be done in many different ways – for example, the supervisor could act as an observer or the work could be shared (giving the supervisor an opportunity to model skills). The important point is that the supervisee needs to be clear about the plan, and that supervisors are clear about the conditions under which they will intervene during sessions, since there is a risk that they can inadvertently undermine the supervisee.

Conducting supervision in group formats is an important skill, since (used appropriately) it can be an efficient way of using supervisory resources and also helping supervisees to learn from each other. However, it does require supervisors to prepare and support group members by helping them to think about how to present casework, by managing and structuring the group and by being responsive to group dynamics (especially if these are such that learning is being inhibited

The **ability apply standards** is a critical though often demanding area of skill. It is a matter of observation that supervisors can find it hard to be appropriately critical or to fail supervisees, perhaps because the supportive nature of supervision can make it harder to make decisions which could be upsetting for supervisees. Nonetheless, this is a critical area, since the interests of clients are poorly served by failing to act on evidence of poor or incompetent practice. Broadly, there are two contexts in which supervisors set standards. With supervisees who are yet to qualify this role translates into ‘gate keeping’, or making decisions which relate to allowing the practitioner to qualify. This process is usually facilitated by courses, who act as external consultants to support what can often be a difficult process of decision-making. This support can be lacking when the supervisee is an autonomous practitioner whose practice is revealed by supervision to be deficient in some way. For this reason, systems of governance around supervision need to be clear and explicit, and specify how concerns about practice will be managed and communicated.

Applications of supervision to specific models or contexts

This section of the framework sets out competences for supervising therapeutic approaches, therapy modalities or work with specific client populations – specifically:

Supervision of a clinical caseload
Supervision of low-intensity interventions

Supervision of therapy modalities:
- Cognitive and behavioural therapy
- Psychoanalytic/ psychodynamic therapy
- Systemic therapy
- Humanistic –person-centred/ experiential therapy
- Interpersonal Psychotherapy

Supervision of client populations – work with:
- people with psychosis/ bipolar disorder
- people with personality disorder

Although it identifies the distinctive elements of supervision in each these areas, an important assumption is that all good-quality supervision rests on the set of competences described above, which form the context and the underpinning for the supervision of specific skills.

Supervision which focuses on the management of the supervisee's **overall caseload** is relevant both to low and to high intensity interventions delivered in the IAPT programme. Intentionally, this has a more managerial flavour than other areas of competence described in the framework, focussing as it does on arrangements for overviewing and tracking progress across the supervisee's complete caseload, and gauging the supervisee's capacity to manage their work.

The starting point for **supervision of low-intensity interventions,** specific **therapy modalities** or work with **specific client** is the supervisor's own experience of delivering these interventions. Supervisors need to have direct knowledge of the models they are applying and personal expertise in the therapeutic approaches they are supervising.

Supervision should begin by developing an understanding of the supervisee's learning needs – for example, establishing their prior knowledge about, and experience of, the models being applied, and any assumptions and preconceptions that they hold. Orienting supervisees to the model is more than an 'intellectual' exercise; there is clear benefit to giving supervisees direct personal experience of the methods being used. A major focus for supervision will be the application of the model to the individual case and achieving this will involve case conceptualisation and careful consideration of how best to apply the full range of competences. Learning how to implement specific skills is part of this, using a range of methods to help supervisees practice these skills in supervision and 'in-vivo'. Monitoring supervisee's progress in learning skills is critical, because it helps to indicate

what areas would benefit from more focus, and (if the supervisee is at a prequalification level) contributes to the overall evaluation of progress.

Metacompetences

Most of the **metacompetences** associated with supervision focus on the need to make appropriate adaptations in order to maximise the supervisee's ability to learn. A theme which characterises many of the competences in this domain is the need to apply professional judgment to complex issues, such as 'titrating' supervision to support the supervisee's educational development, and acting on concerns about the supervisee's practice.

Using the framework to develop a curriculum

The supervision competence framework can be directly adapted to form a curriculum for supervisor training. In effect it specifies the foundation skills which supervisors of all orientations need to use when undertaking supervision. Taken together, they provide a context in which skills relevant to a particular therapy modality can be developed. Separating foundation from more specific areas of supervisory activity makes sense, because it is based on evidence that attention to the broad context of supervision is likely to improve the capacity of the supervisee to learn. It also alerts supervisors to the fact that however proficient they are in focussing on the technical skills of therapy, this alone will not produce an effective learning environment.

What follows is intended to be indicative rather than prescriptive. It will be for training providers to consider how best to implement the learning outcomes suggested below.

Duration of training

The first consideration is how much time is available for training. It would be a challenge to cover all the learning outcomes face-to-face and in depth within the 5-6 days recommended in the IAPT specification. On this basis, courses would usually need to adopt a learning strategy that identifies those aspects of the curriculum which benefit from face-to-face contact, and those aspects which can be covered through self-guided learning, using the same adult learning model on which the supervision framework itself is predicated. A second observation is also pertinent. Many of the competences described in the framework can be thought of in the abstract, but actually only make sense as competences when put into action. An example is the capacity to build and maintain a good supervisory alliance. Supervisors need to know about the principles to which they should be alert, but putting the principles into practice is probably more challenging. However, this does not require a session dedicated to building the alliance, since once sensitised cross-reference can be made to the alliance when focussing on other competences (for example, while helping supervisors to think about how best to give feedback). Following this through, the implication is that some creative thinking will result in a curriculum that melds different areas of supervisory activity and competence in away which results in an efficient, but still comprehensive, programme.

Scheduling of training sessions
The assumption behind the framework is that supervisees learn by having the opportunity to put theory into practice and the same goes for supervisors. Training needs to be scheduled in a way which gives supervisors some ideas, challenges and "food for thought", allows them to try these ideas out, and gives them the chance to reflect on their experience and to build on this. This implies that while programmes may choose to 'front-end' the training (with an initial more intensive block), it is critical to ensure that this is followed-up with a planned sequence of a workshops which aim to embed and enhance the learning which takes place as supervisors gain experience in the workplace.

Format for delivery of training
Courses will be comprised of workshops combined with self-directed learning. The content of workshops needs to include a mix of learning formats, and as such is likely to include didactic presentations, video presentations, role play and discussion, along with 'practice assignments' aimed at helping supervisors undertake active learning between workshops. To support self-directed learning workshops should be supported by an appropriate range of e-learning materials.

It is important to remember that the teaching formats adopted by a programme need to be those which suit the topic under discussion and this means that a variety of methods will be the norm. It is also helpful to orient these formats, so that they mirror the educational principles identified in the framework, especially those which suggest that learning is more likely to take place if clear connections are made with prior learning and experience, and if the learner can be helped to recognise where their practice would benefit from a change of perspective or approach.

An outline curriculum

The learning outcomes below attempt to summarise the competences identified in the framework. These are divided into three parts, which reflect the flowing domains:

- Part A - Fundamentals of supervision: Generic Supervision Competences
- Part B - Fundamentals of supervision: Specific Supervision Competences
- Part C - Specific applications of supervision

This leaves one significant domain unspecified – that of metacompetences. This is because these metacompetences come into being through practice; they are not 'taught' as such, but are realised through action and reflection – for example, when thinking for oneself about how supervision is progressing, or when having the opportunity to discuss supervision with others (which includes thinking about feedback from the supervisee).). As such, they inform the whole delivery of competences at every level of the course.

Taking account of prior experience

For some supervisors, much of the framework will be familiar but others will have little background in training, and may not be aware of the many issues to which they need to be alert, and which can make the difference between effective and ineffective supervision. It is partly with this in mind that the curriculum outline is in three parts. Novice supervisors would benefit from a comprehensive package of training in all areas of the curriculum. In contrast, supervisors with background experience might only need a brief "refresher" workshop to cover Parts A and/or B, leaving the main focus of training on Part C.

Part A: Fundamentals of supervision
Generic supervision skills

Learning outcomes

1. Knowledge of educational principles which influence learning and skill development

- Knowledge of educational principles which can be applied in supervision

2. Ethical and professional practice

- Knowledge of the context within which supervision is provided (including relevant professional, ethical and legal frameworks)
- Understanding of the ways in which professional and ethical issues are represented in supervision (e.g. managing boundaries, confidentiality, managing power differentials)
- Understanding of issues of difference and diversity in supervision and how these relate both to supervision itself and to the discussion of casework

3. Competence in working with difference

- Knowledge and skills to help supervisees identify the relevance of difference to their practice, and to integrate this thinking into their work

4. Ability to take into account the organisational context for supervision

- Ability to adapt the supervision to the organisational setting in which the supervisee works

4. Developing and maintaining a working partnership

- Understanding of the importance of a safe environment for facilitating learning and of the factors that affect the development and maintenance of a good supervisory relationship
- Skills and experience in developing and maintaining a supervisory alliance

5a Structuring supervision

- Knowledge and skills in establishing a professional framework for supervision and in contracting and negotiating boundaries

5b Ability to help supervisee present clinical information

- Knowledge and skills in helping supervisees identify relevant content and to present clinical material

5c Ability to help supervisee reflect on their work

- Knowledge of techniques and processes to evaluate supervision, including eliciting feedback

5d Ability to give accurate and constructive feedback

- Knowledge of the principles which relate to giving effective feedback
- Skills in giving constructive but accurate feedback
- Skills in using a range of methods to gain information and give feedback (e.g. self report, audio and video tapes, colleague and client reports)

6a) Assessing supervisee competence

- Knowledge of potential sources of bias in evaluation
- Knowledge and skills in specifying and applying criteria for gauging competence
- Knowledge of relevant criteria/ standards set by professional bodies, including assessment procedures relevant to different levels of qualification

6b) Using objective measures to gauge progress

- Knowledge and skills relevant to supporting the administration and interpretation of objective measures
- Knowledge and skills to integrate feedback from objective measures into supervision

7. Ability for the supervisor to reflect

- Awareness of any limitations in their own training and experience, in the development of supervisory skills and the implications of these for further training

Part B - Specific supervision skills

1. Ability to help the supervisee practice skills

- Knowledge and skills to help the supervisee practice specific clinical skills within supervision

2. Using direct observation

- Knowledge and skills to make effective use of audio/video recordings, and to use in-session direct observation

3. Conducting supervision in group formats

- Knowledge and skills to structure group supervision and to manage group process appropriately

4. Applying standards

- Knowledge of procedures relevant to the assessment of poor performance and failure, and skills in implementing these

Part C: Supervising in specific modalities (Caseload management, low and high intensity CBT)

1. Caseload management supervision

- Knowledge and skills to help supervisees manage caseload and deliver interventions efficiently

2. Supervision of "low-intensity" interventions

- Knowledge and skills to identify supervisee's CBT training needs
- Knowledge and skills to support the supervisee assess suitability for low intensity interventions
- Knowledge and skills to support the supervisee deliver low intensity interventions
- Knowledge and skills to support routine outcome monitoring

3. Supervision of specific modalities and contexts

- Knowledge and skills to identify supervisee's training needs
- Knowledge and skills to structure supervision sessions
- Knowledge and skills to structure supervision and identify specific content areas relevant to the modality or context
- Knowledge and skills to support routine outcome monitoring

Audit of outcomes

Audit of outcomes falls into two areas:

- audit of the courses themselves
- audit of the performance of supervisors who attend courses

In both areas, simplicity is probably a virtue, aiming to capture broad quality indicators. This caution applies especially strongly when it comes to monitoring the performance of supervisors, since seeking detailed and specific indicators assumes that we can identify relevant markers of quality, and that we can assess them reliably. At this stage of development, this is probably an unrealistic ambition.

Audit of courses

a) Courses should be able to show how they meet the relevant learning objectives, usually by mapping these objectives to their workshop programme.

b) The content of the workshop programme should be tailored to the time available, with explicit planning which indicates which areas of the curriculum which will be covered in

workshops, which areas will be covered by 'practice-assignments, and how outcomes from these assignments will be integrated into subsequent workshops.
c) Courses should include an appropriate range of training methods and be able to show how this is linked to the objectives of the teaching. Usually the range of methods would include:

- didactic teaching
- modelling and video demonstration
- opportunities for role play and for direct observation
- opportunities for discussion and reflection
- practice assignments

d) Courses should have documentation available for participants which:

- outlines the aims and content of the workshop programme, and includes relevant learning resources (including access arrangements for e-learning materials)
- gives clear guidance about resources for (and expectations of) the learning which is expected to take place between workshops

e) Courses should elicit feedback from participants on the quality of each workshop, and on the course as a whole, and have in place appropriate systems for responding to this feedback.

Gauging the supervisor's skills
The level at which standards are set will vary with factors such as the supervisor's level of experience and training and to some extent the setting and context for supervision. However, although there is no single benchmark which can be used to gauge a supervisor's capacities, it is reasonable to expect that supervisors meet basic criteria for competence.

There is also no single reliable source of information on which to base judgments and using information from more than one source is a good principle. This also applies to comment from the supervisee, whose feedback (while very pertinent) is vulnerable to the same evaluation biases to which supervisors themselves are prone, reflecting the interpersonal aspects of supervision as much as the efficacy of the learning experience. This means that negative feedback sometimes reflects personal more than professional issues, and making it important to have evaluations from more than one supervisee

1) Written feedback from the supervisee: It would usually be helpful to structure feedback in line with the areas identified in the competence framework. This could include feedback on:

a) Setting learning objectives and establishing a context for supervision e.g.

- Arrangements for induction
- Negotiation of a placement contract
- Identification of learning needs

b) Quality of supervision e.g:

- Degree to which supervision was collaborative
- Availability and approachability of the supervisor
- Balance between support and autonomy
- Theory/practice links
- Appropriate clinical advice
- Appropriate methods of teaching
- Use of observational techniques (e.g. modelling, audio/ video taping)
- Style of feedback (e.g. constructive/destructive; concrete/abstract; specific/global)

c) Personal and professional development, e.g.:

- Opportunities for reflection
- Recognition of any personal issues which impacted on the work

d) Opportunities for professional development

2) Direct observation of supervisors: In addition to feedback from the supervisee, it would be good practice for supervisors to be directly observed undertaking supervision (for example, by taping a supervision session) either by a peer or by an appropriate clinical manager who has responsibility for the governance of supervision.

As identified in the supervision framework, direct observation is a more effective way of capturing the quality of a person's work than relying on indirect report. This applies as much to the work of the supervisor as it does to appraisal of the supervisee. However, two observations are pertinent:

a) Direct observation is potentially stressful, especially if the supervisor is aware of any concerns about their performance. On this basis observation will make a more helpful contribution to maintaining quality if the emphasis is on supporting the professional development of the supervisor rather than being an exercise whose sole focus is evaluation.

b) As observed in the competence framework itself, making reliable assessments of complex behaviour is best done by making trying to be as specific as possible, and by trying to articulate the criteria for making any judgments. By way of example, giving feedback to a supervisee is a fairly central supervisory activity. Judging how well this is done is much easier if observations are anchored to the competences set out in the framework. This would give a sense of the sorts of behaviours seen as competent, and hence improve the reliability of any assessment.

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Appendix 2
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