The British Psychological Society

Division of Clinical Psychology

Policy Guidelines on Supervision in the practice of Clinical Psychology

February 2003
Introduction

This guidance and policy has been written to assist DCP members in their understanding of supervision, the general context in which it takes place, what is involved in supervision, its relationship to CPD, who needs it and how often.

Context

The current practice of clinical psychology is subject to a variety of demands. These include the requirements of clinical governance and lifelong learning, the likelihood of statutory registration, the impact of the National Service Frameworks — all having implications for the supervision of qualified clinical psychologists — and the continuing need to supervise trainees. One way in which these demands are satisfied, at least in part, is by the use of supervision. The DCP has long held that time and space to allow for reflection, discussion and feedback on all elements of practice is a valuable way of enhancing practice and improving service quality, whilst being uncertain about the detailed nature of what such supervision and its parameters might be. The demands noted above make it timely to re-state and strengthen our current policy and guidance.

In doing this, the DCP is aware of the many competing pressures on practitioners and that the ability to find time is increasingly difficult. The DCP has no desire to make professional practice more difficult than it already is. This statement of policy and guidance is designed to be facilitative and constructive for both clinical psychologists and their employers. There will be benefits to both in following this policy. Employers will be able to fulfil elements of their clinical governance agenda and also be confident that psychology practitioners are in a position where they can review and monitor their own practice in a non-threatening and collaborative context. For the clinical psychologist, this document will set out a framework to help them make decisions about how best to monitor and improve practice.

Statement of Policy

It is expected that all clinical psychologists, at all stages of their career and in all work contexts, will engage in regular supervision of their own work.

Such supervision is regarded as a core clinical activity to ensure the delivery of effective and high quality services.

All aspects of a clinical psychologist’s work — clinical, research, educational, managerial — should be supervised, although the exact nature of the supervision will vary from individual to individual and over different work contexts. There is no one model or style of supervision that will apply to all clinical psychologists in all settings and at all times in their career.

The DCP regards it as essential that supervision continues throughout a clinical psychologist’s career.

As much as it is regarded as essential to be supervised, it is similarly expected that clinical psychologists provide supervision, particularly to trainees and newer members of the profession. This activity should be regarded as a core part of all clinical psychologists’ work and will require its own training and development.

All supervision should be needs led.

The minimum standard is 60–90 minutes for every 20 sessions worked.

The Supervisor must be a Chartered Clinical Psychologist.
Guidance on the tasks of supervision

Guidelines on achieving the objectives for lifelong supervision can draw advantageously on the parallel but more sophisticated literature on training. The tasks that the supervisor faces are to conduct an assessment of needs, to implement the appropriate supervision and to evaluate its effectiveness.

**Needs Assessment**

This initial task entails that the supervisor clarifies with the supervisee the needs of those with an interest in the supervision. Typically, this will include recognition of the expectations of the employer and the profession alongside those of the two parties directly involved. As a result, a supervision contract should be agreed which takes such legitimate interests into account. This setting of a contract can be undertaken informally, through the joint setting of learning objectives and an agenda for the meeting. All supervision contracts should take account of the various contexts within which clinical psychologists practice (e.g., Primary Care or Day Hospital) and be reviewed and updated regularly.

**Implementation**

Having determined the learning needs and put these into operation in the form of objectives, the next task in supervision is to facilitate learning. It is useful for the ‘needs’ assessment to indicate some learner preferences (‘learning styles’; Kolb 1984). A wide range of learning methods are available. These include ‘symbolic’ approaches, such as case presentation and discussion; ‘iconic’ ones, principally demonstrating how to execute a skill; and ‘enactive’ methods, such as role-play. However, it is important to ensure that, whichever methods one uses, the supervisee is achieving the agreed outcomes.

In general, these will tend to be some combination of:

- **Reflection** – an opportunity for careful and detailed consideration of some aspect of recent work from the supervisee perspective;
- **Conceptualisation** – when the supervisor assists the supervisee to relate his or her reflections to the perspective of others (including that of the supervisor) and to relevant theories and research;
- **Planning** – agreeing the action implications;
- **Experiencing** – carrying out actions and being aware of the accompanying affect.

Such a functional approach carries the advantage of allowing appropriate supervision methods to be deployed flexibly so as to achieve content-free outcomes, ones that are relevant to psychologists throughout their careers.

**Evaluation**

Of all the supervisory tasks, this one seems to be least embraced by psychologists, perhaps because the ‘cult of the positive’ (Brown & Marzillier, 1993) is so strong. As a result, there can be significant discrepancies between supervisor’s and supervisee’s perceptions of the outcomes of supervision. For instance, the supervisor may tend to feel that a session has only gone well only if a specific technique or two is used, whereas the supervisee will tend to value the relationship qualities (e.g., simply being listened to actively; Hirons & Vellerman, 1993). The tasks during evaluation are to provide formative and sometimes summative feedback to the supervisee.

Formative evaluation provides encouragement and corrective information.

Summative evaluation concerns the provision of information on the extent to which standards are achieved, which is most likely to arise as part of the pre-qualification supervision (e.g., whether or not a competence was demonstrated satisfactorily).
Supervision fulfils similar functions to the sterilising and resharpening of surgical instruments. Clinical psychologists need it in order to maintain and improve the quality of care and service delivery. Supervision also bestows personal benefits. It may serve to teach, develop, support and allow for catharsis. It provides space and time for reflection, conceptualisation, planning and experiencing. Regular supervision is, therefore, an essential activity that all clinical psychologists need to integrate into their clinical practice throughout the whole of their careers.

It is implicit in the concept of Continuing Professional Development, as part of Clinical Governance, that all healthcare professionals seek to maintain and improve the standards of all aspects of their work and services. CPD does not just mean updating and additional training. Supervision and reflective practice are key activities in CPD too. Both supervision and CPD are mandatory activities for members of The British Psychological Society and will be statutory as part of the enactment of professional regulation.

The minimum standard is 60–90 minutes for every 20 sessions worked. Newly qualified clinical psychologists will require more than this. This must be needs-led and appropriate to the level of experience, caseload and managerial responsibility. Many clinical psychologists will require more than one type of supervision from one or more supervisors.

Finding time — It is not wise to be too prescriptive about an activity that is needs-led. However, clinical psychologists must ensure that they negotiate sufficient and regular time to fulfil their needs.

Recognition — It needs to be recognised by other professions and managers that giving and receiving supervision are essential core clinical functions for the practice of clinical psychology. The profession may need to think of another term to refer to this, as other healthcare professionals use 'supervision' and 'clinical supervision' to mean differing activities.

Training — Clinical Psychologists need to be formally and systematically trained in models and techniques of supervision so that they can consider the need for periodic updating and development of their supervision skills.

Evaluation — Supervision follows the clinical model of assessment, formulation, intervention and evaluation. There needs to be clear, honest and constructive feedback dialogue between supervisor and supervisee on what are perceived to be the achievements of each supervision session.

References

