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Improving Access to Psychological Therapies

NHS

IAPT Supervision Guidance

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Executive Summary:

Clinical Supervision Principles and Guidance

Purpose

Supervision is a key activity, which will determine the success of the IAPT programme. We are in the process of supporting the commissioning of training for all IAPT supervisors throughout the SHA regions based on a supervision framework specifically developed for IAPT (http://www.ucl.ac.uk/clinical-psychology/CORE/competence_frameworks.htm).

We recognise that as most services and training courses are now being implemented, a summary of principles of IAPT supervision is required for Clinical and Course Directors. Hence, the summary of principles and is reproduced here. It should be stressed that the standards identified are the minimum requirements and individual services may wish to organise additional supervision and support for staff.

The full version of this document provides the rationale upon which this guidance is based and provides further advice around supervision, which will detail the different forms of supervision expected within an IAPT service and the importance of issues such cultural sensitivity and how supervision can be tailored to meet the needs of clients, supervisees and the service.

Principles of supervision for an IAPT service

This guidance applies equally to all staff employed and working therapeutically within an IAPT service including **both** IAPT trainees and qualified staff, and those delivering **high and low** intensity interventions. Supervision for all these staff should entail:

Amount of supervision for qualified staff and trainees:

- Be provided **weekly** on a regular basis and consist of a **minimum of one hour of individual supervision** with an experienced and trained supervisor, and located within the IAPT service.

- In some circumstances, group supervision will be appropriate but will require sessions of a **longer duration** to be effective.

- Supervision should address the review of **all ongoing clinical cases, and routinely be informed by an individual client's IAPT outcome** measures. For Psychological Wellbeing Practitioners (PWP), this will consist of **case management** supervision, as well as clinical skills supervision aimed at individual case discussion and skills development[1].

- The discussion of individual clinical cases during supervision should be **prioritised** according to **clients' needs** and a pre-determined schedule. **All** cases should have been regularly reviewed within a reasonable period of time (2-4 weeks).

[1] BABCP requires 25 hours of clinical case management and 25 hours of clinical skills supervision for accreditation as an individual PWP.

Additional supervision for trainees:

- High Intensity IAPT **trainees** should ***also*** receive during their two-day attendance on the course, additional in depth supervision of training cases, usually in groups of two to three trainees, and lasting for around 1.5 hours per week.

- PWP trainees should ***also*** receive, in addition, to case management supervision, both individual and group supervision aimed at case discussion and skills development. This should normally be around 1 hour per fortnight.

Supervisors:

- Supervisors should have a working knowledge and experience of the specific interventions for which they are providing supervision. Where there are gaps in experience (e.g. low intensity working), these might be addressed by supervisor training and familiarisation with specific services.

- IAPT eligibility criteria exist for all supervisors within IAPT services and all supervisors should have accessed IAPT supervisor training or specific training for supervisors of IAPT approved CPD psychological therapy courses (CfD, CofD, DIT or IPT). Individual supervisors will need to meet specific requirements depending whether they are supervising PWP trainees, CBT trainees or trainees on IAPT CPD therapy training courses. These are documented on the IAPT website or those professional bodies supporting these IAPT trainings. (www.iapt.nhs.uk/workforce/iapt-education-training-and-development/)

- Supervision of trainees will be shared between supervisors who might be university-based and provide specific input into training cases, and supervisors providing routine clinical supervision within the service. Clinical directors and course directors should ensure that appropriate governance arrangements exist for all supervision provided and where appropriate university-base supervisors have honorary contracts etc.

- SHAs are commissioning short training courses (around 5 days) for supervisors within IAPT services. Commissioning guidance for SHAs is available and has been recently updated (http://www.iapt.nhs.uk/silo/files/guidance-for-commissioning-iapt-training-201112-201415.pdf). It is expected that **most** IAPT supervisors will eventually be trained in the specifics of supervising within an IAPT service by attending one of these courses. Courses should address IAPT requirements for supervision of both high intensity practitioners, together with case management *and* clinical skills supervision for the PWPs. Supervisors with existing accredited training in supervision may not need to attend the entire programme but might benefit from familiarisation with IAPT services and supervision principles.

Other considerations:

- PWPs should have access to an experienced supervisor to consult on assessment and risk issues. Clinical decisions to either step up treatment to high intensity, discharge or refer on to specialist services will need to be discussed within regular weekly case management supervision.

- Where it has been decided that an individual has to be stepped up to a high intensity therapist, and may have to placed on a waiting list, there should be a clear agreement as to whether the PWP involved offers any clinical follow up or holding provision, and how this will be supervised.

- Services should consider how they support their supervisors and ensure that they have sufficient time and adjusted caseloads to allow them to provide quality supervision. They should also have access to peer/group support and continuing professional development.

- All staff will also have access to professional and managerial supervision, as appropriate to their role, which will be in addition to the clinical supervision arrangements detailed above. Services should ensure that there is clarity about when these different supervision activities take place and with whom, especially for trainees who may have a range of different supervisors (managerial, clinical service and from the training course) and clear governance arrangements should be in place.

- It should also be stressed that the number of hours of supervision identified within this document are the **minimum recommended** for full-time staff. Flexibility should be adopted for staff on part-time contracts or with reduced caseloads arising from other non-clinical responsibilities.

- A named senior therapist should be responsible for overseeing and monitoring the effectiveness of supervision provided within the IAPT service, in conjunction with the Clinical Director and Course Directors concerned.

Supervision: the key to successful patient outcomes by delivering IAPT interventions of proven high quality and fidelity.

1. Introduction

The purpose of this paper is to provide commissioners and providers of services and training with an overview and a more in depth understanding of what is required to organise, train and promote quality supervision in order to deliver IAPT services.

The intention in circulating this paper now is to provide guidance and support to SHA's and PCTs as they consider how supervision should be organised within IAPT services, the provision of supervisor training via SHA commissioning, and the interface between services and training courses with respect to supervision and management of trainees. It should be stressed that the standards identified are the **minimum** requirements and individual services may wish to organise additional supervision and support for staff.

The advice provided in this document should be read ***specifically*** in conjunction with the earlier short IAPT Workforce Briefing on "Principles of Supervision" (http://iapt.nhs.uk/silo/files/improving-access-to-psychological-therapies-iapt-supervision-guidance.pdf) together with the publication of "A Competence Framework for the Supervision of Psychological Therapies" by Roth and Pilling (2008), which describes the supervision competences and training required to underpin the delivery of IAPT services (http://www.ucl.ac.uk/clinical-psychology/CORE/competence_frameworks.htm) For PWP case management supervision. This document also needs to be read in conjunction with the IAPT Reach Out Manual for PWP Supervisors (http://iapt.nhs.uk/silo/files/reach-out-supervisors-manual-2nd-edition.pdf)

2. Background

Both the National Implementation Plan and the Commissioning Toolkit have stressed the importance of providing high quality supervision to therapists delivering both low and high intensity interventions. However, the provision of supervision is widespread within psychological therapy services, and supervisors and supervisees may have a different understanding of what is required and the function that supervision holds for a particular service. We seek to position the importance of supervision as it relates to the delivery of IAPT services.

3. What is supervision?

Supervision is a term commonly used across health and social services and may describe quite *different* activities ranging from personal development through to management, through to case and clinical supervision. It can be performed individually or in groups, it can be formal or informal, it can focus on processes or outcomes, and involve peers, trainees or senior line-management staff. It is essential that services understand the different functions and types of supervision available.

The emphasis of this guidance is on *clinical supervision* for high intensity therapists and *case management supervision* for PWPs.

Clinical supervision *is a formal relationship in which there is a contractual agreement that the therapist will present their work with clients in an open and honest way that enables the supervisor to have insight into the way in which the work is being conducted. The purposes of supervision are to ensure safe practice for clients, to optimise client outcomes and to promote greater insight and the development of therapeutic skills for the supervisee.*

Case management supervision *is the regular review of the caseloads of practitioners providing low intensity interventions within IAPT stepped care services. It is undertaken at regular (usually weekly), timetabled intervals and is informed by automated IT-based case management systems. A large number of cases will usually be discussed in any one supervision session. Discussions in case management supervision always include supervisee presentations of patients at pre-determined stages in their care pathway and/ or who have particular clinical characteristics. It is structured to enable efficient support and shared decision making by PWPs and their supervisors.*

Clinical Skills Supervision for PWPs *should be focused on the development and maintenance of competence in low intensity clinical methods of behavioural activation, exposure, cognitive restructuring, panic management, sleep hygiene, medication management, guided self help materials and the use of the telephone to support low intensity working. Supervision should be delivered in groups of no more than 12 for shared learning, or have flexibility to be delivered on an individual or smaller group basis according to the need supervisee and any gaps in knowledge that may have been identified in case management supervision or as requested by the PWP. Clinical skills supervisors for PWPs should be aware of the need to manage supervision to avoid drift from specific evidence based low intensity CBT methods into "CBT-lite" or high intensity CBT working.*

Ultimately the purpose of all forms of supervision should be to safeguard the wellbeing of the client and assist the development of the supervisee. There are several aspects of effective use of supervision, which are commonly emphasized and these include: the working alliance between supervisor and supervisee, the quality of this relationship, and the fostering of an atmosphere of trust and openness. Further information on supervision, including common definitions, additional reading and resources are available within an annex to this document.

4. Why is supervision particularly important to the IAPT Programme?

We have stressed already that the first priority of supervision is to enhance and safeguard the delivery of effective therapy for the client. However, in the context of the IAPT programme, supervision has a critical role for the implementation of quality psychological therapies services and optimising outcomes for clients.

Fidelity to the evidence base

Therapists in the IAPT programme need to be able to carry out the same interventions and to the same level of competence, as therapists in controlled trials (which demonstrate the

efficacy of these approaches, and hence forms the basis for NICE guidelines). These trials usually select therapists carefully, provide additional training and offer close supervision of individual cases (Roth et al., submitted).

Although the research evidence to support the added value of supervision to better client outcomes is modest and only in its infancy (see Roth & Pilling, 2008; Milne & James, 2000; Wheeler & Richards, 2007), there is an emerging literature particularly within the US about the impact of routine outcomes monitoring and feedback on obtaining effective clinical outcomes (e.g. Miller, Duncan, Brown, Sorrel & Chalk, 2007; Wampold & Brown, 2005; Worthern & Lambert, 2007). This maybe equally important for both therapists in training and for qualified staff. For example, Mannix et al. (2006) have shown that ongoing supervision is critical for continuing skills and competency development in trainees.

Moreover, within IAPT services clinical supervision should be tailored to the needs of the client and focused on the individual clinical outcomes that must be assessed routinely within any IAPT service. We have already emphasised that a key feature of IAPT services is that supervision should be regular, at least one hour weekly. It should include all clients within the caseload over a 2-4 week period, discussed in priority of clinical need. It should be focused around measured outcomes, and provided by an appropriately experienced and trained supervisor.

Effective case management and collaborative care

The above arguments about the importance of supervision do not just apply to high intensity therapies, as represented in the NICE guidelines, but also to Stepped and Collaborative care as delivered particularly within the Doncaster demonstration site. Here, case managers received regular supervision of their caseload, each client being reviewed at least once every 4 weeks, and outcomes and decisions to step up or down were also subject to review. This process is necessary to ensure that clients are not overlooked in a high volume/high caseload system and relies heavily on an automated IT-based case management system. Within collaborative care, supervision has been demonstrated to impact positively on clinical outcomes. For example, Bower et al, (2006) found in a systematic review that the effectiveness of collaborative care could be optimised by the employment of case managers who had received a specific mental health training *and* who also received regular expert supervision.

Dealing with individual cases and ensuring safe practice for clients

Many therapists receive individual clinical supervision where cases that are seen as challenging, “stuck’ or risky etc may be discussed in detail with a colleague or more experienced/senior member of staff. Although it is important to focus on therapeutic cases that maybe more challenging for the supervisee, it is also important to ensure that all cases within IAPT services are subject to scrutiny and advice by the supervisor. Some clients may appear straightforward but it is always possible to miss something that supervision might appropriately address. One approach is to ensure that every client’s psychological formulation is reviewed and discussed within supervision. Supervision should also address issues of client confidentiality.

Supervision may be individual or in groups. When group supervision is employed, supervisees will require longer periods of supervision (e.g. 60 to 90 minutes) than the

recommended minimum of one hour per week. The individual progress of the client, together with personal development of the supervisee in relation to their clinical work, are frequently the overall aims of clinical supervision, and are **equally** important for both trainees and qualified staff.

Such supervision is important for risk management and governance, especially when less experienced staff such as PWPs or graduate mental health workers are dealing with specific risk areas (e.g. medication or self-harm issues) and will require regular supervision from more experienced mental health staff or GPs. Even for PWPs, it is essential that all clients be discussed in supervision at some point during the course of therapy.

Within this context, it is important in order to ensure client safety that all cases are regularly reviewed and not just those that a therapist or supervisor selects for discussion. Ladany (2004) has reported the failure of some therapists to disclose ongoing difficulties within their clinical work in supervision, which might reflect poorly on their own competence and performance as therapists. Outcomes tracking where the focus of supervision is on clients' progress – both positive and negative – may also ameliorate the effects of a supervisee being reluctant to disclose ongoing difficulties with particular clients.

Supervisors have a prime responsibility to ensure that all client work is undertaken with reference to the ethical policies, procedures and guidance that are published for the service in which therapy is being delivered. They must be familiar with specific ethical guidance that might relate to vulnerable client groups such as children and young people, people with disabilities or vulnerable adults.

Skills development and training

A common model of psychotherapy training within the workplace is for trainees to be on placement within a clinical service and for there to be a named supervisor who is responsible for their clinical work. The supervisor should be available to discuss progress of cases and facilitate skills development either through case review, feeding back on audio/video tapes, being present in situ for therapy sessions/ joint sessions and even formal involvement in the assessment of the trainee's competencies. When required, supervisors should provide advice on provisional diagnoses aligned to ICD-10 codes.

It is a requirement of IAPT training courses, that supervision is integral to both low and high intensity training courses. For high intensity courses this will *supplement* workplace supervision by providing intensive weekly supervision of selected cases by course staff and highly experienced supervisors during teaching days. The use of tape recorded sessions, with the client's permission, together with standardised measures of clinical competence (i.e. Cognitive Therapy Rating Scale; Blackburn et al., 2001) will also characterise IAPT supervision. It is important that training courses and services have a clear understanding as to the relationship between these different types of supervision and that appropriate clinical governance arrangements are in place.

Staff support and the prevention of burn out

The availability of supervision has been shown to prevent burnt out and to ameliorate the negative impacts of therapeutic work (e.g. secondary or vicarious traumatisation) on the health and well-being of therapeutic staff, as well as providing positive effects on staff

wellbeing and performance within organisations (see Sabin-Farrell & Turpin, 2003). This maybe particularly relevant for staff with high caseloads offering low intensity interventions.

Supervision may also enhance patient safety by addressing personal issues of the supervised therapist who themselves may be experiencing psychological distress, an inability to cope with particular situations or challenging organisations which may be addressed within supervision (Wheeler, 2007). Ultimately the supervisor should ensure that the supervisee is fit to practise and to take appropriate action if this is not the case. If the therapist is unfit to practise it is the supervisor's responsibility to take steps either ensure that the therapist improves practice or that he/she ceases to practise until such improvements can be made. A briefing on Accountability and Responsibility in multi disciplinary teams has been published in March 2010, as part of the Mental Health New Ways of Working programme (www.csl.nhs.uk/Publications/.../Responsibility%20and%20Accountability.pdf); this addresses the importance of supervision more generally. More focused guidance on accountability within IAPT services, especially for workers without professional registration, is also about to be published on the iapt website.

5. Frequently Asked Questions:

What supervision competences are required for an IAPT service?

The IAPT Workforce Team commissioned Roth and Pilling to scope supervision competences using a similar approach to the CBT Competences Framework (Roth and Pilling, 2007). This has resulted in a set of generic supervision competences, together with more specific competences applicable to particular therapeutic approaches or service contexts such as low intensity, high volume interventions. These have been published on the CORE website (www.ucl.ac.uk/CORE/), together with an overview of the Supervision Competences Framework (SCF), a suggested curriculum and approach to supervisor training, and information on supervision written for service users (http://www.iapt.nhs.uk/2008/02/24/supervision-comptences-framework/).
Specific supervision competences have been identified for all the high intensity interventions (e.g. CBT and the other four IAPT approved therapies) and low intensity IAPT interventions and are available on the CORE website (http://www.ucl.ac.uk/clinical-psychology/CORE/supervision_framework.htm).

What supervisor training is available to IAPT staff?

All SHAs have been asked to commission supervisor training courses to support IAPT services and to address the suggested curricula identified within the SCF described above. Around a half of SHAs currently have plans in place for such training in order to support the first year's roll out. It is likely that these courses will be between five days in duration and be supplied by the IAPT training courses and other appropriate providers within your locality. Courses should address generic, as well as specific therapy competences, and be applicable to both low and high intensity interventions. Courses should also appropriately audit and assess the supervision competences taught. Ideally, all IAPT supervisors should attend a local training course during the first year of implementation of the local programme. For very experienced supervisors who have had previous and substantial accredited supervisor training, courses may consider using APL/APEL procedures.

Who has the competences in supervision and who is best placed to supervise?

It is assumed that experienced therapists already in post or newly recruited to services will have the skills to supervise. The principle is that the supervisors should be trained practitioners ***in the therapy*** that they are supervising. Such supervisors might be drawn from a range of professions and include nurse therapists, counsellors, psychologists, psychotherapists, etc. When IAPT services offer a greater choice of NICE recommended evidence base therapies in addition to CBT, it will be important that some supervisors are familiar and trained in these therapies.

It is also likely that some differentiation will evolve for those supervising low and high intensity practitioners. All supervisors should have experience in supervising psychological therapists/trainees and have recently attended courses in supervisor training or be booked on a forthcoming IAPT Supervisor Training Course.

Eligibility criteria for all types of IAPT supervisors have been agreed with relevant professional bodies and are available on the IAPT website.

Currently, there are no reliable tools for assessing the competences of supervisors. Claimed competence within therapy may not be related to objective competence as measured independently from therapy tapes (e.g. Brossan et al., 2007, 2008). The Supervision Competence Framework may help in the development of rating scales that could be applied to taped supervision sessions in order to assess supervisors' competence.

Until these competences can be assessed, it is important to ensure that the requirement to provide supervision is specified in IAPT person and job specifications. The capacity to provide supervision is a key factor within the Knowledge and Skills Framework and should, therefore, have a significant effect on the Banding of IAPT posts particularly for qualified staff from band 7 upwards. Not all therapists may wish nor be available to provide supervision. Caseloads and activity levels for supervisors will need to be adjusted to ensure that they have sufficient time to provide supervision. Similarly, supervisors will also require time for their own supervision and continuing professional development and support. A fortnightly supervision group for supervisors could meet this requirement.

As IAPT develops over the coming years, it will be important for SHAs, prospective IAPT services and IAPT training providers to ensure that they have sufficient supervisor capacity locally to support ongoing expansion of IAPT services. For services wishing to become future IAPT implementer sites, it is essential that the profile of existing staff should be examined to determine the therapeutic competences possessed by staff and their ability to provide appropriate supervision. This can be assisted by auditing the skills, training and experience of existing staff using the Worker Registration Form (http://www.iapt.nhs.uk/silo/files/iapt-worker-registration-form.doc) together with advice from your local IAPT Regional Advisor. Where prospective services have insufficient supervisory capacity, alternative strategies such buying in supervision from neighbouring trusts or services, or recruiting additional staff with the appropriate experience will need careful consideration.

Is supervision the same for PWPs and high intensity therapists?

It is likely that supervision will be organised differently to account for the differences in caseloads between low and high intensity practitioners. Moreover, the Supervision Competences Framework, described above, identifies a series of specific competences to support low intensity interventions. Nevertheless, some principles will be common such as the regular review of client's outcomes, risk status, levels of engagement etc.

Supervisors of PWP trainees must have knowledge of low intensity interventions, and ideally have practised or have familiarity with their service delivery. Familiarity and understanding of the relevant information technology system used within the low intensity service will also be essential. Similarly, all supervisors should have received training in supervision, including, where appropriate, specific supervision training tailored for low intensity interventions. Furthermore, given that PWPs may be performing roles unfamiliar to their supervisors (i.e. medication management, telephone support etc), supervisors will require additional training both in low intensity working and supervision. It is also important that both supervisors and supervisees for both low and high intensity interventions are familiar with the content and limitations of each other's work. Arrangements might be considered to provide supervisors from more traditional psychotherapy backgrounds an opportunity to experience and familiarise themselves by working within a low intensity service. Further guidance on the nature of case management supervision for PWPs and a helpful supervision checklist is provided in the training materials provided by IAPT (www.iapt.nhs.uk/workforce/low-intensity/) In addition, there is also a specific Reach Out PWP Training Manual for PWP Supervisors with specific supporting DVD supervision materials (www.iapt.nhs.uk/workforce/low-intensity/)

One area of development for supervisors of both PWPs and high intensity therapists relates to employment and social inclusion. These should be dealt with in the training provided by courses and additional further training sessions, particularly for qualified staff, organised by either IAPT Employment Advisors or local employment support agencies should be considered.

All supervisors should also be familiar with issues of equality and diversity in therapy and supervision, and be sensitive to the cultural needs of particular client groups and therapists. Supervisors should be familiar with the work of the IAPT Special Interest Groups and "Commissioning for the whole community" (www.iapt.nhs.uk/equalities/positive-practice-guides/) Generic competences about equalities and psychological therapy are available on the IAPT site. Similarly, generic competences are also available for assessing depression, risk management, outcomes monitoring etc on the site.

Supervisors of PWPs will need to be clear about the clinical governance arrangements around autonomy and scope of practice. Different services allow different degrees of autonomy for these practitioners, including the extent to which activities such as assessment and risk issues are overseen by a more experienced practitioner. Currently, PWPs tend to be supervised by counsellors, gateway workers, nurse therapists, and psychologists. However, there is a recognition that this might not always be appropriate or a good use of therapists' time. It is intended that there should be career progression and sustainability for PWPs, and it may be feasible for experienced PWPs to take on supervisory roles, given sufficient experience and training in supervision. Nevertheless,

given the relatively brief duration of training for PWPs, and for some, their relative lack of clinical experience, it will be important to consider carefully such a development. Levels of experience and additional training should be assessed for PWPs intending to take on more responsible and supervisory role.

It will be important, therefore, that supervisor training courses should contain some element of the curricula specifically tailored for low intensity interventions. Such courses should encourage current and experienced low intensity practitioners or graduate mental health workers to access supervisor and/or "top up PWP" training. Indeed, BABCP will only recognise clinical supervisors for PWP accreditation, if they have successfully completed a supervisor training course tailored to low intensity interventions and commissioned by the SHA for IAPT supervision.

Will supervision be different for IAPT qualified staff and trainees on low and high intensity courses?

All IAPT staff will be employees of the service in which they work whether they are fully qualified or on an IAPT training course. Accordingly, they should be subject to local management and professional development procedures, including local clinical governance arrangements surrounding accountability and supervision of their clinical work conducted within the IAPT service. Those on high intensity IAPT training courses will receive **additional** supervision on a small number of training cases by supervisors associated with the training course. Similarly, clinical supervisors working within the service and providing supervision for routine clinical work conducted by the trainees away from the course may be asked to assess the quality of the trainee's case work and use of supervision. Accordingly, IAPT services and training providers should draw up a local agreement which details the responsibilities and accountability of trainees to clinical supervisors within the service and course staff. This could extend to local supervision contracts being drawn up for staff, which would help formalise these arrangements. In particular, supervision provided by course staff who are employed outside of the IAPT service will need to be subject to clinical governance procedures within the host trust.

What supervision ratios should be recommended for practitioners, and what caseloads are anticipated?

We have summarised our recommendations for minimum supervision standards in the Executive Summary to this document. Essentially, we recommend a minimum of one hour a week for all qualified staff, plus an additional hour and half for IAPT high intensity trainees and one hour a fortnight for trainee PWPs. These figures are the minimum guidance for clinical or case management supervision, and they will be supplemented by management supervision for job performance and personal development. For senior and experienced staff or staff working part-time, these minimum standards might need to be adjusted to take into account smaller caseloads.

For high intensity interventions, supervision ratios vary from one-to-one supervision, which is commonly the case for trainees, and clinical supervision through to supervision groups ranging from 2 – 4 supervisees or even 6 – 8 trainees. Where group supervision is employed, this is usually undertaken with some additional individual supervision being available. Certain activities such as listening to tapes maybe more appropriate in a one-to-

one setting. Group supervision sessions will usually necessitate longer durations than individual sessions (e.g. 60 vs. 90 minutes).

What support do supervisors need to function effectively?

Group supervision of supervisors by a highly skilled clinician should be considered as a model and may have particular benefits for the supervision of PWPs who are themselves having to deal with large caseloads.

Supervision exemplars:

- The Doncaster site utilised individual supervision of their case managers. According to Richards (pers com), one supervisor can handle 5 case managers (i.e.100 – 250 cases?). Currently, one supervisor is allocated two days purely for the supervision of 10 case managers.

- The Oxford Centre for Cognitive Therapy (OCCT) provided weekly supervision groups for 4 trainees to 1 supervisor, which last around 1.5 hours (Westbrook, pers com). Freeston at Newcastle (pers com) suggests a weekly supervision group of 3 trainees per supervisor, which would last around 2 hours including preparation. For it to be sustainable, he only recommends two groups within a week, which would mean a supervisor being responsible for 6 high intensity practitioners. There may be some distinction in requirements for those in training and those already qualified.

- At the Institute of Psychiatry's Centre for Anxiety Disorders and Trauma, experienced therapists have weekly combination of large group supervision (6 – 8) and individual supervision. The supervision groups are often organized by problem type (PTSD, OCD, Social Phobia, etc) and the symptom scores for all patients at intake and their last session are written on a white board. Overall, experienced therapists receive around 3 hours of supervision per week. Supervision focuses on all cases (not just those that therapists are finding difficult). It is thought that the focus on cases that are progressing smoothly as well as on difficult cases: 1) provides a richer learning experience for the group; 2) helps therapists to see the overall value of their work, and 3) helps maintain a focus on conceptualization, and selection and implementation of treatment procedures (as opposed to supposed "difficult" features of the patient). The Centre has found video- conferencing to be particularly helpful for supervision from a distance. For example, when training Northern Ireland therapists in CT for PTSD following the Omagh Car Bomb (see Gillespie et al, 2002). The strategy of supervising individuals who would become local experts and could supervise other members of their team proved effective and economical. Both supervision and supervision training delivered by distance learning methods should be considered for localities, which may not have the desired capacity to support service development. BACP has developed good practice guidance around telephone support and supervision.

- The Universities of Exeter and Nottingham have developed supervision sessions within their PWP courses based upon the Self Practice Self Reflection (SP/SR) model of clinical skills training (Bennet-Levy et al 2001, Farrand et al 2010). This has been evaluated by students as being a useful way to improve the link between theory and practice and to give structure to clinical skills supervision. PWPs are

given timetabled directed activities to practice the clinical methods in service based learning days and to complete 'blogs' on their experiences of using the interventions as a reflective learning activity. The blogs are read and themed by Course Tutors and form the agenda for the supervision sessions provided in small groups on the training. This provides trainees with up to ten hours clinical skills supervision towards their individual accreditation requirements.

Various professional bodies (e.g. BACP, BABCP, BPS, UKCP) provide their members with guidance around good practice in supervision (see "workforce" for details; http://www.iapt.nhs.uk/services/workforce/). The IAPT minimum standards have been developed in consultation with these professional bodies. Further guidance around accreditation of both IAPT training courses and individual practitioners will shortly be available from the iapt website. www.iapt.nhs.uk

What organisational/ governance structures should be in place for supervision?

It will be important that supervision is integrated with data collection and the monitoring of outcomes. Organisational issues specifically around the IAPT service model such as assessment, "triage", risk assessment, stepping up and down, and outcome and progress tracking, will need to be clearly specified by the service. A training programme for senior staff within IAPT services is forthcoming. Important clinical decisions such as discharge may require routine scrutiny by supervisors, especially for trainees and PWPs. The governance arrangements around clinical responsibility for both low and high intensity practitioners require careful consideration. Clear governance arrangements must be in place describing the responsibilities of supervisors for trainees working within the service and those located within training providers and Universities.

Intensive and quality supervision, together with the routine monitoring of clinical outcomes, are distinctive features of IAPT services. Supervisors and IAPT staff should be encouraged to explore how supervision and outcome tracking might be shared and utilised to enhance patient outcomes, and also to develop and enable therapists' individual skills and competence. The use of routine outcome measurement using the CORE system in the UK has provided useful indicators as to how outcomes and service monitoring can be communicated to staff in constructive and meaningful ways (Lucock et al., 2003; Lucock & Lutz, in press).

Supervision and organisational values and priorities?

The deployment of experienced staff capable of acting as supervisors, gives rise to tensions between offering direct patient contact and seeing fewer clients but supervising other therapists. This has been a source of debate within the management of psychological therapy services. The implementation of key performance indicators that stress direct contacts as opposed to supervision can distort such relationships. Ultimately IAPT services will be evaluated on clinical outcomes and the therapeutic skills of their staff, and not just patient flows or activities. Indeed, recently some concerns have been raised about more business-focused organisations such as Foundation Trusts and private sector organisations, which might be reluctant to release staff for supervision at the expense of direct patient contact. Clear agreement must be reached about caseloads and the importance of more senior staff being free and supported in order to supervise. Financial incentives to buy-back supervisor time will need to be considered and costed in. The ratio

of trainees to supervisors within tender specifications or the make up of new services requires careful consideration. This will mean that the commissioning of education and training, has to be closely integrated with the commissioning of new services. Primary care providers may need to develop arrangements with secondary care providers around the availability and use of more experienced supervisory staff.

4. Conclusion

The organisation and provision of quality supervision to IAPT therapists will be one of the factors, which will determine the success, or otherwise, of the IAPT programme. If the IAPT programme is to return clinical outcomes equivalent to those obtained from the controlled trials upon which NICE guidance is based, it will be essential that IAPT therapists are appropriately selected, trained and supervised. IAPT has offered to service users the promise of clinical improvement and recovery, and services must prioritise the delivery of high quality supervision to their staff in order to ensure that this promise is kept.

Annex I

Supervision experiences and qualities check list? [2]

Please circle the perspective from which you are responding to this questionnaire

A From the perspective of the supervisee (Low or High Intensity Interventions?)
B From the perspective of the supervisor
C From the perspective of the manager/organiser/service lead

1. Do supervisees get adequate supervision to manage their caseload?
2. Does everyone get an hour of individual supervision each week regardless of seniority?
3. Do supervisees receive clinical supervision during which they can explore the process of supervision in addition to regular case management supervision?
4. What feedback or monitoring information about the satisfaction with supervision is routinely collected?
5. Do we know anything about how well supervisees relate to their supervisors?
6. How is the routine outcome monitoring information collected from all clients used in supervision?
7. How directive are supervisors (what action do they take) when routine outcome information indicates that clients are not making progress with their current therapist/therapy?
8. How well qualified are the supervisors in the programme in the model of therapy/low or high intensity that they are supervising?
9. Have supervisors received supervisor training to undertake the work they do with IAPT?
10. How do non CBT therapists access supervision and do they access model specific supervision?
11. Does the model of individual supervision plus group supervision work?
12. Is there a culture in supervision that enables supervisees to reveal their personal distress when it arises?
13. Do supervisors feel supported in the work that they do?
14. What works well in the provision of supervision?
15. What does not work so well and what changes would you like to see?
16. How satisfied are supervisors with their role

[2] **Questionnaire devised by Sue Wheeler and Nick Grey for the IAPT Supervision Workshop, New Savoy Partnership "Psychological Therapies in the NHS" Conference 2010.**

Annex II

Annotated bibliography and definitions of clinical supervision

Definitions:

There are many definitions of supervision that reflect the way in which it is understood by different professions in different contexts and countries.

Wheeler (2003) defines supervision as:

Supervision is a formal relationship in which there is a contractual agreement that the therapist will present their work with clients in an open and honest way that enables the supervisor to have insight into the way in which the work is being conducted. The supervisor is understood to be accountable to the professional body to which the supervisee has allegiance (Wheeler, 2003, p8).

Inskipp and Proctor (2001) describe supervision as:

A working alliance between the supervisor and counsellor in which the counsellor can offer an account or recording of her work; reflect on it; receive feedback and where appropriate, guidance. The object of this alliance is to enable the counsellor to gain in ethical competence, confidence, compassion and creativity in order to give her best possible service to the client. (p1).

A classic definition of supervision that is often quoted is provided by Bernard & Goodyear (1992: 2004) saying that:

Supervision is an intervention provided by a more senior member of a profession to a more junior member of that same profession. This relationship is evaluated, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person, monitoring the quality of professional services offered to the clients seen, and serving as a gatekeeper for those who are to enter the particular profession (p8 of the 2004 edition).

This description might fit current supervision practice in the USA but it does not capture the essence of the complexity of the supervision process, tasks, roles and functions in all settings.

Milne (2007) has conducted an empirical study into the definition of supervision that has resulted in the following definition:

"The formal provision, by approved supervisors, of a relationship-based education and training that is work-focused and which manages, supports, develops and evaluates the work of colleague/s. The main methods that supervisors use are corrective feedback on the supervisee's performance, teaching, and collaborative goal-setting. It therefore differs from related activities, such as mentoring and coaching, by incorporating an evaluative component. Supervision's objectives are 'normative', 'restorative' and 'formative'. These objectives could be measured by current instruments."

Selected BOOKS

There are now many books on supervision available. The selection here provides various different perspectives on supervision that will be valuable for supervisors in an IAPT service.

Bernard, J. M. and R. K. Goodyear (1998). Fundamentals of clinical supervision (2nd Ed.). Boston, MA USA: Allyn & Bacon Inc.

A classic text that provides a comprehensive account of supervision from an American perspective.

Bennett-Levy, J., Turner, F., Beaty, T., Smith, M., Paterson, B. & Farmer, S. (2001). The value of self-practice of cognitive therapy techniques and self-reflection in the training of cognitive therapists. *Behavioural and Cognitive Psychotherapy*, 29, 203-220.

Carroll, M., & Holloway, E (1999). Training Counselling Supervisors. London, Sage.

Discusses many aspects of training supervisors that will aid with the creation of new supervision courses

Copeland, S. (2006). Supervision in Organisations. London, Routledge.

An aspect of supervision that is often ignored is the context in which it takes place. This book provides an overview of the complexities of the organizational influences on therapy and supervision.

Cutcliffe, J. R., Butterworth, T. & Proctor, B. (2001). Fundamental Themes in Clinical Supervision. London, Routledge.

An edited British book that examines a range of themes that would be relevant to the IAPT programme.

Driver, C. and Martin, E. (Eds) (2002) Supervising Psychotherapy, London: Sage.

A standard text that looks at the issues relating to supervision from a psychodynamic and psychoanalytic perspective and relevant to clinical supervision within all clinical services.

Driver, C and Martin, E. (Eds) (2005) Supervision and the Analytic Attitude, London: Whurr

Consideration of aspects of supervision such as the 'absent patient, interpretation, reverie etc.

Falender, C. A. and E. P. Shafranske (2004). What Makes for Good Supervision? Washington, DC,US, American Psychological Association.

An American perspective with a useful summary of supervisor competences

Farrand, P., Perry, J., & Linsley, S. (2010). Enhancing Self-Practice/Self-Reflection (SP/SR) Approach to Cognitive Behaviour Training Through the Use of Reflective Blogs. *Behavioural and Cognitive Psychotherapy*, 38, 473-477.

Fleming, I., & Steen, L. (2004). Supervision and Clinical Psychology: Theory, Practice and Perspectives. Hove, Brunner Routledge.

An edited book to inform clinical psychologists about supervision, which will be crucial for the success of the IAPT programme.

Hughes, L., & Pengelly, P (1997) Staff Supervision in a Turbulent Environment. Managing Process and Task in Front-Line Services. London, Jessica Kingsley.

This book explores the dynamic between the competing needs of service-user, worker and organisation, seeing the supervisory relationship as the centre of good, safe, practice.

Ladany, N., Friedlander, M. L., & Nelson, M. L. (2005). Critical events in psychotherapy supervision: An interpersonal approach. Washington, DC:, American Psychological Association.

This book brings together research on critical events in supervision and presents guidance on dealing with such events.

Milne, D. (2009). Evidence-based Clinical supervision. Wiley-Blackwell, Chichester.

Current review of the literature underpinning supervision, together with practical advice about training and implementation within services.

Page, S., & Wosket, V. (2001). Supervising the counsellor: A cyclical model (2nd Ed.). Philadelphia, PA, Brunner-Routledge.

A well written book that provides a clear generic model of supervision that could be adopted in many contexts.

Proctor, B. (2000). Group Supervision: a Guide to Creative Practice. London, Sage.

Invaluable text for anyone using supervision groups.

Richards, D. A. (2010). *Supervising Low-intensity Workers in High Volume Clinical Environments*. In: Bennett-Levy, J., Richards, D.A., Farrand, P., Christensen, H., Griffiths, K., Kavanagh, D., Klein, B., Lau, M., Proudfoot, J., White, J. and Williams, C. eds. *The Oxford Guide to Low Intensity CBT Interventions.* Oxford, Oxford University Press.

Chapter which covers case management supervision in depth, in comprehensive handbook for low-intensity CBT practitioners such as PWPs.

Richards, D.A. , Chellingsworth, M., Hope, R., Turpin, G., & Whyte, M. (2010). Reach Out National Programme Supervisor Materials to Support the Delivery of Training for Psychological Wellbeing Practitioners Delivering Low Intensity Interventions. (http://www.iapt.nhs.uk/workforce/low-intensity/).

Scaife, J. (2008). Supervision in clinical practice; A practitioner's guide. 2nd edition. London, Routledge.

A focus of mental health will make this good reading in relation to the IAPT programme.

Stoltenberg, C. D., & Delworth, U. (1987). Supervising counselors and therapists. San Francisco, Jossey Bass.

A classic text that uses the results of research into the developmental model of supervision to describe how supervisors might modify their approach to supervisees dependant on their stage of professional development.

Watkins, C. E., Jr., Ed. (1997). Handbook of psychotherapy supervision. New York, John Wiley & Sons Inc.

A book to be used as a reference to find relevant research into supervision and critique of supervision research methodologies.

Wheeler, S. (2003). Research on supervision of counsellors and psychotherapists: a systematic scoping search. Rugby, BACP.

Provides references to supervision research up until 2002.

Wheeler, S., & Richards, K. (2007). The impact of clinical supervision on counsellors and therapists, their practice and their clients: a systematic review of the literature. Lutterworth, BACP.

A review that focuses specifically on ways in which supervision impacts on therapists and clients.

Selected articles:

Bambling, M., King, R., Raue, P., Schweitzer, R., & Lambert, W. (2006). "Clinical supervision: its influence on client rated working alliance and client symptom reduction in the brief treatment of major depression." Psychotherapy Research 16(3): 317-331.

The closest yet to a randomized controlled trial of supervision. Many limitations to the study but overall supervision appears to make a difference to the outcome of therapy.

Beal, D., & DiGiuseppe, R. (1998). "Training supervisors in rational emotive behavior therapy." Journal of Cognitive Psychotherapy 12: 127-137.

This paper describes some of the guidelines that have been found helpful in the training of supervisors in Rational Emotive Behavior Therapy (REBT).

*Bower P, Gilbody S, Richards DA, Fletcher J, Sutton A. (2006). Collaborative Care for depression in primary care. Making sense of a complex intervention: systematic review and meta regression. British Journal of Psychiatry 189: 484-493.

This paper identifies the importance of therapist training and supervision to the delivery of collaborative care.

*Brosan, L., Reynolds, S. and Moore, R.G. (2007). Factors associated with competence in cognitive therapists. Behavioural and Cognitive Psychotherapy, 35, 179–190.

Compares perceived therapist competence with rated performance.

*Brosan, L., Reynolds, S and Moore, R.G. (2008). Self-Evaluation of Cognitive Therapy Performance: Do Therapists Know How Competent They Are? Behavioural and Cognitive Psychotherapy. 36, 581-587

Compares perceived therapist competence with rated performance.

Clarke, D. M. (1999). "Measuring the quality of supervision and the training experience in psychiatry." Australian & New Zealand Journal of Psychiatry 33(2): 248-252.

Describes the development and trial of the use of a "quality improvement" instrument for evaluating the supervision and training experience in psychiatry from a trainees' perspective.

Driver, C. (2008) Assessment in Supervision. British Journal of Psychotherapy, 24, 3.

Gives a detailed account of the issues that require consideration in the supervision of trainees and practitioners to ensure ethical and clinical standards.

Friedberg, R. D. and L. A. Taylor (1994). "Perspectives on supervision in cognitive therapy." Journal of Rational-Emotive & Cognitive Behavior Therapy 12(3): 147-161.

The article stresses that teaching novice professionals to skillfully apply cognitive conceptualizations and interventions is challenging and difficult and suggests that

fostering a learning alliance in supervision forms the basis for acquisition of pivotal cognitive therapy competencies.

*Gillespie, K., Duffy, M., Hackman, A., & Clark, D.M. (2002). "Community-based Cognitive therapy in the treatment of post traumatic stress disorder following the Omagh bomb." Behavior Research and Therapy 40: 345-357.

Reports that the outcome of therapy is greater for clients of therapists who have supervision than of therapists who do not have supervision.

*Ladany, N. (2004). "Psychotherapy supervision: what lies beneath?" Psychotherapy Research 14(1): 1-19.

A good summary of what we know about supervision through research.

Ladany, N. (1996). "Nature, Extent, and Importance of What Psychotherapy Trainees Do Not Disclose to Their Supervisors." Journal of Counseling Psychology 43(1): 10-24.

Article explores non disclosure in supervision. Negative reactions to the supervisor were the most frequent type of nondisclosure. Other reasons for nondisclosures were perceived unimportance, that the nondisclosure was too personal, negative feelings, and a poor alliance.

*Lambert, M. J. and E. J. Hawkins (2001). "Using information about patient progress in supervision: Are outcomes enhanced?" Australian Psychologist Special Issue: Training in clinical and counselling psychology 36(2): 131-138.

The authors present a conceptual framework for the routine assessment of patients and the delivery of feedback regarding patients' progress to therapists.

Liese, B.S. & Alford, B.A. (1998). Recent advance in cognitive therapy supervision. Journal of Cognitive Psychotherapy, 12, 91 – 94.

Review of cognitive therapy supervision.

Liese, B.S. & Beck, J.S. (1997). Cognitive therapy supervision. In C.E.Watkins (Ed.) Handbook of Psychotherapy Supervision. Wiley, New York, pp 114 – 133).

Overview of supervision for cognitive therapy.

*Lucock, M., Leach, C., Iveson, S., Lynch, K., Horsefield, C., & Hall, P. (2003). A systematic approach to practice-based evidence in a psychological therapies service. Clinical psychology and psychotherapy, 10, 389 – 399.

Describes how routine outcome measures can be employed throughout the service to inform practice and service improvement.

*Lucock, M. & Lutz, W. (in press). Methods for constructing and disseminating service level results in a meaningful way. In A Core Approach to Delivering Practice-Based Evidence. Eds. M. Barkham & G.E.Hardy, John Wiley & Sons, Chichester.
Describes how routine outcome measures can be employed throughout the service to inform practice and service improvement.

*Mannix, K. A., Blackburn, I.V., Garland, A., Gracie, J., Moorey, S., Reid, B., Standart, S. & Scott, J. (2006). Effectiveness of brief training in cognitive behaviour therapy techniques for palliative care practitioners. Palliative medicine, 20, 579 – 584.
Describes training palliative care staff in simple CBT skills, with ongoing supervision and support.

*Miller, S., Duncan, B., Brown, J., Sorrell, R., & Chalk, M. (2007). Using formal client feedback to improve retention and outcome. Journal of Brief Therapy, 5, 19 – 28.
Use of regular session feedback on clinical outcomes.

Milne, D. and I. James (2000). "A systematic review of effective cognitive-behavioural supervision." British Journal of Clinical Psychology 39(Pt 2): 111-27.
A systematic review of studies that have assessed objectively the impact of supervision and consultancy that gauges the effectiveness and methodological rigour of the studies.

Milne, D. L., & James, I.A. (2002). "The observed impact of training on competence in clinical supervision." British Journal of Clinical Psychology 41: 55-72.
A qualitative study that describes in detail the process and outcome of supervision.

Milne, D. L., Pilkington, J., Gracie, J., & James, I. (2003). "Transferring skills from supervision to therapy: A qualitative and quantitative N=1 analysis." Behavioural and Cognitive Psychotherapy 31(2): 193-202.
The content and outcome evaluation describes and then assesses the effectiveness of cognitive behaviour therapy supervision, in terms of its observed impacts on a trainee therapist supervisee and her patient.

Perris, C. (1994). "Supervising cognitive psychotherapy and training supervisors." Journal of Cognitive Psychotherapy 8(2): 83-103.
Discusses the supervision of cognitive psychotherapy and the supervision of therapists working with severely disturbed patients. Topics include a conceptualization of the supervisory process, supervision models and modalities, and supervision pitfalls.

*Roth, A.D., Pilling, S., & Turner, J. (submitted). The therapist training and supervision in CBT in major trials for depression and anxiety.
Reviews the requirements of published research trials for training and supervision of therapists.

*Roth A.D. & Pilling, S. (2008). Using an Evidence-Based Methodloogy to Identify the Competences required to Deliver Effective Cognitive and behavioural Therapy for Depression and Anxiety Disorders. Behavioural and Cognitive Psychotherapy, 36,129 – 148.
Describes the development of the CBT competences framework.

*Sabin-Farrell, R., & Turpin, G. (2003) Vicarious traumatization: Implications for the mental health of health workers? Clinical Psychology Review, 23, 449 – 480.
Reviews the impact of working with clients with trauma on mental health workers.

Safran, J. D. and J. C. Muran (2001). "A relational approach to training and supervision in cognitive psychotherapy." Journal of Cognitive Psychotherapy Special Issue: 15(1): 3-15.
Outlines a number of principles and strategies relevant to training and supervision in cognitive psychotherapy from a relational perspective.

Shanfield, S. B., Matthews, K. L., & Hetherly, V. (1993). "What do excellent psychotherapy supervisors do?" American Journal of Psychiatry 150(7): 1081-1084.
A study of tape recordings of supervision variously rated by supervisees.

Townend, M., Ianetta, L., & Freeston, M. (2002). Clinical supervision in practice: A survey of UK cognitive behavioural psychotherapists accredited by BABCP. Behavioural and Cognitive Psychotherapy, 30, 485 – 500.
A survey reporting the variability supervisor practice and training in the UK.

Townend, M. (in press). Clinical supervision in cognitive behavioural psychotherapy: development of a model for mental health nursing through grounded theory. Journal of Psychiatric and Mental Health Nursing.
Qualitative study of attitudes and approaches of CBT course directors to supervision.

*Wampold, B.E. and Brown, G.S. (2005). Estimating the variability in outcomes attributable too therapists: A naturalistic study of outcomes of managed care. Journal of Consulting and Clinical Psychology, 73, 914 – 923.

Examines the contribution of therapist variability to clinical outcomes.

Weaks, D. (2002). "Unlocking the secrets of 'good supervision': a phenomenological exploration of experienced counsellor's perceptions of good supervision." Counselling and Psychotherapy Research 2(1): 33-39.

This paper reflects the findings of a qualitative study carried out to identify the elements of good supervision.

Wheeler, S. (2007). "What shall we do with the wounded healer? The supervisor's dilemma." Psychodynamic Practice 12(3): 245-256.

Discusses ways of managing supervisees who are themselves distressed by their life or their work.

*Worthern, V. & Lambert, M.J. (2007). Outcome orientated supervision: advantages of adding systematic client tracking to support consultations. Counselling and Psychotherapy Research, 7, 48 – 53.

Examines the impact of outcomes tracking on clinical outcomes.

*References cited within the IAPT Supervision Guidance.