The U.S. Competency-Based Model and the Hong Kong Apprenticeship Model Of Supervision for Clinical Psychology

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During an in-person meeting on 3 April 2018, Dr. Patrick Leung (Department of Psychology at the Chinese University of Hong Kong) and Dr. Tatia Lee (Department of Psychology at the University of Hong Kong) reported that the Hong Kong “on-site supervision,” in the context of training clinical psychologists, is the practice of pairing a clinical psychologist who is employed in the hospital with a trainee who shadows the clinical psychologist at all times. Further, it was reported that the justification for this intensive presence and watchfulness, and the reason for Hong Kong’s adoption of this model for training clinical psychologists, is that trainees will inevitably make mistakes, and thus the patient being treated by a trainee must be protected from harm.

Similar to the Hong Kong training as reported by Drs. Lee and Leung, the CSPP-HK PsyD Program’s clinical training also have supervisors who are on-site at the agency where the trainee is placed for his/her supervised clinical training. The difference is that the HK training places the clinical psychology supervisor physically in the same room at the same time as the trainee and the patient whereas in the CSPP-HK model the clinical psychologists supervisor enters the treatment room with the trainee and the patient through video/audio/process note recordings. The CSPP-HK clinical psychologist supervisor may, or may not be physically located in the same agency. When a clinical psychologist is not located in the placement agency, CSPP-HK has both a site-supervisor and an individual clinical psychologist supervisor. The site-supervisor, who may or may not be a clinical psychologist but is always a credentialed mental health professional, working in collaboration
with the individual clinical psychologist supervisor, has oversight of the trainee at the placement site.

An additional difference, as reported by Drs. Lee and Leung, is that their training occurs in the hospital setting whereas the CSPP-HK training occurs in a multitude of agencies in the community, including hospital, long term residential facilities, and out-patient community mental health clinics. Therefore, when appropriate, both site-supervisor and individual clinical psychologist supervisor are involved.

The Hong Kong model of training clinical psychologists, as described, patterns itself after the medical apprenticeship model. In the ‘Hong Kong on-site supervision - apprenticeship model’, the trainee observes the master and in turn is watched over by the master until the trainee is deemed to have gained sufficient knowledge and skill to practice independently. The medical apprenticeship model is described thus: “The practice of surgery is a learned art, built upon a strong foundation of didactic learning, reading, observation, doing under guidance, and repetition. This apprenticeship model has changed little over the years” (Gorman, Meier, Rawn & Krummel, 2000, p. 353). Additionally, the ‘Hong Kong on-site supervision - apprenticeship model’ replicates the practices of “the mid-19th century, [during which] student physicians encountered this knowledge and these skills and values as enacted by their teachers in the course of caring for patients” (Cooke, Irby, Sullivan, & Ludmerer, p. 1341).

The relevant question is whether this model is appropriate for training clinical psychologists. The predominant training and supervision model for clinical psychology used throughout the U.S. and in the CSPP-HK PsyD Program is a different model, the competency-based model (Falender & Shafranske, 2004; Farber & Kaslow, 2010; Hunsley & Barker, 2011). This model is set forth in the *Guidelines for Clinical Supervision in Health*...
Service Psychology (APA, 2014) and the Supervision Guidelines for Education and Training Leading to Licensure as a Health Service Provider (ASPPB, 2015). These professional associations employ the competency-based model as the guiding principle for clinical training and supervision.

According to Falender & Shafranske (2007, p. 233), “competency-based supervision is an approach that explicitly identifies the knowledge, skills and values that are assembled to form a clinical competency and develop learning strategies and evaluation procedures to meet criterion-referenced competence standards in keeping with evidence-based practices and the requirements of the local clinical setting”. In other words, the competency-based model involves a spectrum of research evidence-based training and supervisory practices; these are the practices that have been found to be the most effective for training skilled psychologists, while also protecting patients.

Both the Hong Kong apprenticeship model and the U.S. competency-based model emphasize the need for direct observation of the trainee’s psychotherapy work. Several schools of thought and professional psychology associations, such as the American Psychological Association (APA) and the American Association of Marriage and Family Therapy (AAMFT), guide supervisors to conduct direct observation of trainees. “Direct observation provides essential information regarding trainees’ development of competencies, as well as the quality of the services provided, that cannot be obtained through other methods” (APA-CoA, 2015, p. 89).

However, the Hong Kong apprenticeship model and the U.S. competency-based model diverge regarding how best to conduct direct observation. The apprenticeship model requires the supervisor being present in the room at all times with trainees and their patients, whereas the U.S. competency-based model recommends the review and discussion of
video/audio recordings and process notes from the trainee’s work, in addition to dialogues with the trainee to enhance and evaluate clinical judgment, self-awareness, and therapeutic skill. A recent article recommends, “Evidence of supervisee work should at first be collected in low-inference formats, such as … electronic recording formats. This is especially important for first-time supervisees” (Jordan, 2016, p. 39).

The U.S. competency-based model of supervision via direct observation through review of video/audio recordings and process notes – rather than having supervisor present in the same room as the trainee and the patient – is endorsed for a host of reasons. Each reason is informed by best practice recommendations as derived from research evidence. The remainder of this document provides the rationale, the approach, and the techniques established in the U.S. competency-based model. It also emphasizes ways in which those components of the CSPP-HK PsyD Program that adhere to the competency-based model provide training that is superior to that which emerges from the apprenticeship model.

- **The competency model is more relevant for psychotherapy training than a model based on medical education.**

The Hong Kong supervisor of the kind described by Drs. Leung and Lee, in which a trainee provides services with the supervisor in the room, may be more appropriate in a medical context. The needs of psychotherapy patients are distinct from those of medical patients, and it is therefore necessary to adapt training and supervision approaches to the needs of patients in the psychological context.

The site of the pathology in medicine and clinical psychology are different. When the site of pathology is physical and tangible, like a tumor, the nature of the pathology and how it is assessed does not change depending on the context in which the person consults the medical physician. A tumor does not change its shape, size or type, regardless of whether the
patient consults a medical physician in a hospital or a neighborhood clinic, and regardless of
how many medical physicians are present in a room observing the pathology.

This consistency of pathology across locations and treatment personnel does not apply
to psychological and emotional disorders. Unlike physical pathology, the object of clinical
psychology treatment is the human psyche – a person’s heart and mind. The presentation of
an individuals’ psychological pathology changes depending on the context of treatment and
who is treating it. Additionally, the curative factors in psychological intervention are
extremely sensitive to where and who is providing treatment.

- **The competency-based model of supervision: required for attainment of complex
  clinical skills**

Decades ago, the U.S. largely abandoned the apprenticeship model for training of
clinical psychologists. Milne (2009) suggested that the apprenticeship model originated from
the ancient Greek approach to teaching and re-emerged in psychiatry in the early 19th century
when Freud adopted the medical training model to provide clinical supervision in
psychoanalysis to groups of physicians. However, it became evident that clinical skills for
psychotherapy are not as easily transferrable as the apprenticeship model claims, and Freud
quickly moved away from the apprenticeship model. Psychotherapy skills are acquired better
through direct practice than through observation of a mentor. For the mastery of such
complex and nuanced intervention skills, observational learning is insufficient for students to
develop their clinical style and skills and to grow in insight and judgment as independent
psychologists.

- **The competency model protects the therapeutic relationship.**

The most important single factor in efficacious psychotherapy is the quality of the
therapeutic relationship between the psychologist and the patient (Norcross, 2011). Critical
elements for establishing that successful therapeutic relationship are privacy and a therapeutic alliance with one consistent individual, namely the treating clinical psychologist. Since the curative element in psychological treatment is the therapeutic alliance, much of the structure around clinical psychology treatment is aimed at building and protecting the integrity of the psychotherapeutic relationship. Thus, clinical psychology training and supervision is structured in a manner that assures the privacy and integrity of the therapist-client relationship.

To assure and protect the privacy and integrity of the therapeutic relationship between the treating psychologist and the patient, it is extremely rare in the U.S. and elsewhere in the world that a supervisor would be physically present in the same room with the patient and the therapist. Instead, direct observation is done post hoc through review and evaluation of video/audio recordings and process notes, which is the modus operandi in U.K., U.S., and elsewhere in the world where licensing for clinical psychologists is well-established.

- **The competency-based model protects against imminent harm**

  In psychotherapy there are only two conditions of imminent danger in which immediate intervention is demanded. These two conditions are harm to self, as in suicide, and harm to other, as in assault/homicide or abuse of a dependent person such as a child or an elderly person. CSPP-HK’s curriculum insures that clinical psychology trainees have achieved a level of judgment and skill such that they can safely be in a treatment room with a patient without posing imminent risk and the competency-based supervision model allows for deliver efficacious psychotherapeutic treatment by the trainee.

  Appropriate prior training and ongoing supervision are almost always sufficient to assist trainees in the proper assessment and management of imminent harm. The patient can thus be protected from imminent harm while also protecting the psychotherapeutic
relationship, with the supervisor’s presence not intruding into the physical space of the therapy room. First, protection is secured through a strong training curriculum in detection and management of risk. This ensures that the intern is well-versed in assessment for imminent danger and is able to immediately enact necessary interventions for threat of harm to self or other or abuse.

Critical situations of imminent danger are typically proceeded by warning signs that are discussed by supervisor and trainee well in advance of necessary intervention. An example would be a patient’s self-report of severe hopelessness, negative life events associated with self-harm, a history of impulsivity and substance use. An ongoing supervisory relationship and review of audio/video materials and process notes permits a supervisor first, to assess signs of increased risk over time, and second, to assess the trainee’s appropriate judgment and intervention.

In the CSPP-HK PsyD program, supervisors are available 24 hours a day, 7 days a week in case of emergency; emergency protocols are in place and thorough risk assessments are performed by students and supervisors on an ongoing weekly basis. Finally, formal evaluation of a trainee’s ability to assess imminent risk is submitted to the program as part of each end-of-semester evaluation provided by all three of a trainee’s supervisors.

Furthermore, in the CSPP-HK PsyD program, courses in psychopathology, observation and interviewing, and ethics and legal issues occur during the first year of training, prior to the initiation of clinical training, and training in psychotherapeutic technique is provided prior to or concurrent with clinical training. Combined with regular supervisory experience, this insures that clinical psychology trainees have achieved a level of judgment and skill such that they can safely be in a treatment room with a patient without posing imminent risk.
The competency model provides training from the perspective of multiple therapeutic orientations

In addition to the primary imperative to protect the patient from imminent harm and to protect the therapeutic relationship (Norcross, 2011), it also important for trainees to understand psychological theory. CSPP-HK PsyD program asks the student to accurately conceptualize the patient and his/her problems based on psychological theory, and then the student is taught how theory guides choice of various techniques for treatment. Because efficacious psychotherapeutic intervention is nuanced and guided by clear conceptualization, the U.S. competency-based model places strong emphasis on teaching a variety of theoretical orientations. The Commission on Accreditation (CoA) of the Educational Directorate of the American Psychological Association (APA) holds a philosophical stance that the goal of doctoral training is to provide “the broad theoretical and scientific foundations of the discipline and field of psychology” (CoA-APA, 2015, p.1) and directs programs to assure students are competent in delivery of “interventions … from a variety of theoretical orientations” (CoA-APA, 2017, p. 19, Section C-8, D-VII). Therefore, to provide appropriate foundations in health service psychology, the U.S. competency-based model trains students to think about people’s psychological problems through the lenses of different psychological theoretical orientations.

The CSPP-HK PsyD program provides didactics and applied supervision in the three major theoretical orientations – psychodynamic, cognitive behavioral, and family systems. Furthermore, in order to provide such training, the curriculum is designed so that students have the opportunity to learn from supervisors who are experts in different therapeutic orientation across semesters and from year to year. This insures that student learn about the application of each psychological theoretical orientation to treatment. By use of video/audio
recording or process notes, supervisors are able to observe the therapy session without physically being in the treatment room at the same time. This means that students are able to change supervisors without jeopardizing and protecting the therapeutic relationship because there would not be a variety of supervisors visible to the patient.

- **Training from the competency-based model permits provision of services in the least restrictive environment**

  A basic human right for mentally ill individuals, as articulated in Principle 7 of the *Principles for the protection of persons with mental illness and the improvement of mental health care* Adopted by General Assembly resolution 46/119 of 17 December 1991 of the Office of the United Nations High Commissioner for Human Rights (OHCHR), is for individual experiencing mental illness “to be treated and cared for …in the community in which he or she lives.” This is the principle commonly referred to as ‘least restrictive environment’. This principle is enacted into law by many nations around the world. One example is the Mental Health Act 2007 of New South Wales (NSW), Australia. The NSW Mental Health Act 2007 - section 68 Principles for care and treatment states: “with respect to the care and treatment of people with a mental illness or mental disorder: (a) people with a mental illness or mental disorder should receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given.” In the U.S. State of California landmark case EMILY Q., ET AL.V. BELSHE, ET AL.; U.S. District Court for the Central District of California Case No. CV98-4181 AHM (AIJx). Filed May 27, 1998, it was ruled that least restrictive environments would be provided to the client when rendering necessary services. To this date, that case has shaped treatment planning, risk assessment practices, and government-funded health care in the U.S.
To maintain the highest level of functioning and to prevent costly interruptions to patient’s lives, best practice is for psychotherapeutic interventions to be provided in the community where patients live. In the U.S. this usually means that treatment is provided in various community settings, with hospitalization as the last resort.

Provision of psychotherapeutic treatment in the least restrictive environment in Hong Kong means providing care at community-based out-patient clinics, halfway houses, care homes, etc. – mostly sponsored through Non-governmental organizations (NGOs) that provide services in the community. To train our students to provide psychotherapeutic treatment in least restrictive environments, the CSPP-HK PsyD Program followed the example of their U.S.-based APA accredited sister programs to train students to work in the community, in settings such as outpatient clinics, post-hospitalization residential settings, nursing homes, special needs schools, and community mental health centers.

By Hong Kong tradition, psychotherapeutic interventions in such community settings are primarily provided by social workers, not by clinical psychologists. To enable equitable training for our Hong Kong clinical psychology students, tailored to the local Hong Kong setting, the CSPP-HK PsyD Program follows the best practice for expansion of psychological services permitted under the provision of Delegated Supervision CCR 1387 (c) (1) (State of California Department of Consumer Affairs, 2016) by the California Board of Psychology. This means the PsyD Program collaborates with community agency supervisors, who are Hong Kong credentialed mental health professionals but not clinical psychologists, to team up with U.S. licensed psychologists to train student clinical psychologist. Having a delegated supervisor who is at the physical location where the trainee and patients meet is usually what is understood in the U.S. as on-site supervision. Collaboration between the individual psychology supervisor and agency on-site delegated supervisor makes it possible to train
students who can serve individuals with mental illness in the community, providing them with skills that they will ultimately be able to use to meet local mental health needs.

**Conclusion**

The Hong Kong supervision model described by Drs. Leung and Lee as the standard for training in Hong Kong is equivalent to the apprenticeship model described in clinical psychology literature on training and supervision. This model emerged from medical training of the 19th century and is of limited value for the training of clinical psychologists in the 21st century.

First, the apprenticeship model is an obsolete practice which has been abandoned in the field of clinical psychology in Western countries for several decades because its observational learning model does not inculcate the skills needed by trained independent psychologists.

Second, the placement of supervisors in the therapy room with the trainee and the patient impedes the establishment of therapeutic relationship between the trainee and their patients, a relationship that is a key determinant of successful treatment. Interrupting the establishment of the psychotherapeutic alliance harms the patient by hindering the largest single factor in the efficacy of psychotherapy.

Third, the apprenticeship model encourages supervisors to take control during crisis situations, which impedes the learning opportunities for clinical psychology trainees to develop their competencies as future independent psychologists. This is unnecessary if trainees have had consistent supervision and have taken preparatory coursework in psychopathology, crisis assessment, and crisis intervention and have 24/7 availability of supervisory assistance.
Fourth, the apprenticeship model limits the teaching modality to techniques; it does not sufficiently train students to conceptualize cases and their treatment using a variety of theoretical perspectives.

Fifth, by training students only in settings in which clinical psychologists are already employed rather than where clinical psychology services are needed in the community, the apprenticeship model misses the opportunity to serve underserved individuals and fails to serve clients in a least restrictive environment, thereby restricting many patients from receiving appropriate treatments.

In conclusion, the apprenticeship model currently practiced in Hong Kong is ineffective and insufficient in preparing clinical psychologists to a minimum competency. To address the immediate and critical mental health problems in Hong Kong, it is necessary to modify the apprenticeship model or adopt a more effective training model, thereby effectively serving all individuals in need in our community. This is what CSPP-HK PsyD Program has done.

References


