

**Taking clinical psychology postgraduate training into the next decade: Aligning  
competencies to the curriculum**

**Nancy A. Pachana<sup>1</sup>**

**Andrew Baillie<sup>2</sup>**

**Ed Helmes<sup>3</sup>**

**Kim Halford<sup>4</sup>**

**Greg Murray<sup>5</sup>**

**Mike Kyrios<sup>6</sup>**

**Analise O'Donovan<sup>7</sup>**

**Mia O'Brien<sup>8</sup>**

**Steven Schwartz<sup>9</sup>**

**Kate Sofronoff<sup>10</sup>**

<sup>1</sup> Professor, School of Psychology, University of Queensland, Brisbane QLD 4072, tel +617 33656832, fax +617 33654466

<sup>2</sup> Senior Lecturer, Psychology Department, Macquarie University, Sydney NSW 2109, tel +612 98509436, fax +612 98508062

<sup>3</sup> Professor, School of Arts and Social Sciences, James Cook University, Townsville, QLD 4072, tel +617 47815159, fax +617 47815117

<sup>4</sup> Professor, School of Psychology, University of Queensland, Brisbane QLD 4072, tel +617 33656375, fax +617 33654466

<sup>5</sup> Associate Professor, Faculty of Life and Social Sciences, Swinburne University of Technology, Melbourne, VIC tel + 61 3 9214 830 fax + 61 3 9819 0574

<sup>6</sup> Professor, Faculty of Life and Social Sciences, Swinburne University of Technology, Melbourne, VIC tel + 61 3 9214 4886 fax + 61 3 9819 0574

<sup>7</sup> Associate Professor, School of Psychology, Griffith University, Mt Gravatt, QLD 4122, tel +617 37353373, fax +617 37353388

<sup>8</sup> Lecturer, School of Education, University of Queensland, Brisbane QLD 4072, tel +617 33656648, fax +617 33657199

<sup>9</sup> Vice-Chancellor and President, Macquarie University, Sydney NSW 2109, tel +612 98507378, fax +612 98508378

<sup>10</sup> Associate Professor, School of Psychology, University of Queensland, Brisbane QLD 4072, tel +617 33656411, fax +617 33654466

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### Abstract

Clinical psychology training programs in Australia are under pressure to increase the number of graduates they produce and to ensure that these graduates meet professional competencies. This Australian Learning and Teaching Council funded project aimed to better align clinical psychology training curriculums to competencies in several key areas: competency assessment, problem-based learning, fitness to practice protocols, e-therapy training models and models of university-based clinic operation, distance (especially rural) training concerns and clinical supervision issues and strategies. The project team has drawn together an advisory board of relevant stakeholders, scoped the relevant empirical literature, surveyed current students and program directors, and is in the process of transferring innovations developed in one university to others across the country. This paper provides a summary of important structural components of the proposal, key process issues, and important outcomes to date, as well as overarching future considerations.

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## **Introduction**

In Australia, there are currently 36 accredited postgraduate clinical psychology training programs (Australian Psychology Accreditation Council, 2011), a number that has grown moderately in the last decade, with an increase in the past few years in the number of new psychology registrants, with a growth of about 9% a year (Grenyer et al.,2010). However, in the past decade the mean number of effective full-time equivalent students in clinical psychology postgraduate training courses at each university offering such a program has not increased substantially, remaining at between 9 and 12 (Voudouris & Mrowinski, 2010). A national survey of workforce issues and training revealed that there were approximately 700 postgraduate clinical psychology training places a year offered across 34 university postgraduate training programs (Grenyer et al.,2010). However, the authors of this study also point out that in 2008 half of psychologists undertaking training did not undertake postgraduate training at a university, but instead undertook four years of university psychology followed by a 2 year apprenticeship program. Grenyer et al. have reported growth in the practicing psychology workforce, allowing for retirements, to be at 6.24% per year, and that in the coming decade approximately another 1,200 training places will be required to match current estimates of growth. This would equate to each university roughly doubling the number of places offered, and this also assumes that the apprenticeship pathway to university training ratio remains at 50:50. Now that the apprenticeship model is being gradually phased out in the wake of changes brought about by the establishment of a national psychology registration board, questions arise

as to how clinical training might rise to meet the challenges of the next decade. Certainly training costs are an issue; between costs associated with running University-based training clinics and the costs associated with intensive training of relatively small cohorts of students, clinical psychology training is expensive. Balances between quality of training, financial and supervision constraints, and imperatives of maintaining quality while striving to meet demands for increasing numbers of students being trained is daunting.

Discussions of clinical psychology training can be placed within broader discussions of the best ways to train health professionals more broadly. At issue is how to improve the ability of new graduates operating within the health system of Australia to respond to the changes in a dynamic health care environment, bringing to bear a high level of competency to their work that has its basis in high quality, cost-effective and innovative University training programs.

The Australian Learning and Teaching Council (ALTC) is a national organisation aiming to improve the student learning experience in Australia by supporting quality teaching and practice. One way it does so is through support of large-scale competitive grants scheme to support innovative work in teaching and learning. The ALTC priority project grant described here was awarded in 2008 to a consortium of universities across Australia and led by the University of Queensland. The project aims to re-imagine the curriculum for professional postgraduate clinical psychology training in Australia.

Clinical psychology in Australia has moved through many new developments in the last decade. Significantly, psychologists now are able to bill under Medicare nationwide within a two-tiered framework where clients can access higher rebates for specialist mental health services of clinical psychologists relative to other

psychologists. The Australian Medicare system provides Commonwealth support for a range of public health services, including funding for a public hospital system and subsidized support for health care providers such as general practitioners and other selected health care professions. This recent change has resulted in a pressing need (strongly endorsed by the Commonwealth Government) for increasing the size of the overall cohort of clinical psychology graduates trained to meet an increasing community need for their services (Australian Health Minister's Conference, 2004). Moreover, varying state-based registration requirements across states and territories have been streamlined into a single set of registration requirements through the introduction of a national registration board for psychology as well as other health care professions, including medicine, nursing, and physiotherapy. Finally, the profession itself is changing, most notably in its move away from a deficits-based to a strengths-based model for practice, and from a more hours-based to a competency-based strategy to gauge training outcomes. As with many professions, training often lags behind cutting edge content (e.g. best practice in clinical intervention) as well as pedagogical theory (e.g. competency-based assessment).

The aim of this project is to better align competencies and the curriculum in clinical psychology with best practice for new postgraduates, so that they are prepared to function in the current and future health service climate. We are developing and where feasible, trialling training innovations to both extend the evidence base for best practice in clinical psychology training. These revisions to the curriculum are designed to be flexible and responsive to new initiatives, such as the continuing changes to Medicare access for psychological treatment. This challenge can only be met through a national cooperative effort involving key stakeholders: state registration boards, professional peak bodies, and major university training programs.

## **Background**

### *Issues for Clinical Psychology Curriculum and Pedagogy*

Designing an effective sequence of study in any field is difficult, but is perhaps especially so with respect to designing and implementing curricula in the professional applied disciplines. One reason for this is the range of internal drivers and extrinsic influences on such curricula. For example, in clinical psychology such external agencies as registration boards, peak bodies and the government itself may act as explicit external drivers of training demands, whereas external factors such as community health needs may be influential in other ways. Factors internal to training programs such as traditions and widely-held beliefs also influence training (Helmes & Pachana, 2006), as do particular national practices that remain highly influential, such as implicit models of training (Helmes & Wilmoth, 2002).

The pitfalls of such pressures on professional curricula include the production of a piecemeal approach to training. Educators (Reardon & Ramaley, 1996) speak of a “junkyard curriculum”, which is “littered with reforms... and assorted legacies” but lacks cohesion. Students often pay a heavy price for operating in such an environment, and are described by Reardon as having to “scrounge around the yard... picking and choosing from among the rubble in accordance with minimal house rules” (pg. 517). This again emphasises the need for change to occur in the curriculum within a framework that explicitly recognises both external and internal drivers and adopts a comprehensive perspective.

We use the term ‘curriculum re-imagining’ to refer to a process of disciplinary inquiry and subject matter development in which the subject matter specialists are at the centre of the curriculum renewal process (Cousin, 2008; O’Brien, 2008, in press).

This approach builds upon generalised theoretical principles for curriculum development in higher education that emphasise a whole-of-program orientation (Addis & Jacob, 2000), the articulation to and mapping of performative qualities of disciplinary knowledge and practice (Barnett, Parry & Coates, 2001; Short, 2002) within an integrative and aligned sequence of study (Biggs, 2003; Saroyan & Amundsen, 2004). However, despite the fact that curriculum renewal as a research-led, disciplinary-oriented activity has not been well theorised within higher education (D'Agostino & O'Brien, 2007; Healey, 2005; Hicks, 2007), recent innovations documented in the higher education literature have implications for curriculum renewal practice. These include the potential in a whole-of-discipline curriculum inquiry (D'Agostino & O'Brien, 2007) in the identification of disciplinary-specific threshold concepts and pedagogical models (O'Brien, 2008) as a method for reframing and aligning curriculum with disciplinary ways of thinking and practice (Entwistle, 2005). There is also an emerging emphasis on the need for curriculum renewal processes to facilitate deeper connections between curriculum, teaching, assessment and learning (Cousin, 2008; Nygaard, Hojlt, & Hermansen, 2008), learning innovations (Goodyear, 2004), discipline-relevant graduate attributes (Star & Hammer, 2007), and socio-cultural agendas (Bok, 2006) for enhancement and assurance purposes (Biggs, 2001).

A curriculum renewal methodology that takes account of these priorities and processes has been developed and piloted within the Closing the Gap in Curriculum Leadership at UQ Project (D'Agostino & O'Brien, paper in development). This methodology informed the design of the present project, and in turn will further consolidate and embed this methodology as practice, thereby contributing to a trans-disciplinary research-based process for curriculum renewal within higher education.

### *Challenges from the Field and Profession*

Given the increasing profile of psychology as a profession, and the expansion of the potential roles that professional psychologists can play in health-care settings, questions about how best to train psychologists to take up those roles have become increasingly pressing (Helmes & Pachana, 2006). The current model of training of psychologists in Australia is instantiated through Australian Psychology Accreditation Council (APAC) accreditation guidelines, and includes policies for both masters and professional doctorate level qualifications. The requirements of these postgraduate qualifications are at odds currently with minimum national registration requirements of an accredited four-year Honours degree in psychology, and the situation is further complicated by competing pressures from the Commonwealth to increase the numbers of professionals trained. Given the complexities of the current health-care environment, difficulties with expanding current training programs (e.g. shortages of appropriate placements and qualified supervisors), and the evolving relationship between peak bodies (e.g. the APAC) and the government, discussions around training and especially clinical competencies are urgently needed. In addition, recent political moves to enter into international free trade agreements suggest that Australian psychologists can no longer afford to be indifferent to the training models used in other countries (Helmes & Pachana, 2006). There is a need on several fronts to examine how Australian programs can benchmark themselves against international training programs (Helmes & Pachana, 2005a; Pachana, Laidlaw, Collerson, & Merrick, 2008) and could perhaps incorporate training innovations developed overseas (e.g., Laidlaw & O'Shea, 2004). The varying and inconsistent ways in which Australian universities have constructed the curricular requirements of just a single

degree, namely the professional doctorate in clinical psychology, underscores the fragmented nature of curricular development in this country, which is at odds with other nations, including the USA, the UK and New Zealand (e.g. Helmes & Pachana, 2005b). There is a need for more effective communication between existing clinical training programs, because the many state and regional variations impact directly on professional training in clinical psychology (Helmes & Pachana, 2006; Pachana, O'Donovan, & Helmes, 2006).

Clinical psychology as a discipline is evolving rapidly due to methodological advances (e.g. evidence-based methodologies based on randomised controlled trial methods), technological advances (e.g. advances in neuroscience and web-based assessment and interventions), and innovations in practice (e.g. electronic data-gathering to monitor patient progress, tele-health initiatives). Changes in Australian demographics (e.g. the increasing proportion of older adults in the population and declining proportion of children) as well as the increasing desire to address rural and remote community mental health needs highlight specific populations that are currently underserved by psychology in Australia. In addition, the practice of the profession has moved away from an exclusive focus on individual and small group interventions, to a more balanced strategic approach to address health problems at a population level through prevention, education and early intervention. These are topics which have been traditionally viewed as outside the remit of clinical psychology training.

In Australia, clinical training models have been subject to multiple influences. Peak bodies such as registration boards, differing university degree structures, and multiple implicit or explicit health care provider models have led to multiple forms of degree structures with differing standards for completion depending on location and

point in history rather than well-integrated and systematic models. This has a deleterious effect on the work environment, in terms of the level of financial remuneration of practitioners as well as the professional standing of clinical psychologists. Moreover, this variability in training models creates dissension within the profession and has an effect on the perception and standing of the profession in the eyes of the public (Jones, 2008).

### *Training literature in clinical psychology in brief*

Training in clinical psychology in Australia has traditionally followed the “Boulder model” of a scientist-practitioner approach. In recent years this training model has been criticised as failing to embrace new directions of research and practice within the field. For example, Snyder and Elliot (Snyder & Elliot, 2005) introduced their influential four-level “Matrix model” of clinical psychology training, which incorporates aspects of positive psychology into the curriculum by emphasizing both the strengths and weaknesses of clients, and embraces a more community-based, preventive model of intervention. One of the strengths of the model is its capacity to address the role of the psychologist-in-training with respect to the individual, as well as the role of the trainee in a broader institutional and society-community context. This model also actively embraces populations often neglected in the training context, including older adults, the developmentally disabled, and those in rural and remote areas.

Guidelines, both for training and for competencies, are well established overseas, even for specialist areas of practice such as geropsychology (e.g. Pinquart, Fernandez-Ballestros, & Torpdahl, 2007). While such guidelines are beginning to appear in Australia (e.g. Pachana, Helmes. & Koder, 2006), overall guidelines to

achieve key competencies, which are based on well-articulated theories and models of training in clinical psychology, have been largely absent in Australia.

### **Rationale and Structural Components for the Current Project**

In order to move the clinical psychology training curriculum forward, it needs to be re-examined from a broad, national perspective, with reference to national and international standards. The existing curricula in clinical psychology need to be aligned with best-practice standards in terms of discipline content as well as best-practice in teaching and learning strategies. This project addresses curriculum design and development at a whole-of-program level and aims to take leadership in the development of a national curriculum; while teaching and learning strategies are integral to the project, they are only one aspect of a broader perspective. By engaging universities across Australia, this project facilitates a comprehensive curriculum renewal process, drawing from the breadth of expertise available nationally to respond to contemporary training issues. The project is oriented towards the renewal of clinical psychology postgraduate education in alignment with both contemporary and future imperatives in the field (Addis & Jacob, 2000; Entwistle, 2005).

Partner universities, a reference group of key national stakeholders and an international advisory panel have been key to moving the project forward (see Table 1). Partner universities have enabled a strong and vigorous dialogue concerning training issues, as well as providing a fertile arena for the generation of innovative strategies for better aligning teaching and learning with acquiring clinical competencies. Key national stakeholders provide broad national scope for the project, with the inclusion of peak bodies and registration boards on our reference group ensuring good communication lines for feedback and potential uptake of

recommendations and innovations. Links to existing teaching and learning initiatives, including links via our reference group to an ALTC-funded undergraduate psychology curriculum grant has built synergies and opportunities for dissemination. The international advisory panel has been particularly productive, with both consultative as well as written output from these partners strengthening and expanding our initiatives. To ensure that the project progressed in a timely fashion, a steering committee formed by the core partners and facilitated by a study coordinator was essential. Teleconference and face-to-face meetings at regularly scheduled intervals allowed the schedule of milestones to be met in a timely fashion.

Key facilitative and dissemination events have been supported by the project, including presentations and symposia presented at the International Conference on Psychology Education (Sydney, 2010), the International Congress of Applied Psychology (Melbourne, 2010), and the European Association of Cognitive Behavioural Therapy (Training Stream, under consideration for 2011). A brainstorming workshop for all reference members was held early in the project, with international members participating via video-link. A summative national conference showcasing outcomes and participatory workshops is planned for 2011 in Brisbane. A special issue of the *Australian Psychologist*, the flagship applied journal of the APS, devoted to papers describing critical reviews of topics as well as survey data results from this project is in press; a book expanding on these publications and encompassing a broader international perspective on curriculum innovation in clinical psychology is planned.

### **Core Issues in Curriculum Revitalisation Tackled in the Project**

*The role of competencies and competence in training*

Increasingly, regulatory bodies are stressing competencies for independent practice at the point of completion of training (Helmets & Pachana, 2006). While more generic competencies are often offered in professional psychology (as it is a profession encompassing many subspecialties such as organizational psychology), discipline-specific competencies are gaining increasing currency in the teaching and learning literature (Barnett, 2005, 2006; Barrie, 2006; Entwistle, 2005; Hicks, 2007). It has been argued that the only viable common core of competencies lies in the domain of professional practice, pointing to specific skills such as being sensitive to the client's context and situation (Elman, Illfelder-Kaye, & Robiner, 2005).

Others (e.g. Roberts, Borden, Christiansen, & Lopez, 2005) note competence is generally conceived of as a broad characteristic, while individual competencies form only one aspect of what is generally a career-long endeavour. Generally, regulatory bodies would like to ensure a base level of "overall competence" before an individual is deemed fit to practice. However, training has been hampered by vaguely defined competencies, and absence of a clear vision of how competencies can be successfully incorporated into the curriculum and assessed. Unfortunately, there has been a prevailing climate in which clinical competencies are operationalised in terms of amount of study or hours of client contact rather than by actual measures of performance. Currently the registration boards and the APS colleges provide outlines of competencies that must be achieved. It is, however, number of hours of client contact that is submitted as proof of "competency" to both the APS and to State registration boards.

*Problem-based learning (PBL)*

PBL provides one way to encourage students to integrate their learning around clinical examples and reduces the "junkyard curriculum" aspect of clinical training. While debate continues about cost-effectiveness in implementation in medical training, there is evidence that the approach is superior with respect to student evaluation and clinical performance (Vernon & Blake, 1993). There is also evidence (Stedmon, Wood, Curle, & Haslam, 2005) that it aids integration of otherwise disparate information and that it produces better outcomes when student capacity for analysis and synthesis is measured rather than simple knowledge content (Gijbels, Dochy, Van den Bosshe, & Segers, 2005). This proposal considers PBL in a specific area of the clinical psychology curriculum, namely psychopathology and adult interventions, which typically builds upon otherwise disparate information and professional experience and thus is ripe for a circumscribed PBL trial. Without explicitly addressing techniques to integrate practice information, clinical psychology trainees are left to use ad hoc strategies to do so when they begin to assess and treat their own patients after graduation. We seek to use PBL to achieve more integrative learning earlier and in a more reflective and considered way – a considerable advance upon current training models in the Australian context.

### *Fitness to Practice Protocols*

The concept of a formal FTP in clinical psychology training programs that evaluates students on attributes that are non-academic in nature is relatively new in Australia. From the 35 postgraduate programs surveyed as part of the study, only 3 have a formal policy in place. The exercise of raising discussion on this topic is valuable since it has been found that when a student is deemed unsuitable for the profession, it is most frequently through issues that are not academic such as deficits

in interpersonal skills, supervision difficulties, unprofessional demeanour, emotional problems, or problems caused by stress, addiction and responses to other events (Oliver, Bemstein, Anderson, Blashfield, & Roberts, 2004; Vacha-Haase, 1996).

The impact of such problems is felt throughout a program with students reporting a sense of confusion, resentment and disillusionment if they perceive that such students are allowed to continue (Oliver et al., 2004). The development of a formal FTP is not something to be undertaken lightly. It is necessary that such a document embodies natural justice for the student as well as for the faculty and that the process is transparent with adequate representation for the student. A policy suitable for adaptation to an individual university's circumstances and meshing with APAC professional and ethical standards in clinical psychology is presented in the study.

### *E-therapy Training Models*

Information and communication technologies, particularly online facilities, are increasingly being used to remotely and effectively deliver psychological services (Klein, 2010), and the Australian Federal government has invested heavily in various online forms of service provision. This delivery method confers clear advantages to both client and therapist, including the accessibility of services for otherwise unserved populations and cost effective treatment (for a thorough review, see Bennett-Levy, Richards, Farrand, et al., 2010). However, the rapid proliferation of low intensity and, especially, online services has outstripped the development of all but the most rudimentary of regulatory frameworks, and not surprisingly online psychological interventions are yet to receive systematic attention from the bodies that accredit (and therefore largely determine the content of) postgraduate clinical psychology training

in Australia. Clearly this is an urgent training issue, because without structured training in online service provision, clinical psychologists will be unable to participate intelligently or ethically in this burgeoning form of service delivery.

As part of this project, we have collaborated with Anxiety Online ([www.anxietyonline.org.au](http://www.anxietyonline.org.au)), a federally-funded online service provider, which uniquely offers training opportunities to postgraduate psychology students under supervision. Anxiety Online is an online assessment/triage and treatment service provided by Swinburne University's National eTherapy Centre (NeTC). NeTC also provides a portal for clinicians wishing to access online therapeutic tools and psychoeducational materials. The experience of Anxiety Online has been distilled into a set of specific theoretical, training, ethical and accreditation issues that must urgently be addressed by accrediting bodies. Much work has already been done on these issues by the Anxiety Online group (particularly Associate Professors Britt Klein and David Austin) and subsequently by collaborators on the present project, who have stressed the utility of online therapy placements in, especially, the early stages of professional training. Online training modules for e-therapists and supervisors of e-therapists have already been developed, rolled-out and reviewed. Students currently undertake additional clinical work within an e-therapy context, undergoing training, placement hours and supervision above expected load. However, as we have argued elsewhere, the pressing issue is not how or when to train students in online service provision – the urgent need is for national discussion about guidelines for recognising this form of psychological work and integrating it in the postgraduate curriculum across all psychology specialisations.

*Models of University-based Clinic Operation*

Creating a model of university-based clinical psychology training clinics is essential, as such a clinic is a foundation component of professional training. Little is known about similarities and differences, strengths and weaknesses of these clinics across universities. There are currently no guidelines for minimum standards of operation, or models of how clinics can be optimally responsive to the contexts and communities in which they operate. The minimum requirements of a university clinic are discussed in line with registration board and APAC guidelines, and also include various models for maximising clinical, training and financial outcomes in the post-Medicare environment. The template presented (give website details) builds on i) outcomes from the national Clinic Directors' Forum held at Swinburne in 2005 ii) Swinburne's considerable expertise in operating a large and successful university-based clinic and iii) the new (DoHA-funded) National Centre for e-therapy based at Swinburne. The integration of such a clinic in the psychology-training curriculum, staffing needs and objectives, student and patient through-put, and other resourcing issues and solutions is highlighted.

#### *Distance (especially rural) Training Concerns*

The provision of health care services of all sorts is more difficult in regional areas than in capital cities, including those provided by clinical psychology. Changes to this situation are being promoted by the focus of the University upon health care training, including that in clinical psychology. The model of clinical training adopted by the program at James Cook University provides one form of increased flexibility that may promote better services in the discipline of clinical psychology in the regions of Australia.

Contributions to the project include the provision of data on the distribution of students in regional and remote areas of Australia in comparison to those located in capital cities. Issues related to the provision of appropriate supervision at the levels that students require for State registration in addition to that mandated by the Australian Psychology Accreditation Council (APAC) are summarized, together with results of evaluation of the utility of telephone, video conference, and Voice Over Internet Protocol (VOIP) technology. Feedback from students will be used to determine any difficulties with dual reporting relationships over supervision.

### *Clinical Supervision Issues and Strategies*

Supervision of professional practice is mandated in the training of clinical psychologists, and consensually agreed to be central in such training (O'Donovan, Halford, & Walters, in press). Supervision is intended to serve three related, but somewhat conflicting, functions: (Helmes & Pachana, 2006) normative functions of monitoring and ensuring client well being, and monitoring and evaluating supervisee competence; (Helmes & Wilmoth, 2002), restorative functions of supporting supervisee personal and professional well being; and (Reardon & Remaley, 1996) formative functions of educating and guiding supervisee's professional practice. Research suggests supervision as currently practiced can achieve the restorative - and to some extent the formative - functions of supervision. However, current supervision practice has not been demonstrated to be effective in its normative functions.

Enhancing the benefits of supervision can be achieved by increasing the use of systematic data collection, both to assess clinical outcomes for supervisees' clients and to assess trainee competencies through direct observation of supervisee therapy

by supervisors. These data should be reviewed regularly in supervision, and used to promote supervisee self-evaluation and supervisor-provided formative feedback. Positive supervisory processes should be promoted through supervisor training, use of supervisee feedback to guide supervisors, and external review of the supervisory processes. Finally, the normative function of evaluating the competence of trainees should not be the exclusive province of supervisors, but rather systematic assessment by clinical psychologists other than the supervisor should be part of the basis on which supervisees are judged clinically competent to practice.

### **Key Conclusions Flowing from the Project**

This project is ambitious in the breadth of aspects of training tackled, from supervision and assessment of competencies through to issues of how to cope with students' failure to meet a standard of fitness to practice while enrolled in such a program. These are issues that are faced by clinical programs internationally, involving again a balance between pressures to satisfy the demands of a number of stakeholders: student and academic staff aspirations, accreditation guidelines, university practices and employer preferences. Fortunately the empirical data base with which to successfully negotiate these challenges while still providing high quality training experiences is expanding. This database is more robust for some areas (e.g. supervision, fitness to practice, PBL), and rapidly expanding in other areas (e.g. rural training concerns, ehealth and telemedicine approaches in training). Sophisticated models of conceptualising and operationalising core clinical competencies in clinical psychology are available; they need to find a greater place within the day-to-day functioning of clinical training programs.

It is important that the course individual institutions set out upon when making training decisions is based upon this international empirical literature, as well as upon local data gleaned from all of these aforementioned stakeholders. The value of interpreting such local data within the broader empirical literature, as well as a willingness to invest in innovation and to support the key individuals and institutions responsible for implementing innovative clinical training experiences are the major overarching recommendations from this project.

Footnote:

Support for this work has been provided by the Australian Learning and Teaching Council Ltd, an initiative of the Australian Government Department of Education, Employment and Workplace Relations (Award PP8-900 to N.A. Pachana, K. Sofronoff, M. O'Brien, A. Baillie, K. Halford, E. Helmes, M. Kyrios, G. Murray, A. O'Donovan & S. Schwartz). The views expressed in this report do not necessarily reflect the views of the Australian Learning and Teaching Council.

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**Table 1: Core Curriculum Development Partners, National Reference Group and International Advisory Panel members**

Core Curriculum Development Partners	Location
<i>University of Queensland (lead institution)</i>	QLD, Australia
<i>James Cook University</i>	QLD, Australia
<i>Swinburne University</i>	VIC, Australia
<i>Macquarie University</i>	NSW, Australia
<i>Griffith University</i>	QLD, Australia
National Reference Group Member Organisations	
<i>Australian Psychological Society (APS)</i>	Australia
<i>APS College of Clinical Psychologists</i>	Australia
<i>Australian Psychology Accreditation Council</i>	Australia
<i>ALTC-funded Undergraduate Psychology Curriculum Renewal Group</i>	NSW, Australia
<i>Representatives of Clinical Training Programs from States not represented by Core Partner Universities</i>	WA, SA, TAS
<i>International Advisory Group</i>	CA, USA, UK, NZ