Survey of Current Curriculum Practices within Australian Postgraduate Clinical Training Programmes: Students’ and Programme Directors’ Perspectives

Theresa L Scott, Nancy A Pachana, and Kate Sofronoff
School of Psychology, University of Queensland

The aim of the study described was to capture student experiences in postgraduate clinical programmes across Australian universities. The data collected from the Directors of clinical programmes was used to further illustrate the training practices and constraints within the current Australian context. The data were collected through two survey instruments and were analysed by deriving themes via Leximancer as well as quantitative content analysis of percentage response to direct questions. The results indicate that while many students are happy with the training received, there are also many areas open to significant improvement both in the teaching and assessment of clinical skills and course content more generally. Students overwhelmingly prefer practical, interactive, and competency-based teaching and assessment to didactic, written and exam-based alternatives that are still used in most programmes. The responses from programme Directors further illustrate the concerns currently faced by clinical staff engaged in training programmes, with insufficient training places available in the community, fewer clients accessing training clinics, and concerns related to adequate supervision and the competency of students exited from programmes. The findings are discussed in light of limitations to the study and suggestions for future research directions.

Key words: clinical psychology; curriculum; Leximancer; profession; teaching methods; training.

Introduction

There is a long history of self-reflection on the functioning of clinical psychology training programmes, both within Australia as well as internationally. However, many of these articles present more of a commentary on the processes and outcomes of such programmes rather than data examining those programmes (Merlo, Collins, & Bernstein, 2008; Peluso, Carleton, & Asmundson, 2010). This trend is changing, and certainly within the Australian context the trend is for more data-driven articles examining postgraduate professional psychology training (Hunt & Sharpe, 2008; Pachana, O’Donovan, & Helmes, 2006).

Designing an effective sequence of study in the professional clinical psychology programmes is difficult. This is partly because the many extrinsic drivers of curricula, for example external agencies such as registration boards, accreditation councils, and the government itself via legislation and financial support for additional training places influence training demands and sometimes these influences are not well aligned. The aim for best practice in clinical training can also be hampered by long-held beliefs and implicit models of training that may not have a current evidence base.

The data for this article arises from a series of surveys undertaken as part of an Australian Learning and Teaching Council grant. The purpose of the survey was to present a current perspective, from both enrolled students as well as Directors of Clinical Psychology Training programmes, of the strengths as well as issues in current training practices and processes. The data collected is timely given the complexities of the current healthcare environment (workforce shortages and a new National Registration Board), pressures to expand training programmes (in the context of insufficient appropriate training places or qualified supervisors), and the evolving relationship between peak bodies (e.g., Australian Psychology Accreditation Council (APAC)) and the government. Issues associated with training and clinical competencies need to be urgently addressed if the professional standing of Australian psychologists is to be maintained.

What is already known on this topic
1 International standards and models of training.
2 Recommended outcomes in training programmes.
3 Clinical training demands.

What this paper adds
1 Current practices, strengths and issues related to training and clinical competencies in Australia.
2 Perspectives about training programmes from enrolled students and programme Directors.
3 Recommendations for improving training processes and outcomes for students.
Method

Study One: Survey of First Year Clinical Postgraduate Students

Participants

Australian postgraduate clinical psychology students in their first year of training were the participants in this study. In late semester 2, 2009, the potential participant pool was recruited via the Directors of postgraduate clinical programmes across Australian universities. University of Queensland’s Teaching and Educational Development Institute (TEDI) managed the distribution of the surveys.

Measures

The partners to the project collaborated to develop a survey instrument for this study following a six-month scoping of the clinical psychology literature. The questions were constructed to elicit student experiences of clinical postgraduate programmes across Australian universities. A total of 18 questions were included. The range of areas covered were: overall quality of the training programme, teaching and assessment methods and the respective effectiveness of these, clinical training, supervision of clinical practice, and programme workload. Participants were also asked to report whether their university was classed as urban or regional/rural. The survey items were constructed using a variety of rating scales ranging between 2 and 10 response options to attitude statements. Several open-ended questions were used to elicit students’ preferences or attitudes, or to elaborate their responses to closed questions. All surveys may be requested from Professor Nancy Pachana at the University of Queensland.

Procedure

The survey was developed by the project team and administered by Evaluation Services Unit (ESU) within TEDI at the University of Queensland. In the final weeks of semester 2, 2009, the survey materials were distributed to the Directors of 35 APAC accredited postgraduate clinical training programmes across Australia. Follow-up reminders were also sent by email. The Directors were asked to choose a particular first-year class before the end of semester in which to distribute to students a Participant Information Sheet, Statement of Consent form, and a copy of the survey. Participants were to be informed that participation was voluntary and confidential, and to be allowed 15 min in which to complete the survey during class. The Directors were also asked to coordinate the confidential return of the completed surveys and consent forms, using a reply-paid envelope provided to them by the ESU. Survey responses were sent directly to TEDI at the University of Queensland, who accepted these up until 2 December 2009. TEDI collated the quantitative responses into an aggregate dataset, ready for analyses. The survey was approved by the Human Ethics Committee of the University of Queensland.

Study Two: Survey of Directors of Clinical Programmes

Participants

Participants in this study were 35 Directors of postgraduate clinical training programmes across Australian universities. Initial contact was made with the potential respondents via a listserv held at the University of Queensland. A survey instrument was developed and the surveys were conducted via telephone interview with a representative of the clinical postgraduate training programmes at each of the 35 universities contacted.

Measures

A survey instrument was developed by the partners, following a six-month scoping of the clinical psychology literature to determine national and international trends in curriculum, supervision, and practice delivery as well as synergies and constraints with respect to registration and accreditation. Eighteen questions were included that covered problem-based learning, competency-based assessment, supervision, fitness to practice, university-based clinics, and regional and rural issues. The questions relating to regional and rural issues were included only for those Directors who indicated that their programmes were based in a rural or regional area.

Procedure

The survey was conducted by telephone by an interviewer who was independent of the research project team. Confidentiality and anonymity was assured. The interviewer contacted the Directors of postgraduate clinical training programmes at a pre-arranged time and a copy of the interview survey was sent by email beforehand, so that respondents could familiarise themselves with the content. The interview content consisted of standardised questions and participants were also given the opportunity to make any additional comment at the end of the interview. The order of questioning was counterbalanced among participants to avoid any bias in responding. The telephone interviews were recorded on audio discs arranged by a conference call company. The audio was later transcribed verbatim without names or identifying information, by an independent transcription service. Quantitative and qualitative analyses were conducted once the data were proof read and cleaned. The study was approved by the Human Ethics Committee of the University of Queensland.

Results and Discussion

ESU and TEDI managed the return of responses from the students’ survey and assisted with quantitative analyses. Twenty sets of students’ surveys were returned to TEDI at the University of Queensland. This represented a response rate, at the institutional level, of 57%. Overall, responses were received from 190 individual students across Australia. Due to the confidential nature of the surveys it was not possible to track the proportion of students, nor the location of the universities that responded, however it was established that 125 (66%) were from urban...
universities, 51 (27%) were from regional universities, the location of the remaining 14 (7%) surveys was not specified.

Thirty-five Australian universities were represented in the survey of Directors of Clinical Postgraduate Training programmes, representing a response rate of 100% of the programme Directors that were invited to participate. Ten of the 35 Directors indicated that their training programmes were in a rural or regional area.

The following results represent the analyses of the students’ standardised survey data and the Clinical Programme Directors’ structured telephone interview data. The analyses of the students’ survey involved both quantitative and qualitative methods. The quantitative data were obtained using PASW Statistics 18.0 package and the qualitative results were obtained through manual and computer-assisted content analysis.

Manual content analysis was both summative and thematic. Summative content analysis (Hsieh & Shannon, 2005) was used to extract frequency data from the transcribed interviews, such as the number of programmes that included a particular aspect in their programme. The remaining qualitative data were analysed through manual and computer-assisted thematic analysis. Manual thematic analysis involved manually identifying and coding participants’ responses to the research questions to identify themes. This was a recursive process (Braun & Clarke, 2006) that resulted in a number of identified concepts and themes related to each question.

Manual thematic analysis was used alone for smaller raw data files or in conjunction with computer-assisted thematic analysis for larger or more complex data files. Computer-assisted analysis was conducted to corroborate the themes derived from the manual thematic analysis, using Leximancer (version 3.5) (Smith, 2000), a statistical data mining tool that analyses textual documents. Leximancer extracts the most important concepts, grouping these according to themes and assigns interpretive labels. A concept map is produced by Leximancer, which is a visual representation of the strength of semantic association between concepts. That is, concepts that co-occur in the dataset appear closer together on the concept map. The theme circles represent the most salient concept in that cluster of concepts. The closeness or overlapping of theme circles indicates how much these are related to one another in the dataset. The size of the theme circles indicates their centrality. Leximancer analyses have demonstrated face validity, stability, and reliability (Smith & Humphreys, 2006).

**Survey of First Year Clinical Postgraduate Students**

**Quality of the training program**

The best features of the respective programmes as reported by students, were analysed through manual and computer thematic analysis. The themes that emerged through Leximancer 3.5 analysis are shown in Figure 1. The most salient theme related to the best features of the programme was experience (experiential learning), next were staff and placement, and to a lesser extent coursework and practicum. These main themes were situated alongside each other on the concept map (Figure 1), indicating that although these themes were related, the concepts that defined them were unique to each.

**Aspects of the programme that influenced the decision to apply to it.** The themes that emerged in response to what students said influenced their decision to apply to their respective programmes mapped closely onto what students also saw as the best features. The central position and size of the themes on the concept map (Figure 2) indicated the most salient themes. These were identified as programme, undergraduate, and clinical by Leximancer 3.5. There was a small degree of overlap between the themes staff and programme, practical and clinical; and continue and undergraduate that suggested an association between each of the two themes. The theme location was independent of all other themes, as shown in Figure 2. In their comments students identified the primary importance they placed on the practical focus of a programme. They mentioned the clinical experience in
relation to why they chose the clinical course in particular. The university was an important factor in choosing the programme, which was chosen primarily due to its reputation, or because it was seen as the natural progression of undergraduate study or because of its proximity to work or the place of residence. The reputation and the quality of staff were also identified as important in decision-making.

Problems with the programme that affect quality of training. The range of students’ responses to what they believed were the problems with clinical training programmes varied greatly and the variety reflected personal individual needs to some extent, for example “having no scholarship.” The themes and concepts derived from Leximancer 3.5 (Figure 3) and manual thematic analysis in order of salience, included: (a) clinical issues, such as limited access to clients and therefore ability to meet the clinical “hours”; (b) too great a focus on assessment at the expense of meeting clients’ needs; (c) coursework insufficiently practical; (d) time, programme workload and assessment seen as too intense; (e) limited access to supervisors, limited support from external supervisors; (f) lack of perceived interest and support from lecturers and guest lecturers; (g) information seen as repetitive, out of date, or too great, and (h) a lack of quality resources.

Despite identifying such problems, the majority of students endorsed the quality of training provided by their respective programmes. On a scale of 1–10 (where 1 = inadequate, 10 = excellent) the average of participants’ responses to the item “How would you rate the quality of training provided by your programme?” was 7.74 (SD 1.28).

Teaching and assessment methods

Students were asked to report whether or not each of 11 listed teaching methods were being used in their programmes. These are shown in Figure 4. According to students, the teaching methods that were commonly used across clinical postgraduate training programmes included: case examples, reading lists, individual clinical supervision, and didactic lectures.

Next, students were asked to indicate on a 5-point scale (where 1 = ineffective and 5 = very effective), how effective a particular teaching method being used was in supporting their learning. As Figure 5 shows, six of the 11 teaching methods that

---

**Figure 3** Leximancer 3.5 Themes Related to Students’ Impressions of the Problems that Affected the Quality of Their Training Programmes.

**Figure 4** The Proportion of Students Reporting and the Teaching Methods that were Reported as being Used, Across Clinical Postgraduate Training Programmes.

**Figure 5** The Average Effectiveness of the Teaching Methods that were being Used across Clinical Postgraduate Training Programmes according to Students’ Reports (1 = Ineffective, 5 = Very Effective).
were identified by students as being the most effective in supporting their learning, included individual clinical supervision ($M = 4.54$, $SD = 0.75$), case examples ($M = 4.45$, $SD = 0.68$), lecturer’s own work as example ($M = 4.30$, $SD = 0.81$), demonstrations/modelling ($M = 4.23$, $SD = 0.92$), interactive workshops ($M = 4.23$, $SD = 0.81$), and group clinical supervision ($M = 4.02$, $SD = 1.07$).

Case examples were cited as the most commonly used across Australian universities, these were also reported as being effective in supporting student learning. However, three of the teaching methods that were identified as being particularly effective in supporting learning by students, demonstrations/modelling, interactive workshops, and group clinical supervision, were also the three reported as being least commonly used. A commonly used teaching method, reading lists, was according to the students, not a particularly effective teaching method ($M = 3.47$, $SD = 0.93$).

Students were also asked to nominate any additional teaching methods used in their programme that they found to be particularly effective. Students from regional and rural universities endorsed online forums as an additional effective teaching method.

**Quality of clinical training**

It was apparent that participants either misread or misinterpreted the question that asked them to list a single aspect of training that was the most helpful as they began their clinical practice, because the majority responded “placement” to this item. However, the vast majority of these students also chose to list specific aspects of training. The common aspects of training noted as helpful prior to clinical practice included: role plays, lecturers’ use of their own examples, demonstrations and modelling, viva, educational videos, and shadowing more experienced interns. On average, Australian clinical postgraduate programmes were described as moderately focused on students’ needs. Over half the sample (60%) gave a rating of 4 or 5 on a 5-point scale (where 1 = very little, and 5 = very high). The mean rating was $M = 3.69$ ($SD = 0.79$).

**Specific recommendations to improve overall programme quality.** Students were asked to recommend possible improvements to the overall quality of the programmes. The majority of recommendations related to having more or less of what the programmes already included, with few additional suggestions outside of programme content. As shown on the concept map (see Figure 6) the themes were relatively similar in salience. The theme practical was perhaps the most common and was closely related to several others. The themes learning and workload were independent of the other themes. Students agreed overwhelmingly that the programme workload was excessive. The first suggestion to improve programme quality was to reduce assessment, in particular written assignments. Additional suggestions were to reduce the theoretical content or to remove the thesis component entirely. The majority of students recommended more experiential forms of learning, such as role plays, case examples, case reviews and interactive workshops. Some thought more resources should be available, and a greater number of therapeutic orientations included in their training.

**Clinical competencies**

The majority of students reported that their clinical competencies had been assessed only adequately. Summative content analysis showed that clinical competency was well assessed according to 54% of the sample and “somewhat” to “minimally” for 20%. A further 3% felt that there was “too much” clinical competency assessment. A minority (2%) of students felt that clinical competency had not been assessed at all, suggesting that it was “theory” that had been assessed, or the ability to provide evidence of it that had been assessed, rather than clinical competency per se.

Students felt that the best indication of their clinical competency was via internal supervision, placement, recorded sessions, viva, and role plays. In terms of general assessment, the vast majority of students reported that exams were a common but comparatively ineffective assessment method. As shown in Figure 7, case reports and case studies were used most. Portfolios of client work, and live demonstration of clinical skills by student (viva) were used least.

The four most effective assessment methods identified by students were audio/video direct observation of practice, case studies, case reports, and live demonstrations of clinical skills/viva. Figure 8 shows the relative effectiveness of the assessment methods as reported by those students who indicated the particular method was used in their programme. Students reported that live demonstrations of clinical skills/viva was one of the most effective methods of assessment, however it was also one of the least commonly used according to students’ reports. Therefore in terms of assessing the development of skills related to clinical competency, it appears that some of the more commonly reported assessment methods in use are lacking face validity according to this student sample.
Supervision of clinical practice

Students were asked to indicate how often their clinical supervisors monitored their work with clients. Eight alternative methods of monitoring their clinical work were included and the frequency of use of these methods was measured using a 4-point scale, where 1 = never/rarely, and 4 = frequently. The most frequently used method was supervisee self-report and the least was review of audiotaped sessions. The results are shown in Figure 9.

Students were asked to indicate the extent to which they were exposed to the clinical research that their lecturers undertook, such as through classroom discussion or participation in treatment studies. The majority of students (83%) indicated that they were exposed to their lecturers’ clinical research, either occasionally (50%), regularly (23%), or frequently (10%). A further 16% of students indicated that they were never/rarely exposed to the clinical research that their lecturers undertook.

The number and range of clients that students saw was evaluated. The results indicated that just over half the sample either agreed or strongly agreed (55%) with the statement “the number and range of clients I have seen in the university clinic has been adequate for my training needs.” Almost one fifth of the sample (23%) neither agreed, nor disagreed with this statement, a further 17% disagreed and 5% strongly disagreed.

Students were divided on the issue of rural placements. On average, almost as many students said that they would be prepared to do a placement in a rural setting (41%) as those who said that they would not be prepared to (40%). A further 19% of students were undecided about whether they would be prepared to do a placement in a rural setting.

There was strong satisfaction with the amount of clinical supervision that students received. The greater majority of this...
sample (78%) of students indicated that the amount of clinical supervision they received for their client work was about right. Just under one fifth (19%) felt it was a bit low, few (3%) felt it was a bit high, or that it was insufficient (1%).

Programme workload

Students felt that their programme workload was high, over 61% of this sample rated their workload as 8 or above out of a possible 10 (where 10 = “too much” workload). The average student rating was 7.77 (SD = 1.47). A small minority (9%) rated their programme workload at 5 or below on a 10-point scale. The majority of students also felt quite stressed by their programme workload. The average extent to which students felt stressed by their programme workload was 7.78 (SD = 1.70) out of a possible 10 (where 10 = “most stressed”). Less than 10% of students rated the extent to which they felt stressed as 5 or below.

Survey of Directors of Clinical Programmes

Problem based learning

Historically, varying educational methods have been referred to as problem-based learning (PBL), however what these all have in common is the emphasis on the use of “problems” in the instructional sequence and self-directed learning (Barrows, 1986). For the purposes of the present survey, PBL was defined as “learning that is driven by students solving ‘authentic’ problems using various methods of inquiry, self-directed and experiential.” The Directors of clinical psychology training programmes acknowledged the value of an experiential or problem-based learning methodology in the delivery of the curriculum. The vast majority of the Directors reported that their clinical training programmes used interactive forms of learning together with traditional, didactic approaches. However, ten of the 35 clinical training programmes reported that they did not use any elements of PBL; six of these programmes were based in a regional or rural area.

“Case examples” was the key element of PBL being used across several programmes. Many of the respondents acknowledged that the way in which elements of PBL were featured in their courses was less inductive and less self-directed than in the traditional sense. The elements of PBL were delivered mainly through the presentation of clinical case materials, students were then required to apply their existing theoretical knowledge to problem solve a particular case or ethical dilemma. Students may have been asked to collaborate with other students in solving a problem, work with student “actors” playing the part of a client, or they may have worked alone. The regional/rural programmes featuring elements of PBL did so either via video conferencing, or during residential school when students attended and took part in role plays.

Summative content analysis showed that the main content areas that included aspects of PBL were psychopathology, psychotherapies, psychological assessment, and ethics courses. To a lesser extent health psychology and neuropsychology courses were mentioned, and a couple of respondents also mentioned research methods.

The total percentage of coursework that was covered by interactive forms of learning ranged between five and 75% across the 25 programmes that used PBL; on average almost one-third (29.5%). A few respondents noted that they were unaware of individual course content and that each course coordinator would need to be consulted to give more reliable feedback about approximations of percentages and two respondents declined to give a percentage at all.

No additional resources were required to implement these elements of PBL in their programmes, according to 16 of the 25 respondents using it. This was due in part, to these elements being used, such as case examples and role plays, being already well established in the programmes. For those remaining nine respondents that reported using elements of PBL, additional time was required to implement these elements in their programme, either from the particular course coordinator who was new to the course, or from students who were unfamiliar with the mode of learning. Those respondents who reported using the most PBL in their programmes, reported using additional resources such as extensive video/DVD libraries, or extra teaching rooms, or more personnel, for example if they had used actors or advanced students to take the part of clients in role plays.

The most salient themes associated with what respondents saw as the benefits and disadvantages of PBL relative to traditional methods of teaching were given the labels time, curriculum, clinical relevance, and students by Leximancer 3.5, as shown in Figure 10. The primary benefits were: PBL ensured that students were more engaged in the learning process and in the material presented; the clinical relevance of the topics covered through PBL was important because, these often corresponded with the sorts of things that students would later confront when they began their external placements, which was particularly beneficial as novice students prepared for their university clinic...
work; and PBL forced students to integrate the curriculum into a useful form, such as applying theory to a clinical case.

The main disadvantage for using PBL in clinical postgraduate training programmes was seen as time. This theme overlapped with the themes students and curriculum (the advantages) on the concept map (see Figure 10). Although interactive forms of learning enabled the students to critically engage with the material, other didactic methods of teaching were still seen as the most practical way to cover the range of core curriculum content that was required to meet the set guidelines. The time that would be required to translate the whole of the curriculum into PBL would not be feasible in already overloaded three- and four-year programmes according to respondents.

The programme-specific benefits and disadvantages of interactive forms of learning that were in use in clinical postgraduate training programmes included that students were highly engaged in the learning process, and were able to appreciate the real world significance of the material, according to respondents. As an ongoing assessment tool, PBL had good face validity for students as it enabled the assessment to be formative and ongoing. The types of interactive learning experiences that students were exposed to in their programmes developed higher order thinking and skills that made the students highly competitive in the marketplace according to some of the respondents. However, the constraints of time imposed by the programmes overall and day-to-day, meant that implementing PBL on a larger scale was not possible. The cost of implementing interactive forms of learning was also a constraint, particularly in terms of the need to supply additional staff, which was seen as undesirable by university administrators according to respondents.

**Competency-based assessment**

According to summative content analysis, all 35 Australian postgraduate clinical training programmes used competency-based assessment in some form and to some degree. Analysis of the qualitative responses showed that for most programmes competency-based assessment was either exclusively or largely practicum based, and included mainly video and/or audio review, or live observation of practicum work.

Although each of the 35 programmes included either role plays, or live or video demonstrations and viva, it was clear that examinations were still the most widely used and predominant assessment method. Written examinations were used in 33 of the 35 Australian clinical postgraduate programmes sampled. The extent of exam use varied from 15–90% of the total of coursework content; some programmes included multiple examinations in a particular course. A few respondents advocated for more examinations than at present, and one respondent suggested that examinations would be useful as part of the selection process. Examinations were more common in first year courses than in more advanced courses. Several respondents acknowledged examinations were an important method, if not the only method, to assess theoretical concepts, depth and application of theoretical knowledge, and knowledge of the Diagnostic and Statistical Manual of Mental Disorders (APA, 1994).

**Supervision**

Supervision training and regular workshops were the primary means of providing training and support to supervisors. Often an externships coordinator was appointed to the university, and this role provided some internal support to external supervisors, as did internal supervisory committees according to respondents. In some cases, invitations to become adjuncts to a particular university were extended to supervisors, which provided access to university resources, such as the library and Internet services, and to university functions. Discounted access to professional continuing education workshops was provided at one of the universities, and a field supervisor newsletter was regularly distributed at another. Gratuities, in the form of gifts of wine or “thank you” functions were also given as a way of showing support to supervisors, according to a few of the respondents.

Video review or direct observation of therapy was the primary means of evaluation of clinical work by supervisors. Four broad themes emerged from the summative content analysis of the varying and lengthy responses from programme directors to how supervisors evaluated their students’ clinical work. These were (a) placement, including direct supervisor evaluation, video recordings, and self report; (b) assessment, including supervision contracts, log books, etc.; (c) progress sessions; and (d) reports and case files. One of the more novel methods that was reported was the move to include a measure of client improvement such as the Outcome Questionnaire (OQ-45; Lambert et al., 1996) a self-report measure of client progress, as a way to evaluate students’ clinical work.

The evaluation of the quality of supervision was managed in both a formal and informal way and mostly comprised students’ feedback. Summative content analysis showed the more formal methods of gathering feedback about quality of supervision included the use of feedback forms with standardised questions and rating scales, online surveys, yearly review of the outcome for students (placed at particular sites), and placement visits by university staff. Informal feedback meetings were one way to gather feedback from students, in particular for those who were reluctant to document any harsh comments about their supervisors, but it also appeared that some of the Directors may also have been reluctant, given that one respondent reported that the prior dismissal of a supervisor led to legal proceedings, and another commented upon the shortage of supervisors in general. One respondent suggested, “If we got a lot tougher about how we evaluate [supervisors] we just wouldn’t have enough supervisors.”

**Time spent monitoring the therapist behaviours of supervisees.** Most of the respondents found it very difficult to provide an approximation of the time that supervisors spent using a particular method to monitor the therapist behaviours of their supervisees. Most respondents did attempt to answer this question, at the same time as acknowledging their reservations about the validity of the average reported percentages. Overall, “supervisee self report of their own behaviour,” “systematic assessment of client outcomes,” and “review of videotaped recordings of sessions,” were the most frequently acknowledged as being used a considerable amount of the time.
Duration of required supervision. The majority of respondents thought that the duration of required supervision as set down by the APAC, with the overall balance of the Masters of Clinical Psychology programme was about right (71%). A few respondents thought it was too much (20%), and fewer still thought that it was too little (9%). The majority of respondents thought that the duration of required supervision with the overall balance of the Doctor of Clinical Psychology programme, was about right (60%). Few respondents thought that it was too much (20%), fewer thought that it was too little (11%), and for some this particular programme was not offered at their university (9%).

Those who responded “too little” to the above, reasoned that supervision, being the most fundamental learning experience, was one that could not be properly managed in short sessions/time, however they also acknowledged that this issue was complex to manage, and that some students may have actually needed more supervision than was prescribed.

These prescribed hours were seen as “too much” by some respondents who reasoned that managing supervision in field settings was complex and costly. According to some, the time spent in supervision and the time spent learning skills on the job was seen as out of balance. Respondents also noted the difficulties in finding suitable agencies. This issue did not only apply to field settings: the duration of supervision hours was a complex one for some regional programmes, where the onus was upon the university to cover the majority of the supervision needs of their students.

There was an issue of quality versus quantity to consider in prescribing supervision hours according to several respondents, who felt that the duration of hours was “about right.” Some suggested that the number of hours prescribed was somewhat arbitrary and that the reality was that some students probably should be made to undergo more hours while others could cope with much less. While other respondents felt that in general the more supervision that all students received the better, they also acknowledged the difficulty of finding supervisors who were able to manage the required supervision hours, without diminishing the quality of these hours. It was also noted by some that very few students approached the Directors of training programmes about a desire for more supervisory hours and that there would not likely be agreement from field supervisors that there should be more hours spent in supervision. Overall, increasing the duration of supervision hours for either the Masters or Doctor of Psychology programmes was, according to the majority of the respondents, impractical.

Percentage of students failed by supervisors on their clinical practice. Respondents estimated that supervisors in their clinical practice failed approximately 3% of all students in clinical psychology training programmes in the last five years. The competency deficits that resulted in these failures were varied, but could be summed up as the failure to maintain standards of professional practice relating to clinical competence, and to personal or interpersonal characteristics. Respondents commonly cited the inability to engage with clients as a reason for student failure. Frequently, failures were related to personal deficits, for example failure to take advice or instruction, poor communication, poor punctuality, and unprofessional behaviour such as answering a mobile phone during an assessment, and leaving a placement without contacting clients or closing client files.

Finally, other reasons were related to skills deficits, for example in assessment and report writing or the delivery of treatment. The competency deficits that had resulted in students failing clinical practice requirements were the same that were given for why some students, who were passed, should have been failed. Sixteen of the 35 respondents agreed that their supervisors should have failed some students who had passed their clinical practice requirements in the last five years. The competency deficits that were cited for these particular students included skills deficits related to treatment delivery and report writing, poor communication or interpersonal skills, a lack of organisation, or personal deficits.

The reasons that supervisors were reportedly reluctant to fail these students are shown in Figure 11. The most salient themes that emerged through Leximancer 3.5 analysis were given the interpretive labels university, relationship, knowledge and role. That is, because supervisors: (a) believed that (not failing a student) was what the university wanted them to do, or they felt it was the responsibility of the university not themselves, (b) may have formed a close working relationship with the student, (c) did not see it as part of their role, or (d) lacked the necessary training in understanding how to evaluate competencies and their right to fail students that did not demonstrate these competencies. The salient themes university, knowledge, relationship, and role were situated close together on the concept map (Figure 11) indicating that these themes were related. To a lesser extent, the theme bad appeared separate from other themes, suggesting that the concepts within this theme were unique. These concepts included concerns about the negative consequences for the student (related to failing them) as a possible deterrent to doing so.

Evaluation of supervisors. Evaluation of the effectiveness of supervisors was not something that most programmes managed
in a formal way, and similarly to evaluating the quality of supervisors this was mostly done through student feedback. This feedback was gathered from students during meetings or via evaluation forms. One other method was from observation of students’ development, as an indirect measure of the effectiveness of the supervision they were receiving. The other approaches included regular review and planning sessions between academic staff and supervisors.

Twenty respondents reported that they had discontinued the invitation to supervise to certain supervisors in the last five years. In many cases the supervisors may not have been formally advised, however they had not been allocated further students. The primary reasons for having discontinued with particular supervisors were: (a) poor quality supervision including inappropriate instruction, employing unconventional treatments, lack of engagement and poor interpersonal relationships with students; (b) lack of availability; (c) reluctance to give negative feedback about students, or to fail students when necessary; (d) unethical or unprofessional behaviour; and (e) lack of support of students. Two respondents suggested that some sites were found to be exploiting students as labour, rather than supervising them. Furthermore, it was noted that some supervisors recognised their own inappropriateness and they themselves discontinued in the role.

**Fitness to practice**

Most programme Directors acknowledged that the inability or difficulty to exit an unsuitable student from the programme was of concern to them. The vast majority of programmes did not have a formal Fitness to Practice policy in place. Of the four programmes that did have a formal policy, three were in place at the Faculty level, and one had the policy as a working document. For the remaining 31 programmes that did not have a formal policy in place, the capacity to exit a student who was considered to be unsuited to the profession was limited to the student having failed a course, internship or externship.

To exit an unsuitable student from a programme for non-academic reasons would be difficult unless there was a breach of the Code of Conduct leading to the loss of provisional registration according to respondents. Failing this, the overwhelmed majority of respondents stated that they would counsel a student out of the programme that they believed was unsuited to the profession.

**University-based clinics**

The introduction of Medicare rebates for psychology services has had a negative effect on the operation of university clinics, resulting in a reduction in the number of referrals and an increase in the complexity of cases being referred, according to respondents. The mix of referrals was comparatively more problematic than the number of referrals for most university clinics. Many of the referrals that university clinics received were at a severity and complexity that was often considered unsuitable for novice interns, according to respondents. Furthermore, although in some clinics the number of referrals received was quite adequate, a large amount of these did not involve therapy but rather involved a greater amount of psychometric assessments. Therefore the challenge for Directors was to manage the balance between providing enough referrals for students with exposure to a diverse range of referrals that were ideal for the student’s level of career development. Although 24 respondents had felt that there was an adequate number and mix of referrals provided for in their university clinics to meet their students’ training needs, the majority of these respondents also acknowledged that it presented an ongoing challenge to do so.

The more effective initiatives that respondents reported having taken to influence the number and mix of referrals to their respective university clinics could be grouped into four main themes according to manual and Leximancer 3.5 thematic analysis. These themes included promotion of the clinic through marketing and advertising, specialist services, and group programmes, and to a lesser extent minimising fees.

The vast majority of respondents said that they had to market their university clinic to the wider university population and to the community, particularly since the introduction of Medicare rebates that had resulted in a decrease in referrals. Brochures were one means of marketing and these were distributed throughout the university to source potential student clients, or throughout the wider community and to local general practitioners (GPs). Advertising in press included free community announcements, and paid ads in the local free newspapers or the major daily newspapers. One of the respondents reported having had much success through community radio advertising. Several of the respondents acknowledged the importance of advertising their clinics and clinic specialties to local GPs, particularly as GPs were not routinely referring as many patients to university clinics since the introduction of Medicare rebates. For some it was also necessary to specifically inform the local GPs that their particular university clinic no longer had an extensive waiting list and was now able to take new referrals. Some of the Directors took advantage of their university media office and had gotten some free publicity through novel press articles about a particular staff member or students, or a treatment outcome. Having given presentations to community organisations around a particular treatment outcome presented the opportunity to advertise the university clinic as well, according to one of the respondents.

Identifying a niche or high demand specialist area that was not sufficiently serviced by other agencies was important; 40% of the respondents offered group therapy or other specialist clinics as a means to increase or maintain adequate referrals. Lowering the cost of coming to the clinic to clients had been a successful strategy to increase referrals for some university clinics. Some respondents lowered their fees for a limited amount of time as a way to manage. One clinic sought and obtained permission from their university to offer free services to the student body. One other university clinic kept their clinic operating over summer. Finally, one of the rural/regional university clinics was established separately from the university itself and was operating from shared premises in the town centre. The clinic shared the premises with other social services and was therefore seen as yet another community resource, which was a positive move for increased availability of placements also.
Medicare reimbursable services. Five of the 35 respondents offered Medicare reimbursable services in their clinics. A further one of the clinics did not charge a fee at all. Of the five university clinics offering reimbursable services, three clinics did so if a client saw a member of staff. The further two clinics managed reimbursement through their group programmes, whereby a Medicare-registered psychologist acted as senior therapist and was co-facilitated by a student as a junior therapist.

Regional and rural issues

Ten of the 35 respondents said that their training programmes were classified as being in a rural or regional area. Overall, the regional/rural programmes experienced more challenges related to training and retaining clinical psychologists; however, there was some within group variability around these issues depending upon the remoteness of the programme base.

For many of the regional and rural programmes recruiting potential clinical psychologists into the programmes was not a problem, with many of the students attending from metropolitan centres. However, depending upon the remoteness of the location of the university there were issues around retaining qualified clinical psychologists. As a result there were fewer placement opportunities and fewer qualified psychologists to take on supervisory roles for students. Some of the respondents noted that the issue with retaining graduates was that many of the graduates were not “tied to the local area” because a large amount of students enrolled in rural/regional clinical postgraduate training programmes were from outside of the local area and were therefore far more likely to return home, than remain after graduation. Some of the respondents suggested that the reason students left a particular region appeared to be lifestyle related, given their understanding that the smaller inland communities were less likely to retain qualified psychologists than communities along the coast. Two of the regional respondents said that they had no difficulty with training or retaining psychologists because in general people had made a lifestyle choice to move to the particular area.

Discussion

The responses to the survey were quite robust, and thus generalising from these results across the Australian postgraduate clinical training landscape is appropriate. Overall, students broadly viewed practical work, whether as part of their University courses or as part of placements, as the most valued aspects of their training and indeed as one which influenced their choice of which clinical training programme to attend.

A wide range of teaching methods was reported by students as used in their clinical training programmes. However, three of the teaching methods that were identified as being particularly effective in supporting learning by students, namely demonstrations/modelling, interactive workshops, and group clinical supervision, were also the three least commonly reported as being used across Australian universities. It is perhaps noteworthy that such teaching methods are both vulnerable to being seen as too time/labour intensive in programmes looking increasingly at cost-effectiveness measures, and that hours of group supervision permitted are currently regulated by accreditation guidelines.

Issues negatively affecting the quality of students’ clinical training were wide ranging, including clinical issues (such as difficulty accumulating client hours); coursework that was not practically focused, was out of date, or was too burdensome and stressful; and limited access to resources, supervisors, or other forms of support. Despite these issues, most students rated their training programmes relatively highly.

With respect to suggestions for improving their training, students overwhelmingly agreed that their programme workload was excessive. The majority of students recommended more experiential forms of learning, and fewer theoretical and research aspects of clinical training. Students felt that their clinical competence had only been adequately tested, and felt that supervision, placement, recorded therapy sessions, viva, and role plays best assessed such competence. This was underscored in questions about assessment, where it was suggested that exams were overused while portfolios of client work and live demonstration of clinical skills by student (viva) were used least, yet felt to be most effective. This underscores the need for increasing examination of the place of competency-based assessments within clinical training programmes, as the value of such assessments are recognised both in the empirical clinical training literature (see Pachana, Sofronoff, Scott, & Helmes, 2011) as well as by students themselves.

Similarly, self-report of clinical work was used far more by supervisors in training sessions than direct observation, or viewing/listening to audio or visual taping of sessions. Here again, more direct means of experiencing the nature of client work were preferred but were under-utilised. Clinical directors themselves reported that the evaluation of the quality of supervision mostly relied upon students’ feedback, with note made of the reluctance to give negative feedback to supervisors due to supervisor shortages. It should also be noted that more sophisticated ways of charting progress of trainee competence in supervision have been mooted as a key to advancing the quality of both clinical training as well as training in supervision, as discussed by O’Donovan, Halford, and Walters (2011).

Students were roughly split in their willingness to undertake rural placements, which is important given government focus on strengthening health care delivery to these regions. This underscores the fact that regional/rural programmes experienced some comparatively more challenging issues to those faced by urban programmes related to training and retaining clinical psychologists (see Helmes & Pachana, 2011 for more in-depth discussion of regional issues).

The majority of Directors of clinical training reported that their programmes used a blended model of learning, wherein the elements of problem based learning (PBL) were used with traditional, didactic approaches to teaching. The primary reason for implementing aspects of PBL in clinical training programmes was that PBL approaches benefited the students. It was felt that by encouraging active learning, PBL enhanced the integration of learning across different areas of the clinical curriculum and forced students to integrate theory and practice. Time and costs associated with changing course content over to PBL were the main barriers to its increased use within the curriculum. The situation with PBL implementation in clinical training
programmes points to a need for training programmes to share their experiences of implementing curricular innovations. Australia is a relatively small country with a small number of clinical training programmes; more regular contact between programmes could avoid continual re-inventing of training “wheels.” Ideally, research on such experiences could be published (e.g., Kiernan, Murrell, & Relf, 2008).

Competency-based assessment was used at least to some degree by all of the Australian postgraduate clinical training programmes surveyed. However, despite being highlighted both by students as well as in the international literature (e.g., Kaslow et al., 2007 and Kenkel & Peterson, 2010) as being highly conducive to effective learning, for the vast majority of programmes competency-based assessment was either exclusively or largely practicum based rather than more widely incorporated through the didactic portion of the curriculum, and included mainly video and/or audio review, or live observation of practicum work. Greater use of competency-based assessment within courses could both reduce assessment loads as well as improve students’ perception of the value of coursework and assessment within coursework.

Although students failed and were dismissed from clinical training programmes for a variety of reasons, these could be summed up as the failure to maintain standards of professional practice relating to clinical competence, and to personal or interpersonal characteristics. Similarly, clinical trainees who were passed and received their degree, but who upon reflection should have been failed, had issues similar to those students who had failed outright. These issues of competence are interesting in light of the observation by many clinical directors that there is an issue of quality versus quantity to consider in the current number of prescribed supervision hours, such that some students undoubtedly require more hours of training, whereas others could do with less, based on their individual learning and mastery of basic clinical competencies. Requiring more testing of clinical competencies throughout all aspects of the programme, coupled with better titrating of hours to achieve competencies, in terms of staff and resources, might be most beneficial. In addition, formal fitness to practice standards incorporated formally within clinical training (as discussed by Sofronoff, Helmes, & Pachana, 2011) might clarify what sorts of resources are required when with respect to students moving through a training course.

Clinical directors reported that the introduction of Medicare rebates for psychology services has had a negative effect on the operation of university clinics, resulting in a reduction in the number of referrals and an increase in the complexity of cases being referred. These data have been echoed in prior research (e.g., González, Hyde, Lancaster, & Barrington, 2008) and highlight the need for novel approaches to the recruitment of patients and the services offered in such clinics (see Shandley et al., 2011).

Conclusions

Limitations and Future Directions

The use of self-report data from students and programme Directors could be seen as a limitation of the study. It may be that the methods used in training are producing the best practitioners possible and for this we have no outcome measures or comparisons. It is interesting, however, to note the consistency of responses from students about the type of teaching and assessment methods that they found most helpful and to further note that it is this methodology that is reflected in best training practice internationally. It is also very helpful to see that across 35 training programmes within Australia, the programme Directors are experiencing similar difficulties and concerns in translating training to practice. It is important that the interest and momentum gained through the process of these surveys is not allowed to dissipate. Further interaction and collaboration is required both between programmes and across peak bodies. It is essential that the Australian psychology workforce is able to adequately address the current issues of training and meet the international standards to which we all aspire.

The main recommendations that might be seen to flow from these data are at both a micro and a macro level. More specific recommendations about exploring implementation of particular innovations in course structure (e.g., adaptation of more competency-based assessment throughout the curriculum), processes (e.g., integration of a fitness to practice policy within a program), or content (e.g., providing continuously updated didactic content intimately tied to practical examples and more direct supervision of implementation) might serve as a useful starting point for any clinical training programme to consider.

But the larger issues raised in this article have to do with the thinking behind all of the myriad choices that are made within a clinical training programme, by all stakeholders associated with the programme. Course directors make choices about what to include and not include; supervisors need to make choices about how to shape developing competencies; Schools of Psychology need to make decisions regarding resources within clinical training programmes; accrediting bodies need to decide what are the key aspects of clinical training that lead to desired outcomes in terms of competence, and governments and employers need to decide what are their desired workforce outcomes. Are these decisions (a) being informed by data from relevant sources (e.g., existing clinical programmes), and (b) being informed by the empirical literature, which includes a national as well as international perspectives?

The data contained in this survey provide some specific potential directions for clinical programmes wishing to improve training processes and outcomes for their students. What may be a broader point is the need for programmes to self-reflect on their training structures, processes, and content and endeavour to systematically gather data on outcomes and outputs in order to improve the experience for both the providers and the consumers of this training.

Recommendations

• The extant literature, and our own data, strongly support the use of practice-based demonstrations as assessment to establish levels of competence in clinical training programmes. Clinical students highly value these exercises, they have high face validity, can be tailored to reflect developmental milestones in training and are amenable to a pass-remediation format.
• Perception, or the actual fact, of a rift between didactic and practical work needs to be acknowledged and managed. This requires clinical teaching staff and practicum supervisors to be cognizant of ways to help students bring their theoretical and practical knowledge into their practice with clients.

• Although research is a focus in virtually all academic departments with clinical psychology training programmes, the relatively small degree to which students feel exposed to the clinical research during their degree is of concern. Alternate ways of exposing students to research (e.g., clinical experience opportunities within existing research projects; greater research using data from university training clinics) are clearly required.

• A number of economic, process and programmatic barriers may exist to providing an ideal client mix to students in their experience within university training clinics. Realistic appraisal of what experiences can be reasonably provided, with clear guidelines on how to fill in gaps during subsequent placements, should be addressed within training programmes.

• Policies and procedures to accommodate students who are not progressing should be clear at all levels, including students, clinical teaching staff, placement coordinators, heads of school and university administrators. These policies should be in writing and should be shared with students at intake. The opportunity to intervene to try to get a student back on course should seem accessible and reasonable to all parties involved in clinical training. Fitness to practice policies are one way forward here.

• Workload balances for students in individual programmes need to be assessed. Individual programme requirements with respect to coursework, placements and thesis work present huge challenges for students and staff alike. Meetings at which problems and solutions with respect to workload, timing of key events and strategies when things do not go to plan may offer a shared sense of working together to optimise the training experience for all concerned.

• As placement supervision is acknowledged as such a key training element, improving the process of supervision for all is imperative. Training of supervisors, objective ratings of progress in supervision and the handling of students who are not progressing well are perhaps the key areas for increased attention within training programmes, and an increased focus of research among Australian academics interested in improving clinical training.

Acknowledgements
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). The views expressed in this report do not necessarily reflect the views of the Australian Learning and Teaching Council.

References