Clinical Supervision Resource Kit

Clinical Supervision: A Practical Guide for the Alcohol and Other Drugs Field

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NCETA

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Ann Roche is Professor and Director of NCETA. She holds a PhD and a Masters in Education. She has over 25 years experience as a researcher, educator, policy analyst, and consultant for government and non-government bodies, including the World Health Organization. She has published widely in the alcohol and drug field, including peer-reviewed papers and books on drug education. She is a member of the National Expert Advisory Committee on School Drug Education and the National Expert Advisory Committee on Illicit Drugs established by the Ministerial Council on Drug Strategy. During 2003-05 she was President of the Australasian Professional Society on Alcohol and Other Drugs (APSAD).

Foreword

"Clinical Supervision: A Practical Guide for the Alcohol and Other Drugs Field" is a document for people who want to be part of a clinical supervision program. The Guide forms an integral part of the 'Clinical Supervision Resource Kit'. Readers are encouraged to use the Guide in conjunction with the range of other resources provided in the Kit to support the implementation of clinical supervision in the Alcohol and Other Drugs (AOD) field.

There are a number of ways in which this Guide may be of assistance. Its primary aim is to help individuals to create, maintain and/or participate in a supervision program. It is designed for those working with clients or patients with AOD problems. The Guide is practical in orientation and the information is of an applied nature that primarily reflects cognitive-behaviourally based counselling with AOD clients. A cognitive-behavioural orientation to supervision mirrors the current evidence for 'best-practice' in reducing AOD use. However, it is recognised that cognitive-behavioural strategies can be applied in a complementary manner with many other therapeutic orientations.

If you were to speak with only a few AOD workers, you would frequently hear the view expressed that supervision is a necessary element in any health professional's career, but is one that is not often addressed. Based on these messages, this Guide was developed to help foster supervision in your work environment and practice.

People who might benefit from reading this Guide include:

- *workers who have clients with drug or alcohol problems*
- *health professionals who want to specialise in drug and alcohol but have not received any formal education or training in the area*
- *experienced practitioners who want to supervise others to help them become better AOD workers*

- *researchers who want to study clinical supervision and do not yet have the knowledge to understand its practical intricacies*
- *individuals in management roles (e.g., CEOs, managers) who would like to oversee the development and implementation of a supervision program in their workplace.*

There may be others for whom this Guide might also be relevant.

Clinical supervision dates back to the early 20th century in Europe, but it was only in the 1980s and 1990s that career-long professional supervision was pioneered and supported by specific training and literature. Feltham (2002) writes: "It is challenging and exciting in the Australian context to attempt to devise a [clinical] framework that … accepts the existence of critical issues and local needs and builds in a robust and flexible means for responding to them" (p327).

In the AOD field there is a general lack of research on the topic of clinical supervision. Consequently, it would be quite remiss to name this handbook a "guideline". Since the evidence on clinical supervision for AOD problems is scant we drew from the general field of supervision where there is an expanding body of information (Peake, Nussbaum, & Tindell, 2002).

Supervision is also likely to take off in the near future as a research topic with a focus on system, process and outcome factors. Supervision offers a number of important topics of inquiry for the researcher, research-clinician and policy maker.

Structure of the Document

This Guide contains three parts. Part 1 provides background and contextual information. Part 2 addresses the supervisory relationship from the perspective of both the supervisor and supervisee. Part 3 examines supervision from the perspective of the organisation or agency. The three parts of the Guide are explained in more detail below.

Part 1. Background, is an introduction to the topic of supervision. The main aim of this section is to introduce some of the important issues currently impacting on supervision within the AOD field. Some of the topics covered include:

- *the definitions of supervision*
- *the rationale for supervision*
- *supervision as a workforce development strategy.*

Part 2. The Supervisory Relationship covers all the key players in the supervisory relationship and is divided into three sections. The first and largest section focuses on the supervisor, the second section on the supervisee, and the third section on the organisation. In the first section, information is provided for supervisors that will help them conduct successful sessions with a supervisee. The topics outlined are:

- *the main foci of supervision*
- *features of a successful supervisor*
- *belief building*
- *the content of supervision*
- *principles of learning and supervision*
- *training and observation methods*
- *group work*
- *training effectiveness.*

The second section addresses the supervisee, and outlines a number of key points that may help in developing a productive relationship with a supervisor. The topics covered in this section include:

- *what to expect*
- *choosing a supervisor*
- *belief building*

- *planning supervision*
- *training and observation methods*
- *remote supervision.*

The third section of Part 2 covers supervision from an organisational perspective. The topics in this section include:

- *benefits and barriers of supervision*
- *policy*
- *facilitators for programs*
- *barriers for programs.*

Part 3. Developing and Implementing a Program, provides a practical outline of ways to set up a supervision program in your organisation. It covers:

- *the principles and processes of setting up a program*
- *overcoming anxieties, misunderstandings and a reluctance to engage within the organisation*
- *finding and cultivating supervisors*
- *writing a policy*
- *evaluating what has been put in place*
- *forming partnerships.*

Overall, this Guide provides a broad description of the process of conducting a clinical supervision program in your organisation or practice. The content is of an applied nature and addresses the respective roles and contributions of the supervisor, the supervisee and their organisation. A number of worksheets are also included that can facilitate the process of implementing a supervision program.

This document forms an integral part of the Clinical Supervision Resource Kit. The Kit is a key workforce development tool developed by NCETA to help ensure the delivery of quality interventions and worker well-being in the alcohol and other drugs field.

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March 2005

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Recommendations for Clinical Supervision in the AOD field

1. All AOD organisations/agencies should provide clinical supervision to their practitioners as routine practice, given the evidence from the mental health field that clinical supervision reduces staff burn-out, increases job satisfaction and promotes quality practice.

2. Clinical supervisors should receive training in the process (e.g. contracting frequency/timing, timeframe and review, handling grievances/disputes) and content (e.g. core topics, issues and competencies to be covered) of supervision, as evidence indicates that it increases the quality of supervision. It is widely acknowledged that clinical supervisors must be:

    - open, trusting
    - non-judgemental
    - affable
    - highly accessible
    - up-to-date in their knowledge of evidence-based interventions
    - able to impart skills.

3. AOD organisations/agencies should incorporate policies and procedures for clinical supervision in their clinical guidelines, to ensure a shared understanding amongst all personnel as to the function, process and structure of supervision for staff.

4. A clear distinction should be made between clinical supervision and line management/supervision. Clinical supervision is focussed on developing the worker's clinical roles and performance. Line management/supervision, in contrast, is concerned with the evaluation and appraisal of all aspects of a worker's performance. Ideally, a clinical supervisor will not be the worker's line manager/supervisor, and for counselling staff there are advantages in having a clinical supervisor who is external to their agency and therefore independent of organisational processes and issues.

5. The exchange of information in supervision sessions follows the usual requirements for, and limits to, confidentiality that are observed in clinical practice. The supervisee must be informed as to the limits of confidentiality and the requirements of mandatory reporting at the outset of supervision.

6. Adequate time must be allocated to each supervision session to ensure all currently pressing issues for the clinician are addressed (less than one hour is unlikely to be sufficient). It is not possible to specify optimum frequency of supervision sessions as experienced clinicians are likely to require fewer sessions than the inexperienced, and workloads vary greatly. As a general guide, a full-time clinician is likely to require supervision at least monthly (given the challenging nature of alcohol and other drug work), and an inexperienced clinician will benefit from sessions at least fortnightly. Inexperienced clinicians will have a greater need for one-on-one individual supervision.

7. Clinical supervision should proceed according to a shared understanding (expressed in an informal contract) of the purpose, structure and mutual obligations of the organisation, the supervisee and the supervisor. Specific goals and tasks should be negotiated and outcomes monitored. Clinical supervision should be guided by principles of adult-learning, in which the supervisee determines the areas, tasks, and the pace at which their learning occurs (i.e. 'self-directed learning'). Learning should be active and couched within salient clinical contexts. Learning of specific clinical techniques via observation of clinical demonstrations (modelling) is effective, but care must be exercised that the supervisee does not attempt to mimic the supervisor's, or any other demonstrator's, style in its entirety at the expense of their natural style.

8. Many AOD workers may be apprehensive about clinical supervision when it is first introduced to their agency, fearing that their clinical competency may be challenged. Therefore, managers and supervisors must devote time and energy to providing a strong rationale for, and building belief in, clinical supervision.

9. Quality clinical supervision should:
    a. Increase the supervisee's ability to reflect and critically analyse their clinical practice (occasional observation by the supervisor of the supervisee's practice will be helpful)
    b. Develop the supervisee's knowledge of evidence-based 'best practice' in the AOD field and their understanding of theoretical perspectives
    c. Develop skills in delivering interventions via modelling and skill rehearsal
    d. Map further areas of professional development and career enhancement.

10. Professional boundaries in clinical supervision must be observed. Clinical supervision should never become therapy for the supervisee's personal issues. Whilst issues that impact on clinical performance can be identified and discussed, therapeutic remedies for those issues should occur elsewhere. Nor should the supervisee and supervisor develop or pursue a friendship or relationship beyond that which is appropriate within the supervision sessions.

11. When a poor 'match' between the supervisee and supervisor is hampering the supervisory process, both parties are at liberty, and should be advised, to terminate the arrangement. If clinician's have strong preferences for certain characteristics in supervisors (e.g. gender), then every attempt must be made to satisfy those preferences.

12. When one-on-one supervision cannot occur in person, other modes of delivery should be considered (e.g. electronic, at a distance, group supervision).

13. Like many relationships, eventually a sense of diminishing returns may occur after a lengthy period of supervision. This should be openly acknowledged, and a new clinical supervisor sought that can further progress the supervisee's professional development.

14. Evaluation of the effectiveness of clinical supervision should occur within every agency, even if limited in scope. The process of evaluation should be determined when planning the supervision program.

clinical supervision

PART 1: Background

Introduction

Part 1 provides a general overview of the issues relevant to supervision within the AOD field. This first section focuses on whether or not supervision is worth doing and asks why we should even think about supervision. The benefits of supervision are outlined and a brief summary of relevant research is presented. A definition of supervision is also outlined in order to provide a common understanding of the term. Finally, supervision as a workforce development issue is discussed.

What is Clinical Supervision?

It is important to define the term "supervision" at the outset. Doing so enables us to ensure that there is a common understanding of concepts, roles and activities. It will also help to ensure that the implementation of supervision in practice occurs as smoothly as possible.

The definition of supervision may differ across groups or settings (Kavanagh et al., 2002), but in general there are three meanings attached to the term:

1. Quality assurance, usually managed by organisations
2. A method to improve clinical practice (e.g., learn skills, solve problems, obtain suggestions)
3. Professional support.

Although reference is made to all three meanings throughout this Guide, emphasis is placed on the second definition: that is, supervision as a method to improve clinical practice. In this context, we support the definition of supervision:

> *… as a working alliance between practitioners in which they aim to enhance clinical practice…meet ethical, professional and best-practice standards …while providing personal support and encouragement in relation to professional practice (Kavanagh et al., 2002, p247).*

The general literature on supervision focuses on several elements that may be helpful in defining supervision in the AOD field (Shanley, 1992). These elements include:

- a helping relationship between an experienced AOD worker and a less experienced AOD worker
- a relationship whose purpose may change over time and in different situations. Supervision may have a number of purposes such as personal support and development, professional support and development, skills building, delivery of quality health care and a system that qualifies a supervisee for registration or licensing
- a process that may involve counselling, teaching and consultation
- an in-depth exploration of the supervisee's work with clients, which occurs on a regular basis. The process is conducted in a systematic and planned way.

For some, the distinguishing feature of supervision is the manner in which it differs from other forms of professional development. Lambert (1980) succinctly defines supervision as a modification of behaviour that occurs within therapy, which excludes therapeutic work on the supervisee by the supervisor, as might occur during psychoanalytic approaches. He writes: *"Supervision can involve a number of methods, including instruction, supervisor modelling, direct observation and intervention by the supervisor in the actual process and feedback after the process"* (Lambert, 1980, p342). However, this

approach will almost certainly involve cognitive elements involved in developing self-reflection of clinical practice to complement behaviour change.

Four parties have been identified as being involved in a supervisory relationship (Kavanagh et al., 2002). These are the:

1. Supervisor
2. Supervisee
3. Client group
4. Agency (if the worker is not in private practice).

The supervisory relationship may also involve a professional organisation (e.g., Australian Psychological Society, Australian Association of Social Workers, Royal College of Nursing Australia) and/or a registration board. In this respect, the content, structure and process of supervision is likely to be governed by the role of each profession, as well as the context in which the clinical work is conducted. All workers are encouraged to approach their professional association and/or registration body in order to obtain details of any requirements for appropriate clinical supervisory practice.

Clinical Supervision versus General Supervision

It is important to distinguish between supervision in a broad sense and what takes place in a clinical setting. In the present context:

> *Supervision literally means "super" or "over" and "videre" or "to watch, to see". … It is … an educational process in which a person with expertise and skills takes responsibility for training another person with less background and competency. It is a far broader concept than that associated solely with administrative functioning (i.e., hiring, firing, promoting, disciplining, etc.) (Powell, 1980, p30).*

This distinction between administrative or managerial supervision and clinical supervision is further highlighted by Hart (1982), who maintains that *"administrative supervision is aimed at helping the supervisee as part of an organization, and clinical supervision focuses on the development of the supervisee specifically as an interpersonally effective clinician"* (p13).

Why the need for Supervision?

The need for supervision is increasingly accepted by all professions (Muijen, 1997). The benefits of clinical supervision are highlighted by David Powell, a leading advocate of clinical supervision and a well-known alcohol and drug counsellor, who writes:

> *Clinical supervision makes a significant impact upon counselors[1]. It is the most advanced, threatening, and challenging form of clinical training. It is also a prerequisite for the maintenance of quality health care. To not utilise the problem-solving techniques of clinical supervision is to believe in magic, that conflicts, inadequacies, and problems will go away by themselves. It is similar to one wishing he could lose weight and believing in the "fat fairy" who comes at night and takes away all ugly fat* (Powell, 1980, p28).

For many, supervision is an essential and integral component of developing and maintaining proficiency in counselling. As Harvey and Schramski (1984) write: *"Counselor educators believe that supervision is a necessary part of counseling and encourage systematic supervision practices in public and private sector counseling settings"* (p198). Some of the benefits of supervision include:

- improved consumer service
- higher practitioner satisfaction
- decreased staff turnover
- lower training and administrative costs.

(Harvey & Schramski, 1984)

[1]American spelling is retained in quotes from American sources.

A plethora of other benefits from supervision have also been identified in the literature. They include:

- general support for the supervisee (Shanley, 1992; Webb, 1997)
- discussion of clinical issues during supervision (Shanley, 1992)
- maintenance of high quality practice (Reeves, Culberth, & Greene, 1997; Webb, 1997)
- learning of complex clinical skills (Kavanagh, Spence, Wilson, & Crow, 2002; Webb, 1997)
- improved job satisfaction and self-efficacy (Kavanagh et al., 2002; Milne & Westerman, 2001; Shanley, 1992; Webb, 1997; Schroffel, 1999)
- improved staff communication (Webb, 1997).

Ways that the supervisee can derive satisfaction from supervision include:

- emotional support
- sharing of clinical responsibility
- availability of a resource person to discuss client behaviour
- professional development enhancement
- discussion of the theory and practice of counselling
- provision of critical feedback
- culturing of appreciation of the employing organisation
- creation of a sense of belonging
- encouragement of personal growth.

(Kadushin, 1976)

However, there has been little investigation in the AOD field of whether or not supervision improves client outcomes (Kavanagh et al., 2002; Webb, 1997). There is scope for research to assess whether supervision leads to better clinical practice and improvement in client outcomes.

It is maintained that if supervisees are able to adopt and sustain clinical skills of proven efficacy, such as assessment (e.g., determining stage of change), motivational interviewing (MI), Multisystemic Therapy (see Schoenwald, Brown, & Henggeler, 2000) and goal setting, then this increases the probability that improved client outcomes will be achieved.

Supervision in the AOD Field

AOD supervision programs should be tailored to the unique needs of each organisation and its workers. This requires planning and preparation, and systematic implementation. Consideration should be given to the educational and experiential background of the workers. Also, supervision should be offered to almost all AOD staff working in a clinical capacity, and delivered on a consistent, on-going basis.

Two important features of supervision are widely reported by experienced practitioners, researchers and managers in the AOD field.

Firstly, supervision occurs sporadically, if at all.

Secondly, the literature on supervision *"is heavy on opinion, theory and recommendations, but very light on good evidence"* (Kavanagh, et al., 2002). There is little research in this area and there is considerable scope for further work. The field would benefit from researchers studying issues such as the process of clinical supervision and the impact of supervision on clinical practice.

The lack of evidence in the field represents a challenge in the development of a guide that seeks to inform workers and managers about best practice in supervision. As noted above, this Guide is not presented as evidence-based guidelines since there is little evidence

available on clinical supervision for AOD workers. In the absence of such evidence, literature from the general field of supervision was used to develop this document.

There is an expanding body of information available on supervision. As Peake et al. (2002) observe: *"Researchers have been visiting these topics much more frequently in the past decade. Deciding how supervision is best delivered is a challenging, but exciting, task"* (p116).

In summary, supervision currently appears to be delivered only on an ad hoc basis. There is a need to develop more concentrated, sophisticated and tailored supervision programs. Only in this way can the AOD field advance with a reasonable degree of consistency and strive for higher standards of clinical care.

Workforce Development

Clinical supervision is also an important aspect of workforce development. The concept of workforce development is one that is gaining increased currency (Roche, 2002). In a nutshell:

> *Workforce development is a broad term used to encapsulate a number of key factors pertaining to individuals, the organisations within which they operate and the systems that surround them. Workforce development is a multifaceted approach which addresses the range of factors impacting on the ability of the alcohol and other drug workforce to function with maximum effectiveness* (Skinner, Freeman, Shoobridge, & Roche, 2003, p5).

Within the AOD field in Australia there is a complex and variable mix of professions, qualifications, vocational training, skills, knowledge and experience amongst workers. This creates particular challenges for the design of workforce development strategies. For example, recent national surveys found that one third of all AOD workers in Australia do not have formal qualifications (Roche, O'Neill, Wolinski, 2004).

A review of the Australian AOD field conducted by Allsop et al. (1998) concluded that the role of drug specialist staff is to provide services for people with chronic and complex problems. Drug users often present to agencies and treatment services with serious and complex concerns, such as legal, welfare, housing, employment and family problems. A significant number of drug users also have co-existing physical and/or mental health problems. AOD workers and generalist health care providers (such as GPs and nurses) must have the capacity to help drug users, liaise and manage clients jointly with various services, and provide expert advice and support to other health workers.

Partnerships

There are many barriers to creating and maintaining a supervision program. Common challenges include funding and resource constraints. Establishing effective partnerships is one means of overcoming some of these constraints (Bush & Mutch, 1998). What distinguishes a partnership from other types of relationships is *"reciprocal investments and exchanges of human, social and economic capital"* (Bush & Mutch, 2002, p21). This Guide addresses how partnerships may be formed in creating a supervision program (see Part 3).

Evidence-Based Practice

Evidence-based practice is a central workforce development issue that is of particular relevance to supervision. In the AOD field there is some debate about the role and meaning of evidence-based practice. At our current state of knowledge, evidence-based practice primarily reflects cognitive-behavioural strategies that have been demonstrated to reduce AOD use to varying extents, depending on the client population and type of drug use (Proudfoot & Teesson, 2000). However, a common misconception is that evidence-based practice focuses on conducting, scrutinising and applying research with little reference to the role of clinical experience (Allsop & Helfgott, 2002).

However, evidence-based practice is perhaps best described as:

> *The conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgement that individual clinicians acquire through clinical experience and clinical practice. … By best available external clinical evidence we mean clinically relevant research, … especially from patient centred clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens.*
>
> *Evidence based medicine is not "cookbook" medicine. Because it requires a bottom up approach that integrates the best external evidence with individual clinical expertise and patients' choice, it cannot result in slavish, cookbook approaches to individual clinical expertise, and it is this expertise that decides whether the external evidence applies to the individual patient at all and, if so, how it should be integrated into a clinical decision* (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996, pp71-72).

There are clearly important considerations for AOD clinical supervision. A narrow and rigidly applied conceptualisation of evidence-based practice may be inappropriate. Perhaps the most meaningful approach is to see evidence-based practice as being informed by clinical experience as well as research.

In other words, AOD workers should synthesise scientific evidence with their real world practice and experience. For example, two clients may present with the same disorder or condition, but each is assessed and found to have a range of different issues, problems and priorities. Rigidly applying evidence-based guidelines in the treatment of both clients may prove to be unwise and inexpedient.

This document provides a general guide to clinical supervision and AOD workers should apply their own experience wherever possible in order to enhance the concepts and strategies presented here.

In summary:

- Supervision has been largely overlooked in the AOD field until relatively recently
- Partnerships are encouraged to overcome resource constraints that pervade the field so that supervision programs create a network that caters for all drug specialists
- Considerable workforce development with drug specialists is required to build the field's capacity to respond to AOD problems, and provision of clinical supervision is an important and valuable workforce development strategy.

PART 2:

The Supervisory Relationship

Introduction

Part 2 is divided into three sections, namely, The Supervisor, The Supervisee and The Organisation. Together these sections constitute the triad of the supervisory relationship.

The first section focuses on the supervisor. Key information is offered on what the supervisor can do in order to optimise a successful supervisory experience.

The second section focuses on the supervisee, and prepares them for the supervisory process. Those considering undergoing supervision should read this section in order to understand central issues such as what to expect during supervision, how to choose a supervisor, and how to plan the supervision process and experience with their supervisor.

The final section is for managerial staff who are considering the development and implementation of a supervision program in the organisation within which they work.

The Supervisor

This section focuses on a number of issues that are relevant to the supervisor. Topics covered include the reason why AOD workers need a clinical supervisor, the four foci of supervision, the elements for success, belief building, the content of supervision, principles of learning, training and observation methods, and group work. Experienced supervisors with a sound understanding of supervision may also benefit from reading this section, as there have been recent advances in our understanding of effective supervision.

The Need for a Supervisor

Have you ever had a colleague approach you and ask for advice on a clinical matter? The probability is quite high that at least one person has approached you seeking advice for a clinical problem. How often in your career did you receive support and ongoing clinical training at work? The probability is quite low that you ever received on-site training for any extended period of time.

Most AOD workers receive little quality supervision in the workplace, and currently there is only a limited number of supervisors who are fully trained to provide ongoing supervision. If you are an experienced clinician, the potential for you to play an important role as a supervisor should not be underestimated. The scope to expand the delivery of effective supervision in Australia is substantial.

The Four Roles of Supervision

What are the roles of the clinical supervisor? Four key roles of the supervisor have been identified in the literature (Powell & Brodsky, 1998):

1. An Administrative Role
2. An Evaluative Role
3. Clinical Skill Development Role
4. A Supportive Role.

Powell and Brodsky (1998) write that:

> *Clinical supervision is all of the above, blended together into a comprehensive program of structured and unstructured learning and professional and personal growth. It is a method of education designed to permit the integration into practice of self-understanding, relevant theory, substantive knowledge, and functional skills. As such, it enables the supervisee to bridge the gap between vital preparatory learning and actual practice. At the same time, it prepares the supervisee to function as a member of a community of practitioners* (p15).

These four key roles of the supervisor are described in more detail below.

1. An administrative role

As stressed above the clinical supervisor is not a line manager. Ideally, a clinical supervisor would not have any administrative role beyond confirming to management that supervision did take place as planned and is conforming to the organisation's requirements. However, if the worker is doing something that is dangerous, unethical or less than ideal for the client's health and well-being, or is at risk of imminent harm, then the supervisor may have to contact the worker's manager and/or professional body under mandatory reporting obligations. There are limits to confidentiality in supervision just as there are in clinical practice, and the supervisee should be informed of this at the outset of supervision.

Increasingly, there is a preference by counsellors, if not their managers, for a supervisor to be external to their agency in order to avoid any confusion of clinical and management roles/issues. However, in the real world of service provision, most clinical supervisors have line responsibility for the daily activity of the AOD worker and therefore carry administrative responsibilities. Supervisors not only guide development of assessment and treatment planning, but also:

- listen, plan, organise, coordinate and delegate tasks
- select and assist staff
- determine clinical and administrative privileges.

Whilst these tasks may overlap with organisational management issues, it is important not to confuse the two. It is important, where possible, to differentiate the role of a clinical supervisor from that of a general supervisor; after all, each role requires a distinct set of learned skills and expertise.

2. An evaluative role

The supervisor also carries out an evaluative role with the supervisee. They assess the worker's skills, clarify clinical performance standards, negotiate objectives for learning and utilise appropriate strategies for job performance impairment and skill deficits (Powell & Brodsky, 1998). Evaluation is usually for use within the confidential supervision sessions; i.e. it is not given to management and does not form part of a worker's performance appraisal unless the worker requests that it be made available or when it is required for an investigation of unethical conduct.

Evaluation occurs during:

1. *Goal setting*

2. *Feedback* (giving clear and constructive communication concerning the degree to which goals have been attained).

A typical anxiety experienced by the supervisee is associated with being observed or evaluated. The supervisee is asking the supervisor "How am I doing?", but may fear a negative response or an outcome that may require change. The supervisor should have received training in the evaluation process, in other words, on effective strategies for delivering feedback so as to create motivation for growth in the supervisee.

A key to successful evaluation is to focus on the positive aspects of their performance, rather than just giving negative feedback about what needs to change to become a better practitioner. The focus should be on the supervisee's strengths, unless of course the worker is doing something that contravenes professional standards (as mentioned earlier).

3. A clinical skills development role

There are many roles that the supervisor plays. These roles include being a teacher, mentor, trainer and role model (Powell & Brodsky, 1998). A good supervisor instructs the supervisee on clinical practice, however a great supervisor also teaches by example (i.e., not just instructing but also modelling clinical competencies). The supervisor as instructor evaluates clinical interactions, identifies and reinforces effective actions by the supervisee, teaches and demonstrates counselling techniques, explains the rationale for strategies and interventions, interprets significant events in the counselling process and challenges the supervisee in a constructive manner.

To facilitate modelling, the supervisor needs to maintain a case load. In this way, the gap between "saying" and "doing" is smaller; and the supervisee can see that the supervisor is a more experienced, practising practitioner and is able to perform the techniques that are being espoused. This is vitally important, especially when dealing with cases that are chronic and complex, such as those often encountered in relation to AOD problems.

4. A support role

AOD clinicians often work on their own when seeing clients/patients. This can be an isolating and daunting experience, particularly for workers who are at the start of their career or who lack experience with AOD clients. The support that can be provided by the clinical supervisor in such settings is a very important. The role of the supervisor in these instances is to support the worker's clinical efforts, reduce feelings of isolation and minimise professional uncertainty.

The importance of the support role played by the supervisor is captured in the following statement.

> *The supportive functions of clinical supervision include handholding, cheerleading, coaching, morale building, burnout prevention, and encouragement of personal growth. In certain respects the supervisor may be said to be-friend the supervisee, although the boundaries of the professional situation make a close personal relationship between the two inappropriate* (Powell, 1980, p13).

However, the supervisor's role is not to counsel the supervisee on personal issues (e.g., their own drug or alcohol problems) that may be affecting their work. The aim is to facilitate the AOD worker's professional growth so they are more capable of assisting individuals with drug, alcohol and other related problems in the most effective and humane way possible. Powell and Brodsky (1998) write:

> *The supervisor explores the supervisee's feelings during the counseling and supervision sessions (including feelings about specific interventions), provides opportunities for the supervisee to process his or her own affect and/or defences, facilitates the supervisee's self-exploration, and helps the supervisee identify personal issues and areas of growth* (p14).

Clinical material is the main focus of supervision. Personal issues that affect functioning (including work roles) are best dealt with by referring the supervisee to somebody who can help, usually to an employee assistance program or to a therapist who operates externally to the organisation.

In summary:

1. The supervisor is not a line manager
2. Evaluation occurs in two areas, namely, goal setting and feedback. The supervisor should be trained in evaluation
3. A good supervisor instructs by example
4. Supervision is not therapy, although there are some qualities common to both. The role of the supervisor is to support the supervisee's AOD work and not to support him/her through personal issues that may impact on their work.

Successful Supervisors

The four roles of supervisors have been outlined above, and we will now discuss the six key elements and activities of a successful supervisor. These include:

1. The supervisor's characteristics
2. The supervisor's behaviour
3. The supervisor's approach
4. Goal setting and planning
5. Initial and follow-up sessions
6. External factors that influence success.

1. The Supervisor's Characteristics

The characteristics of an effective supervisor are well covered in the literature. For example, Powell (1980) lists the following characteristics of an ideal supervisor:

- open
- honest
- approachable
- helpful
- non-judgemental.

In addition, a supervisor must be:

> *Ethical, well informed, knowledgeable in his/her theoretical orientation, clinically skilled, articulate, empathic, a good listener, gentle, confrontive, accepting, challenging, stimulating, provocative, reassuring, encouraging, possess a good sense of humor, a good sense of timing, be innovative, solid, exciting, laid back - but not all at the same time* (Kaslow, 1986, p6).

Powell and Brodsky (1998) cite a further 30 descriptive terms that capture the essence of a good clinical supervisor. They summarise these characteristics as the four "A's of supervision":

> *Available*: open, receptive, trusting, nonthreatening
>
> *Accessible*: easy to approach and speak freely with
>
> *Able*: having real knowledge and skills to transmit
>
> *Affable*: pleasant, friendly, reassuring.

Above all, supervisors cannot be expected to be perfect. Supervisors also need to work on developing their skills.

2. The Supervisor's Behaviour

There are a number of positive and negative supervisory behaviours. Effective behaviours during supervision include:

- helping
- protecting
- warmth
- affirmation
- understanding.

(Najavits & Strupp, 1994)

Some of the verbal behaviours that increase the supervisee's satisfaction with supervision include:

- praise
- empathy
- positive statements about the relationship.

(Kavanagh, Spence, Strong et al., 2002)

Negative behaviours that are counterproductive to effective supervision include:

- belittling
- blaming
- neglecting
- attacking
- rejecting.

As a supervisor, you should also monitor your own behaviour during supervision; your role is not only to evaluate the supervisee, but also to evaluate yourself.

3. The Supervisor's Approach

The supervisor needs to have a coherent approach to supervision that is evident in action. A supervisor should be able to answer the following questions as a means of testing and developing a coherent approach to supervisory practice:

1. What do I believe about how change occurs for people (particularly in relation to addictive behaviours)?
2. What are the crucial variables in training and supervision?
3. How do I measure success in supervision?

4. How do I contribute to that success?

5. What learning objectives do I have for supervision and what techniques will I apply to achieve these objectives?

(Powell & Brodsky, 1998)

Regular supervision sessions are more likely to occur if the AOD supervisor:

1. Builds a solid relationship with the supervisee

2. Assesses the supervisee's counselling skills

3. Writes a contract that ensures regular supervision sessions

4. Determines the supervisee's learning goals.

(Juhnke & Culberth, 1994)

Finally, supervision sessions should be supervisee-centred. In this way, the supervisee is able to own the process, rather than feel that the process is driven and dominated by external factors. A supervisee is more satisfied if the supervisor affords them the freedom to develop their own style. This is consistent with most views on psychotherapy training, which encourage practitioners to develop a unique style of practice that is a reflection of one's personality (for example see Gelso & Fertz, 2001).

4. Goal Setting and Planning

Setting goals with the supervisee and developing a prospective plan for supervision is essential.

Goals set by the supervisor and supervisee should be SMART, that is, **S**pecific, **M**easurable, **A**chievable, **R**ealistic and **T**imely. Moreover, goals for supervision should be written and agreed upon by the supervisor and supervisee, and have the following qualities:

1. S.M.A.R.T.
2. Specific actions that lead to an outcome
3. Specific procedures that evaluate the outcome.

(Borders & Leddick, 1987)

A part of this Guide is devoted to the supervisee's goals. If you are planning to set goals with supervisees, then you may find it useful to use these. If so, please turn to page 70.

5. Initial and Follow-up Sessions

There are a number of key topics that should be addressed in the initial session:

1. Introduction of supervisor and supervisee
2. Presentation of specific requirements of supervision
3. Anticipated structure and process of supervision
4. Contracting.

The core topics, and their content, are outlined in Box 2.1.

Box 2.1 Topics for Initial Sessions

I. Introduction of supervisor and supervisee

- **A.** Supervisee's description of counseling experience and background
  1. Types of experience
  2. Settings worked
  3. Influence of these experiences on current counseling orientation
  4. Reasons for becoming a practitioner and for undertaking the training/employment *(why focus on AOD work?)*
- **B.** Supervisor's description of their background
  1. Connecting the supervisor's experiences to those of the supervisee
  2. Demonstrating the supervisor's qualifications for being a supervisor

II. Presentation of specific requirements of supervision

- **A.** Meeting time and place (duration, frequency)
- **B.** Observation procedures and requirements, including those pertaining to taping
  1. Consent releases required
  2. Number of tapes required
  3. Tape review procedures
  4. Variety of taped material (different clients, phases of care)
  5. Format of write-up
  6. Co-facilitation procedures
  7. Process notes
  8. Confidentiality restrictions *(very important in AOD work where clients may be engaging in illegal activities)*
- **C.** Evaluation procedures
  1. Acknowledgment of supervisee's anxiety and fears about observation and evaluation
  2. Presentation of evaluation criteria and methodology
  3. Feedback from supervisee regarding evaluation
  4. Agreement on type and frequency of evaluation
  5. Site visits by field supervisors, if relevant
- **D.** Supervisee plan

continued over page…

III. Anticipated structure and process of supervision

- **A.** Teaching methodology
- **B.** Supervisory process issues
- **C.** Supervision versus therapy
- **D.** Clarification of any other supervisory relationships
- **E.** Group supervision
- **F.** Resources available, reading assignments, homework
- **G.** Supervisee's and supervisor's expectations & desired outcomes
- **H.** Plans for the next session, first quarter of training / supervision
    1. Time / scheduling
    2. Arrangements for taping, observation, write-up
    3. Time management, scheduling, cancellation procedures, administrative tasks, job requirements, filing, confidentiality of information
- **I.** Ethical, legal and professional requirements

IV. Contracting

- **A**. Establishment of a contract between supervisor and supervisee
- **B**. Criteria for evaluation of outcomes
- **C.** Rewards for fulfilment of contract
- **D.** Criteria for supervisee progress, including skills and knowledge gain, behavioural changes, expectations of level of change, developmental expectations
- **E.** Obstacles to progress: lack of time, fear of success, fear of failure, performance anxiety, resource limitations
- **F.** Progress review

Source: Powell & Brodsky (1998, pp139-140)

Supervisors and supervisees should ask a number of key questions when contemplating undertaking or engaging in the supervision process. For example, the supervisor should ask themself whether the relationship is working, when to meet with the supervisee and what records are to be kept. Table 2.1 below contains a number of suggested questions for supervisors and supervisees that are utilised at different stages in supervision.

Table 2.1
Sample questions for the supervisee and supervisor at different stages in supervision

Stage	Supervisee	Supervisor
Before supervision	• What practical issues do I need to consider (e.g., location, time, cost, frequency of supervision?) • How do I learn best? • What type of supervision have I had before? What worked for me and what didn't? • What is my role in supervision and what do I perceive as the role of the supervisor? • What type of person am I looking for as a supervisor (e.g., theoretical framework, specialist expertise, experience, gender?) • What are my professional needs (e.g., develop more skills, feel supported?)	• Do I want to supervise? • What practical issues should I consider (e.g., how much to charge, availability to supervise?) • What do I expect of a supervisee? • What is my approach to supervision and how will I describe it to a supervisee? • What is my role in supervision and what do I perceive as the role of the supervisee? • What are my strengths as a supervisor? • What counselling orientations or professions am I comfortable supervising?

Continued over page…

Stage	Supervisee	Supervisor
The first session	• What costs are involved and how is payment preferred? • What happens if one of us cancels our meeting? • How available is the supervisor between sessions if I experience difficulties? • What is expected of me in presenting cases and issues for supervision (e.g., detailed case notes, video recording?)	• Can we work together? • When will we meet, for how long and where? • What records will we keep of supervision, who will keep them and where will they be kept? • What reporting, if any, will occur, what process will it follow and who will receive copies? • How will confidentiality and other ethical issues be dealt with?
After each session	• I found it helpful when you… • What have you learned from our session together? • What did I do that met your expectations? • What did I do that did not meet your expectations? • What would you like to do differently?	• What I liked about your presentation today was… • What have you learned in this session? • What new insight have you gained? • How will you apply what you have learned in your work? • What could we have done differently? • What was helpful about what I did or said? • What was not helpful? • What would you like me to do differently?

Continued over page…

Stage	Supervisee	Supervisor
Review	• How is my client work progressing? • What have I learnt from supervision? • What are my on-going learning needs? • What new learning needs have I discovered? • What would I like to tell my supervisor? • What feedback would I like from my supervisor that I have not already received?	• How do I feel about supervising this person? • What am I offering them? • What can I continue to offer? • What would I like to change in my supervisory arrangement? • What change have I seen in my supervisee? • What has pleased me about our supervisory arrangement? • What would I like to tell my supervisee? • Have I provided a balance of support and challenge?

6. External Factors

The complex array of external and internal factors that may impinge on the supervisory relationship are grouped into five categories:

1. *Supervisor*: background, training, philosophy, personality
2. *Supervisee*: formal training and credentials, recovery history, gender, age, race, ethnicity, professional goals
3. *Client*: level of functioning, clinical profile
4. *Setting*: inpatient versus outpatient, type of care (acute, continuing), agency philosophy, organisational climate, sources of funding, budgetary constraints
5. *Training program affiliation*: academic requirements, credentialing or certification programs, internships.

(Powell & Brodsky, 1998)

The above factors and their interactions can affect a supervisory relationship (Reeves et al., 1997). Such interaction effects include:

- gender - same sex can facilitate the relationship
- race - same racial background can facilitate the relationship
- collegial orientation - discipline-aligned supervisory pairs are more effective than non-discipline-aligned pairs
- style of supervisor and supervisee.

The drug use history of the supervisor also affects the relationship (i.e., drug history congruence facilitates the relationship), regardless of whether the supervisee is a para-professional or professional (Culberth & Borders, 1999). A mismatch in the drug use history of the supervisor and supervisee may contribute to problems in the supervisory relationship.

In summary:

There are a number of qualities that make a successful supervisor and they were outlined in this section. In sum, successful supervisors are:

- available
- accessible
- able
- affable.

There are also a number of positive and negative behaviours that facilitate or obstruct the supervisory relationship.

Supervisors should have a coherent approach to supervision. Each supervisor needs to ask themself some key questions before participating in a supervisory relationship. A successful supervisor:

- builds a professional relationship with the supervisee
- assesses skills
- writes a contract with the supervisee
- determines goals and develops a supervision plan.

A number of external factors influence the supervisory relationship and these should be considered in the selection and allocation of supervisors.

Being "supervisee centred" facilitates the supervisory process.

Building Belief in Supervision

Some AOD workers will be excited by the idea of supervision and some will not. A worker's response to supervision can be influenced by many factors. Some workers will be very apprehensive, fearing that it is no more than scrutiny of their performance with implications for job security. This is likely to be encountered more frequently among AOD workers with little experience and expectation of clinical supervision.

For this reason, AOD supervisors are advised to engage in a belief building process with potential supervisees in order to strengthen their confidence that supervision has benefits for the individual, the client and the organisation. The belief building process involves giving information to potential supervisees, answering any questions or concerns about supervision and dispelling any misconceptions or myths.

It will be helpful if a supervisor can identify the specific concerns a worker may have. For instance, the supervisee may feel that they are:

- losing independence
- losing work autonomy
- being scrutinised, spied on or interrogated
- open to criticism.

Reluctance to engage in supervision can be addressed by the supervisor to generate a positive view of supervision. One simple strategy is to use a persuasive technique called "feel-felt-found". To take an example:

> Supervisee: *I don't like the idea of supervision because it makes me feel like I'm being interrogated.*
>
> Supervisor: *I know how you feel because I felt the same way when I was first supervised early on in my career. I was working on placement in the local drug service and I found that supervision actually helped me a lot in my career. I learnt skills faster because somebody was showing me how to do it better and I had somebody's shoulder to lean on when I wasn't getting the sort of results I was expecting from my clinical work.*
>
> Supervisee: *Won't I feel like somebody is controlling what I do with my clients?*
>
> Supervisor: *You might feel that way at the start. Just let me know if you feel that way and we can discuss it. What I found during supervision was that I felt a bit intimidated by my supervisor, who always seemed to have a better answer; later, I understood the benefit of someone giving me advice, particularly with tough cases*.

The "feel-felt-found" approach permits the supervisor to utilise the supervisee's experience and relate it to their own. If the supervisor does not have personal experience to draw from, then third-party stories can be used to illustrate her case. For example:

> Supervisee: *I don't like the idea of supervision because it makes me feel like I'm being interrogated.*

> Supervisor: *Yeah, … I had a supervisee called Bob who I supervised about a year ago and he felt the same when we started with supervision. But Bob found that once the supervision got going it wasn't anything like he imagined or believed. He soon began to appreciate the benefits of supervision and didn't ever feel like he was being interrogated by ASIO. Anyway, if you ever feel negatively about supervision, just let me know and we can talk about it.*
>
> Supervisee: *OK*.

Another technique that the supervisor can use is to explore why the supervisee feels the way they do. The supervisor begins by asking the supervisee what makes them feel interrogated, for example, and then asks probing questions to explore the issue further (e.g., "Tell me more about that"). In this way, the supervisor is validating the perspective of the supervisee by exploring and addressing underlying ideas and misconceptions.

In summary, some supervisees are likely to lack information about supervision, and as a result may resist the idea of supervision. The role of the supervisor is to build belief about the value of supervision for all key players. A number of techniques are available to persuade the supervisee that supervision is valuable, if not essential, to their professional development. One approach is to give information to supervisees and validate accurate ideas about supervision and dispel myths. A useful technique is the use of "feel-felt-found" to emphasise personal ownership of responses to supervision. To become an effective supervisor, it is important to gently encourage supervisee's to explore the reasons for not readily engaging with supervision.

Supervision Content

What should the supervisor place on the agenda when supervising somebody with respect to AOD work? The literature on clinical supervision identifies a number of key themes relevant to the content of supervision. These are:

- the importance of general training
- empirically supported AOD treatments

- legal and ethical issues with respect to AOD
- AOD treatment issues
- supervision in special settings
- multicultural issues / populations
- collateral dimensions of supervision.

(Peake et al., 2002)

In addition, there are some common issues that the AOD supervisor may encounter and/or focus on during supervision. These include:

- burnout
- frustration
- ambivalence
- uncertainty about what to do with clients.

(Powell, 1980)

There are a number of competencies that an AOD worker should develop to be clinically effective. The following list captures some supervisee competencies.

1. Affective qualities: empathic, self-actualised, respectful, genuine and congruent
2. Assessment skills which are based on a biopsychosocial approach
3. Ability to develop a plan of care with a client/patient
4. Knowledge of, and ability to refer clients to, appropriate services
5. Skills to build a genuine relationship with clients

6. Case conceptualising skills
7. Ability to deliver person-centred counselling
8. Ability to coordinate a client's care (i.e., case manage)
9. Knowledge of, and ability to work in, various settings (e.g., inpatient, outpatient)
10. Ability to implement evidence-based therapeutic interventions (e.g., MI, Multisystemic Therapy, CBT)
11. Understanding and practice of confidentiality
12. Ability to maintain an ethical and professional practice
13. Skills that facilitate clients in recognising and solving problems
14. Ability to create appropriate closure in therapy
15. Skills in maintaining client reports and records.

(Powell, 1980)

Principles of Learning within Supervision

There are many models of learning and supervision. Many of the models have considerable overlap and do no more than emphasise a particular orientation. Therefore, generic principles of learning in relation to supervision are presented here, distilled from a number of models. Inherent within the following summary is the principle that *"adults learn best when they control the pace of their learning…feel the need to learn and when they have a sense of responsibility for what, why and how they learn"* (Brookfield, 1990, p25).

Learning via modelling and guided practice

The ability to deliver evidence-based "best practice" interventions in the AOD field is largely dependent on acquiring the requisite skills via modelling and supervised practice. There is ample evidence that the most efficient and effective means of learning new skills is through the immediate application of new knowledge, a "hands-on" approach or "direct teaching methods" (Dodenhoff, 1981; Henry, Schacht, Strupp, Butler, & Binder, 1993; Lambert & Ogles, 1997). Whilst this may largely occur through training (e.g. professional development workshops), supervision also provides an excellent opportunity for skill acquisition.

Implicit in the behavioural approach to learning is the parallel cognitive process of developing frameworks or schemas in which to locate new skills. The acquisition of skills should be imbedded within a salient context that is imbued with much meaning for the supervisee; this "semantic-based learning" is known to be a powerful aid to integrating new learning and aiding recall (Regehr & Norman, 1996). Within supervision, a meaningful context is usually provided by developing skills in relation to a currently challenging case(s).

In learning new skills a supervisee is guided through a series of steps. Essentially this involves:

1. Discussing the rationale for acquiring the skill and how it relates to current client(s) and a broader therapeutic approach (building belief in the supervisee that they require this skill)

2. Providing a clear conceptualisation of the skill and its various components

3. The supervisor (or other role model) demonstrates a skill(s), followed by both supervisee and supervisor critiquing the performance. The intention is not for the supervisee to mimic the supervisor's general style of communication (although it is likely that some mannerisms will be adopted), but rather to focus on the strategies employed by the supervisor and the manner of their delivery. The supervisor should ensure that the supervisee is aware of

this distinction, and encourage the supervisee to retain and develop their own style that is congruent with their personal qualities

4. The supervisee practises the skill, followed by self-critique and constructive analysis by the supervisor

5 Ideally, the supervisee is later observed (directly or via video recording) using the skill with clients, followed by a critique.

More complex skills are taught effectively when a trainee receives:

- immediate feedback
- an opportunity to practise newly acquired skills (O'Donovan & Dawe, 2002).

Moreover, practice sessions of counselling skills are more effective when delivered over repeated sessions, rather than in a concentrated, time-limited period (Beck, 1986).

Goals and related tasks

Learning proceeds more effectively if guided by some clear and achievable goals set for the medium to long term (over several months of supervision or longer), rather than attempting to develop skills in an entirely reactive manner (e.g. a challenging case has presented requiring a new approach/skills almost immediately). Tasks are then identified that will need to be completed within specified time-frames in order to achieve the goals. This emphasis can be thought of as a task-centred approach to supervision (Powell & Brodsky, 1998, p99). Considerable emphasis is given to the use of goals and related tasks throughout the remainder of this Guide.

Table 2.2 outlines a process for the development of skills in supervision (Powell & Brodsky, 1998, pp97-98).

Table 2.2
The steps in skill development in supervision

Step	Description
Working relationship	• The supervisee and supervisor establish a working relationship that is dynamic.
An effective practitioner	• Supervision begins by asking what one needs to learn to be an effective practitioner. • The role of the supervisor is to assess the supervisee's knowledge and skills before any training takes place. • The supervisor must determine which competencies are to be targeted during supervision and the manner in which these competencies translate into discrete skills to be taught.
Set goals	• Goals are set that enhance the supervisee's motivation and direction. • All goals should be 'SMART'. See Box 2.2 for further details of the goal setting process. • Goals are set for the medium-term (i.e., 3 to 12 months). This is broken down into bite-size goals. • Specific tasks are identified to help achieve goals.
Modelling and reinforcement	• Modelling and reinforcement are utilised to enhance goal achievement.
Skills are monitored	• Skills are monitored on an ongoing basis in order to gauge performance.

Continued over page…

Step	Description
Role playing and simulation techniques	• Role-playing and simulation techniques are used. • Role-playing entails a dramatisation of a contrived situation for the purpose of altering behaviour, whilst simulation recreates a specific clinical situation.
Micro-training	• Micro-training breaks down a specific skill into well-defined, measurable categories, enabling the practitioner to acquire skills in small steps. • During micro-training, the supervisee simulates a clinical situation that is video-taped and evaluated by the supervisor. • The supervisor gives feedback and then the supervisee repeats the skill on video-tape again.
Transference of skills to other contexts	• The supervisee's learning is transferred to another context. • The supervisee is asked to think about the generalisability of, say, a specific technique based on limited experience with a client or within a particular context.

Self-directed learning

A popular methodology for adult learning is self-directed learning, with the rationale, as mentioned earlier, that adults learn best when they are controlling the learning process. General principles for facilitators in guiding self-directed learning include:

1. Helping the learner to use resources so as to become progressively more independent of the facilitator

2. Assisting the learner in defining their learning needs and to organise their learning in relation to priorities and concerns

3. Assisting learners to assume increasing responsibility for their own learning

4. Assisting the learner in organising material

5. Fostering learner decision-making, expansion of options, and adoption of others' perspectives

6. Training in the use of criteria for reflexive, self-evaluation

7. Facilitating problem-solving approaches

8. Reinforcing self-efficacy of the learner as a learner via progressive mastery (within)…a supportive risk-taking environment with an absence of competitive evaluation of performance

9. Emphasising a range of instructional methods, with appropriate use of modelling and learning contracts.

(Brookfield, 1990, p36-7)

A prominent form of self-directed learning in clinical training is 'problem-based learning' (PBL) in which the 'problems' simulate professional practice and for which there may be more than one solution (in some cases, definitive solutions may not exist). The primary role of the supervisor is to act as a facilitator, helping students to solve problems rather than supplying answers. PBL is "a way of constructing and teaching using problems as a stimulus and focus for activity…(with a) focus on process knowledge, knowing how rather than what" (Boud & Feletti, 1991). Although usually used in group learning, it would seem to have application for any learning environment, including one-on-one supervision. PBL essentially involves:

- defining the problem to be worked on (the supervisee should be able to generate 'problems', perhaps with assistance, that relate to their work)

- framing the questions and/or developing hypotheses (e.g. "Which intervention(s) will best suit the needs of this particular client and how best to deliver them?")

- formulating an inquiry strategy (i.e. “How will I proceed in my investigation?”)
- review, critique and refinement until adequate information is obtained on which to base action.

Competent ‘problem-solvers’ are considered to be:

- curious and quick to show initiative
- confident in dealing with uncertainty and complexity
- able to reflect critically and to evaluate one’s own performance
- able to use resources profitably.

It would seem, therefore, that PBL (or one of the closely aligned methodologies such as Project-based and Case-based learning; Woods, 1994) could help equip supervisees with the ability to be reflective, analytical and adaptable in relation to their work, essential qualities in challenging AOD workplaces.

It is not envisaged that every clinical supervision session would be dedicated to a self-directed approach at the expense of the aforementioned skills training, but rather that self-directed learning could be incorporated when appropriate.

In summary:

1. A skills-based approach, with specific tasks and goals, will most effectively convey techniques and interventions during supervision.
2. A direct, active, approach is better than an indirect approach that relies on verbal instruction alone.

3. An ability to formulate and solve problems will give a sense of mastery and confidence, and will promote greater flexibility and resourcefulness in a counsellor.

4. Appropriate learning methods (e.g., role playing) should be utilised when a trusting relationship with the supervisee has been established.

The Process & Structure of Supervision

As with theories of learning, there are many models of supervision that could be presented here. However, we have opted to illustrate some principles extracted from a few leading models.

A developmental perspective on supervision

Somewhat akin to a client's journey through the stages of change when giving-up or cutting-down AOD use, a supervisee passes through different stages of professional development. The role of the supervisor is to tailor sessions according to the stage in which the supervisee falls.

Whilst we should not limit ourselves to thinking that the process of professional development is necessarily limited to progression through discrete stages, some useful observations do seem to be related to a counsellor's general level of development. Four stages (that summarise most developmental models of supervision quite well) have the supervisee progressing through the stages of:

1. Novice

2. Journeyperson

3. Independent Craftsperson

4. Expert.

(Holloway, 1995)

During the **Novice** stage, the supervisee is usually highly motivated but lacks indepth knowledge of the therapeutic process. The Novice may feel insecure and unsure of their competency as a practitioner and will look to the supervisor for support, guidance and feedback. The task of the supervisor is to provide a structured environment and positive feedback whilst being careful that the supervisee doesn't become overly dependent on the supervisor's approval and direction. Knowledge and skill acquisition should be a priority during this stage.

During the **Journeyperson** stage, the supervisee fluctuates between some degree of dependence on supervision and autonomy. The supervisee swings from feeling confident with clinical practice to feeling overwhelmed. They will realise that the art of AOD work is elusive and is more than the sum of theories, models and techniques. The supervisor should provide an environment in which the supervisee can express emotion and feel supported.

In the next stage as an Independent **Craftsperson**, the supervisee begins to trust their own judgement and competence. They are less likely to be swayed emotionally by the challenges of clinical practice. Discussions between supervisee and supervisor are less emotive and reflect different viewpoints. At this stage, the supervisor needs to pull back and trust the supervisee's development, but still provide support, guidance and occasional challenges. There will be less direct teaching by this stage.

During the final stage **(Expert)**, the supervisee is able to function autonomously and understand their limits. They reach a level of self-reflective practice in which learning deepens and undergoes a process of integration. Acquisition of new knowledge per se is less common in this stage. The supervisor will have a more collegial role by this stage.

The process of supervision

Critical components of the process of supervision include (Australian & New Zealand College of Mental Health Nursing [North Queensland Branch], 2000):

- Establishing confidentiality. This is crucial to the development of trust and to the clinical supervision relationship but cannot be absolute as mentioned earlier. Supervisors must outline to supervisees the circumstances in which confidentiality might be breached and the likely mechanisms to be used in such an event. Any proposed breach of confidentiality deemed necessary by the supervisor should be discussed in full with the supervisee except in the most extreme (and unlikely) cases where serious danger to self or others is imminent. It is desirable for supervisors to take problems or issues encountered in providing supervision to their own clinical supervisors and this process should be explained to supervisees.

- Frequency and timing. This may require consultation with line managers to arrange release. Both parties are responsible for arranging a mutually suitable time and venue and both parties must take responsibility for advising the other with adequate notice of cancellations.

- Timeframe and review. A reasonable practice is to initially undertake to meet for a limited number of sessions (e.g. 3-5) and review the progress of the supervision at an agreed time. Should the supervisor and supervisee then agree to continue a new timeframe can be agreed and a framework for review established based on agreed goals for the supervision.

- Nature of the relationship. This is unlikely to require formal recording but should be explicitly stated by the supervisor at the outset. This is not to say that the supervisory relationship cannot change in the course of supervision but there is a crucially important parallel here to the…(workers) development of a relationship with a patient; boundaries and roles are central not only to the safety and efficacy of the process but to the teaching and development

that occurs in the relationship… the skill of the clinical supervisor lies to some extent in focusing the process on the clinical work.

There is an inherent power differential in the supervisor-supervisee relationship which is open to abuse… Supervisees should be encouraged to be aware of such issues and should be informed as to who they can approach should they have concerns which they do not feel can be safely explored within the supervisory relationship.

- Disputes / grievances. As discussed above supervisees should have access to a designated person to whom they can take concerns about the supervision process, preferably after an attempt to resolve such concerns with the supervisor. As supervisees are not bound by the same confidentiality requirements as supervisors they have a range of choice in such matters, but the supervisor should advise that the…professional senior is available to hear any concerns. Such identified organisational processes for grievance or dispute resolution may also be utilised.

Further to the issue of focus within sessions, when the focus is on the clinical relationship between the supervisee and their clients, the supervisor and supervisee reflect together and analyse the work done with the client. Alternatively, the supervisor and supervisee can use the 'here-and-now' of the supervision session to reflect on the process of supervision (which can include their relationship and how that is impacting on the supervision process and the supervisee's work practice). A competent supervisor will move between both styles (Hawkins & Shohet, 1989).

Bringing structure to supervision

Some supervisors and supervisees will welcome a well defined structure to supervision that includes a comprehensive framework and a step-by-step guide that indicates what to do and how to go about it, starting from the first meeting between potential supervisor and supervisee. Others will be less keen on a highly structured approach, but nevertheless most supervisors and supervisees will benefit from a shared understanding (an informal contract if you like) of what is to

take place, especially in the early stages of supervision. As mentioned earlier (and dealt with in detail later), the setting of medium to long-term goals, with related tasks, is essential to this process.

One example of an attempt to outline a structural guide for supervision, in fairly general terms, is that of Page and Wosket (1994) below. It can readily be seen that these steps are entirely consistent with, and similar to, the characteristics outlined in the section "Successful supervisors":

1. Contract: The supervisor and supervisee establish ground rules, negotiate boundaries in the relationship, enforce accountability and expectations, and build a relationship

2. Focus: Issues to be discussed are stated, objectives are set for the relationship, a format for presentation and an underlying approach for supervision re outlined, and priorities are negotiated

3. Space: A collaborative relationship is formed between supervisor and supervisee, an investigative approach and challenge are formulated, and an affirmation of future activities is explicated

4. Bridge: Activities are conducted and consolidated, the supervisor gives information to the supervisee, goals are set, and an action plan is formulated

5. Review: Feedback is provided by the supervisor, evaluation of progress is conducted, and an assessment of goals and action plans is conducted and reviewed if need be.

Terminating supervisory relationships

On most occasions supervision will be terminated due to circumstances intervening (i.e. the supervisor or supervisee relocating or changing jobs), or because the contracted number of sessions has been reached. When the length of a supervisory relationship is open-ended, mutual agreement will often determine that a relationship has run its course, resulting in diminishing returns for effort invested. For example, it might be agreed that the supervisor has imparted

the range of their knowledge and expertise, and that the supervisee wishes to explore areas of professional development for which another supervisor is better equipped to help. This kind of termination occurs in a planned manner and is based on periodic and candid discussion of needs and expectations.

Less common, but of critical importance when it does occur, is the need to terminate because of:

1. *A poor 'match' (incompatibility) between the supervisee and supervisor resulting in unsatisfactory outcomes*

   A poor match may be easily resolved through discussion and a mutual decision to terminate. Supervisees should avoid staying in an unhappy supervisory relationship through a sense of obligation or a desire to protect the feelings of the supervisor. On the other hand, a supervisor must be prepared to address any difficulties in providing adequate supervision. Failure to do so may lead to an escalation of difficulties.

2. *Unethical conduct on part of the supervisee and/or supervisor*

   Unethical conduct by either, or both, parties must be addressed. When either party fails to report unethical conduct on the part of the other, then they are at risk of complicit involvement. Behaviour for which mandatory reporting to relevant authorities is necessary is stipulated in the procedure manuals of organisations, the ethical codes of professional and registration bodies, and in legislation (e.g. sexual misconduct). Other behaviours of less severity (e.g. the use of inappropriate language) could be dealt with in the first instance by requesting the offending party to acknowledge their misconduct and to undertake to change their behaviour (even when the relationship is terminated).

3. *A dispute or grievance between the two parties*

   Any unresolved dispute or grievance between a supervisor and supervisee could, in the first instance, be dealt with by mediation, with a third party (experienced in mediation) facilitating a mutually agreeable outcome or

compromise. Should mediation fail, then written complaints to the relevant bodies should follow so that appropriate organisational and legal processes can occur.

Whilst the above situations are not likely to occur (and indeed occur relatively infrequently in clinical supervision situations) it is, nevertheless, important to be aware of the potential for them to occur and to have appropriate contingencies and response plans in place.

Training and Observation Methods

There are a number of suitable learning methods that can be used when working with the supervisee. These include:

- intensive case review and analysis
- utilising "live materials" such as audio-visual presentations
- direct observation of sessions (or "co-facilitation")
- indirect (i.e., audio-tape, video-tape, audit of case notes) observation of sessions.

Each of these methods is discussed in greater depth below.

Intensive case review and analysis

There are many methods that can be used to review and analyse cases. One of the most popular is 'case presentation'.

Case presentation is an important activity in the supervisory relationship. It is recommended that a prescribed format for case presentations is used. Each organisation will need to determine its preferred structure for case presentations. This will be determined by its unique reporting and administrative requirements and teaching methods. Powell and Brodsky (1998) suggest that *"the case presentation format should be built around problem-and-solution-oriented questions to be answered and should move from client information to dynamics, prognosis, and treatment plan"* (p165).

It is not uncommon for supervisees to experience some anxiety when presenting cases. Such anxiety can be reduced if the supervisor provides a template of how cases are presented and delivers a case herself in order to demonstrate the methodology. Presentations should be clear, organised and focussed.

For further details on case presentation and the intricacies of this activity see Section 2 of the Supervisee section below.

Another method used to review cases is called Interpersonal Process Recall (IPR) developed by Kagan (1980). This method is best used with video- or audio-tape technology (see the section below on video-tape observation). The aim of IPR is to increase the practitioner's awareness of intra-psychic processes that influence perceptions, judgements and actions when working with clients.

IPR is not task oriented. Rather, it is designed to increase the practitioner's self-awareness regarding the therapeutic relationship. The following steps are taken when conducting a recall session:

1. The supervisee reviews a video-taped session and selects a segment that they want to explore with the supervisor

2. The supervisee then introduces the recall session with the supervisee. The purpose of this exercise is to reflect on the thoughts, feelings and actions of the client and supervisee

3. The video-tape is played and either the supervisee or supervisor pause the tape in order to delve into a thought, feeling or action that occurred during the counselling session. The supervisor facilitates the discovery process by asking open-ended questions

4. During the recall session, the supervisor does *not* act as a teacher to educate the supervisee on what they should have done. Instead, the supervisee is permitted to explore thoughts and feelings that lead to resolution.

Asking open-ended questions is important. It is also important that the supervisor asks such questions in order to enhance the supervisee's awareness of blind spots. There are a number of example questions that serve this purpose, including:

- *What do you wish you had said to her?*
- *How do you think she would have reacted if you had said that?*
- *What would have been the risk in saying what you wanted to say?*
- *If you had the chance now, how might you tell her what you are thinking and feeling?*
- *Were there any other thoughts going through your mind?*
- *How did you want the other person to perceive you?*
- *Were you aware of any feelings?*
- *What did you want her to tell you?*
- *What do you think she wanted from you?*

IPR provides supervisees with a safe place to examine internal reactions by re-experiencing the encounter with the client. Research has consistently supported the use of IPR as an effective tool in supervision. Cashwell (2001) cites research that found that practitioners who were involved in IPR training improved client wellbeing relative to practitioners who were not. Moreover, IPR is an effective tool with practitioners from varied educational and experiential backgrounds.

Role playing and role modelling

Transmitting skills to the supervisee is one of the principal goals of the supervisory relationship. Skills are conveyed to a supervisee primarily using two training methods, namely, *role playing and role modelling.*

During role playing, two participants (usually the supervisee and supervisor) rehearse a set of activities in a contrived situation in order to simulate the work between a client and practitioner. Role playing is ideal for a supervisee who lacks confidence or experience with a skill; it allows you to provide feedback to the supervisee in an environment that is not a real therapeutic situation. You can also pair up two supervisees and observe them (i.e., you do not have to participate in role playing directly).

Such observational learning can also be very powerful. For the novice supervisee, this is also a non-threatening way to ease into the supervisory relationship and to learn the "rules of engagement".

There are some rules to adhere to during role plays in order to promote a productive session. These rules are:

1. Establish a clear and realistic scenario that reflects a situation the supervisee will probably face during clinical work
2. Swap roles frequently so that the supervisee is not always the client or practitioner
3. Simulate clinical problems, rather than role playing a personal problem
4. Avoid emotional roles (e.g., the abusive client) that may spill over into the simulated situation and generate hostility between participants
5. Conduct a debriefing session after the role play in order to give feedback and switch out of the simulated situation
6. End the role play with a summary statement of the concepts learned.

If in doubt that role playing is suitable, use the following criteria as a guide. Role playing is suitable:

- for an inexperienced supervisee who needs to work on basic counselling skills

- for an inexperienced supervisee who requires work on a specific skill and works in a setting where co-facilitation is difficult to organise or undesirable

- for an experienced supervisee who needs to practise an advanced technique (e.g., MI)

- if a supervisee is having difficulty with a particular clinical activity and would like immediate feedback (e.g., case conceptualisation).

Role modelling, in contrast to role playing, involves demonstrating a skill that is conveyed to the supervisee. In this instance, the supervisor is an active participant, whilst the supervisee is a passive observer. The supervisor acts as the expert.

Learning is further reinforced when the supervisor and supervisee discuss the skill after the modelling has taken place. Video-tapes of modelling presentations are also useful and provide the supervisor with a timely opportunity to discuss with the supervisee the skill that is being modelled by an expert.

Role modelling is an active and interactive process that offers the supervisee the chance to observe, and later emulate, an expert. Successful role modelling involves the following three components:

1. An expert role model

2. A clear understanding of the purpose of the exercise

3. A follow-up discussion led by the supervisor or expert.

Co-facilitation

Co-facilitation is a situation in which the supervisor and supervisee are both present during a consultation with a client. Co-facilitation is effective for a number of reasons, the most evident being that the supervisor is able to observe the supervisee 'live'. In addition, the supervisor is able to model counselling behaviours that they would like the supervisee to learn and integrate into their practice.

This approach is particularly useful in the early stages of supervision when a supervisee is initially exploring the use of techniques and interventions with which they may be relatively unfamiliar. The supervisor is close at hand to help the supervisee when they are first practising new skills.

A disadvantage of co-facilitation is the potentially intrusive nature of having more than one AOD worker trying to help a client; the client may feel overwhelmed and/or interrogated. The supervisee can also feel under scrutiny and this may be counter productive to the development of the therapeutic relationship. The ground rules for video technology also apply here: the client is given a choice of whether or not to participate in a co-facilitation session.

Co-facilitation should adhere to the following set of simple principles:

1. The supervisor sits beside the supervisee in an individual counselling session. That is, the supervisor is an active participant in therapy and not an outside observer

2. The session begins with a pledge of confidentiality. Any material that is discussed outside of the therapeutic situation is for supervision purposes only

3. The supervisor and supervisee must have a plan of action before they enter the session. Both parties may even benefit from "walking through" what will occur during the session, including the interventions to be used

4. The supervisor takes notes of key issues to raise after the session

5. The supervisor's interventions during the session are limited to three or four only

6. Feedback is delivered to the supervisee soon after the session is completed

7. Co-facilitation is used in conjunction with videotaping wherever possible/appropriate.

(Powell & Brodsky, 1998)

Indirect observation

There are many types of technology that facilitate indirect observation of sessions. The most common are audio- and video-tape. The use of video technology is a powerful tool for observing and being observed by the supervisee. Video cameras are relatively inexpensive and allow for observation that is close to actually being present in the consulting room. The major advantage of video technology is that the supervisor does not need to be present when the supervisee is consulting and thus does not need to sit through clinical sessions unnecessarily. Supervision can then focus on specific aspects of the taped session.

Videotaping should follow a set of clear steps in order to maximise its value. These steps are:

1. Clear goals are set to determine why, when and how video technology takes place. A one-hour session is amenable to hours of analysis and so the task of video-tape analysis must be clear and focused

2. Interactive processes recorded on tape are contextualised. The supervisee has the opportunity to comment on the context in which a clinical action was taken. The supervisor has a broader perspective of each interaction with the client and is able to assess the supervisee's rationale in reaching clinical decisions

3. Tape segments are selected for review because they provide teaching moments. To strengthen the supervisory relationship, supervisors should ask the supervisee to select a segment they would like to analyse. In this way, the supervisee takes ownership of the session

4. The supervisor provides feedback.

(Powell & Brodsky, 1998)

The most important rule with respect to video technology is client consent. The AOD worker must obtain written consent from the client to authorise videotaping and a clear explanation is provided about the purpose of the taping, including who will view the tape and when it should be erased. This ground rule is important as the prevalence of illicit activities (such as sex work, theft, assault, drug dealing) is relatively high amongst the drug using community.

Group Work

Definition

The role of group supervision is often under-valued amongst health professionals because of a common misconception that supervision only comprises a one-on-one arrangement. However, group supervision is widely practised (McMahon & Patton, 2002) and, in some therapeutic models, like Multi-systemic Therapy (Schoenwald, Brown, & Hengeller, 2000), group work is the norm.

Group supervision has been defined as:

> *A working alliance between a supervisor and several counselors in which each counselor can regularly offer an account or recording of her work, reflect on it, and receive feedback and where appropriate guidance from her supervisor and her colleagues. The object of this alliance is to enable each counselor to gain in ethical competence, confidence and creativity so as to give her best possible service to clients* (Inskipp and Proctor, 1993, p72).

The fundamental difference between individual and group supervision is that the latter process is conducted within a group dynamic in which there is a supervisor and a small number of supervisees. The group is pursuing a common goal or goals.

Group supervision is contrasted with peer-driven approaches, in which there is no formal supervisor who facilitates the group. Group supervision is a cost-effective alternative for drug and alcohol organisations that have funding constraints, or for health professionals who must pay for supervision themselves.

Advantages and disadvantages of group work

The advantages of group supervision are that:

- it is a cost effective way of supervising more people at the same time
- it is an approach amenable to teaching methods like peer debates, case reviews and role playing
- it involves the sharing of clinical problems amongst colleagues with the view of drawing from a wealth of knowledge and experience to handle difficulties
- the range of clinical problems and therapeutic techniques is large; all members are exposed to more knowledge
- the therapeutic and support milieu of group supervision has a powerful effect on each member
- group supervision is less threatening to some people, in contrast to individual supervision
- the participant can play many roles in the group, such as supervisee, supporter, adviser or facilitator.

(Powell, 1980)

There are also a number of disadvantages to group supervision (Powell, 1980):

- competition may emerge and interfere with group dynamics
- imbalances can occur in which some supervisees dominate discussion and prevent others from contributing

- entry into the group by new members may be difficult, particularly if the group has been running for a long time
- "loafing" can take place in which a member does not contribute to the group
- creative growth and problem solving may be stifled when some members pressure others to conform to their ideas.

Models of group supervision

Four models of group supervision have been identified (Inskipp & Proctor, 1993):

1. *Peer-driven:* There is no supervisor and one or more peers facilitate group work
2. *Individual:* The supervisor attends to one individual, whilst the other members watch
3. *Group:* A supervisor facilitates all members to participate simultaneously
4. *Cooperative:* The supervisor facilitates the group to supervise each other.

There is little evidence to suggest which of the three supervisor-based models (i.e. models 2-4) is more effective. The group-focused approach can be appropriately used at specific stages (e.g., beginning of supervision, entry of new members into the group), while the individual and cooperative approaches may be more appropriate when the supervision program is functioning cohesively (Gelso & Fertz, 2001).

While there are many suggestions/options for the ideal structure of group supervision, there is general agreement that any given session should:

- contain four to six members
- be held once a week or fortnight, depending on the delivery of other forms of supervision
- last 1.5 to 2 hours.

Group supervision processes

There are processes and elements of group supervision that parallel those found in any interactive group. These processes include:

- a sense of “we-ness”
- a shared frame of reference
- tolerance of diverse opinions
- movement toward common goals.

The role of the supervisor as “group leader” is to facilitate and nurture these processes.

The group leader has three fundamental tasks to undertake during group work (Figure 2.1)

1. Creation and maintenance of the group
2. Group culture building
3. Activation and illumination of the here-and-now.

(Yalom, 1995)

The first task of the leader is to create and convene the group. This involves more than just informing colleagues of the possibility of group supervision taking place. A more proactive approach is required.

One way to progress is to call for an expression of interest so any interested worker is able to assess whether they may benefit from participating in group work. Later, the supervisor selects members by interviewing each candidate and determining their suitability for the group. If more than one group is to be run, then the supervisor may place candidates into separate groups according to professional and experiential background, work history, age, gender and interpersonal style.

The second task of the leader is to stimulate a group culture. The group is a social system and as such the leader begins by establishing a code of behavioural rules or norms that govern the group (Gelso & Fertz, 2001). Rules are made in relation to level of involvement, disclosure of client information, presentation of information and style of appraisal (e.g., non-judgmental acceptance of others). The group leader facilitates norm building through two roles, namely, technical support and modelling (Yalom, 1995).

The third task of the leader is to focus on the here-and-now. That is, the supervisees are asked to focus their attention on the present. Yalom (1995) writes that there are two tiers to the here-and-now focus: firstly, experiencing of each member in the present, and secondly, illuminating the changes that take place (i.e., behavioural and cognitive change).

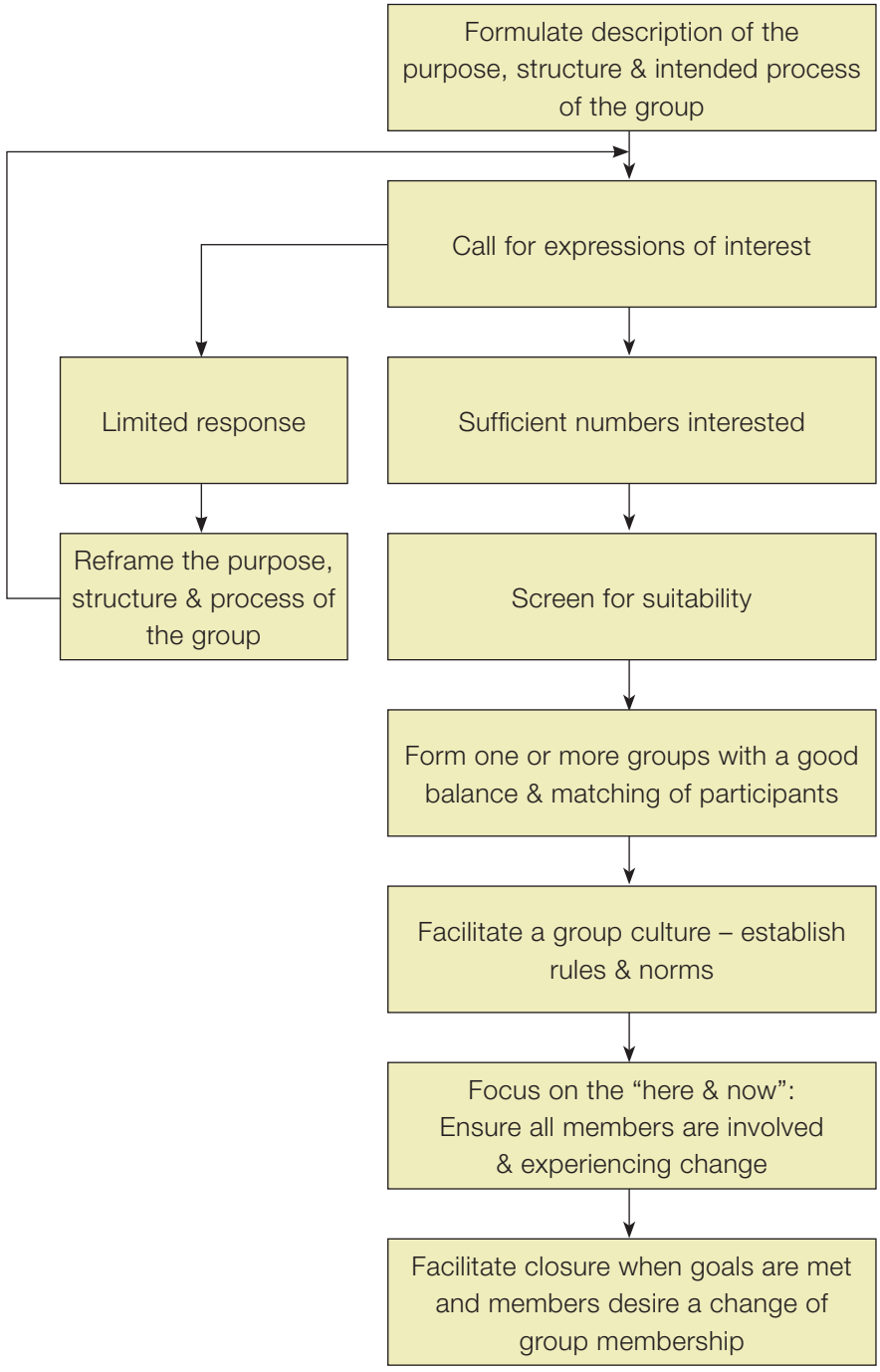

Figure 2.1: Establishing and guiding a supervision group

Yalom states that:

> *When you grow accustomed to thinking of the here-and-now, you automatically steer the group into the here-and-now. Sometimes I feel like a shepherd herding a flock into an ever-tightening circle. … Whenever an issue is raised in the group, I think, "How can I relate this to the group's primary task? How can I make it come to life in the here-and-now?"*
> (Yalom, 1995, p143)

Characteristics of effective group leaders

There are numerous personal characteristics of effective group leaders. Corey & Corey (1997) suggest that there are 15 key characteristics:

1. Courage
2. Willingness to model
3. Presence
4. Goodwill and caring
5. Belief in the group process
6. Openness
7. Becoming aware of the culture
8. Non-defensiveness in coping with criticisms
9. Personal power
10. Stamina
11. Willingness to seek new experiences
12. Self-awareness
13. Sense of humour
14. Inventiveness
15. Dedication.

In summary:

Group supervision is similar to individual work in that it is held regularly and there is a 'specific' agenda for each meeting. Sessions should be run in such a way that all supervisees can contribute information, rather than the supervisor presenting material to passive participants. The supervisor's role is to help the supervisee take responsibility for their learning and the problem-solving process.

There are a number of advantages and disadvantages to group supervision as outlined above. These are mentioned to improve understanding of the relative benefits of doing group work in contrast to one-on-one work. There are four basic models of group supervision and the developmental stage of the group should determine which is most appropriate to use at any point in time. The underlying processes of group supervision include creating and maintaining a group, building culture and directing participants to a here-and-now focus. These models and processes are borrowed from the counselling literature, and are also applicable to group supervision.

Training Effectiveness

Supervisees do not enter clinical supervision as "empty vessels". They bring into supervision a range of skills, professional experience and individual traits which may affect the impact of training (O'Donovan & Dawe, 2002). This is very apparent in the AOD field, where workers come from varying occupational and experiential backgrounds.

There appears to be little connection between years of clinical experience and client outcome (Crits-Christoph et al., 1991; Smith & Glass, 1977; Stein & Lambert, 1984). However, some evidence (Burlingame, Fuhriman, Paul, & Ogles, 1989) shows that:

- intensive training leads to better client outcomes than self-instructional training or no training at all
- experienced therapists have more successful outcomes than less experienced therapists after intensive training.

In a review of the literature, O'Donovan & Dawe (2002) found little evidence to show that factors like gender, age or ethnicity influence training effectiveness. However, therapist characteristics such as warmth, genuineness and the ability to form a therapeutic relationship all influence client outcomes. The characteristics outlined in Table 2.3 may influence training effectiveness, and therefore should be assessed. Table 2.3 contains some assessment questions that you might ask the supervisee during this type of assessment.

Table 2.3
Supervisee characteristics that influence training effectiveness

Supervisee characteristics	Description	Example assessment questions
1. Personality	Is the supervisee open, likeable and warm during interactions with you and with clients?	
2. Coping patterns	Some ex-users are vulnerable to relapse when counselling current users. AOD cases are chronic and complex and may tax the AOD worker.	• Have you ever had a drinking or drug problem? • How long ago? • Tell me about your experience? • Have you ever experienced a friend or family member go through a drinking or drug problem? • How long ago?

Continued over page…

Supervisee characteristics	Description	Example assessment questions
3. Attitudes	Positive attitudes are statements like: *"Anybody can develop a drug problem"* Negative attitudes are statements like: *"Drug users are bad people"*	• How much can you help drug users get off drugs? • What are the typical characteristics of a drug user?
4. Beliefs	Positive beliefs are statements like: *"All drug users are human beings"* Negative beliefs are statements like: *"That client is a lost cause!"*	• What beliefs do you have about drug users? • Why do feel that that client is a lost cause? • Have you ever had any experience with drug users? • Tell me about your experience?

Continued over page…

Supervisee characteristics	Description	Example assessment questions
5. Emotional wellbeing	A health professional's emotional wellbeing influences the nature of work she performs.	• How do you feel generally with your life in recent times? • Are you experiencing any emotional difficulties that you believe might affect your work with clients? • Have you ever suffered from an affective disorder or problem e.g., panic attacks, depression? If so, have you ever received treatment for this problem? Do you believe that you have overcome this problem • How do you feel generally with your life in recent times? • Are you experiencing any emotional difficulties that you believe might affect your work with clients? • Have you ever suffered from an affective disorder or problem e.g., panic attacks, depression? If so, have you ever received treatment for this problem? Do you believe that you have overcome this problem?

The Supervisee

The aim of this section is to discuss the role of supervision from the supervisee's perspective. This section addresses:

- what to expect from supervision
- choosing a supervisor
- belief building
- planning supervision
- training and observation methods
- remote supervision.

There is nothing more frustrating and dejecting than a significant clinical problem that needs to be dealt with without support. Supervision can play a role under these circumstances. Supervision acts like a bridge between what you are currently doing and what you have the capacity to do. In other words, supervision can support your work and empower you to achieve better counselling skills and practices when delivered in the right environment, by the right people.

Supervision is a journey towards a positive working relationship with a supervisor you know and respect. Supervision can enhance therapeutic drive. In supervision, the supervisee is responsible to a significant other who has the capacity to help clients more effectively. Powell (1980) writes:

> *Clinical supervision is the most appropriate learning medium for the adult counselor because it is a "learning by doing" process rather than a distant, classroom type of experience. Supervision provides us with an ongoing assessment of our skills and areas of clinical strengths and weaknesses. It has been demonstrated that it directly impacts on job satisfaction and burn-out by professional and personal growth. It provides the counselor with emotional-refilling, needed to function in an emotionally-draining field.* (p37)

What to Expect

The supervisor is a coach, cheerleader and fellow-team member. They will know more about AOD counselling than the individual being supervised. Moreover, a supervisor should not have the philosophy "do as I say, not as I do".

There are some elements to supervision that can be expected. Supervision should:

- be individualised to the needs and goals of the supervisee
- provide a safe, accepting and secure atmosphere to express feelings, thoughts and actions
- involve a contribution by the supervisee of the content and agenda for the supervisory sessions
- encourage questions and debate
- build strengths and clinical skills.

Clinical supervision is conducted as a combination of individual and small group sessions. Sessions should be held regularly and conducted at mutually convenient times in a quiet place. During an average week, supervision would ideally include:

- a 1 one-hour session with the supervisor on a one-to-one basis

  or

- a 1.5 to 2 hour group session with four or five colleagues and a supervisor

  or

- a 1 one-hour case review session with five to ten colleagues with or without the supervisor present.

However, the ideal length of a session may vary according to the setting in which the supervisee conducts their clinical work (Winstanley & White, 2002).

There are many situations that may appear to be like supervision but are probably not. These types of situations include casual conversations in the hallway with a colleague about a difficult case, attending a workshop, networking with colleagues over the phone and ringing a support line for professional advice. Whilst these are effective methods for information transmission, advice and support, they do not constitute clinical supervision.

A supervisor may adopt different methods to help facilitate the supervisee's acquisition of clinical skills. Some of these methods include:

- directly observing the supervisor's practise with clients
- listening to or watching somebody else conduct therapy
- use of role play or simulation games
- being observed directly by the supervisor as you practise with clients
- observing or being observed through a one-way mirror
- tape or audio recording sessions
- case note auditing.

These methods are designed to facilitate the acquisition of clinical skills; however the supervisee should not partake in any activity that makes them feel uncomfortable. For example, if you as a supervisee are anxious about delivering a skill (say, MI) for the first time, then you have the option of letting the supervisor know that being observed in any capacity is something you would prefer not to do. You might then like to consider the possibility of partaking in a role play to build your confidence, and then consider being observed, perhaps indirectly at first. Do what feels right for you and always speak up about anything you do not feel comfortable with during supervision.

In summary:

1. The supervisor is a coach, cheerleader and a team member
2. Supervision is tailored to the supervisee's wants and needs
3. Supervision should be delivered as structured or focussed individual and group work with a supervisor
4. There are many methods for acquiring clinical skills, such as being observed and observing others, role playing, tape recording sessions or case note audits.

Choosing a Supervisor

Research shows that the quality of a supervisory relationship is enhanced when a supervisee is able to choose their supervisor (Winstanley & White, 2002). Thus, in an ideal world, the supervisee would choose the supervisor and make a selection based on a number of characteristics and criteria. Characteristics to consider when selecting a supervisor include:

- gender
- area of specialisation (e.g., setting, client type)
- professional experience
- personality.

A number of characteristics that facilitate supervisor success were outlined in the previous section. Some of the most important points are re-iterated below:

- successful supervisors are *available, accessible, able* and *affable*

- positive behaviours in supervision include *praise, empathy* and *positive statements about the relationship*, whilst negative behaviours include *belittling, blaming, neglecting, attacking* and *rejecting*

- a successful supervisor builds a professional relationship with the supervisee, assesses skills, writes a contract with the supervisee and determines goals

- an effective supervisor is *supervisee centred*.

Building the Supervisee's Belief in Supervision

An important starting point for a supervisee involves building belief with respect to the role and benefit of supervision. The supervisee is encouraged to learn about supervision by asking their supervisor what to expect during sessions, what time commitment is involved, what will be achieved and in what timeframe, and how the sessions will impact on work practice. Indifferent feelings about supervision on the part of the supervisee are not uncommon and may reflect misconceptions about the nature and process of the supervisory relationship.

Mixed feelings about supervision arise from many sources. You might, for instance, feel:

- interrogated, scrutinised or spied on

- threatened by someone who knows more

- that you are losing work autonomy

- that you are inviting criticism.

There are some questions that the supervisee can ask when considering supervision (or when required to undergo supervision

as a part of their employment contract) that can help to identify and overcome possible areas of concern. These questions include:

- Am I resisting supervision, and if so, why?
- Do I feel threatened because I will expose my weaknesses?
- Is my resistance a sign of fear or insecurity?
- Is there an image that I have to keep up in front of my peers or my clinical supervisor?
- Is self-preservation an issue for me in supervision?
- Are there underlying personal issues or personal characteristics that are inhibiting the process?
- What are my problem-solving skills? Do they create a problem for me during supervision?
- Am I concerned with skills or status?
- Am I a slow learner and threatened by others in supervision?
- Do I oppose my agency's policies and procedures? Does this create a problem for me in supervision?

(Powell, 1980)

When concerns do exist, they are not likely to be resolved instantaneously. They may also emerge (or at least become apparent) after the supervisory process has been under-way for a period of time. For this reason, it is important to remain alert to the supervisee's anxieties and address them accordingly.

Planning Supervision

Planning supervision with your supervisor is a pivotal task. Developing a clear path for supervision and a plan of action will increase the probability that goals are achieved. A *structured approach* to supervision planning is presented below. There are three stages to the structured approach:

1. Developing Long Term Goals

2. Write Medium Term Goals and incorporate within a Supervision Plan

3. Complete a Weekly Worksheet.

The first stage involves developing long-term goals that identify where the supervisee would like to be in the future (2-5 years). Developing long-term goals also allows you to form a career path or "career track". The second stage involves writing medium-term goals (e.g. 3 months to one year) that shows what will be achieved during supervision. The medium-term goals should be aligned or congruent with the long-term goals. Achievement of medium-term goals should indicate that the supervisee is moving closer to the long-term goals.

To facilitate this second stage, the supervisor and supervisee should complete a Supervision Plan (discussed in more detail later), which includes medium-term goals and specified tasks to achieve these goals. The third and final stage is to complete a Weekly Worksheet (discussed in more detail later) that informs the supervisee about the precise tasks to be undertaken between the current and following sessions. These precise tasks are taken from the Supervision Plan.

The supervisee is strongly advised to develop their Supervision Plan in collaboration with their supervisor. This will allow the supervisor to help the supervisee formulate a clear and precise plan of action. The supervisor and supervisee may find the worksheet provided in this section (e.g., the Career Track, Supervision Plan and Weekly Worksheet) helpful in this process.

Developing a career track

When planning supervision, the supervisee first needs to develop a career path or direction. To do this as a supervisee, it will be helpful for you to think about where you would like to be in four or five years with respect to your clinical practice work. It is recognised that there is often little job security in the non-government AOD sector due to funding constraints, with many workers on short to medium term contracts. If this is your situation, complete the following exercise as if your hopes for more permanent employment in the AOD sector will be realised (if indeed that is what you desire).

In order to facilitate the task of developing a career track, try this exercise. Close your eyes and allow your mind to imagine where you will be in five years in regard to clinical practice. Try and visualise the following:

- Where do you see yourself working?
- What do you see yourself doing?
- How far into the future is it?
- What type of clients are you working with?
- What setting are you working in?
- What sort of interventions are you using?
- With whom are you working?

Explore these questions as you begin to formulate a career track.

Whilst imagining, the supervisee should be mindful of self-limiting beliefs or thoughts. Self-limiting thoughts are often acquired from others and include such things as:

- *"You'll never do that"*
- *"That's not the way things work around here"*

- *"Quit dreaming"*
- *"That never happens to people like us"*
- *"You need 10 years of training to be able to do that".*

Next, write down a sentence that describes where you will be in two to five years with respect to clinical practice (i.e., long-term goals). This sentence should be written on the Career Worksheet (see the Tools section). An example of a completed worksheet is shown below (Figure 2.2). This worksheet should be completed by the supervisee and examined by the supervisor.

It is important that there is congruence between the supervisee's long-term goals and their current work. For example, if a supervisee wants to deliver a range of interventions to problem drinkers in general practice, but is currently working with heroin users in a hospital, then the long-term goal and current training are incongruent. The supervisor and supervisee should examine the supervisee's current work position, what he/she plans to achieve during supervision and where he/she hopes to be in two to five years.

As a final task, the supervisee should rate how hard they want to work in order to achieve this long-term goal on a scale of 1 to 10. A rating of "1" would suggest that they do not want to work hard at all, whilst "10" would suggest that they will do whatever it takes to reach the goal.

The supervisee is advised to complete all fields in the Career Worksheet. (See the Tools section for a master copy of all worksheets.)

Sample Career Worksheet

Dream list	Answer
Where do you see yourself?	*In a senior position*
How far into the future is it?	*5 years*
What are you doing?	*Counselling and supervising*
What clients are you working with?	*Problem drinkers*
What setting do you work in?	*An outpatient clinic*
What interventions are you using?	*Cognitive-behavioural interventions*
With whom are you working?	*Psychologists, AOD practitioners, nurses*

My long-term goals are (stated in the now):

I'm 5 years in the future. I'm a fully trained AOD psychologist who practises with clients and supervises other health professionals (i.e., psychologists, AOD practitioners and nurses. I'm working in an outpatient setting with problem drinkers). I'm using and teaching cognitive-behavioural interventions.

My desire to work hard to achieve these long-term goals:

1	2	3	4	5	6	7	8	(9)	10
Low				**Moderate**					**High**

Figure 2.2 Sample Career Worksheet

Medium-term goal setting

Setting long-term goals is the first step towards realising a long-term career path. However, these goals are more likely to be reached if medium-term goals act as a bridge between the present and the future. Moreover, medium-term goals should be related to the immediate purpose of supervision, which is to train the supervisee in a set of salient clinical tasks that will help them in their present and future clinical practice.

For example, the supervisee's career aspiration may be to open a multi-disciplinary AOD clinic that offers a free service to the entire southern metropolitan area of the city. He/she has worked as a practitioner in the public service for the last four years and has no experience as a service manager. There are some important differences between what this supervisee is doing currently and where they want to be in five years time. During the early sessions of supervision, the role of the supervisor would be to help the supervisee increase their competence as an AOD worker in their current work role, and also to provide a bridge to the future goal of supervising others. One strategy may be to assist the supervisee in a supervisory role at some point during supervision.

There are a number of steps for the supervisee to complete with the supervisor in order to formulate a Supervision Plan. The plan displays the supervisee's medium-term goals and tangible tasks to undertake in order to reach the goals.

The first step then is to write medium-term goals that the supervisee will achieve in three to six months under the supervision of the supervisor. Once again, the medium-term goals should be congruent with the supervisee's long-term goals, as well as the organisation's policies and directions. Goals should be written as though the supervisee were undertaking the action in the 'now' in order to make it more salient and attainable.

Goals should be SMART: that is, **S**pecific, **M**easurable, **A**chievable, **R**ealistic and **T**imely. Read Box 2.2 in order to acquire a richer understanding of how goals are written effectively. There are some questions that the supervisee can ask to help formulate medium- and

long-term goals. They are:

- *What strengths do I possess that will contribute to my ability to achieve these goals?*
- *What weaknesses will I need to address to achieve these goals?*
- *Apart from my supervisor, who can help me achieve these goals and how?*
- *What known or potential obstacles (internal or external) could interfere with achieving these goals? How will I deal with them?*
- *How will I reward myself when I achieve each goal?*

The supervisee should write down any answers that come to mind when exploring these questions. These responses will be used later when developing a supervision plan with the supervisor.

Box 2.2 SMART Goal Setting

Specific: Exactly what do you want to achieve? Try not to be vague when you are writing goals with your supervisor. Use clear and exact terms to describe what it is you would like to achieve. Writing clear goals will facilitate the process of identifying what you need to do in order to reach them.

Measurable: How will you know if you have achieved your goal? Every goal should be measurable. Wherever possible, quantify your goal with numbers that define how much, how long, how high, etc. A quantifiable measurement takes the goal from an abstract idea into clear, sharp focus. The idea is that you can clearly see whether you met, exceeded or fell short of the goal – and by exactly how much. Goals that suggest you want to become "good", "better", "successful" or "the best" at something are not measurable.

Attainable: Be honest with yourself with respect to what you can reasonably achieve in your life at present. Setting a goal too high only ensures failure. How much time and energy can you devote to your Supervision Plan? Based on how much time and energy you can devote, set a goal that you have a reasonable probability of reaching, but do not stretch yourself so far that you lose hope of attaining it.

Realistic: Can you do it? The goal must be realistic. Goals are something you work to achieve. They are not miracles or magic. Set goals with your supervisor that you can reasonably achieve based on your background, skills and talents as they currently exist.

Timeframe: When should you have completed this goal? How long do you have to complete the goal? If you do not set an expectation of how much time it should take you to accomplish it, then you will never feel a sense of urgency to complete the goal. Once again, your supervisor can help you in this area as they will have greater experience in knowing the length of time required to, say, acquire an AOD skill. Setting a timeframe also provides a built-in checkpoint so you can reassess your goals and make sure you are progressing toward your career dream.

Supervision plan

Once medium-term goals have been determined, the supervisee and supervisor should complete the Supervision Plan (Figure 2.3). The Supervision Plan is a collection of goals and tangible tasks that show how the supervisee will reach their goals in various areas of development. The supervisee can periodically rate their progress towards achieving their medium-term goals. At regular intervals (e.g., every four weeks), the supervisor should review the medium-term goals with the supervisee. Once the supervisee has completed all tasks and feel they have achieved their goals, they will be ready to write a new Supervision Plan with their supervisor that provides the next map on the Career Track.

In the sample Supervision Plan shown below (Figure 2.3), Motivational Interviewing is an area identified for development. This generates a number of goals and related tasks. For example, learning MI via observation of a demonstration is one *goal* and involves the *task* of watching a 1-hour video-tape prior to the next supervision session.

A complementary tool is the Weekly Worksheet (Figure 2.4 - this can be modified to a fortnightly worksheet). This tool centres on goals and tasks for the following week (transferred from the Supervision Plan) and can also be used to record any questions, answers or thoughts the supervisee experiences whilst doing the task. The supervisee can then raise these comments with the supervisor during the next supervision session.

It is important to review the Supervision Plan and Weekly Worksheets at every session. Goals that are regularly reviewed are always in the forefront of the conscious mind, rather than a distant dream that is written out once and placed in a drawer to be remembered at some later date.

SAMPLE SUPERVISION PLAN

Skill or Area of Focus **Feb – April 2005**	**GOALS**	**TASKS**	**DATE REVIEWED**	**My progress towards achieving this goal** 0 1 2 3 4 5 6 7 8 no success 25% 50% 75% 100%
Motivational Interviewing (MI)	To learn MI via observation	Watch a MI demonstration tape	20/2/05	80% - watched tape but to seek clarification
	To update my knowledge of MI	Read latest MI textbook	27/2/05	75% - two chapters left to read
			6/3/05	Completed
	To complete a MI on a suitable client (for review)	Book appointment with a suitable client, deliver MI and tape session	13/3/05	25% - appointment made, client consent form filled out…still to conduct interview
			26/3/05	Interview & taping completed
	Receive performance feedback	Watch taped session with supervisor; self-critique and receive feedback from supervisor	10/4/05	Completed

Figure 2.3 Sample Supervision Plan

WEEKLY WORKSHEET

MY GOALS THIS WEEK Date: 20/2/05	TASKS	THOUGHTS, QUESTIONS, ANSWERS	My progress towards achieving this goal 0 1 2 3 4 5 6 7 8 no success 25% 50% 75% 100%
To have MI modelled to me	To watch demonstration tape	I thought the practitioner's style was excessively probing – seek clarification with supervisor Does the delivery of MI change with different drugs? Can MI be used with issues other than AOD use?	80% - to seek clarification re my concern and questions
To increase knowledge of MI	To begin reading text-book	Is it really as powerful a technique as claimed?	75% - almost completed

Figure 2.4 Sample Weekly Worksheet

The supervisee should participate in regular sessions with their supervisor in order to learn and reflect upon their own practice, and also to give them an opportunity to review progress towards medium-term goals. The first step in the process of reviewing the Supervision Plan is to examine the task for the week. The supervisee should talk to their supervisor about the weekly task, review whether it was completed and address associated issues. Were the tasks completed? If so, how did it go? If not, what difficulties and challenges did they confront that prevented progress?

Identifying obstacles

There are a number of reasons why the supervisee may experience difficulties.
For example:

- the goal was unrealistic for the period under review (see SMART goals)
- the task was too difficult
- there were unforeseen obstacles (e.g., unable to get a client to participate in a MI session).

Obstacles to goals can come in many forms. Obstacles may be external or internal. External obstacles might include a shortage of time. If the supervisee is unable to devote sufficient time to the tasks agreed upon with the supervisor, then the process of supervision is self-defeating. In these instances, the Supervision Plan may require revision.

Although external obstacles are thought of first, it is often the internal obstacles (e.g., 'uncertainty', 'worry', 'pessimism') that are the most difficult to overcome. These are natural reactions given that a supervisee is learning new knowledge and skills with which they were previously unfamiliar. The supervisee can address internal obstacles by identifying them as the Supervision Plan is completed with the supervisor.

Strategies should also be developed to overcome obstacles as they occur. Dealing with an obstacle is not dissimilar to a relapse prevention strategy that aims to help the user feel confident that they will not relapse when confronted with cravings in a particular environment.

Difficult tasks or goals may require revision and continual refreshing. The supervisor can help here. The supervisee can also assess progress towards medium-term goals outside the supervision session by regularly 'eyeballing' the Supervision Plan.

Identifying personal benefits

It is important to reward completion of tasks and achievement of short-term goals, otherwise the process will become arduous. The supervisee should identify tangible benefits or rewards they will receive when medium-term goals are achieved. This could be a feeling of satisfaction, a reduction in work stress, feeling more confident in their ability to help clients, and/or witnessing better outcomes with clients.

In reviewing a goal, the supervisee should identify the primary motivation for completing the goal. In addition to this medium-term benefit, the supervisee should build in rewards at critical points in the plan that will motivate them towards success. The supervisor also plays a major role in this process, and can become a motivator by rewarding with verbal reinforcers (e.g., "Well done!") or material rewards (e.g., shouting lunch).

A longer-term perspective

Figure 2.5 provides a schema to map the relationship over time between a Career Track, Supervision Plan and Weekly Worksheet. By definition, when a Weekly Worksheet is fully completed, part of the Supervision Plan is completed. If enough Weekly Worksheets are completed, then the Supervision Plan is complete and a new one will be formulated.

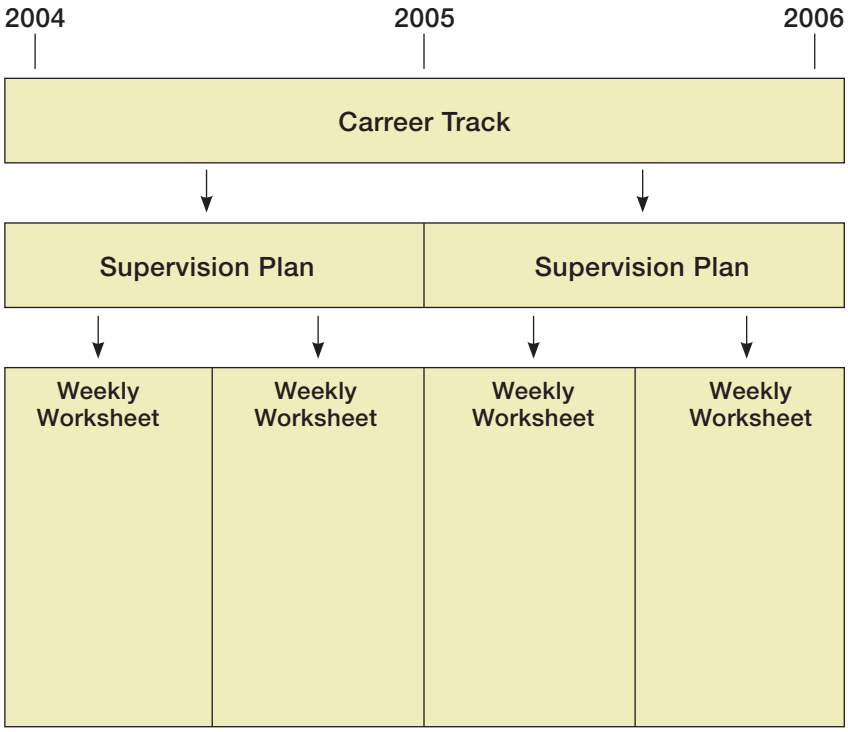

Figure 2.5 The relationship of a career track with a Supervision Plan and Weekly Worksheet over time

Case presentations

An effective way to organise an approach to treating a client is to present the case to colleagues (i.e., peers and supervisor). When colleagues are provided with the opportunity to evaluate the supervisee's work, the supervisee receives advice on what they are doing well and what areas of practice and client management can be improved or enhanced.

Case conceptualisation is an important skill to be learned. It involves turning unorganised data into themes and concepts with a view to linking assessment and diagnosis information to treatment planning and intervention. Presenting a case allows the supervisee to consolidate their understanding of how a case may be conceptualised.

Each client case is presented in a “problem- and solution-oriented” format with questions to be answered and “should move from client information to dynamics, prognosis, and treatment plan” (Powell & Brodsky, 1998, p165). There are standard formats that are used for presenting cases, although each organisation can design its own template based on its own specific reporting and administrative needs. A template for case presentations can be found in Box 2.3.

Box 2.3 A Template for Case Presentations

Client name:
Town or residence:
Age:
Marital status
(number of marriages, number and ages of children):
Occupation or trade:
Employment status:
Referral source:
Presenting complaints:

Diagnosis:

History of Present Problem

- Years drinking and/or drug using
- Longest period of sobriety/abstinence
- Recent drinking/drug patterns
- Medical complications, history
- Hospitalisations: Number, length of time, dates
- Arrests, charges, amount of time spent in jail
- Suicidal or homicidal ideation, gestures
- Job or situational changes
- Previous treatment.

Interview Results

- Behaviour and appearance
- Preliminary attitudes
- Entry into room
- Brief physical description, cleanliness, clothing
- Physical characteristics
- Attire, build
- Quality of rapport
- Quality of talk
- Posture
- Facial expressions
- Cooperativeness, suspiciousness, hyperactivity
- Energy levels
- Affect (e.g., anxiety, hostility)

continued over page…

- Mannerisms
- General body movements
- Amplitude and quality of speech.

Affect

- Appropriateness, flat, absence of affect
- Depressed, anxious, happy, anger, bizarreness
- Mood differences or changes (e.g. euphoria, elation, apprehension)
- Blandness, lability of affect.

Intellectual Functioning

- Efficiency, mental deficiency, abstraction ability
- Reality testing
- Thought order and disorder
- Clarity, goal directedness, insight ability, blaming
- Appropriateness, coherence
- Attention, concentration, breaks, impaired level of consciousness
- Discrepancy, delusions
- Perceptions (e.g. illusions, hallucinations)
- Memory (e.g. immediate recall, recent and remote memory)
- Judgment about daily living and making reasonable life decisions.

Interpersonal Relationships (Social and Emotional Functioning)

- Functioning: Marriage, job
- Family history.

Prognosis

- Reality factors, environmental
- Recommendations for treatment
- Prognosis.

Source: Powell & Brodsky (1998)

Factors that can undermine the case presentation procedure include:

- too many presentations in a short time frame
- focusing on a specific problem instead of giving a case overview
- anecdotal material that is not well conceptualised
- lack of free and open discussion about a case
- suggestions for interventions that are beyond the presenter's capabilities.

Role playing and role modelling

The nature of role playing and role modelling has been outlined in the previous section. It is sufficient to say that role playing and role modelling are important teaching methods that should be utilised by the supervisor and supervisee during supervision sessions, particularly when skills are being taught and learnt.

Remote Supervision

Some people are not as fortunate as others in having access to a supervisor or the time to participate in supervision. Rural and remote centres tend to have a shortage of services, difficulty attracting and retaining qualified trained workers, and low remuneration (Crago & Crago, 2002). If you are in this type of situation, the following section is directly relevant to you.

Outlined here are some strategies that can help a supervisee set up and participate in a supervision program. A number of complementary strategies are presented that offer a vehicle for supervision, although the specifics of implementation are entirely up to the individual and determined by one's ability to leverage time, access technology and invest effort in the process.

Letters or e-mails

An age-old method of distance communication is *correspondence*. This is quite easily the most reliable and effective method for giving and receiving information. Correspondence is no longer restricted to letters. It now also encapsulates email, which overcomes the time factor commonly attached to the post. Some people who live in rural and remote areas may not have access to the Internet, whilst others cannot afford the Internet or are not adept at computers. These individuals can still use letters as a primary method of communication.

There are a number of advantages and disadvantages to electronic communication or "e-supervision" (Graf & Stebnicki, 2002). Trainees report that correspondence via email stimulates thinking that is more reflective and insightful, in contrast to traditional face-to-face approaches. Other reported advantages include:

- ongoing access to a clinical supervisor
- more relaxed communication style
- increased time dedicated to processing and clarifying thoughts
- greater immediacy of responses
- greater monitoring capacity.

In contrast with face-to-face work, group supervision conducted using email reduces inhibitions and frees up information being conveyed to the supervisor and supervisees (Kiesler & Sproull, 1992). A further advantage of email is its compatibility with other tools like audio- and video-tapes.

There are several disadvantages to correspondence, regardless of the modality used. These include:

- lack of direct contact limits supervision to reflective practice only, in other words, there is limited opportunity for skill building

- time must be devoted to writing letters or emails
- there is limited interpersonal interaction.

Those who are interested in correspondence are encouraged to read Crocket's (2002) paper on narrative supervision letters.

Chat rooms

There are important advantages to chat rooms. For example, a number of workers are able to contribute simultaneously to a single discussion, which may provide a wealth of information that would not be possible if sessions were conducted conventionally. Participants in the chat room may be individuals from interstate, or even overseas. In this way, chat rooms are like group supervision sessions that are conducted in a virtual realm. Another advantage is that topics can be highly focussed with individuals giving relevant information in real time. As in group settings, the supervisor is able to facilitate the introduction and development of topics.

A potential limitation of chat rooms is that effort is required to create and establish a room, and co-ordinate the room's operating hours. It would be unrealistic to assume that individuals are available for several hours each day in order to contribute to a discussion. Particular hours each week or month need to be devoted to 'live' time in which nominated topics are discussed with the supervisor present. Time outside of supervision in the chat room can be devoted to a peer-driven support group.

Telephone and video stream Internet supervision

Telephone supervision may offer a viable alternative to face-to-face supervision. This is seen to have particular relevance for rural and remote AOD workers. Telephone supervision is relatively cost effective (if travel and accommodation costs are factored into the cost of accessing face-to-face supervision) and it provides real time dialogue (unlike tape, letter or email supervision).

Telephone supervision is best conducted after initial face-to-face sessions. That is, the supervisor and supervisee meet in person to begin with and then communicate over the telephone (Crago & Crago, 2002). The advantage of this strategy is that better rapport is likely to be established than if the telephone alone was used as the method of communication.

An alternative to telephone contact is the use of video streaming using a computer and a computer camera (a 'cam'). Using this technology, the supervisor and supervisee can talk whilst viewing each other, almost as if they were face-to-face. Another advantage is that the supervisor can observe the supervisee conduct 'live' clinical work from a distance, as though they were present in the room.

Video stream technology using a 'cam' does have disadvantages, the most obvious being confidentiality. Confidentiality can be breached, particularly if information seeps from the internet into the hands of unauthorised people. Clients may also feel uncomfortable about the notion of video streaming because of the threat to privacy, particularly for AOD clients who may be reporting illicit activities such as drug dealing, theft and sex work. A second disadvantage of video stream technology is that one must purchase, or have access to, the necessary equipment to use this system of communication, including a telephone line, a computer and a cam.

External supervision

External supervision is a further option worth considering. Whilst little is written on external supervision, there has been an increasing tendency amongst health workers to seek professional support from outside the place of practice to ensure that clinical supervision is separate from line-management supervision with its emphasis on evaluation of performance and productivity (Ung, 2002). The trend in the AOD field is not known, although it may parallel the general trend.

For some practitioners, external supervision supplements the support that they already receive from an organisation. External supervision may be the only option available to private practitioners, rural and remote workers, and individuals who work for agencies that do not provide internal supervision (e.g., non-government organisations, NGOs).

There are a number of advantages to external supervision (Ung, 2002). The most obvious is that the supervisee can choose a specific supervisor based on their professional needs and what they would like to achieve in supervision. In addition to choice, an external supervisor can provide the opportunity to discuss clinical issues without the potential for organisational constraints. Another advantage is the greater scope it provides for development of collaborative relationships.

Some disadvantages of external supervision are that:

- there is a financial outlay
- it takes time, particularly when the external supervisor is located a significant distance from the supervisee
- the supervisor may have a limited contextual understanding of the supervisee's practice.

Terminating Supervisory Relationships

(This section is repeated from "The Supervisor" section given its critical importance.)

On most occasions supervision will be terminated due to circumstances intervening (i.e. the supervisor or supervisee relocating or changing jobs), or because the contracted number of sessions has been reached. When the length of a supervisory relationship is open-ended, mutual agreement will often determine that a relationship has run its course, resulting in diminishing returns for effort invested. For example, it might be agreed that the supervisor has imparted the range of their knowledge and expertise, and that the supervisee wishes to explore areas of professional development for which another supervisor is better equipped to help. This kind of termination occurs in a planned manner and is based on periodic and candid discussion of needs and expectations.

Less common, but of critical importance when it does occur, is the need to terminate because of:

1. *A poor 'match' (incompatibility) between the supervisee and supervisor resulting in unsatisfactory outcomes*

   A poor match may be easily resolved through discussion and a mutual decision to terminate. Supervisees should avoid staying in an unhappy supervisory relationship through a sense of obligation or a desire to protect the feelings of the supervisor. On the other hand, a supervisor must be prepared to address any difficulties in providing adequate supervision. Failure to do so may lead to an escalation of difficulties.

2. *Unethical conduct on part of the supervisee and/or supervisor*

   Unethical conduct by either, or both, parties must be addressed. When either party fails to report unethical conduct on the part of the other, then they are at risk of complicit involvement. Behaviour for which mandatory reporting to relevant authorities is necessary is stipulated in the procedure manuals of organisations, the ethical codes of professional and registration bodies, and in legislation (e.g. sexual misconduct). Other behaviours of less severity (e.g. the use of inappropriate language) could be dealt with in the first instance by requesting the offending party to acknowledge their misconduct and to undertake to change their behaviour (even when the relationship is terminated).

3. *A dispute or grievance between the two parties*

   Any unresolved dispute or grievance between a supervisor and supervisee could, in the first instance, be dealt with by mediation, with a third party (experienced in mediation) facilitating a mutually agreeable outcome or compromise. Should mediation fail, then written complaints to the relevant bodies should follow so that due organisational and legal process can occur.

Whilst the above situations are not likely to occur (and indeed occur relatively infrequently in clinical supervision situations) it is, nevertheless, important to be aware of the potential for them to occur and to have appropriate contingencies and response plans in place.

An Organisational Perspective

This section explores issues related to supervision from an organisational perspective. The topics covered in this section include the benefits of supervision, the importance of supervision policy, and the enabling factors and barriers to supervision programs.

Supervision forms a small but important component of any organisation that delivers AOD services to clients. There are some commentators who argue that supervision is a necessity in any AOD organisation: *"Programs are obligated to provide supervision to maintain quality care, and counselors have a right to expect it"* (Valle, 1984, p102). All AOD organisations should be encouraged and supported to provide supervision.

Benefits of Supervision

Some of the benefits of supervision to the organisation include:

- improved consumer service
- higher practitioner satisfaction
- decreased staff turnover
- lower training and administrative costs.

Often line managers cannot see the direct benefit of supervision. For example, school principals may have a limited understanding of what clinical supervision for school counsellors means, and may view supervision as a reduction of time with clients (Campbell &

Wackwitz, 2002). A common misconception is that supervision is for trainees only or for those who are experienced but performing poorly. Put another way, some believe that if a competency is learned, demonstrated and sustained, then there is no real reason for on-going supervision to take place. In reality, the situation is very different.

Practitioners report that they:

- desire supervision in virtually all work settings
- have high expectations with respect to the quality of supervision
- feel that a positive supervisory relationship will impact on professional development
- expect that the supervisor will provide information and support.

(Reeves et al., 1997)

Clinical Supervision Policy

Organisations should establish a clear policy on supervision that is supported by the majority of AOD workers employed by the organisation (Kavanagh et al., 2002). An organisation with a clear and consistent policy on supervision is likely to create a harmonious environment that will foster effective work and lead to positive client outcomes, whilst an unclear or strict policy is likely to create ambivalence or frustration amongst supervisors and supervisees.

Conflict between AOD workers, clinical supervisors and management may arise from a number of sources. These include:

- the program's goals (e.g., harm reduction versus abstinence-based programs)
- professional perspectives (e.g., biological/disease models versus the bio-psycho-social approach)

- industrial issues
- work practices (e.g., cognitive-behaviour therapy versus psychodynamic therapy).

There are a number of features that a supervision policy should ideally have in order to avoid conflict in the workplace, and to reduce ambiguity about what the program is attempting to achieve. There are three features that are particularly important.

Firstly, a clinical supervision policy should reflect, or be consistent with, an organisation's *philosophy*. This should underpin the supervision program. The clinical supervision program should reflect the organisation's overall purpose and orientation.

Secondly, a clinical supervision policy should have a specific purpose or direction. For example, to "assist all new AOD workers to identify long-term career goals and to pursue them within organisational policy". The purpose underlying the supervision program and the organisation's overall philosophy must be congruent in order for the policy to succeed. Likewise, the program's purpose and those of the individual worker must be congruent. Clear and congruent goals ensure that:

- a *qualified* supervisor delivers the program to the AOD worker
- the program is supervisee-centred
- the program is sensitive to the needs of the AOD workers
- the professional development of each AOD worker will be considered and satisfied where possible
- the AOD worker will be supported towards the better health outcomes of clients.

Thirdly, the supervision policy should contain a *structure* for the supervision program. The structure of supervision describes the manner in which supervision is conducted between supervisee and supervisor, such as the nature of delivery (e.g., individual, group work), and when, where and how often it will occur. A clear structure reduces ambiguity about the conditions of supervision and the manner in which it operates. The policy may also include a broad indication of the content of supervision (e.g., harm reduction interventions).

In summary, organisations that deliver AOD services and have a supervision program should have a supervision policy that clearly articulates the framework of the program. The supervision policy will have an underlying philosophy that shapes what takes place. The supervision policy will also have a purpose that is congruent with the philosophy. Finally, a supervision policy will outline the structure of the supervision program.

Critical Factors in Establishing a Supervision Program

Many factors can either impede or help set up, operate or sustain a supervision program. Clinical supervision programs are more likely to be implemented and effective if:

- AOD workers contribute to the planning process
- practical barriers are tackled adequately by allowing sufficient time for the project
- a policy is written that outlines the goals, structure and process of supervision.

(Shanley, 1992)

Part 3, is a practical guide to setting up a supervision program, and it covers these issues in greater depth.

There are a number of barriers that prevent clinical supervision from taking place. These include:

- managers do not understand the benefits or value of supervision
- supervisors are not trained in supervision (Peake et al., 2002)
- few supervisors are experienced at supervision (Shanley, 1992; Webb, 1997)
- there is expertise at work but there is no one willing to devote time and effort to develop a program
- conflict between clinical and managerial staff, whose roles are often blurred (Webb, 1997)
- a lack of common language between supervisors, supervisees and managers (Campbell & Wackwitz, 2002)
- funding is short and supervision is an expensive commodity
- geographical distance between supervisors and supervisees (Campbell & Wackwitz, 2002).

Finding a clinical supervisor is one of the most difficult steps in developing a clinical supervision program, particularly in the AOD field where there is a shortage of experienced workers. Developing a pool of supervisors for a program can be achieved through a number of strategies:

- training existing experienced AOD workers in the theory and practice of supervision (Shanley, 1992; Webb, 1997)
- recruiting experienced supervisors who work in other fields (Shanley, 1992)
- utilising established agencies (e.g., health centres) to organise groups for supervision (Shanley, 1992).

In summary, there are a number of barriers to and facilitators of clinical supervision programs. The most important facilitators are inclusion of AOD workers in the planning process and allocation of sufficient time and resources to the program's development and implementation. Some of the barriers that may prevent the implementation of a program include:

- an insufficient pool of qualified supervisors
- conflict between managers and clinical staff over the nature of the program
- a lack of a common language and/or conceptual framework between staff members about supervision.

A key step in activating facilitators and minimising barriers is the development of a policy that clearly states the nature of supervision in the organisation, the conditions under which supervision will occur and the key players who will be involved.

PART 3: Developing and Implementing a Program

Introduction

This section provides a practical guide for developing and implementing a supervision program. It draws on the work of Shanley (1992) and others, and addresses the principles that underlie program development, difficulties in engaging with supervision, finding clinical supervisors, writing a policy, evaluation and partnerships.

Principles and Processes

There are some principles that should be adhered to when setting up a supervision program that will facilitate the implementation process (Shanley, 1992). These principles are outlined in Table 3.1

Table 3.1
Key principles for setting up a supervision program

Principle	Description
Needs	• Supervision will reflect the needs of the AOD workers and clients involved. • Initial assessment of need is necessary to demonstrate that there is a demand for the program and thus warrants funding. • Assessment is crucial at the planning stage, and should also be conducted at regular points throughout the life of the program. • Assessment should be conducted in a systematic way.
Engaging	• Engage the AOD workers involved in the planning and implementation of the program. • Who is being targeted? • How many workers will participate in supervision? • What are the characteristics of these workers? • What process will be used to engage them individually and as a group?
Planning time	• Considerable planning is involved in setting up the program to minimise pitfalls. • Objectives are established prior to the initiation of activities. • Aims and objectives should be clear and specific so they act as a guide for the project's activities. A clear indication must be provided as to when these activities will be achieved and give a criterion against which the success of the project is evaluated. • Planning is frequently revised.
Routine	• Supervision becomes a routine practice in the workplace.
Quality	• Sufficient time is allocated to individual and group sessions. • Group supervision is conducted with small numbers in order to allow sufficient interaction between group members.
Contract	• All parties agree to a mutual contract which includes the aims and structure of the supervisory sessions, the roles and responsibilities of each member, an evaluation process and a time frame for the group.

These principles provide a useful checklist against which to establish the development of a program. The whole process of program development is divided into three sequential stages.

1. Planning

Planning involves undertaking a needs assessment of the targeted client group, establishing aims and objectives for the clinical supervision program, selecting and developing supervision activities, establishing baseline supervision measures and assessing resources required (e.g., staff, funding, premises) to implement the program.

2. Implementation

The next stage involves the realisation of structures (e.g., supervision committee) that need to be in place in order for the supervision program to function effectively, the style (e.g., respect, equality) of the program, the environment (e.g., conditions of work, training and support) under which the service delivery and supervision will take place (e.g., nature, frequency, and duration of supervision; number and type of clients served), systems to ensure ongoing assessment of the program (e.g., monitoring, feedback, quality assurance, information management), and a strategy to engage groups outside of the direct implementation of the program (e.g., networking, community involvement).

3. Review

The third and final stage involves an outcome / impact assessment and review.

A more detailed explanation of each of these stages can be found elsewhere (Ruddle & Prizeman, 2001).

Impediments

Not all people who are involved in the supervision program are likely to be enthusiastic about it. There are a number of factors that may contribute to a reluctance to engage. These include:

- fear of being exposed as an inadequate worker
- rigid work practices and fear of having these challenged
- lack of trust between fellow workers or between workers and administrators.

(Shanley, 1992)

Unless impediments are recognised and addressed directly the program may remain a low priority. Low motivation and lack of engagement can be addressed using basic counselling skills such as active listening and motivational interviewing. If all parties are involved in the process and are allowed to freely express concerns, objections and opinions, then the program is more likely to succeed.

Finding and Cultivating Clinical Supervisors

Clinical supervision is not always (or even usually) a routine requirement in the AOD field and there are relatively few individuals who have had first hand experience with ongoing clinical supervision. There are two consequences of this situation. Firstly, there are few AOD workers in Australia who have had clinical supervision on a regular basis, which suggests that they have not been exposed to a clinical supervision role model. In other words, AOD workers have not participated in supervision in order to know what a clinical supervisor might say or do to facilitate learning and skill development. Secondly, there are relatively few clinical supervisors who can contribute to the knowledge and skill development of frontline clinical workers in the AOD field.

Whilst the first consequence is difficult to overcome immediately, the second can be addressed by providing training in the theory and practice of clinical supervision. The following criteria, which were identified by key AOD workers in Australia, can be utilised when selecting candidates for training as clinical supervisors:

- experience in the AOD field (2-5 years)
- up-to-date knowledge and skills
- a willingness to supervise
- not a line manager.

If training is too difficult to arrange (e.g., because of a lack of suitable staff in the organisation), then experienced AOD supervisors from local networks may be employed on a sessional basis to conduct supervision. In some cases, there may not be an experienced AOD supervisor available to the organisation and workers who are experienced in supervision from other fields may be considered for the role. Lastly, it may be possible to provide supervision on an exchange basis, whereby an experienced worker from one organisation may visit another organisation on a regular basis to provide clinical supervision to staff. See the section on Partnerships if interested in networking in this way with other organisations.

Finding and training clinical supervisors is only the first step towards an effective clinical supervision program. Supervisees should also receive ongoing supervision if they are to sustain behaviour change and, likewise, supervisors should be provided with the opportunity and encouragement to continually update their AOD knowledge and skills. Supervisors are transmitting knowledge and skills to individuals who are less experienced, and it is imperative that the information imparted is current and sound. The supervisor should regularly attend workshops and seminars on supervision, and undergo review by management and/or another supervisor.

Writing a Clinical Supervision Policy

A policy is a set of rules or guidelines by which the organisation conducts its affairs in order to achieve its goals and purposes. A policy for clinical supervision is important to an organisation that pursues the development and implementation of an effective supervision program. The organisation should have an overarching policy that subsumes clinical supervision. In so doing, the organisation should develop a supervision program that is congruent with the overall mission and goals of the organisation. Organisations with a supervision program that is not supported by a clear policy may have supervision approaches that are internally inconsistent and which create confusion about the purpose of supervision and the conditions under which it is to be delivered.

There are number of key points to consider when writing a policy. These are displayed in Table 3.2

Table 3.2
Key elements for consideration when writing a clinical supervision policy

	Description	Example
1. Why supervision	An explanation of the importance of clinical supervision in this workplace	• Supervision improves clinical practice, supports AOD workers and helps clients get better
2. Policy statements	What the organisation is committed to deliver	• All staff who have direct contact with AOD clients will have access to clinical supervision that is delivered on an individual or group basis
	The conditions under which supervision is to be delivered	• The provision of clinical supervision to AOD staff will be equitable, systematic and responsive to supervision needs
3. An aim	An overall aim that describes the organisation's direction with the program	• Clinical supervision occurs within an AOD framework to promote quality clinical practice, professional standards and competencies
4. Outcome standards	The standards that the organisation would like to achieve in the program	• All supervision is provided by qualified and experienced practitioners • The quality of clinical practice and the professional needs of staff are identified and monitored

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	Description	Example
5. Evaluation	The evaluation protocol of the program	• An annual survey will be conducted of supervisees and supervisors to evaluate the supervision process
6. Key players	Identification of key players	• Supervisees, supervisors, managers
	The role of key players	• Supervisees negotiate the model of supervision which best meets their needs
7. Specific clinical arrangements	The specific arrangements under which supervision will take place in the organisation	• Group supervision by a member of the counselling team to the Hope Clinic Staff

These key elements can be applied to create a sound clinical policy. An example of a sound supervision policy can be found in Box 3.1.

Box 3.1: Example Supervision Policy

ACME ALCOHOL AND OTHER DRUG SERVICE

Clinical Supervision Policy and Procedures

1. Policy Statement/s

1.1. ACME is committed to providing clinical supervision for all staff who have direct contact with clients. Clinical supervision is to be adaptable and relevant to professions and service components within the service.

1.2. Clinical supervision will provide staff with the opportunity to develop and improve clinical skills, thus enhancing work satisfaction, reducing work stress and giving clients the best possible care.

1.3. The provision of clinical supervision to staff will be equitable, systematic and responsive to supervision needs.

1.4. ACME is to ensure that all clinical staff has access to relevant and regular supervision by suitably qualified and experienced supervisors.

2. Rationale

2.1. Clinical supervision occurs within an ACME framework to promote quality clinical practice, professional standards and competencies.

3. Outcome Standards/Performance Indicator/s

3.1. All staff who have direct contact with clients will have access to regular supervision.

3.2. All supervision is provided by qualified and experienced practitioners.

3.3. Training will be available for all those providing supervision.

3.4. Supervision between supervisors and supervisees will be planned.

3.5. The quality of clinical practice and the professional needs of staff are identified and monitored.

3.6. Supervision will contribute to the development of professional standards of service provision to clients.

4. Evaluation Method

4.1. Records will be kept to monitor the number of staff receiving supervision by managers, and the frequency of supervision received.

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4.2. All supervision arrangements are to be incorporated into performance management work plans.

4.3. An annual survey will be conducted of supervisees and supervisors to evaluate the supervision process.

4.2. All supervision arrangements are to be incorporated into performance management work plans.

4.3. An annual survey will be conducted of supervisees and supervisors to evaluate the supervision process.

5. Key Principles

5.1. Clinical supervision is defined as a form of supervision by a person with specific expertise in clinical supervision. This is distinguished from line management and peer supervision.

5.2. All staff should have access to supervision on an individual or group basis.

5.3. Clinical supervision will occur weekly, unless otherwise negotiated with one's line manager.

5.4. Supervision can be provided internally or externally. The cost of external supervision will not be met by ACME unless authorised by the Service Director.

5.5. Time spent in approved clinical supervision will be considered paid work.

5.6. Confidentiality of supervision sessions must always be maintained.

5.7. Functions of clinical supervision will usually include:

- 5.7.1. Review and assessment of clinical work.
- 5.7.2. Clinical feedback
- 5.7.3. Problem solving
- 5.7.4. Setting clinical goals
- 5.7.5. Education and professional development
- 5.7.6. Support.

5.8. Supervision should be focussed on client issues, rather than the practitioner's personal issues. If personal issues are of concern to either supervisee or supervisor, the other forms of support need to be considered (e.g., referral to the organisation's EAP).

6. Supervisees

6.1. All staff are responsible for:

- 6.1.1. Maintaining an ongoing commitment to clinical supervision and incorporating it into their work practice

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6.1.2. Initiating arrangements and appointments with a supervisor

6.1.3. Negotiating the model of supervision which best meets their needs

6.1.4. Negotiating supervision arrangements with their manager including any required changes to working times or movements

6.1.5. Notifying the manager of any changes to work practice or professional development needs

6.1.6. Ensuring supervision arrangements are reviewed at least annually during staff appraisal or as required

6.1.7. Contacting supervisors and following the relevant procedures for external clinical supervisors.

7. Supervisors

7.1. Supervisors are responsible for:

7.1.1. Negotiating a clinical supervision arrangement with the supervisee

7.1.2. Utilising the principles of ethical practice with respect to confidentiality and accountability. Confidentiality can be breached if the supervisor has sufficient concerns about a supervisee's practice and the issue cannot be resolved with the supervisee. The advice of the Service Director should be sought

7.1.3. Maintaining professional development and practice that is required to provide quality clinical supervision.

8. Managers

8.1. Managers are responsible for:

8.1.1. Ensuring all staff are aware of policy and procedures and have access to clinical supervision

8.1.2. Arranging and approving all supervision requirements

8.1.3. Reviewing and discussing supervision arrangements at least annually with staff

8.1.4. Providing information on available supervisors to staff.

Evaluation

This section addresses issues that are important to the evaluation process, including research issues.

A supervision program should contain an on-going evaluation that examines the program's progress towards its objectives, whether workers' and supervisors' needs are being met by the program, discrepancies with expected needs, and any identifiable benefits to work practice. Evaluation is also critical for any new program that requires justification to management and funders for its existence. Information obtained through the evaluation process can lead to modifications, additions and new directions in supervision. All programs, whether new or old, should be subjected to ongoing evaluation.

Evaluation questions

For the purpose of the evaluation exercise, there are some specific questions that evaluators may ask as the evaluation structure is put in place. These include:

- What framework will be used to guide the evaluation process?
- What questions will be answered?
- From whom will information be collected?
- What measures will be used to measure success?
- How will the information be collected?
- What time scale will be involved?
- When will the data be collected and how often?
- How will the findings be used?
- Who will be informed of the outcomes?
- When will the findings be available for review?

(Ruddle & Prizeman, 2002)

Once these questions are answered, an evaluation framework can be designed. There are some key areas to focus on when the framework is being discussed and formulated. These are listed in Table 3.3.

Table 3.3
Focus of evaluation process, measured factors and questions to explore

Focus	Measured factors	Research questions
Pre-existing trainee variables	• Empathy • Warmth • Client congruence • Clinical experience • AOD experience • Demographics: age, sex • Education level • Professional background	• Does trainee background and previous experience influence training effectiveness? • If so, what training do we deliver to trainees with varying experience?
Method of training	• Type of learning model (e.g., social-cognitive) • Delivery: Individual, group, mix model • Methods: Live, video-tape, role modelling	• What training methods do supervisors and supervisees prefer? • What models of training delivery facilitate supervision?
Training focus	• Diagnostic approach: Medical, psychological, bio-psycho-social • Model (e.g., scientist-practitioner model)	• What is the relationship between diagnostic approaches and client outcomes? • Does knowledge of a model translate into practice? • If so, in what way?

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Focus	Measured factors	Research questions
Supervisor outcome	• Satisfaction • Clinical experience • Training education and experience • AOD experience • Demographics • Staff: Communication, morale, teamwork • Working alliance • Confidence with supervision	• What supervisory processes contribute to satisfaction? • What type of supervision training contributes to better supervisory practice?
Supervisee outcome	• Satisfaction • Staff: Communication, morale, teamwork • Work role • Knowledge of AOD • Confidence with clients • Attitude towards drug users • Skills: Assessment, interventions • Working alliance	• Are supervisee satisfaction levels related to support, skill gains or improved client outcomes? • How does the program foster staff communication, morale, and teamwork? • In what way has the supervisee changed (i.e., knowledge, confidence, attitudes)? • What impact has training had on skill acquisition?
Client outcome	• Satisfaction: Service, life • Behaviour change • Psychology (e.g., anxiety, depression) • Attrition rates	• What components of service delivery create client satisfaction or dissatisfaction? • What interventions cause behaviour and psychological change? • What factors cause clients to remain in treatment?

Key evaluation issues

There are some key issues to consider when evaluating the outcomes of a supervisory program. These include:

- evaluation is most useful when built into the project from the planning stage
- create an evaluation culture in the program in order to facilitate the evaluation process
- success is dictated by the extent to which the evaluation appears credible and justified by those affected by it
- the evaluation should fit the program's characteristics and needs
- draw clear boundaries around the information to be collected
- consider the cost involved in conducting the evaluation
- consider the demands that the evaluation will make on staff (and client) time
- more than one measure of success is to be used
- the evaluation measures reflect the objectives of the program and refer to the needs identified in the planning stage
- pilot test all evaluation measures in order to save time and money or use evaluation measures that have proven validity and reliability
- the findings are to be pitched towards the audience that will read it
- consider how changes will be implemented given the findings
- consider the lessons learned and seek publication in a journal or transmit the information to those who will benefit from the findings.

(Ruddle & Prizeman, 2002)

There are a number of approaches for evaluating a program, including:

- focus group interviews
- semi-structured interviews
- self-completion questionnaires
- existing research instruments (e.g., Minnesota Job Satisfaction Scale).

(Winstanley & White, 2002)

Research questions

A range of research questions are raised within the general supervision literature (Feltham, 2002). These questions challenge the common and accepted statements made in the literature about supervision. Some common and yet to be fully supported statements include:

- supervision is essential: it may be more expedient to examine what part of supervision is essential, rather than asking the broader question
- supervision equals quality control: this popular belief has thwarted the growth of research in the field and has led to a dearth of empirical evidence in this area
- a supervisee-centred approach equals accountable supervision: how can the supervisee feel empowered by the process of supervision, whilst the supervisor is upholding standards and monitoring the supervisee?

Networking

All AOD programs should be developed using the existing structures and resources of the organisation(s) (Shanley, 1992). The most obvious resource that is immediately available to the organisation is existing staff who are candidates for training as supervisors. They,

in turn, may then be able to train less experienced AOD workers. However, not all organisations have enough experienced staff to undergo training, and others may not have sufficient funding or resources to provide the necessary training.

An effective strategy to overcome the 'lack of staff' barrier is to network with AOD workers with similar interests, or who work in a similar setting. The idea is to develop a joint program with both organisations that achieves mutually relevant goals. During initial contact, the topic of supervision is raised, plans to form a supervisory program are entertained and a partnership is established. Networking can occur at professional workshops, through 'cold calling', referral, word-of-mouth or advertisement. The idea of developing a program will only come to fruition if a group believe in it and persevere.

There are some identified barriers with respect to collaborative work and these include: *"competing work schedules, the difficulties of merging activities when everyone has pre-existing work commitments, limited time, varying experience and monetary constraints"* (Wilkinson, Browne, & Dwyer, 2002, p211). Managing projects 'in house' affords an organisation greater freedom to do what they desire, and control the quality of the supervision program. Different levels of experience, expectation and professional backgrounds may lead to disagreements or an unequal distribution of work for each party. Whilst these barriers may act as a disincentive to embark on a partnership, the original aim of the collaboration should be examined to assess the project's viability and worth (Wilkinson et al., 2002).

An effective strategy for successful partnerships is to identify potential barriers to collaboration, as well as each partner's assets, capabilities and strengths. There are five elements that underpin successful partnerships (Wilkinson et al., 2002). These are outlined in Table 3.4

Table 3.4
Key elements that underpin successful partnerships

Elements	Strategies
1. Shared goals	Identify appropriate partners that have goals, objectives, resources and people necessary to implement initiatives. Establish a need to work together and develop shared goals.
2. Relationships	Develop positive and constructive relationships. Enhance lines of communication. Hold regular meetings, document agreements and closely monitor progress. Develop shared agreements. Invest time to build and maintain the relationship. Monitor changes in partnership.
3. Planning and implementation	Identify the resources required to develop, negotiate, implement, evaluate and sustain the action plan. Involve all parties in the planning and implementation. Develop an agreed way of working at the outset. Set aside time to review and re-negotiate the planned action.
4. Evaluation	Ensure measurable project outcomes are meaningful to all partners. Develop evaluation methods that reflect the funds allocated and probable outcomes.
5. Sustained outcomes	Ensure partners have an understanding of each organisation's values and goals. Respect and value emerging autonomy of the partnership. Consider appropriate ongoing contact for future actions.

Future Developments

The trend within the AOD field is for increasingly complex presentations, with poly-drug using clients now increasingly common, if not the norm. In particular, large increases in cannabis and amphetamine use, often used in conjunction with alcohol, have been observed at AOD treatment centres Australia-wide. High rates of mental health conditions (e.g. depression, anxiety/paranoid states, personality disorders, schizophrenia) are co-occurring with risky levels of drug use. These trends are not likely to abate, and indeed are likely to become more pronounced given the ready availability in the community of an array of illicit drugs, shifts in drug-using norms and expectations, and rapidly rising rates of 'clinical depression'.

Consequently, the challenges for the AOD field are immense, notwithstanding the expanding evidence base for treatments, more sophisticated interventions and the growing role of pharmacotherapy as an adjunct treatment. Most AOD workers will, at least occasionally, feel very challenged, if not overwhelmed, by the inherent difficulties of their work. Therefore, routine quality clinical supervision will be needed more than ever. There is a real risk that a failure to implement supervision policy and programs within an organisation/agency will undermine the provision of optimal clinical care, with the added penalty of high levels of burn-out accompanied by skilled workers leaving the field. This may then compound an expected shortage of skilled AOD workers in the near future, due partly to Australia's ageing population demographic. Critically, in an absence of good clinical supervision, clients will be done a disservice.

There is a need to promote the merits of clinical supervision to all segments of the AOD field. Some workers will be ignorant of what it entails, and perhaps fearful or sceptical. Some managers will need to be convinced that the expense incurred in supplying clinical supervision (particularly when delivered by personnel external to their agency at consultancy rates) is justified by the benefits (e.g. greater staff satisfaction and retention; the delivery of evidence-based 'best practices'). When supervision for individual staff members cannot be afforded, then group and/or peer supervision can be arranged. With rapid improvements in electronic communications, distance or difficulty of access to face-to-face supervision should not act as a deterrent.

Clinical supervision training programs are urgently required for AOD personnel (a sample training program with accompanying slides is included in the Kit that accompanies this book). Training programs may need to vary to reflect audience needs (e.g. type of personnel in attendance; experience in the field; point of contact with clients). Whilst the emphasis in this Guide has been on supervision for counselling within the AOD field, the principles generalise to any workers whose contact with AOD users requires skilled communication and management (e.g. personnel dispensing pharmacotherapies, exchanging syringes, or conducting medical assessments).

Clinical supervision must also reflect interventions appropriate for disadvantaged groups, such as Indigenous Australians who continue to be greatly over-represented in AOD-related mortality and morbidity. Likewise, the special language and cultural sensitivities of ethnic groups are important topics within supervision, with Australia becoming an increasingly diverse 'melting-pot' of peoples. Interventions (and therefore clinical supervision) may need to vary to accommodate the needs of the physically disabled and those with mental health conditions.

When the AOD field is permeated with quality clinical supervision, it will be an indication that the level of professionalism that it so urgently requires across-the-board, is finally being achieved. As Powell and Brodsky (1998, p253) have persuasively argued:

> *"It is evident that the role of clinical supervision will be fundamental to the development of the future (AOD) professional. Supervision will grow in value, importance and sophistication…supervision is on the verge of a major growth spurt in interest, credentialing, and training."*

Hold on for the ride!

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Tools

Contracts

Supervisee

My role as a supervisee is to:

- Uphold ethical guidelines and professional standards
- Build a working relationship with you
- Attend supervision meetings that we organise
- Help you figure out what my work goals are
- Be open to change and consideration of alternative methods of practice
- Complete the work tasks that we agree to each week
- Help me build my confidence and skills as a AOD worker
- Express my thoughts and feelings about supervision

I have been given an overview of the organisation's aims and objectives.

I have read the organisation's policy on supervision and I am familiar with its general operation.

This contract can be revised at any time upon my request and it will be reviewed annually.

Name _____ Date ____

Signature _____

Supervisor

My role as a supervisor is to:

- Oversee the practice you do
- Build a working relationship with you
- Attend supervision meetings that we organise
- Help you figure out your work goals
- Challenge your approaches and techniques
- Help you to help your clients
- Assist you to acquire knowledge and skills that you can use with your clients

I have given you an overview of the organisation's aims and objectives.

I have read the organisation's policy on supervision.

This contract can be revised at any time upon my request and it will be reviewed annually.

Name _____ Date ____

Signature _____

Categories to Explore in a Supervisee Survey

Listed below are some categories and items that may be included in a survey of supervisees. For a model survey related to work practice, see Addy et al. (2003), The Work Practice Questionnaire: Alcohol and Other Drug Training Evaluation Tool (NCETA) at www.nceta.flinders.edu.au/.

Current Position and Other Details

Age in years
Gender
Current position in the workplace
Length of time in the organisation
Total experience in responding to AOD problems
Percentage of time spent responding to AOD problems
Current occupation
Principal areas of practice.

Previous and Current Education and Training

Highest formal qualifications completed
Current status in formal education
Education and training in AOD.

Drugs

Knowledge of the experiential and health effects of:

- heroin
- amphetamine
- cocaine
- marijuana
- alcohol
- ecstasy
- prescribed medication.

Knowledge and understanding of the philosophy of harm reduction.

Assessment

The ability to assess a drug user for:

- Family history
- Drug use
- Current and past treatment
- Psychological problems related to their drug use
- Psychological problems unrelated to their drug use
- Stage of change
- Psycho-social issues (e.g., legal, financial, family problems).

Intervention

The ability to intervene or treat a drug user using:

- A client-centred approach
- Information
- Motivational interviewing
- Cue exposure therapy
- Behaviour therapy
- Cognitive therapy.

Career Worksheet

Dream list	Answer
Where do you see yourself?	
How far into the future is it?	
What are you doing?	
What clients are you working with?	
What setting do you work in?	
What interventions are you using?	
With whom are you working?	

My Career Track:

.....

.....

.....

My desire to work hard to achieve this Career Track

1	2	3	4	5	6	7	8	9	10
Low				Moderate					High

Supervision Plan

SKILL OR AREA OF FOCUS	GOALS	TASKS	DATE REVIEWED	My progress towards achieving this goal 0 1 2 3 4 5 6 7 8 no success 25% 50% 75% 100%

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Weekly Worksheet

MY GOALS THIS WEEK Date: ___/___/___	**TASKS**	**THOUGHTS, QUESTIONS, ANSWERS**	**My progress towards achieving this goal** 0 1 2 3 4 5 6 7 8 no success 25% 50% 75% 100%

Appendix A:

Useful Links to other Clinical Supervision Resources

The prioritising of clinical supervision within the AOD field is relatively new. Hence there are a limited number of existing resources (some pertaining to disciplines such as mental health nursing rather than dedicated to the AOD field) that complement the content of this Kit. Some of these resources contain protocols and checklists (which could be used in conjunction with the Worksheets provided at the rear of The Guide) to help structure supervision.

Useful links are listed below. They can also be found in the Overview booklet (Appendix 1) and on the CD ROM.

1. *Network of Alcohol & other Drugs Agencies (NADA)*

   www.nada.org.au/training/WorkforceDevelopment_ResourceKit.pdf

   This is an excellent Workforce Development Resource Kit.

   Chapter 3 (p27) "Professional development strategies" contains a section on clinical supervision and the related topic of mentoring. In a succinct format (largely checklists), recommendations are made for the framework and rules governing clinical supervision, good practice, finding supervisors, advertising for supervisors, interviewing supervisors and contracting.

2. *Nth Queensland Branch of the Australian & New Zealand College of Mental Health Nurses*

   www.nq-anzcmhn.org/superv.html

   This 2-3 page summary of essential issues relating to clinical supervision is very strong definitionally, particularly with regard to the essential nature of clinical supervision versus line management/supervision, the mutual obligations of participants, and the contractual processes involved (the latter section has been quoted in our Guide).

3. *The College of Education: The University of Alabama*

   www.bamaed.ua.edu/~kcarmich/bce619/Models.html

   This paper provides a succinct outline of various models of supervision (beyond the scope of 'The Guide') that are consistent with models of psychotherapy. It presupposes reasonably advanced knowledge of various theoretical orientations, and has a revision question attached.

4. *Southern Coast Addiction Technology Transfer Center*

   www.scattc.org/pdf_upload/Beacon004.pdf

   This short paper succinctly discusses some of the challenges of providing clinical supervision, especially for those organisations with limited resources in which line managers/supervisors will also be providing clinical supervision. The paper contains a very useful table in which the differences between therapy, line management and clinical supervision are highlighted.

5. *American Psychological Association*

   www.apa.org/books/4317045.html

   Clinical Supervision: A Competency-Based Approach (Falender, C A; Shafranske, E P, APA, 2004) is a recently published, generic, text-book for training and supervising mental health practitioners.

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