

Clinical Supervision Guidelines for the Victorian Alcohol and Other Drugs and Community Managed Mental Health Sectors

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Prepared by

Tina Whittle
(Project Officer)

Pam Rycroft
(Project Officer)

Michelle Wills
(Project Officer)

Shane Weir
(Team Manager)

Naomi Rottem
(Team Leader)

The Bouverie Centre
Victoria's Family Institute
La Trobe University



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Consultants from the Alcohol and Other Drugs Sector

Ange Lajoie
Senior Project Officer
Department of Health
Mental Health, Drugs & Regions
Division

Annie Baker
Sr. Clinician, Counselling Team
Drug & Alcohol Services, Barwon Health

Carolyn Lee-Smith
Team Leader
Eastern Drug & Alcohol Services
Monashlink CHS, Ltd.

Cheryl Sobczyk
General Manager,
Primary Health & Integrated Care
Bendigo Community Health

Donna Ribton-Turner
Director, Clinical Services
UnitingCare Moreland Hall

Ipsita Wright
Director, Services
Youth Support & Advocacy Service (YSAS)

Jo Howard
Program Manager, Frankston
Peninsula Drug & Alcohol Program
(PenDAP)

Kim Scott
Manager, Counselling
Primary Care Connect

Sam Biondo
Executive Officer
Victorian Alcohol & Drug Association
(VAADA)

Dr. Stefan Gruenert
Chief Executive Officer
Odyssey House Victoria

Consultants from the Community Managed Mental Health Sector

Andrew Shakespeare
Manager, Apollo Service
Mind Australia

Ian Oliver
Manager, Prevention & Recovery Care
Program, Doutta Galla Community Health

Jenni Richardson
Manager, Helpline
PANDA

Julia Brumley
PANDA

Kerry Cornish
Manager, Recovery and Complex Care
The Salvation Army, Eastcare

Kim Koop
Chief Executive Officer
VICSERV

Matthew Colledan
Eastern Regional Manager
NEAMI

Milan Poropat
Operations Manager
ARAFEMI

Ros Cairns
Manager, Mental Health
Healthcare Chaplaincy Council of
Victoria Inc

Sue Harrison
Senior Trainer
VICSERV

1 Introduction and Background

These guidelines and the recommendations contained within have been developed for the Alcohol and Other Drugs (AOD) and Community Managed Mental Health (CMMH) sectors in Victoria.

The document opens with a discussion of the differing definitions of clinical supervision. This is followed by a description of current models within a historical context, the benefits of clinical supervision and an outline of the central principles underpinning the process. Chapters six through nine are more practical in orientation, providing ideas and advice for supervisors, supervisees, and team leaders and managers seeking to better understand and effectively engage in clinical supervision.

1.1 *Initial Impetus for the Guidelines*

As part of a broader approach aimed at attracting, supporting and retaining well qualified staff and building workforce capacity to deliver high quality client services, The Department of Health sponsored a strategy to improve the practice of clinical supervision in the AOD sector. The Bouverie Centre was engaged to develop and deliver a Clinical Supervision Training and Support Program appropriate to, and reflective of, the sector. Close to three hundred practicing supervisors and workers received the training and several teams were supported in their efforts to develop and maintain consistent, high quality supervision.

A 2008-2009 audit of the initiative revealed that while the concept of clinical supervision was widely embraced by the AOD field, there was still considerable variability across organisations regarding how the practice was delivered. This finding, combined with the strong interest expressed in the process remaining useful and sustaining over time, suggested the sector would likely benefit from articulating and documenting:

- what clinical supervision is; including the values and guiding principles underpinning the process
- roles and responsibilities
- effective supervision practices, grounded in the day to day realities of the workplace

1.2 *How the Guidelines were Prepared*

Development of the first edition of the guidelines was informed by a series of consultations with representatives from the Victorian AOD Sector (see AOD Consultants, p. vi), a review of the available literature and the practice wisdom of several experienced supervisors from The Bouverie Centre.

In 2012, following the restructure of the Department of Health and a move towards closer integration between the Mental Health and AOD sectors, a working group comprising representatives from Victorian Community Managed Mental Health services and VICSERV was convened (see CMMH Consultants p. vi) to discuss the feasibility of updating the guidelines in order to make them equally applicable for the CMMH workforce. The group deemed the update a worthwhile exercise; reasoning that the guidelines represented a

sound body of work, with much of the existing content relevant for workers, supervisors and managers of community managed mental health services. In addition to serving as a helpful resource, members of the working group explained that joint guidelines had the potential to create greater consistency in the clinical supervision programs offered by the different sectors. The group agreed to serve as consultants during the remainder of the re-development process.

1.3 *Intended Use*

It is important to stress that these are *guidelines only* and that there will be no compliance standard required by the Department of Health, although it is hoped that they will form the basis of ongoing clinical supervision policy formation in the Victorian AOD and CMMH sectors.

We have aimed to make the guidelines broad and flexible enough to be useful across all programs and services, while recognising that great diversity exists within, and between the sectors, and that all variations have not been taken into account. It is our hope that these guidelines will make a substantial contribution to the clinical governance policies which organisations should customise to meet their particular needs.

We wish to emphasise that these guidelines are specific to the Victorian AOD and CMMH sectors and that they are intended to exist alongside the codes of ethics set forth by the various professional regulatory boards and associations in the state, as well as the governing policies of the organisations in which workers are employed. These guidelines are not an attempt to replace or contend with the standards and regulations to which the sectors' workers are bound by their individual professional affiliations or organisational protocols.

1.4 *Practical Information*

The *Clinical Supervision Guidelines for the Victorian AOD and CMMH Sectors* were funded by The Mental Health, Drugs and Regions Division. The guidelines are available via www.clinicalsupervisionguidelines.com.au both as a series of linked webpages and as a downloadable PDF. The Bouverie Centre will oversee updates of the guidelines as part of our commitment to clinical supervision within the sectors and as part of our own accountability processes. We would appreciate feedback and will incorporate requested changes or additions, as appropriate, to future versions of the documents.

References for this section: Bernard & Goodyear (2009); The Bouverie Centre (Ryan, Wills et al., 2009); Powell & Brodsky (1998); Roche, Pidd et al. (2009).

A note about the language

We use the term *clinical supervision* throughout these guidelines to describe a process intended to support workers in a variety of human service organisations to provide a better quality, more confident and creative service to clients. In this case, the focus is largely on the actual doing of the work and how workers can extend themselves in relation to their practice. By contrast, *managerial supervision* almost exclusively centres on whether certain

performance standards have been attained and organisation protocols followed (organisational outcomes).

We recognise that the term ‘clinical’ is imbued with many meanings, including a strong association with the medical model of health. We wish to stress that the practice referred to in these guidelines is not based on any one approach to recovery, let alone one which defines health largely as the absence of disease. We concur with the Mental Health Coordinating Council, that:

“Recovery is a deeply personal process and no single, universally accepted definition of recovery currently exists.”

(2012, p.x)

We have aimed to make these guidelines useful to professional groups with different practice orientations and philosophies (e.g., social workers, counsellors, occupational therapists and psychologists) as well as workers in the field who have certificate or diploma level qualifications.

We also want to acknowledge that the word ‘supervision’ commonly implies a hierarchy of power, with one party favoured as the authority or master and the other typically a recipient of advice or direction. Clinical supervisors are often accomplished and /or experienced clinicians. At different times and with different supervisees they may assume the role of a teacher, coach, mentor, role model and/or advisor. This will vary according to many different factors, not least, the level of experience in the field of the supervisee. Although supervisees may require guidance and direction at times, we view effective supervision as a collaborative process, wherein supervisees are encouraged to take an active role in:

- choosing what aspect of their practice to focus on and explore
- determining how the supervisor-supervisee dyad works together
- offering feedback to the supervisor about the experience of the supervisory process and the relationship
- developing and being accountable to their own professional standards

In this context, supervision is a process of guided reflection rather than simply a top-down exchange emphasising the organisation’s expectations.

References for this section: Amies & Weir (2001); Mental Health Coordinating Council (Bateman, Henderson & Hill, 2012).

2 Defining Clinical Supervision

There is not a single, definitive answer to the question, “What is clinical supervision?”, but in the available literature on the topic, there are some very solid ideas about the intended focus and content of clinical supervision and how it differs from teaching, counselling (or therapy) and consultation. However these roles may be seen to differ, it remains true that clinical supervisors have a variety of functions and that their roles may shift appreciably in relation to supervisees’ skills, knowledge, needs and experience levels.

Another important factor...is the defining of clinical supervision. We attract so many different disciplines into this sector; so social workers, psychologists, other workers all have their own idea of what CS is. The definition is one thing, but how it translates into understanding is another. The principles are important: why we do it, what its value is, what would it be like if we did not do it. I like to ask, "What would your work life be like if supervision were not there?" (Manager, AOD Service)

A clinical supervisor may act as teacher, coach, mentor, consultant, role model and/or advisor at different times and with different supervisees, with the same supervisee at different stages of development, and with an individual supervisee or group during the course of a single clinical supervision session. Furthermore, a clinical supervisor may conceptualise his or her role(s) from a particular theoretical perspective that resists such titles as "teacher" or "mentor" and embraces the less-hierarchical position of "consultant." Essential to effective clinical supervision is a process by which supervisors adopt models of practice that suit their professional styles and practice principles, that meet the needs of their supervisees, and that satisfy the expectations of the organisations in which they work.

Clinical supervision at its most effective exists within a formal, but flexible, structure, as an aspect of the organisations' overall clinical governance policies. For the purpose of these Guidelines, clinical supervision shall be defined as follows:

Clinical supervision is a formal and disciplined working alliance that is generally, but not necessarily, between a more experienced and a less experienced worker, in which the supervisee's clinical work is reviewed and reflected upon, with the aims of: improving the supervisee's work with clients; ensuring client welfare; supporting the supervisee in relation to their work, and supporting the supervisee's professional development.

In contrast to clinical supervision's focus on the development of a supervisee's competency, administrative or managerial supervision is directly intended to meet organisational demands and expectations. Tasks which fall to administrative supervisors include such things as performance reviews, workload planning and management, and general problem solving and decision-making regarding staff whom they supervise.

It is common in many services for supervisors to hold line management responsibility for those whom they supervise clinically. In order to reflect that reality, one may refer to the supervisory relationship in such contexts as having four foci: administrative, evaluative, clinical and supportive (Powell, 1993). The key to managing this dual role effectively is to be very clear where one task begins and the other ends (e.g., when a supervisor is in a performance evaluation mode vs. a clinical support mode), which requires a strong relationship of trust and flexibility between supervisors and those whom they supervise. It is also necessary to have clear accountability processes in place.

In some services, line managers serving as clinical supervisors do so only with staff members for whom they are not administratively responsible. In this type of arrangement, the clinical supervisors focus on the clinical and supportive aspects of the work and leave administration to line managers. This approach of separating line management from clinical supervision has long been the preferred arrangement in academic settings, postgraduate

training for professional accreditation and many professional organisations world-wide, yet this model does not necessarily fulfil the organisational and daily functioning requirements of all health and welfare services, many of which rely on their managers to perform dual roles for a variety of reasons. Both approaches have benefits and challenges (see section 6.1)

These Guidelines will focus on the role of clinical supervisor as distinct from the role of line manager/administrative supervisor (regardless of who is performing the work), but will also examine how one might manage that dual role successfully, as reflecting the work experience of many supervisors across services. However, administrative functions, as an aspect of management which have their own governing protocol, will not be discussed in detail in these guidelines. It is important to emphasise that clinical supervision, even when provided through the line management structure, should remain distinct from managerial supervision, just as it should remain distinct from casework, case allocation meetings and informal debriefings. All share something in common with clinical supervision, but each differs in its structure, function, focus and intended aim from the clinical supervision process.

One good thing about a line manager model is that they feed back directly to the organisation, whereas the external supervisors do not necessarily do that. If there was a major issue, our managers would bring it up, but external supervisors may not be providing regular, formal feedback to managers. (Manager, AOD Service)

References for this section: Bernard and Goodyear, 2009; Carroll, 2007; Inskipp and Proctor, 1993 (cited in The Bouverie Centre [Moloney, Vivekananda & Weir, 2010]).

3 Models of Clinical Supervision: Current Approaches within an Historical Context

What follows is a brief history of clinical supervision. It is not all-inclusive, but touches on the developmental highlights. The models discussed are still in use today.

3.1 *Psychoanalytic Foundations of Clinical Supervision*

Psychoanalysis as a discipline was founded by Sigmund Freud towards end of the 19th century. From the beginning of his working life, Freud was discussing his ideas and practices with others and they with him, although the terms clinical consultation and clinical supervision had not yet been adopted. As far back as 1902, he was involved as teacher, mentor and observer in the work of young doctors practising to become psychoanalysts. This early type of supervision was didactic in form and the work centred on the patients' dynamic processes.

Other helping professions began to develop their own supervision practices at this time and it is difficult to know who influenced whom, or precisely in what order events unfolded. Social workers in the U.S. were introducing supervision as a "supportive and reflective space" (Carroll, 2007, p. 34) and other types of welfare workers were picking up these ideas at, or around the same time.

No matter which discipline or what form of clinical supervision one practices, psychoanalytic concepts have brought much richness to clinical supervision in all its phases. Freud's psychodynamic ideas of parallel process and creating a working alliance are foundational across models of clinical supervision, having "informed the work of supervisors of all orientations" (Bernard & Goodyear, 2009 p. 81). It is believed that Max Eitington of the Berlin Institute of Psychoanalysis first made supervision a formal requirement for psychoanalytic trainees in the 1920s, just as mandatory standards for both coursework and observational treatment of patients were established by the International Psychoanalytic Society (Carroll 2007; Bernard & Goodyear, 2009).

The two schools of thought on clinical supervision that competed for dominance in the 1930s were the Budapest School and the Viennese School. The former held the concept of clinical supervision as a "continuation of the supervisee's personal analysis" (Bernard & Goodyear, 2009, p. 82) which meant having the same analyst (supervisor) performing dual roles as both therapist and supervisor. In therapy, the focus would be on the analysand's (supervisee's) transference issues in relation to the analyst; in supervision, the focus would be on the analysand's countertransference issues in relation to his or her own clients. The latter school held the idea that the analysand's transference and countertransference issues were both to be processed in therapy, so that supervision was retained as a teaching forum.

A psychodynamic model which emerged later on, in the 1970s, had a wide resonance for many practitioners both inside and outside psychoanalytic circles. This work marks the beginning of the supervisee as the centre and focus of the supervision process. Ekstein and Wallerstein conceptualised clinical supervision as both "a teaching and learning process that gives particular emphasis to the relationships between and among patient, therapist and supervisor and the processes that interplay among them" (Bernard & Goodyear, 2009, p.

82). Thus, the focus was on teaching rather than providing therapy, with the aim being for the supervisee to understand the overt and covert dynamics between supervisor and supervisee; to learn how to resolve difficulties which arose, and to develop the skills necessary to help his or her clients in the same fashion.

In the past decade, two psychodynamic therapists and supervisors, Mary Gail Frawley-O'Dea and Joan E. Sarnat, introduced a fresh psychodynamic supervision model in their book *The Supervisory Relationship: A Contemporary Psychodynamic Approach* (O'Dea, M.G. and Sarnat, J.E. , 2001, New York: Guilford Press), which suggested a new philosophical and practical position for the supervisor in relation to the supervisee. Previously viewed as an objective expert with a mastery of theory and technique, the supervisor in this model is afforded space to act less the dispassionate expert and more an active participant in the unfolding process of supervision. Thus, his or her authority "resides in the supervisor-supervisee relational processes" (Bernard & Goodyear, 2009, p. 82), rather than in the absolute, immutable position of the all-knowing superior. In such a relationship, both parties acknowledge a mutual influence and the supervisory stance shifts effectively from that of outside, reflective observer to informed and purposefully influential insider.

Points to remember about psychodynamic supervision:

- Process and relationship oriented, with a focus on intrapsychic phenomena and interpersonal processes, in order to develop insight and provide containment
- Close parallels between therapy and supervision

References for this section: Bernard & Goodyear (2009); The Bouverie Centre (Moloney, Vivekananda & Weir, 2007); Carroll (2007).

3.2 Clinical Supervision Based on Counselling Models

In the 1940s - 1950s, there was another shift in the delivery of clinical supervision. The new models which emerged were based upon and tightly bound to the counselling theories and interventions of the practising supervisor.

3.2.1 Person-Centred Supervision

Carl Rogers, the founder of a humanistic, person-centred model of therapeutic practice, did not differentiate greatly between therapy and supervision, but simply shifted his role during sessions depending upon what his supervisees required at the time - personal therapy, or professional supervision. As with the psychodynamic models, the person-centred model, to be effective, relied upon a strong and trusting relationship between supervisor and supervisee.

Rogers was among the first to use electronically recorded interviews and clinical transcripts in supervision (Bernard & Goodyear, 2009, p. 83), rather than relying only on the self-report of those he supervised. Carl Rogers' influence on both therapy and clinical supervision practices has been profound. Though Rogers' approach is less focused upon today in the U.S., it is still widely taught in the UK and many of the skills learnt by new practitioners world-wide can be traced back to him.

Points to remember about person-centred supervision:

- Process and relationship focused, with genuineness, warmth and empathy being imperative relational traits
- Exploration of self, both personally and in the context of the work, is essential to the process, with movement towards differentiation and self-actualization the goal of both therapy and supervision
- Encompasses both teaching and therapy:

“I think my major goal is to help the therapist to grow in self-confidence and to grow in the understanding of himself or herself, and to grow in the therapeutic process...Supervision for me becomes a modified form of the therapeutic interview” (Rogers, cited in Bernard & Goodyear, 2009, p. 83).

3.2.2 Cognitive-Behavioural Supervision

Cognitive-Behavioural Supervision, like the various models of therapy related to it, emerged in the 1960s. It was a far cry from what had come before, in that the focus shifted dramatically away from the relationship and dynamic processes existing between supervisor and supervisee (or therapist and client) to the development of practice skills. Becoming an effective therapist, like becoming an effective person, involved mastering specific tasks and learning to think in ways which were beneficial to the personal or professional self, whilst taking actions to extinguish (in CBT terms) unhelpful thinking and behaviours that create problems. Thus, success as a therapist depended upon one’s ability to learn the work and to do it well, rather than on a good fit between therapist and client.

The tasks assigned to supervisees in clinical supervision would mimic that offered to clients in therapy, such as imagery exercises and role playing. As with cognitive behavioural therapy, this type of clinical supervision would hold that it is the intervention which counts, and specific interventions lead to specific outcomes, if followed precisely and faithfully. Assessment and close monitoring of supervisees was routine, as it was considered essential to the work that they both understood and properly utilised the theory and practice of the therapy, as expressed in the treatment manuals.

CBT in its current form, or forms, is more variable and open to influence than fifty years ago. For instance, more attention is now paid to relationship than in the past, and ideas from Eastern philosophy have been incorporated into the work by some practitioners (e.g., mindfulness, meditation). Similarly, these ideas tend also to be incorporated into clinical supervision and training in CBT work.

Points to remember about cognitive behavioural supervision:

- Instructional and skills-based (or strategy-based), with focus on achieving technical mastery, e.g., how to challenge negative automatic thoughts
- Explicit and specific goals and processes followed, e.g., negotiating agendas at the beginning of each session

- Use of behavioural strategies with supervisee, e.g., role play and visual imagery

3.2.3 Family Therapy (Systemic) Supervision

Family Therapy (Systemic) Supervision theory and practice has been documented since the 1960s, with family therapists taking the unique step of making therapy a highly interactive and involved team effort, by observing their colleagues' clinical work with families and engaging with them and the client family as part of the treatment team.

Although family therapy had been emerging for several decades, it broke through as a formal discipline with its own clear set of ideas in the 1950s, as a direct result of the work of an anthropologist named Gregory Bateson, and his colleagues at the Palo Alto Institute. Findings from The Bateson Project created a paradigmatic shift in the field of family therapy and refocused the energies of its practitioners. Family therapists began to understand the family as an interactive system; to pay close attention to communications between family members; to view causality as circular rather than linear and to believe that change could start with any member of a family, thereby impacting the whole.

These ideas influenced the way in which family therapy clinical supervisors approached their work with supervisees, as supervisees were themselves understood to be part of an interlocking group of systems, all of which affected how they performed their work (e.g., family of origin; interaction with the client's family system and the supervisory system).

There were several models of family therapy and it was considered essential that clinical supervision be consistent with the model of therapy that the supervisee was learning to practice. Despite differences in opinion regarding how problems emerged and what might help to solve them, all models held in common the role of the therapist as "active, directive and collaborative" (Liddle et al., cited in Bernard & Goodyear, 2009). This was also the case with clinical supervision, in which supervisors were highly engaged with their supervisees.

It was then and is now common practice for clinical supervisors to observe the work of their supervisees. Sometimes this was (and is) done live, as in training programs, with the supervisor offering interventive suggestions via phone through a one-way mirror to the supervisee during sessions. This is a unique contribution of family therapy to the practice of clinical supervision that is called simply "live supervision." More common is for supervisees to present recorded sessions of their work with clients and/or to offer written transcripts of sessions, which are then reviewed and discussed in clinical supervision sessions.

Another unique contribution of family therapy to clinical supervision is the reflecting team, a therapeutic model introduced by Norwegian family therapist Tom Andersen in 1985. A reflecting team is a group of therapists who observe a colleague conducting a family session, then have an open conversation with one another, observed by the colleague and client family, about what they noticed in the session. This is done respectfully and thoughtfully, with great care and consideration taken in relation to the possible impact of their observations. The idea is to generate fresh possibilities for the clients and to offer multiple perspectives and a sense of hopefulness.

In the same way, a reflecting team can observe a family session facilitated by a supervisee, focusing their reflective comments on what they noticed in the supervisee's work. This is

common practice in training programs, where a group of supervisees might act as a reflecting team, under the guidance of a clinical supervisor.

Points to remember about systemic supervision:

- Focus on relational approach to understanding of and intervention in presenting problems
- Makes explicit connections between people and the wider social context
- Greater use of direct observation and live supervision (compared to other supervision models)
- Supervisor's role is that of director or consultant
- Focus on the supervisee's position within the broader system
- Principles and techniques used in therapy are congruent with those used in supervision and may be applied to supervisee, e.g., strategic interventions, family of origin exploration

References for this section: Bernard & Goodyear (2009); The Bouverie Centre (Moloney, Vivekananda & Weir, 2007); Carroll (2007).

3.3 Developmental and Social Role Model Approaches to Clinical Supervision

Developmental and social role model approaches to clinical supervision have been in use since the 1950s, but began to gain great popularity during the 1970s and 80s.

Developmental models

There are many models of clinical supervision that can be defined as developmental, which can be further categorised into three types: stage developmental models; process developmental models and life-span developmental models. These focus on the developmental stages of the supervisee in relation to the clinical supervision process. Clinical supervisors are also understood to go through developmental stages as they hone their talents and skills in their work with supervisees.

Stage developmental models describe supervisees moving through progressive stages in their professional maturity and within the supervisory relationship. The beginning counsellor is seen as highly motivated, but with only limited awareness and quite dependent on the supervisor. Over time and through experience gained, the counsellor becomes more consistently motivated, more fully aware, but less self-conscious, and more autonomous. An example of a stage developmental model is The Integrated Developmental Model (IDM) developed by Cal Stoltenberg, Brian W. McNeill and Ursula Delworth.

Process developmental models are those which focus on processes in the supervisee's work which "occur within a fairly limited, discrete period" (Bernard & Goodyear, 2009, p. 92).

Examples include:

- *Reflective models of practice* - models which encourage the use of reflection to improve practice, by focusing on an experience in a counsellor's professional practice which is having an emotional or intellectual impact that requires deeper understanding. Originally based on the concepts of John Dewey in the 1930s, these models continue to be developed and widely used today.
- *The Loganbill, Hardy and Delworth model* - a counsellor development model based on processes which are "continually changing and recursive" (Bernard & Goodyear, 2009, p. 94) and expressed by characteristic attitudes towards the work, the self and the supervisor. A key difference in this model is that it dismisses ideas of linear progression through stages in favour of continual cycling through "with increasing...levels of integration at each cycle" (Bernard & Goodyear, 2009, p. 94).
- *Event-based supervision* - a task focused model in which the supervisor and supervisee focus on analysing how the supervisee has managed particular discrete events in his or her work. Supervisor and supervisee decide where to focus their attentions by either a direct request of the supervisee, or by the supervisor picking up on subtler, or less direct, cues.

Task-focused developmental models of clinical supervision, such as Michael Carroll's, break down supervision into a series of manageable tasks. In Carroll's integrative model (which is also a version of social role model), he suggests the following seven central tasks of clinical supervision: creating the learning relationship, teaching, counselling, monitoring (e.g., attending to professional ethical issues), evaluation, consultation and administration.

Lifespan developmental models, such as The Ronnestad and Skovholt Model, focus on the development of counsellors across the lifespan, rather than just the few years when they are new to their work. This six-stage model begins with "The Lay Helper Phase" and ends with "The Senior Professional Phase" (Bernard & Goodyear, 2009, p. 98), and is unique in articulating the differing needs in clinical supervision for counsellors at each stage of their professional lives.

Social role models

Social role model approaches to clinical supervision focus on the roles, tasks, foci and functions of clinical supervision. Two examples are Hawkins and Shohet's "Seven-eyed Model," (originally called the "Double Matrix Model") and Holloway's "Systems Approach to Supervision (SAS)."

The "Seven-Eyed Model" (Hawkins and Shohet) recognises that the clinical supervisor employs different roles or styles at different times, but also concedes that the role or style, is likely to be most influenced by the particular focus of the work at the time. This is a process model, which stresses attending to the processes that occur during supervision and within the supervisory and therapy relationships. Hawkins & Shohet coined the term the "good enough" supervisor, alluding to the object-relations idea of the "good enough" mother (i.e. one does not have to be perfect, or get everything right). They believe that a primary and consistent role of the supervisor is that of providing containment for the

supervisee.

The “Seven-Eyed Model” of supervision is called such because it recommends seven areas of focus for exploration in supervision: (1) content of therapy session; (2) supervisee’s strategies and interventions with clients; (3) the therapy relationship; (4) the therapist’s processes (e.g., countertransference or subjective experience); (5) the supervisory relationship (e.g., parallel process); (6) the supervisor’s own processes (e.g., countertransference response to the supervisee and to the supervisor-client relationship), and (7) the wider context (e.g., organisational and professional influences).

Holloway’s “Systems Approach to Supervision Model” is integrative and comprehensive, taking into account a number of factors which impact upon supervision. Holloway recommends that five systemic influences and relationships be considered: (1) the supervisory relationship (phase, contract and structure); (2) the characteristics of the supervisor; (3) the characteristics of the institution in which supervision occurs; (4) the characteristics of the client, and (5) the characteristics of the supervisee.

Holloway then offers a task and function matrix for conceptualising the supervision process, in which the five functions are: monitoring/evaluating, instructing/advising, modelling, consulting/exploring, and supporting/sharing. The five tasks of the matrix are: counselling skills, case conceptualisation, professional role, emotional awareness and self-evaluation. The matrix provides twenty-five task-function combinations. The tasks and functions together are said to equal process, and all are conceptualised to be built around the “body” of supervision, the relationship.

Points to remember about developmental and social role model approaches to clinical supervision:

- Historically, a point of transition when the focus of supervision shifted from the person of the worker to the work itself
- Conceptualise clinical supervision as related to, but separate from, counselling, and as a unique process requiring its own practice principles, knowledge base, and skill set
- Focus on the tasks, roles and behaviours in clinical supervision

References for this section: Bernard & Goodyear (2009); The Bouverie Centre (Moloney, Vivekananda & Weir, 2007); Carroll (2007).

3.4 Postmodern Approaches to Clinical Supervision

Postmodern approaches (a.k.a. Social Constructionist or Post-Structural models) to therapy and clinical supervision have been emerging since the 1980s and include narrative therapy models, solution-focused models and feminist-influenced models. The therapeutic models built upon postmodernist ideals began to have a heavy influence on the practice of therapy in general and on family therapy, specifically, in the 1990s, which inevitably changed the practice of clinical supervision for those involved. This was considered to represent a major paradigm shift in the practice of systemic therapies in particular.

The philosophical perspective of postmodernists, in their various disciplines, is that:

“Reality and truth are contextual and exist as creations of the observer...grounded in their social interactions and informed by their verbal behaviour” (Philp, Guy, & Lowe, cited in Bernard & Goodyear, 2009, p. 86).

Thus, there is no objective, observable reality or one truth, but multiple realities and truths based on a wide range of human experience and interpretation, expressed predominantly through language - itself a tool with which we construct our worlds.

Anyone practising narrative, solution-focused, or any other type of therapy underpinned by a postmodern world view, would give a strong emphasis to language and would understand the power implicit in words. Practitioners of these models attempt to understand the client's world as the client understands it and do not assume a shared reality or truth between themselves and others. Since knowledge is not held as absolute, open and reflective questions which maintain a stance of curiosity in relation to the client is a hallmark of the work. These traits would be apparent in clinical supervisors as well as therapists.

Although there are significant differences in the various models of clinical work and supervision which fall under the umbrella of postmodernism, they have some shared qualities which are distinctive to them. Firstly, the role of the clinical supervisor is more consultative than supervisory, with the relationship being valued as a collaboration and dialogue being guided by questions rather than answers. There are some clinical supervisors working from these modalities, in fact, who refer to themselves as consultants and their supervisees as colleagues, no matter the difference in their levels of experience.

This leads to the second distinctive feature of these models, which is that there tends to be a very conscious effort to avoid emphasising hierarchical differences between supervisor and supervisee and in fact, to minimise those differences in status as much as possible. Thirdly, there tends to be a strong focus on the strengths and successes of the supervisee, with a view to building upon those, rather than close analysis of perceived failures or faults.

Special mention should be made here of Johnella Bird, from The Family Therapy Centre in Auckland, New Zealand, who has emphasises the use of relational language and what she calls “prismatic dialogue” in evoking directly the voices of all the participants (including the client) in counselling and supervision. To this end, a thirty to forty minute long prismatic interview (that is, one in which the counsellor is invited to consider aspects of the situation from the position of client) is audio-taped, and the tape taken back to the client for comment and reflection. According to Bird (2006) counsellors:

“...experience a sense of movement as they engage in prismatic dialogue. Invariably this movement produces awareness of new possibilities for therapeutic directions and conversations. I believe one of the principal tasks of super-vision is to liberate the mind in order to foster the counsellor's sense of creativity.”

(p.4)

Points to remember about postmodern models of supervision:

- Focus on subjective experience

- Multiple truths are understood in relation to context
- Strong emphasis on language and its relationship to power (e.g., the dominant discourse)
- Supervisor's role is that of consultant
- Effort to subvert hierarchy, with striving towards equality between supervisee and supervisor
- Focus on the supervisee's strengths
- The client's perspective is included directly where possible

References for this section: Bernard & Goodyear (2009); Bird (2006); The Bouverie Centre (Moloney, Vivekananda & Weir, 2007); Carroll (2007).

4 Benefits of Clinical Supervision

Particular requirements must be met in order for clinical supervision to bear fruit for workers and the organisations employing them; specifically, clinical supervision must be accessible, regular, and consistent and must be provided by clinical supervisors who have the necessary experience, skills and knowledge to meet the demands of the work. Effective clinical supervision that is perceived by workers to be at least satisfactory, or of high quality, benefits them, their organisations and their clients in the following ways. It:

- Aids workers' acquisition of complex clinical skills, expands their clinical practice and increases their competence and confidence
- Fosters professional development of workers at all experience levels
- Is associated with higher levels of job satisfaction or morale
- Safeguards against worker burnout and encourages worker retention
- Potentially improves communication and team cohesion among workers
- Promotes development of specified skills and competencies, to bring about measurable outcomes
- Raises level of accountability in counselling services and programs
- Provides a mechanism by which consistency in treatment modalities and other service delivery standards can be established across the organisation
- Ensures client welfare, in relation to clinical safety and competence, professional and ethical standards and organisational service delivery protocol, thereby functioning as a risk-management tool

... the strongest benefit is the clear parallel between the worker-client relationship and the line management-worker relationship. So I think that in a sense the supervisory relationship at its best can model an effective worker-client relationship, particularly in terms of establishing rapport and coming up with agreements about how to work. (Manager, CMMH Service)

A major benefit is that what comes out in supervision is able to be fed back into the organisation for our learning and development goals (i.e. bring to our attention on the workforce strategy committee, such as staff feeling like they are stuck, not being challenged enough anymore, etc.). We like to address issues with more than just a particular individual, on an organisational level. The learning that comes out of supervision with one person can be extended and shared with other staff. That is a benefit, because those “light bulb” moments do not have to be kept exclusive to one supervisor and one supervisee. (Manager, AOD Service)

... and that’s to me fundamentally why supervision exists – to ensure a great service and the psychological and physical safety of the worker and consumer. (Manager, CMMH Service)

References for this section: Bambling, King, Raue, Schweitzer & Lambert (2006); Bernard & Goodyear (2004); The Bouverie Centre (Ryan, Wills et al., 2009); Kavanagh, Spence et al. (2002); Powell & Brodsky (1998); Roche, Chelsea et al. (2007).

5 Central Principles of Clinical Supervision

Eleven central principles of clinical supervision have been identified by Consensus Panel Members who collaborated on the *Clinical Supervision and Professional Development of the Substance Abuse Counsellor, Treatment Improvement Protocol Series* (Center for Substance Abuse Treatment, 2009) for the U.S. alcohol and drug service sector. In introducing these principles, the Consensus Panel, whose names are listed at the end of the Principles, stated that it recognised the costliness of clinical supervision, but that clinical supervision remains a cost-saving measure overall, due to the following four effects: (1) enhancing the quality of client care; (2) improving efficiency of counsellors in direct and indirect services; (3) increasing workforce satisfaction, professionalisation and retention, and (4) ensuring that services uphold legal mandates and ethical standards of practice.

Though created with the U.S. alcohol and drug sector in mind, these principles are documented here for two reasons: firstly, because they are solid core values expressed by world leaders in supervision (albeit in the field of AOD work), which are congruent with The Bouverie Centre’s own ideas in regard to clinical supervision; secondly, they are relevant to and valid for the Victorian AOD and CMMH sectors. Taken as a whole, they provide a sound rationale for the necessity of clinical supervision, while offering good advice to administrators.

(The Central Principles appear as written by the Consensus Panel with some adaptations.)

Clinical supervision is an essential part of all clinical programs. Clinical supervision is a central organising activity that integrates a service's mission, goals, and treatment philosophy with clinical theory and evidence-based practices. The primary reasons for clinical supervision are to ensure (1) quality client care, and (2) clinical staff continue professional development in a systematic and planned manner. Clinical supervision is often the primary means of determining the quality of care provided.

Clinical supervision enhances staff retention and morale. Staff turnover and workforce development are major concerns in many fields. Clinical supervision is a primary means of improving workforce retention and job satisfaction (see, for example, Roche, Todd, & O'Connor, 2007).

Every clinician, regardless of level of skill and experience, needs and has a right to clinical supervision. In addition, supervisors need and have a right to supervision of their supervision. Supervision needs to be tailored to the knowledge base, skills, experience, and assignment of each worker. All staff need supervision, but the frequency and intensity of the oversight and training will depend on the role, skill level, and competence of the individual. The benefits that come with years of experience are enhanced by quality clinical supervision.

Clinical supervision needs the full support of agency administrators. Just as services want to cultivate an atmosphere of growth and openness to new ideas for their clients, workers should be in an environment where learning and professional development opportunities are valued and provided for all staff.

The supervisory relationship is the crucible in which ethical practice is developed and reinforced. The supervisor needs to model sound ethical and legal practice in the supervisory relationship. This is where issues of ethical practice arise and can be addressed. This is where ethical practice is translated from a concept to a set of behaviours. Through supervision, workers can develop a process of ethical decision-making and use this process as they encounter new situations.

Clinical supervision is a skill in and of itself that has to be developed. Good practitioners tend to be promoted into supervisory positions with the assumption that they have the requisite skills to provide professional clinical supervision. However, clinical supervisors need a different role orientation toward both program and client goals and a knowledge base to complement a new set of skills. Programs need to increase their capacity to develop good supervisors.

Clinical supervision often requires balancing administrative and clinical supervision tasks. Sometimes these roles are complementary and sometimes they conflict. Often the supervisor feels caught between the two roles. Administrators need to support the integration and differentiation of the roles to promote the efficacy of the clinical supervisor.

Culture and other contextual variables influence the supervision process; supervisors need to continually strive for cultural competence. Supervisors require cultural competence at several levels. Cultural competence involves the worker's response to clients, the

supervisor's response to workers, and the program's response to the cultural needs of the diverse community it serves. Since supervisors are in a position to serve as catalysts for change, they need to develop proficiency in addressing the needs of diverse clients and personnel.

Successful implementation of evidence-based practices requires ongoing supervision. 1) Supervisors have a role in determining which specific evidence based practices are relevant for an organization's clients (Lindbloom, Ten Eyck, & Gallon, 2005, cited in U.S. Dept of Health & Human Services, 2009). 2) Supervisors must ensure that evidence based practices are successfully integrated into ongoing programmatic activities by training, encouraging, and monitoring workers. Excellence in clinical supervision should provide greater adherence to the evidence-based practice model.

Supervisors have the responsibility to be gatekeepers for the profession. Supervisors are responsible for maintaining professional standards, recognizing and addressing impairment, and safeguarding the welfare of clients. More than anyone else in an agency, supervisors can observe worker behaviour and respond promptly to potential problems, including counselling some individuals out of the field because they are ill-suited to the profession. This gatekeeping function is especially important for supervisors who act as field evaluators for practicum students prior to their entering the profession. Finally, supervisors also fulfil a gatekeeper role in performance evaluation and in providing formal recommendations to training institutions and credentialing bodies.

Clinical supervision should involve direct observation methods. Direct observation should be the standard because it is one of the most effective ways of building skills, monitoring worker performance, and ensuring quality care. Supervisors require training in methods of direct observation, and administrators need to provide resources for implementing direct observation. Although many agencies might not have the resources for one-way mirrors or videotaping equipment, other direct observation methods can be employed.

Consensus Panel Members: David J. Powell, Ph.D. (Chair); Bruce Carruth, Ph.D.; Charles F. Gressard, Ph.D., LPC, NCC; Bettye Harrison; Sharon Hartman, M.B.A., LSW; Pamela Mattel, M.S.W., LCSW-R, ACSW, CASAC; John Porter, M.S.

References for this section: adapted from Center for Substance Abuse Treatment (CSAT) (2009, public domain).

6 Clinical Supervision Modalities

When setting up a clinical supervision program there are two key considerations for services: Whether to provide internal or external supervision and the choice between an individual and/or group approach to clinical supervision. Whilst the modalities (internal and external; individual, facilitated group, peer group) share similarities, each one has unique features. This section compares the different modalities to assist with the decision making process.

6.1 *Choosing Internal or External Supervision*

Powell (1998) mentions that definitions of clinical supervision frequently overlook the supervisor's administrative functions (other than where they directly pertain to the supervisee's work with clients). He writes that "...in the real world of service provision, most clinical supervisors have line responsibility for the function of their counsellors" (Powell & Brodsky 1998, p. 11). This statement reflects the reality for many services where clinical supervision is being provided. For many services, it may be the preferred way of managing clinical supervision provision; for others, it may be because they struggle to find money in the budget for external supervision.

For this latter group, Tromski-Klingshirn suggest a cost-effective way to keep the supervisory positions separate, by employing a full-time administrative supervisor to handle the administrative supervision and contracting a clinical supervisor to solely provide that service. There is some support for this scenario in Itzhaky's study (2001, cited in Tromski-Klingshirn, 2006) which found that supervisees perceived external supervisors to provide more constructive criticism and to have more expertise (or expert-based authority), but to use less formal authority than internal supervisors. Tromski-Klingshirn adds that having one full-time staff member provide administrative supervision and another provide both clinical supervision and clinical counselling may be a viable solution.

Another alternative for organisations preferring to use their own staff to supervise, or in which room in the budget cannot be found for external supervisors, is the use of internal clinical supervisors who meet the following criteria: they are not managerially responsible for the worker, they do not work in the same program as the worker, and they are perceived to be an appropriate and desirable choice by the worker. At least one AOD organisation in Victoria uses such an 'across-teams' clinical supervision, and reports that it works very well. Workers are extremely satisfied with the arrangement.

In the event that organisations prefer to use internal supervisors who double as line managers for the workers they supervise, or in organisations where it is simply necessary to do so, there should be vigilance maintained in regard to separating the responsibilities and tasks of administration from that of clinical supervision.

When organisations contract external supervisors, it is important that the needs, expectations and values of the organisation are clearly communicated to and accepted by these other parties. Also, the supervisor should contract with managers to provide regular reviews of supervision, and should negotiate a method of providing feedback. It is unhelpful for the organisation itself if an external clinical supervisor fails to appreciate the organisation's culture and context and offers no dialogue about, or evaluation of, those whom they supervise. Evaluation should protect the confidentiality of the supervisee, just as with internal supervision, but should highlight such things as the supervisee's goals, progress and areas for development in relation to their clinical work.

Our external supervisors come from a diversity of backgrounds: psychiatry, psychology, social work, and child & adolescent psychology, reflecting the diversity of our workforce. We choose a wide range of external supervisors for their expertise, but we choose others for their general knowledge and skills. Consultations with people who hold particular expertise in a relevant area to supplement supervision can be very useful. (Manager, AOD Service)

Below are tables outlining the benefits and challenges of three supervision provider options:

- internally, via line management structure
- internally, outside line management
- externally

References for this section: Gazzola, De Stefano, et al (2013); Powell & Brodsky (1998); Tromski-Klingshirn (2006).

Table 1 Internal Clinical Supervision via Line Management Structure

Benefits of Internal CS via Line Mgmt.	Challenges of Internal CS via Line Mgmt.
<ul style="list-style-type: none"> • Cost and resource effective for the organization • Line Manager has comprehensive overview of supervisee's work performance and job requirements • Line Manager has knowledge of the organisation's culture, constraints and expectations • Compared to external supervision, there is greater opportunity for establishing and monitoring consistency in treatment modalities and other service delivery standards across the organisation • Can work well when there is a positive relationship between supervisee and manager • Easier accountability processes than with external supervisors • Benefits for agencies and clients (Tromski, 2000; cited in Tromski-Klingshirn 2006, p. 60): <ul style="list-style-type: none"> • qualities of a good supervisor being used effectively in both roles; • consistency & convenience; • broader perspective brought to 	<ul style="list-style-type: none"> • Supervisees may find it difficult to reveal their areas of ignorance, their vulnerabilities, and their mistakes and fears with the person who manages them professionally, evaluates their overall performance and influences their fate within the organisation • Supervisors hold "double power" (by virtue of their hierarchical power as line manager as well as their positional power as clinical supervisor) • If the supervisor and supervisee have a difficult or conflictual relationship in a managerial context, this arrangement leaves the supervisee at risk of shutting down and engaging defensively in clinical supervision • Does not offer the opportunity for a fresh outsider perspective, which could be provided by a supervisor outside one's own clinical team, or outside the organisation

Benefits of Internal CS via Line Mgmt.	Challenges of Internal CS via Line Mgmt.
<p>supervision;</p> <ul style="list-style-type: none"> • supervisee may receive additional professional opportunities, support and knowledge; • closer relationship between supervisor and supervisee; • administrative supervisor gets better sense of clinical issues and supervisee's cases by experiencing first-hand the supervisee's work 	

References for this section: The Bouverie Centre (Ryan, Wills et al., 2009); Tromski-Klingshirn (2006).

Table 2 Internal Clinical Supervision, outside Line Management Structure

Benefits of Internal CS, outside Line Mgmt. Structure	Challenges of Internal CS, outside Line Mgmt. Structure
<ul style="list-style-type: none"> • Cost effective and manageable for the organization • Internal Clinical Supervisor has knowledge of the organisation's culture, constraints and expectations • Greater opportunity for establishing and monitoring consistency in treatment modalities and other service delivery standards across the organisation • Overcomes the limitations imposed by one's line manager in this role (e.g., revealing weaknesses and mistakes to a person who evaluates overall job performance) • Offers opportunity for cross-disciplinary, cross-team involvement which can build relationships and strengthen sense of belonging and unity within organisations • Offers a fresh outsider (e.g., outside one's own program or team) perspective, but stays within the organisational bounds; this overcomes the limitations of external supervisors, who may not have a comprehensive 	<ul style="list-style-type: none"> • May be difficult to organise, depending on availability of supervisors and schedules of supervisees • Necessary to ensure that confidentiality of supervisee is protected (e.g., information shared in clinical supervision is not passed on to line manager except as clarified in contracting stage of supervision) • Supervisee may be at a developmental level which requires intensive supervision by someone within his or her own discipline (e.g., pursuing credentials or registration, or trying to develop particular skills pertaining to the profession). In such instances, inter-disciplinary clinical supervision will not suit the supervisee's needs

Benefits of Internal CS, outside Line Mgmt. Structure	Challenges of Internal CS, outside Line Mgmt. Structure
<p>grasp of the culture, policies and protocols of the workplace</p> <ul style="list-style-type: none"> Easier accountability processes than with external supervisors 	

References for this section: The Bouverie Centre (Ryan, Wills et al., 2009).

Table 3 External Clinical Supervision

Benefits of External CS	Challenges of External CS
<ul style="list-style-type: none"> Supervisee relieved of potential constraints imposed by line management hierarchy (e.g., self-conscious need to impress one's line manager with one's knowledge, talent and competence; avoidance of seeming ignorant; avoidance of shame) Potential for a wider range of choice of supervisors for the supervisee (e.g., clinical supervisor who shares theoretical orientation and practice principles) Potential to develop relationship, unfettered by workplace politics, culture or dynamics Opportunity to gain outsider perspective Greater chance of wide-ranging discussion regarding supervisee's professional development and future prospects 	<ul style="list-style-type: none"> Can be more expensive and time consuming for the organisation External supervisors will not have a comprehensive, insider's understanding of the organisational culture, practices, protocol and expectations (unless previously employed by that same organisation) There is an often overlooked need to put accountability processes in place, which provide feedback and evaluation to the organisation employing the supervisor, but which also protects the confidentiality of the supervisee(s) (e.g., quarterly, bi-annual or annual, reports to the organisation, created via a transparent process, with the full knowledge and involvement of the supervisee)

References for this section: The Bouverie Centre (Ryan, Wills et al., 2009); Koper, M. (2009).

6.2 Choosing Individual, Group, and/or Peer Supervision

There are many and varied supervision formats, each with its own benefits and limitations. When considering the format to be offered, it is necessary to take into account both the needs of the individuals and the requirements and constraints of the organisation, in order for supervision to be effective. A combination of formats is often useful, but depends upon the work setting, the resources available, the size of caseloads being managed and other variables (e.g., there can be a mix of group and individual supervision, or individual and peer supervision).

Staff receive supervision once a fortnight, but recently my role changed and I took over the management of one of the other programs which brought my team up to about ten in number. And I was finding over that fortnight it meant that I was providing supervision every day. Just fitting it in to my busy schedule was a little onerous so I had a bit of a rethink and went to my regional manager and decided that group supervision once every four weeks and individual supervision once every four weeks would cover it for staff. I gathered the staff together and spoke to them about it and they were all actually quite excited about the prospect of group supervision. (Manager, CMMH Service)

Individual supervision has traditionally been the cornerstone of professional skill development and the needs of workers will not necessarily be met if this is excluded from their working lives, though this will vary depending upon workers' individual needs. Group and peer supervision, as well as intensive case consultation on a case-by-case basis, are useful and less costly additions to a clinical supervision plan, but they may be inadequate as substitutes for one-on-one support. An exception to this might be highly experienced, well-educated and very competent counsellors who are able to review their work with an equally competent peer group on a regular basis and who have some knowledge of effective peer supervision processes.

There are workers who may prefer group supervision to individual supervision for a variety of cultural, personal, or professional reasons (e.g., less intensive focus on individual, opportunities for group bonding and a chance to hear about how their colleagues work, to use more creative approaches which rely on group participation), or who find that their caseload and professional development level is such that group supervision adequately meets their needs.

It is important to note that, if an existing supervision practice is not working, there may be structural reasons for this, such as that the appropriate format has not been chosen (e.g., a peer supervision group in which most or all members are inexperienced; a pairing of a very experienced worker with an inexperienced supervisor, etc.). Often such difficulties are mistakenly understood as arising from interpersonal conflict or personality clashes, and this view only further complicates the problem.

Choice of modality should take into consideration the supervisees' learning goals, levels of experience, stages of development and learning styles. Also, an effort should be made, when possible, to include supervisees in their choice of modality and their choice of supervisors. It is helpful to consider supervisors' levels of experience, stages of development and theoretical orientation when pairing them with supervisees, or when placing them in charge of a supervision group.

Several different modalities of supervision, along with some of the key benefits and challenges presented by each, will be listed directly.

References for this section: The Bouverie Centre (Moloney, Vivekananda & Weir 2007, 2010).

6.2.1 Individual Clinical Supervision

The traditional approach to clinical supervision is a one-on-one supervisor-supervisee relationship, usually (though not always) a more experienced worker paired with a less experienced supervisee, with sessions held regularly, in professional and private settings.

Table 4 Individual Clinical Supervision

Benefits of Individual CS	Challenges of Individual CS
<ul style="list-style-type: none"> • Full attention on the skill development, strengths, challenges and professional enhancement of the individual supervisee • Plenty of opportunities for developing the working alliance as well as teaching, mentoring, sharing of wisdom with supervisee • More time and potentially safer environment in which to explore supervisee's interpersonal dynamics with clients and the impact of the work upon him or her (e.g., counter-transference issues, secondary trauma, compassion fatigue, burnout) • Very appropriate to particular theoretical orientations, such as psychodynamic and object-relations models, which emphasise transference/counter-transference issues and containment, as provided within the safe haven of the supervisor-supervisee relationship • Supervisee can organise the time and has the opportunity to review more of his or her work with the supervisor • Less exposure to peers and competition, which may have a negative effect on a supervisee • Higher level of clinical accountability 	<ul style="list-style-type: none"> • Potential for supervisee to feel intimidated by the supervisor, with no one else present to observe, or break up the intensity of the one-to-one focus • Potential for supervisee to feel exposed, especially if the supervisor is also the line manager • More of an opportunity and perhaps tendency to focus on the personal experience of the supervisee within the context of the work, which may be uncomfortable, or feel intrusive for some supervisees (also, boundaries can become blurred in negotiating appropriate levels of personal exploration) • Limited possibilities for some types of teaching that require a group (e.g., role plays of families) • Costly and time consuming • No input from others outside the dyad • No opportunity for supervisee to compare self with others, or gain support from peers

References for this section: The Bouverie Centre (Moloney, Vivekananda & Weir, 2007).

6.2.2 Facilitated Group Clinical Supervision (with a Supervisor)

This supervision format can be especially effective with an intact and well-functioning counselling team. It is unlikely to provide support and learning opportunities for teams in which there is entrenched divisiveness, lack of cohesion and/or polarising disagreement on theory, treatment modalities, or practice principles.

A facilitated clinical supervision group typically consists of a supervisor and anything from three to eight or ten group members. Too large a group lessens opportunities for members to present their cases and can result in overload (of voices, ideas, etc.), but too small a group means less input, feedback, support and stimulation. Group supervision is not simply individual supervision with an 'audience': it employs the entire group in the supervision process.

Table 5 Facilitated Group Clinical Supervision

Benefits of Facilitated Group CS	Challenges of Facilitated Group CS
<ul style="list-style-type: none"> • Learning from each other's practice examples and ways of working • Self confirmation in giving feedback • Shared responsibility, which takes some load off the supervisor • Supportive environment for the supervisees • Opportunities for role play and other action techniques • Offers a range of ideas, experiences and perspectives • Input and feedback from peers • Can reflect the therapeutic context being supervised (i.e. parallel process) • Provides enough difference to avoid consensus collusion • Less expensive and time consuming than individual supervision • Opportunities for personal growth via group dynamics • Supervisor can check out whether group members share concerns without seeming critical, or possibly shaming a supervisee 	<ul style="list-style-type: none"> • Supervisor must be skilled in working systemically with groups and must be able to facilitate whilst also supervising (dual tasks) • Supervisor's anxiety about his or her own competence may pose a barrier, as there is greater exposure of the supervisor's abilities and experience • Supervisees' anxiety about their levels of competence may cause reluctance to participate in the group (or to engage passively and silently) • Less time for each supervisee, as the group must balance the needs of each member • Group needs to have a high level of trust in order for participants to feel safe • Potential for overload of ideas, or confusion about which ideas to use • Enough similarity must exist between group members to have some overlap of ideas and perspectives (e.g., shared client group; general theoretical approach, or practice principles) • Important to clarify purpose and needs of supervisee presenting a case, or that can get lost in the group process

References for this section: The Bouverie Centre (Moloney, Vivekananda & Weir, 2007).

6.2.3 Peer Group Clinical Supervision (without a Supervisor)

An unsupervised clinical supervision peer group is likely to work best when members are self-selected. As with other group supervision formats, limiting the number of participants is necessary, so that there are enough peers to provide a stimulating exchange of ideas and ample support, but not so many that privacy, trust and cohesion are compromised.

This supervision format is non-hierarchical and does not include a formal evaluation process, so is not appropriate on its own in organisational contexts where accountability and evaluation is essential. However, it can be a useful adjunct to other supervision formats and perhaps is most useful for supervision of supervision (SOS).

Table 6 Peer Group Clinical Supervision

Benefits of Peer Group CS	Challenges of Peer Group CS
<ul style="list-style-type: none"> • Each group member can offer and receive wisdom, experience and ideas from the group (i.e. enjoy both 'teacher' and 'student' roles) • Shared influence and responsibility regarding how the group is run • Group-owned: Success of the group is dependent upon how group members exercise their responsibilities • Avoids the chance of getting stuck with an unwanted supervisor • Can be mutually agreed membership • Opportunities for personal growth via group dynamics • An alternative to line manager providing clinical supervision • Participants as equals encourages lateral help and peer support 	<ul style="list-style-type: none"> • Group members may avoid challenging a member in order to prevent anxiety • Group must agree on structure, format and roles and keep to these in order to offset the absence of a designated leader, or facilitator • In an effort to support and empathise, one view may be reinforced rather than alternatives being offered (i.e. consensus collusion) • Potential for unconscious designation of more experienced/skilled member as de facto supervisor • Success is dependent upon how group members exercise their responsibilities • Mutual trust, openness and respect are essential and this takes time. Usually requires that the group remain a closed one, at least for a period of time • Competition, defensiveness and criticism between peers can occur • Need for all members to be aware of and to address group processes, especially if they get in the way of group functioning • Clinical case discussion frequency, depth and intensity is limited by the time available and the number of members participating in the group

References for this section: The Bouverie Centre (Moloney, Vivekananda & Weir, 2007).

7 Clinical Supervisor Guidelines

This chapter is intended to provide clinical supervisors with guidance about the responsibilities and activities that define their role, such as keeping the processes of clinical and line management separate, establishing a contract for supervision, structuring sessions, directly observing supervisees at work, upholding ethical and professional codes of conduct and seeking supervision for one's supervision.

7.1 Balancing Clinical and Administrative Roles

Line managers or team leaders who hold a dual position as clinical supervisors to staff are advised to adhere to the following protocol:

- Have clear, explicit and documented responsibilities and tasks pertaining to each role, to which both supervisor and supervisee can refer
- Ensure that clinical supervision does not take place in the context of administrative supervision sessions (i.e. do not share time)
- Discuss with the supervisee the complexity of the dual role, the potential conflicts, and ways of addressing problems which arise

Tromski-Klingshirn points out:

It is not the dual role of the supervisor per se that threatens the clinical supervision, but the increase in power that a supervisor has in that dual role. It is not only the kind of power that each of these roles has that may be problematic...but the amount of power involved: the clinical-administrative dual role of the supervisor carries the 'double power' with it, as each supervisory role has its own evaluative component, or function, with respect to the supervisee. (Tromski, 2000, cited in Tromski-Klingshirn, 2006, p. 59).

The implications for the dual relationship to negatively impact upon the supervisee and, in turn, upon the supervisee's clients, should not be underestimated. In many cases, the supervisee may never express his or her misgivings to the supervisor, despite being asked, for fear of it affecting his or her job. In other cases, the supervisee may not fully grasp the ways in which being clinically supervised by a line manager is impacting upon supervision, but finds himself or herself reticent to fully disclose difficulties, mistakes, or vulnerabilities encountered in the work. Therefore, it is imperative that supervisors holding dual roles remain vigilant in their management of them and do their utmost to provide the safe place needed for supervisees to excel in their clinical work, on behalf of clients.

Ann Roche, Ken Pidd, and Toby Freeman stress the importance of separating supervisees' assessments in the context of clinical supervision from their performance evaluations:

Evaluation of a supervisee's performance within the setting of clinical supervision should not be linked to performance appraisal, or promotion via reporting back from the clinical supervisor to the administrative supervisor, or organisation. Feedback about the supervisee's performance would not normally be disclosed

beyond the clinical supervisory relationship unless there were serious breaches of ethical, legal, or safety standards...Nonetheless, the supervisor may have a reporting responsibility to the organisation in regard to the effective use of time and resources dedicated to clinical supervision. It may also be beneficial for supervisors and supervisees to agree to communicate progress on performance and skill development with the supervisee's manager.

(Roche et al. 2009, p. 550).

With that said, there may also be benefits to supervisees having a dual role supervisor (refer to sections 6.1 - 6.1.1). Tromski, who researched this question, reported that 73% of supervisees in her study indicated benefitting “personally and/or professionally” from having a dual role supervisor (Tromski, 2000, cited in Tromski –Klingshirn, 2006). She also stated:

Supervisees reported overall satisfaction with clinical supervision, with no statistically significant differences between those whose supervisors served in both clinical and administrative roles and those receiving supervision from only a clinical supervisor...The majority of supervisees receiving clinical and administrative supervision from the same person did not view this supervisory role as problematic (82% of n=70).

(Tromski-Kingshirn & Davis, 2007, p. 294).

More locally, Elisabeth Shaw (2004) presents an integrated model of supervision that “attends to the demands of service delivery management while preserving the traditional nurturing and supportive qualities of the supervision relationship.”

For this to occur effectively, she writes, “the role needs to be conceptualised as one of clinical governance, and thus organizations and management need to provide adequate levels of support and clarity to the supervision role. Supervisors require more training in the management and administrative components of their role, and management and supervisees need education about management and its boundaries.” (p.70)

References for this section: Powell & Brodsky (1998); Roche, Todd & O'Connor (2007); Shaw (2004); Tromski-Klingshirn (2006); Tromski-Klingshirn & Davis (2007).

7.2 Qualities of Effective Clinical Supervisors

7.2.1 Clinical Supervisors' Desirable Qualities and Behaviours

There are some basic qualities considered essential to effective clinical supervisors at all stages of development, which Powell & Brodsky (1998, p. 34) summarise with the following mnemonic, known as the four 'A's of supervision:

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

Kaslow describes competent supervisors in this way:

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 humour, a good sense of timing, be innovative, solid, exciting, laid back - but not all at the same time.

(Kaslow, 1986, cited in Powell & Brodsky, 1998, p. 34).

Workers responding to The Bouverie Centre's 2009 Clinical Supervision Survey of the Victorian Alcohol and Other Drugs Sector were asked to describe what they thought made a good clinical supervisor. The themes that emerged from their responses are as follows:

- Experience and knowledge (expertise in working with the client group; training in the skills specific to the supervision process)
- Good interpersonal skills
- Someone who shows respect for supervisees and creates a safe space for learning (unafraid to challenge and stretch supervisees; collaborative; focuses on a supervisee's strengths; approachable; maintains confidentiality)
- A capacity to identify a supervisee's learning needs and facilitate his/her professional growth (provides honest feedback; aids with acquisition/refinement of clinical skills; utilises different interventions to cater to the learning styles and needs of supervisees)
- Someone who is not a direct line manager but where unavoidable, adept at assuming "different hats"
- A proficiency in facilitating group processes
- Someone who is self-reflective, motivated to do a good job and attends to the full spectrum of supervision tasks

Frontline and middle management representatives from the NSW community managed mental health sector interviewed by the Mental Health Coordinating Council (2012) argued that to in order to perform their role effectively, supervisors need:

- a capacity to listen respectfully and suspend judgement
- emotional intelligence
- flexibility, in particular with respect to adapting sessions to suit supervisees' varying needs for structure
- sensitivity to cultural differences
- knowledge of the specific needs of the community sector
- skills in reflective practice
- courage to provide feedback and challenge supervisees where appropriate
- a willingness and commitment to eliciting and receive feedback on the process of supervision

References for this section: The Bouverie Centre (Ryan, Wills et al. 2009); Mental Health Coordinating Council (Bateman, Henderson & Hill, 2012); Powell & Brodsky (1998).

Clinical Supervisors' Undesirable Traits and Behaviours

Bernard and Goodyear (2009) gathered a consensus on qualities of poor clinical supervisors. Table 8 summarises the authors' findings.

Table 7 Qualities of Ineffective Clinical Supervisors

Source	Traits & Behaviours of Ineffective Clinical Supervisors
From Worthen and McNeill (1996), cited in Bernard and Goodyear (2009)	<ul style="list-style-type: none"> • Don't establish a strong supervisory alliance with the supervisee and don't reveal any of their own shortcomings to the supervisee • Don't provide a sense of safety so that the supervisee can reveal his or her doubts and fears about competency
From Kozlowska, Nunn and Cousins (1997), cited in Bernard & Goodyear (2009)	<ul style="list-style-type: none"> • Place the importance of service delivery above the supervisee's educational needs • Ignore the supervisee's need for emotional support in a new and challenging context
From Wulf and Nelson (2000), cited in Bernard & Goodyear (2009)	<ul style="list-style-type: none"> • Involve the supervisee in the conflicted dynamics among professional staff in the work context • Don't support the supervisee's strengths, only point out weaknesses, and don't take an interest in the supervisee's interests • Talk mostly about their own cases in supervision
From Nelson and Friedlander (2001), cited in Bernard & Goodyear (2009)	<ul style="list-style-type: none"> • Don't conduct a role induction process with supervisees that explores each party's expectations about how supervision should proceed • Feel threatened and retaliate over the supervisee being more competent or more mature than they are in one or more areas • Insist that the supervisee work from the same theoretical orientation as the supervisor and that s/he act like a student rather than a colleague • Criticise the supervisee in front of his or her peers • Deny responsibility for interpersonal conflicts that arise and, if there is tension in the relationship, don't bring it up • If the supervisor-supervisee relationship becomes difficult, do not consult a third party • Treat the supervisee as a confidante, or counsellor • Engage in sexist, ageist, culturally incompetent attitudes and behaviours

Source	Traits & Behaviours of Ineffective Clinical Supervisors
	<ul style="list-style-type: none"> • Reveal intimate details of their own sexual experiences • Don't take the supervisee's expressed concerns about any of the above issues seriously

References for this section: Adapted from Bernard & Goodyear, cited in The Bouverie Centre (Moloney, Vivekananda & Weir, 2007).

7.3 Clinical Supervisor Competencies

Clinical supervisors are likely to function most effectively when they achieve competency in both clinical supervision, generally, and in supervision as relevant to their specific work context. However, while clinical supervision training programs and internal clinical governance policies aim for the professionalisation of clinical supervision practices in the Victorian AOD and CMMH fields, a set of comprehensive, demonstrable and detailed competencies which clinical supervisors are expected to meet, have not been mandated for the sectors.

Section 7.3.1 lists a general set of competencies (meaning, applicable to all clinical supervisors) derived from a variety of sources that clinical supervisors need to possess in order to perform their functions effectively. Bernard's & Goodyear's (2009) recommendations for ways to remain competent as an established supervisor are noted in section 7.3.2.

NB: For a comprehensive, detailed breakdown of competencies relevant to supervisors performing in clinical as well as administrative supervisory roles, refer to the United Nations Office of Drugs and Crime *Drug Dependence Treatment Training Package, Vol. D: Administrative Toolkit, Clinical Competencies for Substance Abuse Treatment Clinical Supervisors* at http://www.unodc.org/ddt-training/treatment/VOLUME%20D/Topic%202/7.Compentencies_for_SA_Treatment.pdf which was prepared by the Center for Substance Abuse Treatment.

7.3.1 General Clinical Supervisor Competencies

1. Familiarity with the major models of clinical supervision, in terms of their philosophical assumptions and practical implications, and the ability to compare and contrast them with other models.
2. The capacity to articulate a personal model of supervision, drawn from existing models of supervision and from preferred styles of therapeutic practice.
3. Awareness of and sensitivity to the wider context and its influences on the supervisory relationship and processes (e.g., the organisational culture and policies, the client population, etc.)
4. The capacity to attend capably to the multiple functions and tasks of clinical supervision (refer to section 7.6.2 for an overview).

5. The capacity to facilitate the co-evolving relationships between the counsellor-client and supervisor-counsellor-client relationships, identifying and addressing problems that arise.
6. Ability to structure supervision and implement supervisory interventions within a range of modalities (e.g., case presentations; role plays; live supervision; review of transcribed or videotaped sessions).
7. Awareness of and sensitivity to contextual variables such as race, culture, gender, sexuality, disability, economics and lived experience, and how they impact on the range of working relationships (e.g., worker-client; supervisor-worker-client; peer-peer).
8. Knowledge of the service delivery protocol and treatment standards of the employing organisation(s) as well as the ethical mandates of relevant professional bodies.
9. Knowledge about processes for working through ethical dilemmas in clinical supervision.
10. Awareness of legal issues which may arise in clinical supervision, and commitment to ensuring that supervisees are also aware of these (e.g., duty to report, limits of confidentiality, etc.)
11. Skill in giving and receiving feedback in clinical supervision, both informally (e.g., in the course of supervision sessions) and formally (e.g., planned and documented reviews of supervision process and evaluations of supervisee's clinical skills).
12. The capacity to provide a high standard of record keeping for clinical supervision sessions.
13. The capacity to reflect on one's own clinical supervision practices, with a network of peers, or one's own clinical supervisor.
14. Advanced knowledge of the major issues experienced by clients (e.g., mental illness, alcoholism, drug abuse).
15. Familiarity and operational experience with the various approaches or interventions commonly used in the field to promote, restore, sustain and enhance client wellbeing.

We recruit to a competency base rather than a discipline specific base. Our supervision model isn't a discipline based one where, you know, psychologists must supervise psychologists, and O.Ts - O.Ts. It's not about (the supervisor) having the same skill set (as the supervisee), but rather a set of competencies about delivering what we call good practice development. (Manager, CMMH Service)

References for this section: AAMFT (2007); Bernard & Goodyear (2009); The Bouverie Centre (Moloney, Vivekananda & Weir 2007, 2010); Powell & Brodsky (1998).

7.3.2 Tips for Remaining Competent

Bernard and Goodyear (2009) stress the importance of actively pursuing continuing education, staying up-to-date with research in the field, and accessing regular consultation with a network of peers in order to remain competent in the work of clinical supervision. They warn against the diminishment of competence that can occur when one practises in isolation, without the ongoing influence of other colleagues and organisations outside one's own immediate, routine working life.

The continuing evolution of the AOD and CMMH fields globally necessitates a review and potential upgrading of competencies on a regular basis. In order to stay fresh, well-informed and relevant to one's supervisees, clinical supervisors would do well to keep current with research in the field; to be aware of the implications of shifting demographics in the population served, and to continue to pursue innovative ideas in evidence-based practice.

References for this section: Bernard & Goodyear (2009); The Bouverie Centre (Moloney, Vivekananda & Weir 2007, 2010); Powell & Brodsky (1998).

7.4 Planning

It is helpful for clinical supervisors to have a formal plan for managing the various components of their work. When a supervisor has a framework in place, it means he or she can focus attention on the supervisory relationship itself, rather than being concerned about missing pieces of practical information while trying to conduct a session. As part of planning, Bernard & Goodyear (2009) recommend supervisors ask themselves a series of questions in preparing to work with a new supervisee, a subset of which are listed here:

- What do I know about the supervisee I will work with? How do learning style, cultural worldview, experience level, and so on, affect my thinking about working with this supervisee?
- In light of what I know about my supervisee, is there any additional preparation I need to do in order to be helpful to this person?
- As I understand the supervisee's goals, which are most likely to be met in this experience? Which are less likely to be met? Is the supervisee clear about this?
- What supervision modalities are available to me? Can I supplement those that are provided by the organisation? What is my rationale for beginning where I intend to begin? What supervision schedule will we adhere to?
- How will I determine if the supervisee is adequately aware of ethical and legal imperatives? When will I introduce my evaluation plan?
- Knowing the institution as I do, what are the predictable challenges that will face the supervisee? How can I make these productive learning opportunities?
- To whom will I turn for consultation when I am challenged in my work with this supervisee?

References for this section: Bernard & Goodyear (2009).

7.5 Contracting

Contracting takes two forms in clinical supervision: firstly, the contract between the clinical supervisor and the organisation employing him or her; secondly, the contract between supervisor and supervisee. Before engaging in clinical supervision, it is imperative that a supervisor be clear on the expectations of organisational administrators, in regard to evaluation and feedback on the supervisory process.

It is necessary and appropriate that supervisors provide regular reviews of their work with supervisees (e.g., frequency and duration of sessions, methods of supervision, etc.) and evaluations of their supervisees (e.g., developmental progress, areas for further learning, etc.), but within bounds of confidentiality which need to be clearly explained. This is especially important when a supervisor is operating externally, outside the supervisee's particular program or team, or completely outside the employing organisation. Supervisors should familiarise themselves thoroughly with the expectations of the supervisee's program, team, or organisation, in order to ensure that they are aiding the supervisee in meeting those standards. Additionally, supervisors must be knowledgeable about the professional codes of ethics to which the supervisee is held accountable, in addition to, or where it differs from, the supervisor's own.

Whether it is written or not, stated or not, agreed to or not, there is always a contract. Most supervisors and organisations prefer that contracts are written, agreed upon, and signed. This should involve a two-way process, with supervisees actively participating in the development of the particular contract. A standard layout may be used for all supervisees, including key areas that need to be negotiated. However, the detail is likely to vary depending on particular needs and in order to reflect the individual relationships and agreement. If the modality is group supervision, the contract should be negotiated with all of the group members, but may also include such things as separate learning goals for each participant.

*Accountability between line managers and clinical supervisors has been implemented in the last six weeks. A report template was developed for supervisors to write basic information, which will then be submitted to managers (e.g., how many supervisees they are currently seeing; time spent with each; trends; agency professional development needs).
(Manager, AOD Service)*

References for this section: The Bouverie Centre (Moloney, Vivekananda & Weir 2007, 2010).

7.5.1 Benefits of Contracting

Having an open and explicit discussion in the beginning about expectations, and difficult, or typically unspoken, topics can have many advantages, including:

- supporting the development of a trusting and safe relationship

- promoting joint responsibility
- helping to develop a collaborative relationship in which the supervisee is given authority and is encouraged to participate actively
- preparing for the management of disruption
- creating a reference point for subsequent reviews of the process

References for this section: The Bouverie Centre (Moloney, Vivekananda & Weir 2007, 2010).

7.5.2 Key Areas of Contracting

Hawkins and Shohet (2006) suggest six key areas that should be covered in contracting: practicalities and meeting arrangements, boundaries, the working alliance, session format, organisational and professional context, and note-taking. Examples within these areas include, but are not limited to, the following:

- objectives of supervision, including personal learning objectives and expectations of supervision
- practicalities, e.g., frequency and duration of sessions, suitable days and times and protocol to follow if a cancellation is necessary
- the form supervision will take, e.g., who will be involved, what methods, models and theories will be used
- boundaries
- responsibilities of each party
- how assessment and evaluation will occur and how feedback will be managed
- accountability both to the organisation and to the supervisee and how that will be managed
- note taking and record keeping
- issues of confidentiality
- grievance processes for both supervisor and supervisee(s)
- whether supervision is a compulsory part of the employment contract

References for this section: The Bouverie Centre (Moloney, Vivekananda & Weir 2007, 2010); Hawkins & Shohet (2006).

7.5.3 Negotiating the Contract

While the final product (i.e. the contract) is important, it is the discussion and processes that have to occur to produce the contract that are most important. Supervisors can help

supervisees prepare for the discussion by giving them a list of questions to consider. Supervisors might also invite their supervisees to ask questions of them.

The supervisee and supervisor should then discuss their different views, expectations and experiences of clinical supervision before developing the contract. The contract should be reviewed and updated periodically throughout the supervisory relationship.

*We developed a little set of slides basically around what supervision is, the benefits and challenges, confidentiality, the ground rules and then we formed another group where we could talk through that and develop our own set of norms and responsibilities ... We certainly had the slides to go by, we had an agenda, but I think it is really important to get some buy-in, and the group came up with some really useful suggestions as well.
(Manager, CMMH Service)*

7.5.3.1 Questions and Topics for Negotiation

Table 8 Questions and Topics for Negotiation

Area to be Negotiated	Questions and Topics for Negotiation
Practicalities and past experiences	<ul style="list-style-type: none"> • Times, dates, location of sessions • Supervisor's and supervisee's educational and professional backgrounds and relevant work experience • Previous difficult and positive experiences of supervision and lessons that have been learned • What are the lines of accountability: who is accountable to whom and for what?
Aims	<ul style="list-style-type: none"> • What the supervisee wants to gain from supervision and the preferred methods of achieving that (i.e. goals and processes) • Areas of competence and learning needs of the supervisee
Session content	<ul style="list-style-type: none"> • Views about models and theories to be used (inc. supervisor's and supervisee's own theoretical orientations) • How each party will prepare for supervision • What types of issues should be brought to supervision? Are there any no-go areas for either party?
Session process	<ul style="list-style-type: none"> • Preferred teaching (supervisor) and learning (supervisee) styles and techniques • What the functions and tasks of supervision will be and how these will be prioritised in each session • What methods and techniques will be used (e.g., self-report, videotaped session, direct observation; talk only, or mix of talk and expressive art techniques, use of objects.) • How feedback and evaluation should be managed

Area to be Negotiated	Questions and Topics for Negotiation
Relationship	<ul style="list-style-type: none"> • How the supervisee's learning style fits with supervisor's style • Boundaries, e.g., limits of confidentiality and inclusion of personal material in supervision sessions (should only come into sessions if it is relevant to the work, or if it is affecting the supervisory relationship) • Culture and context (e.g., cultural differences that are significant for either party; contextual factors that influence the work) • Areas which are difficult for either party to discuss and how such discussions can be facilitated, or supported • How to identify if/ when one person is becoming defensive and how best to handle this • How to recognise ruptures in the supervisory relationship and how they should be managed • What to do if either the supervisor or supervisee has major concerns in relation to the work being described
Ethics	<ul style="list-style-type: none"> • Ethical and legal codes of conduct to be followed (e.g., professional bodies; local, state and federal policies; sector protocol and organisational standards) • Limits of confidentiality • Process when ethical or legal breach occurs

In negotiating the contract, supervisors should model the attitudes and behaviours that they wish to encourage and support within the supervisory relationship.

Keep in mind adult learning principles (refer to Resource "Adult learning principles")

Demonstrate respect for the individual. Consider what makes this supervisee unique. What are their particular experiences, strengths and resources? How can one demonstrate respect for these?

Pay attention to and acknowledge ruptures in the supervisory relationship. Research suggests that doing this can strengthen the relationship (Gray et al., cited in Bernard & Goodyear 2009).

Provide support and encouragement. Uncritical warmth and unending supportiveness serves little purpose, but there are times when people seek blessing and others can offer benediction. Stone provides an example of this: "In the midst of the horror and tragedy and brokenness, you did all that anyone ever could do. You did right" (Stone 1998, p. 261, cited in Moloney et al. 2007).

Keep it collaborative. The supervisee should be active in the supervision process. Consider that knowledge and practices can be collaboratively generated. Encourage supervisees to prepare for supervision and to raise issues which they feel are important. Passive

participation in the supervisory process by either party is unproductive and disappointing, and is unlikely to lead to positive outcomes for supervisors or supervisees.

References for this section: The Bouverie Centre (Moloney, Vivekananda & Weir 2007).

7.5.3.2 *Managing Reluctance or Resistance to Clinical Supervision*

Contracting is an ideal time to open up a conversation about reluctance or resistance, on the part of the supervisee to engage in clinical supervision. There are many reasons why this might occur and it is much better to directly address the problem rather than ignore it, as such a choice can have damaging consequences, including setting a precedent for avoiding difficult conversations, or acknowledging tension in relationships. This would be getting off to a poor start at creating a safe and trusting working alliance.

Examples of factors that may contribute to a supervisee's resistance or reluctance to clinical supervision:

- Fear of being deemed an inadequate practitioner
- Fear of having work practices challenged and losing work autonomy and independence
- Additional workload associated with preparing and participating in the process
- Ageism, sexism, racism, or classism
- Tension between those who believe lived experience (of substance abuse or mental illness) is necessary for the work and those who do not
- Greater field experience or academic qualifications than one's supervisor

The Center for Substance Abuse Counselling offers the following advice in confronting resistance (CSAT 2009, pt. 1, pg. 7):

In addressing resistance, you must be clear regarding what your supervision program entails and must consistently communicate your goals and expectations to staff. To resolve defensiveness and engage your supervisees, you must also honor the resistance and acknowledge their concerns. Abandon trying to push the supervisee too far, too fast. Resistance is an expression of ambivalence about change and not a personality defect of the counsellor. Instead of arguing with or exhorting staff, sympathize with their concerns, saying, 'I understand this is difficult. How are we going to resolve these issues?'

When counsellors respond defensively, or reject directions from you, try to understand the origins of their defensiveness and to address their resistance. Self-disclosure by the supervisor about experiences as a supervisee, when appropriately used, may be helpful in dealing with defensive, anxious, fearful, or resistant staff. Work to establish a healthy, positive supervisory alliance with staff. Because many substance abuse counsellors have not been exposed to clinical supervision, you may need to train and orient the staff to the concept and why it is important for your agency.

In situations where it seems that the reluctance or resistance cannot be overcome (e.g., the supervisee remains defensive and unwilling to engage appropriately), it may be necessary to seek a third party to help with negotiating a way forward. If the supervisee does not have a problem with clinical supervision, but only the supervisor he or she has been assigned, this may be an even more difficult dynamic to manage. Again, it is necessary to explore and try to understand the source of the conflict for the supervisee, as it may be based on resentment for not having been consulted rather than anything about the supervisor personally or professionally.

References for this section: Center for Substance Abuse Treatment 2009; Mental Health Coordinating Council (Bateman, Henderson & Hill, 2012)

7.6 Session Guidelines

7.6.1 Structure

The structure of clinical supervision sessions may be flexible, but should be disciplined, and coordinated. Planned supervision is supervision that is clear in its aims and coordinated in its delivery and which sets measurable and well-defined goals in collaboration with the supervisee.

It is important that clinical supervisors are clear on several factors in beginning work with a supervisee (refer to section 7.5 for specifics of Contracting), specifically: (1) the supervisee's expectations of supervision and how it matches the supervisor's own expectations and abilities; (2) the supervisee's past experiences of supervision and how they perceived that (e.g., helpful, unhelpful, etc.); (3) the supervisee's professional background, affiliations and work experience, and (4) the supervisee's current developmental level, based on self-appraisal and supervisor's appraisal. In addition to this, supervisors must have a solid comprehension of the wider contextual influences that impact the work, such as the policies and procedures of their employing organisation; the professional boards to which both supervisor and supervisee are accountable, and the professional, legal and ethical standards which they are expected to meet.

Organisational constraints faced by some services may mean that clinical supervision sessions are held less frequently than needed (if at all), or that they are not available to all clinical staff.

*The policy is the same for everyone, but there are a couple of areas that have put in a policy variation to suit their roles, such as the rehab program staff who wanted to do much more immediate, on-the-spot supervision, because stuff comes up daily which they need to deal with; so they meet daily to plan and review, rather than holding group supervision.
(Manager, AOD Service)*

Generally, clinical supervision sessions are held on an ongoing basis (with opportunities for review), at regular intervals and for a prescribed duration, with the terms of the relationship negotiated via contract between the supervisor and the supervisee(s), within the bounds of the employing organisation's policies and protocol. Common practice for individual

supervision is a sixty to ninety minute session held either weekly, or fortnightly to monthly, but supervisees will differ in their needs, based upon their experience levels, their caseloads and other such variables, so one cannot state categorically what is best for particular workers in a particular context. Facilitated groups and peer group meetings may be less frequent, in general, than individual supervision, but they are usually longer sessions to accommodate the larger number of participants.

Decisions such as frequency and duration of supervision sessions must be based upon a negotiation which takes into account organisational constraints, availability of qualified supervisors and various needs of supervisees. There are many contributing contextual factors, such as making special arrangements for residential, night-time staff and for casual staff, which will influence how clinical supervision is organised within a given service.

A safe, comfortable, private, and professional space in which to conduct clinical supervision sessions is a necessity and its importance should not be underestimated. Public meeting spaces such as cafes or open office spaces are inappropriate, and potentially undermining of the supervisory process.

References for this section: Bernard & Goodyear (2009)

7.6.2 Functions and Tasks

Though definitions of clinical supervision may vary, the principle aims are fairly consistent across definitions and can be summarised as follows:

- to enhance the supervisee's skills, competence and confidence
- to provide reflective space and emotional support
- to provide assistance with professional development
- to ensure that service to clients is safe, ethical, and competent
- to ensure compliance with professional and organisational treatment standards and practices

Powell and Brodsky (1998) state the three main purposes of supervision are:

- to nurture the counsellor's professional (and, as appropriate, personal) development
- to promote the development of specific skills and competencies, so as to bring about measurable outcomes
- to raise the level of accountability in counselling services and programs

The defining functions and tasks of clinical supervision will depend upon the developmental level of the supervisee and supervisor in any given situation, as well as the model of clinical supervision one chooses to adopt. Kavanaugh et al. (2002, p. 249) note that, "The types of strategies that are most preferred by supervisees appear to change as skills and confidence increase."

They give the following examples based on research outcomes:

- Inexperienced practitioners prefer directive, problem-focused, or skills-based supervision, as do more highly skilled clinicians who are facing difficult clinical issues (Tracey, T.J. & Ellickson, J.L et al., cited in Kavanaugh et al. 2002)
- More experienced practitioners prefer to examine conceptual issues raised by therapy (Heppner, P.P. & Roehlke, H.J., cited in Kavanaugh et al. 2002, p. 249)

The functions may be conceptualised broadly as educational, supportive and managerial (Kadushin, cited in Hawkins & Shohet 2006) or, in the terms used by Proctor (cited in Hawkins & Shohet 2006): formative, restorative and normative. Hawkins and Shohet developed their own concepts, with consideration of Kadushin's and Proctor's ideas, and determined that the functions could best be captured in these terms: developmental, resourcing and qualitative. Fundamental to all of the functions is a comprehensive understanding and openness to discussing the multi-dimensional wider context and its implications (e.g., client context, supervisor-supervisee relational context, organisational context, cultural context, etc.)

The developmental (clinically focused) function is focused upon:

developing the skills, understanding and capacities of supervisees...through reflection on and exploration of the supervisees' work with clients.
(Hawkins & Shohet 2006, p. 57)

Supervisees should be provided with a regular space in which to reflect upon the content and process of their work. In this way, they may be helped to understand the client better; become more aware of their own reactions to the client; understand the dynamics of the interactions between themselves and the client; consider their interventions, and the outcomes of those interventions, and explore alternative ways of working (adapted from Hawkins & Shohet 2006).

Supervisory tasks which support the developmental function include: assisting with case conceptualisation; reviewing clinical interactions; identifying and supporting effective interventions; focusing on teaching, or developing skills; offering feedback to the supervisee, and generating new ideas for the work in collaboration with the supervisee.

The resourcing (supportive) function is a way of both acknowledging and providing space for the emotional impact of the work upon supervisees. This is a complex and delicate function, which may include such things as exploration of supervisees' over-identification with, or aversion to, particular clients; supervisees' defensiveness or protectiveness in relation to particular clients, and/or supervisees' being overwhelmed by secondary trauma, or compassion fatigue. The resourcing function also encompasses support for the supervisee's professional development.

Supervisory tasks which support the resourcing function include: providing understanding, reassurance and support for emotional distress (e.g., trauma triggers, transference, or counter-transference) that may emerge from the work; validating and supporting the supervisee as both a person and a worker; sharing the load (i.e. the supervisee is not expected to bear the burden on his or her own); assisting the supervisee to identify resources and skills to better support them in their work; assisting the supervisee to develop

a plan for professional and personal support outside the context of supervision (e.g., a self-care plan); assisting the supervisee to explore growth potential and ideas for fulfilling it.

The qualitative (evaluative) function of supervision is the accountability aspect of the work, involving identification and exploration of the supervisees' abilities, including potential blind spots and weaknesses in their clinical work. Powell & Brodsky (1998) divide the evaluative functions into four areas of responsibility: assessment of counsellor skills; clarification of performance standards; negotiation of learning objectives; utilisation of appropriate safeguards, and strategies to address performance and skill deficits (Powell & Brodsky, 1998, p. 11).

Supervisory tasks which support the qualitative/evaluative function include: helping the supervisee to identify areas of difficulty, or knowledge deficits in his or her work; discussing ethical dilemmas; monitoring adherence to legal, ethical and organisational standards of practice; ensuring the quality of supervisee's work; planning specific strategies and steps to address problems or deficits a supervisee is exhibiting in the work.

References for this section: Bernard & Goodyear (2009); The Bouverie Centre (Moloney, Vivekananda & Weir 2007, 2010); Hawkins & Shohet (2006); Kavanaugh et al. (2002); Powell & Brodsky (1998).

7.7 Methods

The avenues through which supervisors gain knowledge of supervisees' work vary. Indirect experience of the supervisee's work via supervisee self-report is the most common way that clinical supervisors become familiar with a supervisee's clinical practice. Certainly, it is an essential part of the process, but it is not the only way in which the supervisee's work can be explored. It is helpful and appropriate for clinical supervisors to directly observe some of their supervisees' work, at various phases of the supervisees' development. Indeed, there is some evidence that such observation directly aids the acquisition of skills related to core practices of AOD work, such as motivational interviewing (Smith et al., 2007). Observation of supervisee work can be done either in a live session, or via recorded session. Another option is to have the supervisee transcribe a portion of a session which is then reviewed in supervision. Four methods of observation, with their challenges and benefits are presented below.

NB: Informed consent includes clients being notified about the contexts in which their confidentiality will not be maintained. This includes all clinical supervision methods, since supervisees will be bringing clients' cases into supervision sessions. Additionally, specific permission should be requested and granted from clients before any sessions are recorded, or observed live.

*... in a situation like I'm in where most of what I manage is a residential service, being the line manager, I am in a position to assess the effectiveness of a supervisee's work. I can observe interaction between workers and their clients ... I have a very good understanding of what the client-worker relationship is like already. So it puts me in the position whereby I know the areas in which people need to be challenged.
(Manager, CMMH Service)*

Table 9 Methods of Supervision

Method of Supervision	Benefits	Challenges
<p>Case Discussion / Presentation</p> <p>The supervisee selects a client case to review with his or her supervisor, submitting a genogram, describing the client's presenting problem(s), summarising the work so far, conceptualising the situation and reflecting upon effective interventions and stuck points.</p>	<ul style="list-style-type: none"> • Useful when caseload is high and general management ideas wanted • Counsellor can learn to present clearly and identify specifically what they want from supervision • Easy to arrange • Adequate for developing conceptual skills • Potential to give positive feedback about what is being done as well as ideas about what to do differently 	<ul style="list-style-type: none"> • Relies on supervisee's self-report • Needs an agreement as to the purpose and format of presentation, otherwise describing the case content can consume all of the time, so that it becomes a debrief without the benefits of conceptualisation, or generating new ideas • Less helpful with specific skill development, beyond conceptualisation • Can be a challenge for supervisees to convert supervisor's verbal feedback into effective actions
<p>Observation of Recorded Session</p> <p>The supervisor and supervisee review selected segments of a client session that has been recorded on video tape or DVD by the supervisee (with the prior expressed permission of the client).</p>	<ul style="list-style-type: none"> • Actual sessions observed • Session chosen by supervisee, so there is some control by them over what supervisor observes • Allows for specific feedback about skills and case management • Less anxiety provoking than live supervision • Supervisor or supervisees can stop recording at various points to discuss • Provides an excellent 	<ul style="list-style-type: none"> • Anxiety at being observed • Difficulties deciding how to deal with so much information (e.g., which parts of session to view and where to focus attention) • Can be time consuming

	resource for developing self-supervision	
<p>Live Supervision</p> <p>The supervisor directly observes a client session (by prior arrangement with the supervisee and expressed permission of the client), usually through a one-way mirror, or via camera.</p> <p>The supervisor usually offers input regarding process and interventions during the session.</p>	<ul style="list-style-type: none"> Provides direct opportunity to shape and develop supervisee's skills Can be very supportive for supervisee Supervisor's direct input can allow supervisee to feel empowered by intervening effectively beyond his or her usual level of skill (knowing s/he has backup) May be helpful to client, especially if they have an inexperienced counsellor Can be a very exciting and moving experience with great learning opportunities for all, especially if there is a team involved 	<ul style="list-style-type: none"> Initially, potentially highly anxiety provoking Stressful for the supervisor managing multiple and simultaneous direct responsibilities for the supervisee(s) and the client(s) Possible contradiction for supervisee, who is expected both to be competent and to take direction: could lead to feeling de-skilled May be a challenge finding the time and the best process to communicate effectively feedback to the supervisee
<p>Live Consultation</p> <p>Supervisor conducts a one-off interview with the supervisee's client(s) while the supervisee observes (by prior arrangement with the supervisee and expressed permission from the client).</p>	<ul style="list-style-type: none"> Observation of the supervisor's intervention as well as possible effect on client(s) can help move the work forward and help supervisee to get 'unstuck' Demonstration of clinical skills on part of the supervisor can be useful Can be useful for future case discussion for the supervisor to experience client(s) directly 	<ul style="list-style-type: none"> Requires advanced skills on the part of the supervisor (e.g., how to explore supervisee's stuckness and the supervisee/client interaction without undermining supervisee) Clients may have high expectations of the supervisor If supervisor becomes just as stuck, or the session does not go well, relationships could be negatively affected (between client-supervisee and supervisor-supervisee) Potential for supervisee to feel de-skilled by observing supervisor's successful intervention with client(s) whom he or she feels unable to help

References for this section: The Bouverie Centre (Moloney, Vivekananda & Weir, 2007).

7.7.1 Techniques

Techniques used in clinical supervision need not be limited only to verbal representation and exploration of the work. Expressive, visual techniques such as the use of drawing, painting, and working with representational objects or sand-play can be highly effective; particularly if a supervisee is feeling stuck and needs to do something different to gain a fresh perspective. Counsellors who are already familiar with expressive therapy techniques may find it easy and natural to incorporate the ideas into their clinical supervision, while others may require training in these ways of working.

For groups, role plays, sculptures, enactment, and reflecting teams or outsider witness groups can generate new energy, and ideas for both understanding a case, and moving the work forward.

Role plays involve one of the group members acting as the counsellor asking his or her colleague(s) to be in the role of his or her client(s), setting up a real situation that the supervisee is trying to work on. In this way, the role players are able to demonstrate a version of what actually happens in the work and the group can provide ideas for interventions. This may take the form of direct verbal feedback, a reflecting team process, or an interview of the supervisee by another group member (or the supervisor). The supervisee then may choose to repeat the role play, incorporating the group's suggestions and then gaining further feedback.

Sculptures are a nonverbal way of expressing an aspect of a client's (or clients') struggles by group members standing-in as people or issues in the client's world, and the supervisee arranging (or "sculpting") them into a physical representation of the situation. Participants in the sculpture offer feedback about what it feels like to be in their positions, after which the supervisee attempts to create a more useful version of the sculpture (i.e. one which represents a development, or solution).

Enactment is an acting out, or exaggeration, of a difficult situation between client and supervisee, in an effort to stimulate discussion about what might be impeding progress (or change). The supervisee then practises a new interaction with the role playing client.

Reflecting teams and outsider witness groups, adapted from their narrative therapies' origins to the context of clinical supervision, require group members to observe a role play and then talk together about what they have seen while the role play participants observe their conversation. Reflections may be offered as straightforward support for the role play clients' struggles, validation of the complexity of their situation, or suggestions for a way forward. Reflecting teams and outsider witness groups are powerful ways of amplifying strengths and instilling hope in clients' lives.

'Internalised Other Questioning' can be employed to provide the opportunity for the supervisee to have the experience of sitting in the client's shoes. This process involves the supervisor, with permission, interviewing the supervisee as their client. Supervisees sometimes surprise themselves with the level of knowledge and understanding they hold

about clients, even those they may feel somewhat stuck with in the work. It also has the potential to increase compassion for the particular client's position.

References for this section: The Bouverie Centre (Moloney, Vivekananda & Weir 2007).

7.8 Record keeping

Record keeping in clinical supervision can be divided into two basic categories: what the supervisor records and what the supervisee records. Whether and how notes are taken and kept will vary depending on theoretical orientation(s) for supervisor and supervisee, as well as the model of practice for clinical supervision.

7.8.1 Supervisor Records

The types of notes taken by supervisors vary according to theoretical orientation and model of supervisory practice, but the act of keeping records is considered a standard of competent supervision and is a necessary aspect of risk management. Records need to be as clear and transparent as possible, whenever possible. What follows are some ideas for the types of records that are useful to keep and the tasks associated with keeping them.

NB: These suggestions pertain to reported supervision (as distinct from live supervision, in which the supervisor actively observes and intervenes in a supervisee's work with a client, and which may necessitate a different, or additional type of record keeping).

Table 10 Clinical Supervision Records: Types and Examples

Type of Record	Examples
Records concentrating on the direct clinical content and pragmatics of the work.	<ul style="list-style-type: none"> Client information including genograms and interventions Information about starting and finishing with clients
Records concentrating on the supervisee's work.	<ul style="list-style-type: none"> Issues that are presented for supervision Strategies used by the supervisee Reflections, values, personal/professional interface
Records regarding critical, ethical, or accountability issues.	<ul style="list-style-type: none"> Detailed notes will be required where safety, medical, ethical, or legal issues are discussed and in circumstances where the supervisor has given advice, or direction to the supervisee It is important to note any follow-up, or action that is agreed to, or required
Records regarding process of supervision sessions, focused on the working alliance between supervisor and supervisee.	<ul style="list-style-type: none"> Notes on parallel process Notes on boundary difficulties Notes on relationship ruptures and repairs

Type of Record	Examples
Records of Supervisor musings.	<ul style="list-style-type: none"> Anything that provokes the supervisor's curiosity, or any observations and themes Issues that were not presented in supervision that provoke curiosity
Records of administrative functions that relate to the clinical work.	<ul style="list-style-type: none"> Supervisee's reviews of client work after a predetermined number of sessions Handovers with case plans when workers are on leave
Records of agreed upon action, or follow-up.	<ul style="list-style-type: none"> Interventions, or new treatment approach Phone calls to other professionals involved in the client's life
Records required by the organisation	<ul style="list-style-type: none"> Regular reviews of work with clients Goals and contracts for supervision and how these link to professional development, or workplace performance plan
Records which identify areas for professional development (these may be linked to work place performance review forms), and to professional self-care.	<ul style="list-style-type: none"> Plans for ongoing training, or further academic studies Supervisee's self-care plan

A sample note-taking format can be found in the Resources section of the companion website www.clinicalsupervisionguidelines.com.au.

References for this section: The Bouverie Centre (Moloney, Vivekananda & Weir, 2007); Falvey & Cohen (2003, cited in Center for Substance Abuse Treatment, 2009).

7.8.2 Supervisee Records

It is common place in training programs for students to keep logs about their clinical work and their interface with their professional development. Mason (2002, cited in Moloney et al. 2007) suggests a format that includes theory, technique, research, ethics, the therapeutic utilisation of the self, supervision and peer consultation as a way to stay rigorous about reflective practice.

The aim of supervisees recording information for supervision sessions is threefold:

- It is a means to assist with clarity about what aspects of the clinical material will be discussed
- It is a means to assist with the supervisee's reflection on his or her work
- It is a means to assist the supervisee in engaging the supervisor and setting the parameters for supervisory sessions

Supervisees may find it useful to keep a journal for reflection on their work and the supervisory process.

References for this section: The Bouverie Centre (Moloney, Vivekananda & Weir 2007).

7.9 Feedback and Evaluation

Scaife defines feedback as “a response or reaction providing useful information, or guidelines for further action and development” (Scaife 2001, p. 216, cited in Moloney et al. 2007). The aim of feedback is to enhance the supervisee’s capacity to provide the most effective service for the client. It is primarily concerned with reinforcing, or changing behaviour. Within the clinical supervision relationship, feedback is both informal and formal, meaning it occurs naturally within the course of dialogue in both direct and indirect ways, as well as being provided in the form of documented evaluations. More specifically, feedback is defined as both “formative” and “summative” (Bernard & Goodyear 2009).

Formative evaluation represents the bulk of the supervisor’s work and is ongoing, targeted at the supervisee’s level of ability with an eye to the next learning step. Formative evaluation does not feel like evaluation, as it stresses processes and progress, not outcome. Summative evaluation is evaluation of the supervisee against competency standards.

Evaluative tasks of the clinical supervisor include the following (1-8 from Williams 1995, cited in Moloney et al. 2007):

1. Checking attainment of goals as set out in the supervisory contract
2. Checking whether the supervisee has implemented interventions discussed in previous session(s)
3. Following up on client progress
4. Giving feedback to the supervisee on knowledge of theory, work performance and personal qualities (as relevant to the work)
5. Helping the supervisee identify strengths and weaknesses
6. Conducting regular sessions where progress is reviewed
7. Confronting/challenging the supervisee when appropriate
8. Monitoring the ethical standards of the supervisee
9. (In an organisational context, it would also include) monitoring a supervisee’s adherence to treatment and service delivery protocol

Supervisors have their own personal styles with regard to how they offer feedback which may, or may not, fit well with individual supervisee’s expectations, or own personal style. It is helpful to negotiate with the supervisee, as part of contracting, how this will be handled. Exploring the supervisee’s past experiences of helpful and unhelpful feedback and gaining his or her perspective on what works best for him or her can be highly illuminating for the supervisor, and can help to avoid unnecessary ruptures further down the track. Supervisors

would do well to remember that intense anxiety, fear of being seen as incompetent and a potential for shame can be all be present for supervisees when undergoing evaluative processes.

I tend to follow an AID model. So we'll talk about the action, talk about the impact and talk about the desired effect. And I think that can work for both positive feedback and negative feedback. It's pretty much 101 stuff really. Like if it's something positive - I'll acknowledge the work that's been done with a client, reinforce the positive impact it's had and just encourage them around where to go from there ... (Manager, CMMH Service)

It is also useful to discuss openly what methods of evaluation will be used and to ask for the supervisee's input in making those decisions. Supervisees will differ in how they are most or least comfortable having their work judged; while this may not be completely open for negotiation, it can help to know and to prepare ahead of time (e.g., a supervisee who is unused to having his or her work with clients observed directly, or via videotape, may be extremely anxious at the thought and may benefit from a practice run).

The Center for Substance Abuse Treatment advises the following considerations when undertaking evaluative processes with a supervisee:

It should be acknowledged that supervision is inherently an unequal relationship. In most cases, the supervisor has positional power over the counsellor. Therefore, it is important to establish clarity of purpose and a positive context for evaluation. Procedures should be spelled out in advance, and the evaluation process should be mutual, flexible, and continuous. The evaluation process inevitably brings up supervisee anxiety and defensiveness that need to be addressed openly. It is also important to note that each individual counsellor will react differently to feedback; some will be more open to the process than others.

There has been considerable research on supervisory evaluation, with these findings:

The supervisee's confidence and efficacy are correlated with the quality and quantity of feedback the supervisor gives to the supervisee (Bernard & Goodyear 2004, cited in CSAT 2009).

Ratings of skills are highly variable between supervisors, and often the supervisor's and supervisee's ratings differ or conflict (Eby 2007, cited in CSAT 2009).

Good feedback is provided frequently, clearly, and consistently and is SMART (specific, measurable, attainable, realistic, and timely) (Powell & Brodsky 2004, cited in CSAT 2009).

(CSAT 2009, pt. 1, p. 18)

In addition to supervisors evaluating supervisees, supervisees should be able to give feedback to their supervisor about the quality of their supervision and their experiences of the supervisory relationship. Supervisors should initiate discussion about this in the

contracting stage of the relationship as well as actively soliciting feedback from supervisees on a regular basis (e.g., checking in at end of sessions about what was most or least helpful to the supervisee).

Supervisees should also be able to provide feedback more formally about the quality of the supervision they receive. The processes and methods by which they do this should be made clear to them and should be backed up by organisational policy and procedures to which they can refer. On an administrative level, there should be an overall evaluation of the supervisory structure itself, for accountability purposes, to ensure the quality of the supervision, and to make changes where necessary.

An annual experience survey takes place, through which feedback is provided by both supervisees and supervisors. From this, a list of recommendations are developed which are implemented in collaboration by Management and Clinical Supervisors. (Manager, AOD Service)

Carol Falender, PHD consultant and clinical professor, provides examples of areas to consider and questions to ask when evaluating supervisees and supervisors. (Visit: www.cfalender.com)

References for this section: Bernard & Goodyear (2009); The Bouverie Centre (Moloney, Vivekananda & Weir 2007, 2010); Center for Substance Abuse Treatment (2009).

7.10 Ethical and Legal Considerations

Clinical supervisors are accountable to multiple ethical and legal codes of conduct, both directly in their own practice and in overseeing the work of their supervisees. These include: professional bodies in which they and their supervisees are members; local, state and federal laws; sector standards and their organisation's policies. Supervisors must always bear in mind that the parties involved in supervision include not only the supervisor and the supervisee, but also the supervisee's clients and the employing organisation.

It is a common aspect of supervisory practice to encounter difficult and murky ethical problems from time to time. When determining a way forward in resolving complex ethical dilemmas posed in supervision, Page and Wosket recommend following five general principles of ethical decision-making (see 7.10.2).

Ethical and legal issues that are critical to clinical supervisors include: (1) vicarious liability, (2) dual relationships and boundary concerns, (3) informed consent, (4) confidentiality, and (5) supervisor ethics (see 7.10.1 -7.10.3).

7.10.1 Clinical Supervisor Ethics

Clinical supervisors adhere to the same standards and ethics as counsellors, and as others who share their credentialing body, regarding most issues. There are also codes of conduct and standards which they must maintain, and support in others, related to AOD or CMMH work and to their particular organisational context.

In addition to those codes of conduct, clinical supervisors should adhere to the following:

7.10.1.1 Code of Ethics and Standards of Practice

The supervisor should ensure the supervisee understands the appropriate Code of Ethics and Standards of Practice and legal responsibilities. The supervisor and supervisee ought to discuss sections applicable to the worker.

7.10.1.2 Dual Relationships

Since a power differential exists in the supervisory relationship, the supervisor shall not utilise this differential to her or his gain. Since dual relationships may affect the objectivity of the supervisor, the supervisee should not be asked to engage in social interaction that would compromise the professional nature of the supervisory relationship.

7.10.1.3 Due Process

During the initial meeting, supervisors should provide the supervisee information regarding expectations, goals and roles of the supervisory process. The supervisee has the right to regular verbal feedback and periodic formal written feedback, signed by both individuals.

7.10.1.4 Evaluation

During the initial supervisory session, the supervisor should provide the supervisee with a copy of the evaluation instrument used to assess the supervisee's progress.

7.10.1.5 Informed Consent

The supervisee must inform the clients that he or she discusses their cases with a clinical supervisor, and must receive written permission from the client to audiotape or videotape sessions (also see Confidentiality 7.10.1.6.)

7.10.1.6 Confidentiality

The counselling relationship, assessments, records, and correspondences must remain confidential. Failure to keep information confidential is a violation of ethical code and the counsellor, supervisor and/or organisations may be subject to a malpractice suit. The client must be informed that the worker receives supervision and that his or her details may be discussed.

7.10.1.7 Vicarious Liability

The supervisor is ultimately liable for the welfare of the supervisee's clients. The supervisee is expected to discuss the counselling process and individual concerns of each client with the supervisor.

7.10.1.8 Avoiding Professional Isolation

The supervisor should consult with peers regarding supervisory concerns and issues.

7.10.1.9 Termination of Supervision

The supervisor should discuss termination of the supervisory relationship, help the supervisee identify areas for continued growth, and explore professional goals.

Some general principles of ethical decision-making, as well as a more detailed explanation of vicarious liability, dual relationships and boundary concerns, informed consent, and confidentiality can be found in sections 7.10.2 -7.10.3.

References for this section: The Bouverie Centre (Moloney, Vivekananda & Weir, 2007).

7.10.2 General Principles of Ethical Decision-Making

The following principles of ethical decision-making were adapted by Page and Wosket from the medical profession, for the benefit of helping professionals (Page & Wosket, cited in Scaife, 2001):

- Autonomy - the principle that individuals have the right to freedom and action
- Beneficence - the principle that actions taken should do good, using knowledge to promote human welfare
- Fidelity - being faithful to promises made
- Justice - ensuring that people are treated fairly
- Non-maleficence - striving to prevent harm

Stadler (1986, cited in Moloney et al., 2007) suggests that people making difficult ethical decisions explore an additional three moral principles:

- Universality - do my actions stand the test of generalisation? Given the context, would most people think my chosen course of action was reasonable?
- Publicity - am I prepared to have my actions publicly scrutinised?
- Justice - would other people find my actions fair and reasonable? Would I apply the same treatment to another person in similar circumstances?

References for this section: Scaife (2001); Stadler (1986, cited in The Bouverie Centre [Moloney, Vivekananda & Weir 2007]).

Most professional Codes of Ethics are about what we *shouldn't* do. Michael Carroll (2010) took on the task of assisting an organisation to capture and develop the positive values which they wanted to live to in their work. This led to his notion of “ethical maturity – having the reflective, rational and emotional capacity to decide what actions are right and/or wrong, having the courage to do it and being publicly accountable for my decision.” (Carroll, 2010)

7.10.3 Defining Ethical Terms

7.10.3.1 Vicarious Liability

Vicarious liability is the duty of care which the clinical supervisor holds in relation to the supervisee's clients. The implications of this are that the supervisor may be held ethically and legally responsible if harm comes to clients as a result of negligent, or incompetent supervision practices (e.g., a supervisor failing to recommend a suicide evaluation of a severely depressed client, or suggesting herbal remedies as a viable treatment for psychosis). It is important for supervisors to bear in mind that the line of responsibility leads back to them, especially when overseeing inexperienced or over-worked supervisees struggling with their caseloads.

Reference for this topic: Center for Substance Abuse Treatment (2009).

7.10.3.2 Dual relationships

Dual relationships and boundary concerns are relevant to the client-supervisor relationship, the supervisee-client relationship, and the supervisor-client relationship. Clinical supervisors are expected to maintain appropriate boundaries with their supervisees, and to be aware of signs that a supervisee's boundaries with one or more clients are crossing into potentially vague or dangerous territory. Additionally, the supervisor has an indirect relationship with the clients whose cases are brought into supervision sessions, which means that they have a responsibility to protect the confidentiality of those clients and not to engage in social relationships with them. These are grey rather than black and white areas of supervisory practice and must be considered on a case-by-case basis when an issue arises.

Reference for this topic: Center for Substance Abuse Treatment (2009).

7.10.3.3 Informed consent

Informed consent should be part of the supervisory relationship, just as it is part of the client-counsellor relationship. The areas of informed consent should be covered in the contracting stage of supervision and should be reiterated as necessary throughout the course of the supervision relationship. The process should address the following topics:

- The purpose of supervision: the structure and mutual understanding of supervision
 - goals of supervision
 - how goals will be evaluated and the specific timeframes
 - specific expectations of the supervisor and the supervisee
 - integration of theoretical models
- Professional disclosure: information about the supervisor that includes credentials and qualifications and approach to supervision
 - educational background
 - training experiences

- theoretical orientation
- clinical competence with various issues, models, techniques, populations
- sense of mission or purpose in the field
- Supervision process: methods and format of supervision
 - individual, group, peer, dyadic
 - methods of direct observation
 - permission to record sessions on audio- or videotape

Reference for this topic: adapted from Falvey, 2007, cited in Center for Substance Abuse Treatment (2009).

7.10.3.4 Due process

Due process includes written procedures to be followed when a grievance or complaint has been made against the administration, the supervisor, or the worker. It ensures that all sides are heard and that the complaint and response to the complaint receive due consideration. In this case, informed consent means that all parties are aware of the process for lodging a complaint.

Reference for this topic: adapted from Falvey, 2007, cited in Center for Substance Abuse Treatment (2009).

7.10.3.5 Ethical and legal issues

Policies, regulations, and laws regarding supervisory and therapeutic relationships include:

- emergency and back-up procedures (e.g., supervisor accessibility)
- ethical codes of conduct
- process for discussing ethical dilemmas
- confidentiality regarding information discussed in supervision
- confidentiality issues when more than one supervisee is involved
- dual roles and relationships
- process for addressing supervisee issues (e.g., burnout, countertransference)
- a statement of agreement
- signed acknowledgement by all parties that they understand and agree to comply with the contract

Reference for this topic: adapted from Falvey, 2007, cited in Center for Substance Abuse Treatment (2009).

7.10.3.6 Confidentiality

The parameters of confidentiality should be clearly explained to workers engaging in a clinical supervision relationship and should be included in the supervision contract. Just as

with the counselling relationship, there are limits to what is and is not kept private. Supervisors must not only waive confidentiality and/or intervene when harm to the supervisee, clients, or others is at stake (duty of care, and duty to warn), but also when carrying out evaluations of supervisees' work that is shared with line managers and other organisational administrators.

Other circumstances under which confidentiality may be waived include: a breach of the organisation's codes of conduct; a breach of law (e.g., failure to report abuse); and a breach of professional ethics. When information gained in the course of clinical supervision is to be shared with others (e.g., line managers, professional boards), it is important that the supervisee be informed and, to the extent possible, included in the process of disclosure.

References for this section: Center for Substance Abuse Treatment (2009).

7.11 Cultural Competence

One's identity and its meaning in relation to power, status and entitlement may be very significant to the supervision process. Just as gender and power are integral, so too are those factors that uniquely identify, engage, or set us apart from others. However, differences that create distance should be distinguished from those that serve to draw us closer to one another. Indicators that there is a separating difference present include a feeling of discomfort, or awkwardness, or a feeling of being unwelcome.

If arranging cultural factors impacting relationships along a continuum, on one end would be big issues, such as race, ethnicity, religion, gender, sexuality, class and illness, or disability; on the other end would be the smaller, but still potentially significant differences, existing between families, professions and workplaces.

Cross (1989) created a Continuum of Cultural Competence describing the range of attitudes and behaviours from destructive on one end to proficient on the other:

1. Cultural Destructiveness - superiority of dominant culture and inferiority of other cultures; active discrimination.
2. Cultural Incapacity - separate, but equal, treatment; passive discrimination.
3. Cultural Blindness - sees all cultures and people as alike and equal; discrimination by ignoring culture.
4. Cultural Openness (Sensitivity) - basic understanding and appreciation of importance of sociocultural factors in work with minority populations.
5. Cultural Competence - capacity to work with more complex issues and cultural nuances.
6. Cultural Proficiency - highest capacity for work with minority populations; a commitment to excellence and proactive effort.

(Cross, 1989, cited in Center for Substance Abuse Treatment 2009, pt. 1, p. 12).

The assumption in striving for, at minimum, cultural competence in the caring professions is that we all carry our own cultural and political baggage and are prone to ethnocentric bias.

Two fundamental principles underpinning competence are that: (1) people will have personal and unique experience of and reactions to diversity (their own and others'), and (2) one cannot assume what those reactions will be. In making assumptions, one risks exaggeration, or over-generalisation of differences (i.e. stereotyping), or minimising the differences (i.e. cultural blindness) relevant to the work.

The topic of diversity is also important in our organisation. I have been discussing with staff, "what is culture?" Our staff is very diverse and we need to be conscious about how the dynamics between different workers play out at work. Also, we have to manage the realities of dual relationships, which are going to happen, especially within particular cultural groups. (Manager, AOD Service)

Power inequalities are built into our society and are often based on difference. Inequalities are manifested through the over-representation of certain groups in some instances (e.g., indigenous peoples in the criminal justice system) and under-representation in others (e.g., women in leadership roles). Power and hierarchy also manifest themselves in small systems, such as who speaks, who interrupts and who listens the most in conversations; whose opinion is privileged, and whose knowledge is considered legitimate.

To follow are three groups of suggestions, from the most general to the most specific, regarding steps towards culturally competent supervision. The first is about taking charge of one's own personal competence; the second about competence within the supervisory relationship; and the third about competence within the supervisor-supervisee-client triad.

(Also see Falender, C.A. & Shafranske, E.P. (2004). *Clinical Supervision: A Competency-based approach*. Washington, D.C.: American Psychological Association. or Bernard, J.M. & Goodyear, R.K. (2009). *Fundamentals of clinical supervision (4th ed)*. Boston: Allyn & Bacon.)

7.11.1 Self-Review & Personal Action

Rapp proposes four steps toward culturally competent supervision:

1. Personally challenge and support - work to uncover our personal blindness and prejudices
2. Raise political awareness - act to oppose forms of institutional racism, sexism, homophobia and discrimination against people living with disabilities
3. Review ethics and professional practice
4. Revise and scrutinise the theories and history that inform practice

(Rapp, cited in The Bouverie Centre [Moloney, Vivekananda & Weir 2007].)

7.11.2 Creating an Anti-Oppressive Supervisory Relationship

Brown and Bourne recommend four guidelines for creating an anti-oppressive supervisory relationship:

1. Acknowledge the power differential and encourage an exchange of feelings about this
2. Acknowledge any lack of choice of supervisor and support any wish for access to other resources
3. Incorporate regular feedback, review and evaluation of supervision, actively inviting any comments about perceived supervisor bias, etc.
4. Stay mindful of these issues within the supervisee-client relationship

(Brown & Bourne, cited in The Bouverie Centre [Moloney, Vivekananda & Weir 2010]).

7.11.3 Attending to the Supervisor-Supervisee-Client Triad

Hawkins and Shohet have developed seven modes for attending to the cultural differences between clients, supervisees and supervisors:

1. Focus on the culture of the client and their context. This includes attending to possible culture-specific behaviours (e.g., avoidance of eye contact, or shaking hands in greeting).
2. Find ways of responding to cultural differences and the hidden cultural assumptions implicit in the supervisees' interventions (e.g., that people all share a common idea of normal and desirable behaviour).
3. Consider the culture inherent in the relationship between client and supervisee (e.g., how this influences the process of the work), and what supervisory interventions might correct any problems resulting from the supervisee's mismanagement of this.
4. Focus on the cultural assumptions and the countertransference of the supervisee as they relate to cultural differences (e.g., racial stereotyping, gender biases).
5. Focus on parallel process (e.g., how cultural difficulties experienced in the client-supervisee dynamic are mirrored in the supervision relationship). Also, attend to cultural differences in the supervision relationship.
6. Attends to one's own cultural assumptions and countertransference with regard to cultural differences.
7. Consider the cultural norms and biases in the wider context in which the work takes place (e.g., social, political, organisational). This includes such problems as institutional racism and oppressive practice.

(Hawkins & Shohet, 2000, cited in The Bouverie Centre [Moloney, Vivekananda & Weir 2007]).

References for this section: The Bouverie Centre (Moloney, Vivekananda & Weir 2007, 2010); Center for Substance Abuse Treatment (2009).

7.12 Professional and Personal Self-Care

7.12.1 Supervision of Supervision

Having a reflective space to review one's clinical supervision work is essential to the wellbeing of supervisors. It is also a principle of accountability and good practice. This is present in some services in the form of individual supervision sessions between clinical supervisors and their own managers, though one faces the same potential challenges here as when a worker's line manager functions as his or her clinical supervisor. Nevertheless, just as with this latter duality, the former can have benefits and can work well, depending on the quality of the working alliance and the ability of the senior manager conducting to distinguish between the roles and to avoid mixing them.

Supervisors have to have supervision; the reflection time is crucial to the work. (Manager, AOD Service)

... there's a heavy emphasis in the provision of supervision to supervisors on ethical decision making. ... A huge component of supervision (of supervision) is ensuring that there is absolute due diligence given to reflect on and look at every single potential possibility and what our duty of care is to the consumer but also, what our duty of care is to the counsellor undertaking the work. (Manager, CMMH Service)

It really provides a forum to consider and hold the tensions that can emerge in meeting the needs of various stakeholders (consumers, counsellors and the organisation). (Manager, CMMH Service)

Other options for supervision of supervision include:

- Engaging the services of clinical supervisors external to the organisation
- Supervision-of-supervision groups, facilitated by an external supervisor
- Peer supervision-of-supervision groups, in which clinical supervisors meet to review their work practices together, and to offer one another feedback and support

7.12.2 Self-Care Planning

In addition to engaging in supervision-of-supervision, a well-considered self-care plan is an essential component to a comprehensive work management portfolio. A good self-care plan should be achievable, concrete and designed to attend to a particular source of stress.

Examples of categories in creating a self-care plan include:

Organisational: strategies that may involve negotiating changes in your work place (e.g., seeking to diversify your work life, or accessing supervision for yourself).

Professional: strategies for attending to your professional development and career path needs (e.g., undertaking further training that will assist you in dealing with a particular client group).

Personal: strategies that assist you on a personal level (e.g., improving nutrition, reading non work-related books, etc.)

References for this section: The Bouverie Centre (Moloney, Vivekananda & Weir 2007).

7.12.3 Compassion Fatigue and Vicarious Trauma

Given the experiences of their clients, it is likely that workers in human service organisations will hear about and witness severe trauma and distress in performing their roles. Research has demonstrated that listening to stories of trauma and having a responsibility to respond with compassion and care can have a cumulative negative effect on workers' wellbeing. These cumulative effects can be the cause of compassion fatigue, or burnout, and are not related to a worker's inherent weakness, inexperience, psychopathology, or lack of professionalism.

Generally, it is understood that one's risk of being negatively impacted (including traumatised) by the work increases when:

- working in the field for a long time
- working with children
- working with clients who have been sexually abused
- working with clients for whom society has little compassion, or who are blamed and scapegoated (e.g., homeless clients, clients with substance abuse problems, sex workers, refugees)
- having little variety in the work
- having a history of unresolved personal trauma
- experiencing currently stressful life circumstances
- having personal coping strategies that lead to avoidance and internalisation of problems

Figley (1995, cited in The Bouverie Centre [Moloney, Vivekananda & Weir 2007]) notes that the more compassionate and empathic a worker is, the more likely he or she will be affected by compassion fatigue. The answer is not to make workers less compassionate, obviously, so effective self-care strategies become paramount.

Focus on self-care in the trauma field can be usefully translated to other areas, such as the CMMH and AOD sectors. Clinical supervisors can help themselves by being aware of the potential hazards of the work and developing effective self-care plans to deal with these.

Good supervision also requires that workers are helped to understand the potential impact of the work that they do; to assess their personal risk factors and resources; to recognise the signs of compassion fatigue and vicarious trauma, and to develop a self-care plan that monitors and addresses negative effects should they arise.

References for this section: The Bouverie Centre (Moloney, Vivekananda & Weir 2007); Center for Substance Abuse Treatment (2009).

8 Clinical Supervisee Guidelines

When entering into a clinical supervision relationship, supervisees need to be aware of what is expected from all parties involved in, or affected by, the process. It is the responsibility of clinical supervisors to ensure that this knowledge is discussed explicitly in the early stages of the work.

To reiterate what is stated in section 7.6.2:

Though definitions of clinical supervision may vary, the principal aims are fairly consistent across definitions and can be summarised as follows: to enhance the supervisee's skills, competence and confidence; to provide reflective space and emotional support; to provide assistance with professional development; to ensure that service to clients is safe, ethical, and competent, and to ensure compliance with professional and organisational treatment standards and practices.

Such variables as academic and professional background, years of experience in the field and overall developmental maturity as a worker will impact what supervisees want, need and expect from the clinical supervision relationship, content and process.

Supervisees are advised to maintain the following attitudes and behaviours to ensure clinical supervision is a worthwhile pursuit that benefits their work, clients and organisation:

1. Actively participate in developing a working alliance with one's supervisor.
2. Actively participate in negotiating the supervision contract at the beginning of the relationship. As a supervisee, you are not responsible for initiating the contract, but you should be prepared to discuss practicalities such as scheduling, past experiences of supervision, goals and expectations of supervision, theoretical, or philosophical underpinnings of one's work, hopes and concerns about the supervisory relationship, current developmental level as a counsellor, particular skills and knowledge, and learning needs. The contracting stage may include many other topics, and its depth and breadth depends entirely upon the sense of safety, trust, openness, and awareness that exists between you and your supervisor, which should amplify over time. It is expected that contracting would be reviewed and revised as needed. (Also see section 7.5.1-7.5.2 for more on contracting.)
3. Prepare for supervision sessions in whatever manner is agreed upon with your supervisor. Your supervisor should discuss with you the methods and techniques that will be used in the supervision process so that you know how to prepare (e.g., case presentation, videotaped session, etc.). Additionally, you should identify what you are hoping to achieve by raising a particular problem or issue in supervision (e.g., Why this client? Why now? What would be a helpful outcome of the supervision session?).

4. Keep records of supervision as a reminder of helpful ideas and possible interventions, to ensure agreed-upon action is taken, and to refer to in future if needed. These should be kept separate from clients' files.
5. Be prepared for reflective processes. Clinical supervision is about much more than the actual content of client work; it is also about the process of the work, which includes the dynamics occurring between you and your client, and reflection on whether your emotional responses to the client aid or hamper a successful outcome.
6. Be open to feedback and reflect on its implications for future practice. Also, be prepared to offer feedback to your supervisor about your experience of the supervisory process and relationship.
7. Take responsibility for one's own defensive responses, and be prepared to address them. This requires awareness of what is triggering a defensive reaction: is it the clinical supervisor, about whom one was given no choice? Is it the idea that clinical supervision is only for students, or inexperienced workers? Is it that an uncomfortable dynamic has occurred in the course of supervision, such as perceiving the supervisor as overly didactic and directive? Is it fear of being seen as incompetent?
8. Take responsibility for one's own professional development and personal self-care. Clinical supervisors should assist you in developing a plan that helps you to enhance your knowledge and skills as well as resourcing you against compassion fatigue and burnout, but it is your job to collaborate in this effort, and to look after yourself.

NB: It is important to remember that there is a beginning, but not an end, to gaining clinical knowledge and enhancing one's skills: be wary of workers or supervisors who think they know all there is to know and who believe they require no input from others.

NB: Supervisees are advised to read the Resource "*Supervisee's Bill of Rights*" (downloadable from the companion website).

9 Administrative Guidelines: the Organisation's Role in Clinical Supervision

Developing, supporting and maintaining high quality supervision requires commitment at every organisational level and cannot be achieved without active, consistent and positive management support.

The administrative activities required to create and sustain a clinical supervision framework consist of several steps, which must be preceded by an assessment of organisational readiness. It is also essential for administrators and managers to understand the organisational factors that support good clinical supervision practices.

Steps to building a clinical supervision framework within an organisation should include:

1. Understanding the organisational factors that support good clinical supervision practices.
2. Assessing organisational readiness.

3. Consulting with workers.
4. Creating internal policy and procedures appropriate to the organisation's context and culture.
5. Giving priority in budget and/or seeking additional funding to provide clinical supervision.
6. Recruiting or selecting effective supervisors (including contracting with external supervisors).
7. Providing opportunities for ongoing training and consistent support for supervisors, as well as evaluating and providing feedback on their work with supervisees.
8. Monitoring and evaluating the selected framework, including the supervisees' satisfaction with their supervision.
9. Managing problems that arise in supervisory relationships that cannot be resolved within the relationship.
10. Addressing challenges to effective implementation (e.g., rural isolation, access for shift workers, lack of trained supervisors).

9.1 Understanding Organisational Factors that Support or Constrain Good Supervision Practices

Information for this section is excerpted from the final report of The Bouverie Centre's 2009 audit of clinical supervision practices in the Victorian AOD sector (Ryan, Wills et al. 2009) and a document prepared by the Mental Health Coordinating Council (Bateman, Henderson & Hill, 2012) which analyses the current supervision practices of six different community managed member organisations in NSW.

9.1.1 Managers' & Supervisors' Perceptions of Organisational Factors that Support Access to Clinical Supervision – AOD Sector

In The Bouverie Centre's 2009 audit of clinical supervision practices in the Victorian AOD sector (The Bouverie Centre, [Ryan, Wills et al. 2009]), managers and supervisors who participated in focus groups (n=12) and phone interviews (n=13), most commonly cited the following factors as supportive of clinical supervision practice:

- A strong positive management attitude to clinical supervision, where senior managers, managers, and team leaders endorse clinical supervision and are seen as highly supportive of the practice; where staff are made aware of the organisation's commitment to clinical supervision during recruitment and induction; and where sufficient resources are dedicated to supervision
- Defining the concept of supervision clearly and articulating the procedures associated with it well. Some points that were identified as being important to define were: the distinction between line and performance management and

clinical supervision; roles and responsibilities in the supervisory relationship; and confidentiality

- Open organisational discussions of the tensions relating to clinical supervision, tensions such as:
 - managing the dual roles of being a line manager and clinical supervisor
 - managing differences in professional backgrounds of supervisor and supervisee
 - gender issues
 - perception of a mismatch between skill and experience of the supervisor and supervisee
 - perception that accessing clinical supervision is viewed as a sign of weakness or burnout
- Widespread appreciation that the functions of clinical supervision are multifaceted and aim to meet the needs of clients, staff and organisations
- Recognition that workers have a right to clinical supervision, but that responsibility for the content and delivery of supervision is shared between management and staff

Managers and supervisors identified the following as significant barriers to accessing and delivering clinical supervision:

- Lack of consistent organisational standards, including situations where there are no clear guidelines or expectations about the parameters of clinical supervision; where there is no shared definition of the practice and, and where supervision is carried out on an as-needed basis
- Poor supervision and support for supervisors
- Time, resourcing and funding constraints, including poor availability of supervisors and inadequate remuneration for supervisors
- Lack of an appropriate, private space in which to conduct supervision
- Negative attitudes to supervision held by workers. Interviewees noted that a lack of understanding about the purpose and nature of supervision can lead to fears of being judged; a perceived mismatch between supervisee and supervisor can cause the usefulness or appropriateness of the supervision to be called into question; and workers who have been in the field for some time can feel devalued by the idea and concept of supervision
- The absence of clear reporting and contractual arrangements between external clinical supervisors and employing organisations. Some managers were concerned about poor clinical accountability in cases where there were few or no reporting arrangements in place. There were also concerns from managers about how to

ensure that external clinical supervision, where provided by an external consultant, is consistent with the organisational service delivery model

9.1.2 Factors Perceived as Supporting or Constraining the Practice of Supervision - CMMH Sector

Fifteen middle managers and frontline workers from six different NSW community managed mental health workplaces were interviewed by the Mental Health Coordinating Council (2012) to investigate how supervision was being conducted in the sector and the views held in relation to the topic. Interviewees spoke about the importance of sustained leadership from middle and upper levels of management for promoting and sustaining effective supervision and support practices. They suggested managers can act to support supervision by:

- Actively assisting supervisors and workers to make time and space for supervision
- Providing a physical environment conducive for the practice of supervision
- Routinely seeking feedback from supervisees about their experience of supervision
- Communicating genuine support for supervision practices, endorsing supervision as central to daily practice rather than an add-on to be engaged when the rest of the work is completed
- Creating organisational policies mandating the regular provision of supervision and supplying the requisite funds

During the consultation process, interviewees pointed to a number of factors as limiting supervision practice in their organisations, including:

- Supervision time being encroached upon by daily management concerns, immediate needs of clients, etc.
- Lack of support and recognition for the time needed to carry out supervision effectively
- Divisions between managers and workers, or ruptures in the supervisory alliance, resulting in one or both parties seeking to avoid regular supervision sessions
- Worker resistance or aversion to supervision due to a lack of knowledge about the benefits associated with the practice, fear and viewing the process as disrespectful of worker skills and experience

Supervision only does well in organisations that value learning because there is no point bringing your best work and reflecting on what you did well on. There has to be more trust and a culture where you are saying, "I'm baffled by this, what on earth will we do? Or I'm baffled that I just was really triggered. What can we make sense of here?" That's the culture that needs to be developed ... (Manager, CMMH Service)

9.2 Assessing Organisational Readiness

The Center for Substance Abuse Treatment recommends that following organisational issues be considered by agencies before a clinical supervision system is implemented:

Organizational context. How consistently does staff adhere to agency philosophy and culture? To what extent will clinical supervisors teach and support this philosophy?

Clinical competence. What specific knowledge, skills, and attitudes are expected of workers? What is each worker's baseline competence and learning style? What is the level of cultural competence of staff?

Motivation. How can the staff's motivation and morale be characterized?

Supervisory relationships. What is the nature of relationships between administrators and frontline workers? How healthy or unhealthy are those relationships?

Environmental variables. To what extent do administrators expect supervisors to proactively teach ethical and professional values? Do staff members share a common set of goals? How does the organization promote professional development? How is progress toward those goals monitored and supported? What is the cultural, racial, religious, gender, and sexual orientation mix of the clients served by the organization?

Methods and techniques. How familiar is the organization with individual, group, and peer supervision? How familiar is the organization with case progress note review, case consultation methods, direct observation, live supervision, audio- or videotaping, and role playing?

In addition to these considerations, managers will need to evaluate their available resources and deficits in order to build the best possible framework based upon their particular contexts. For instance, services operating in remote areas with few clinical supervisors may need to consider alternatives such as contracting with an external supervisor outside their service area. Services with many shift workers will need to come up with ideas for ensuring they are not left out of clinical supervision, such as alternative shifts or finding a supervisor who can accommodate their needs.

24-hour rosters get in the way of group, certainly. Also, if they miss supervision, it can be hard to get in time to make it up because the work is shift work; and so it means getting them in at non-rostered time, which may mean a supervisor coming in on their time off. (Manager, AOD Service)

Weir (2008), in a study of the implementation of Single Session Work in the Victorian Community Health sector, found that there were ten over-arching variables that affected the uptake of service innovation. This was informed by the work of Rogers (1995) and Greenhalgh, Robert, MacFarlane, Bate and Kyriakidou (2004) - cited in Weir, 2008 - who identified common factors that influence whether a new practice will be taken up in service organisations.

These ten variables are as follows:

Relative advantage: the perception by all stakeholders that the new practice is better than the current one or that the practice can help to solve a current problem

Compatibility: the extent to which the new practice fits with the values, beliefs and needs of the service that is implementing it

Complexity: whether the new practice is perceived as simple to understand and adopt

Trialability: whether the new practice can be easily evaluated

Observability: the visible adopting of the new practice by respected colleagues, and a perceived disadvantage in not adopting the practice

Re-invention: whether the new practice can be modified to suit individual contexts

Organisation adaptability: whether an organisation can adopt their procedures to incorporate the new practice

Risk: whether the benefits of adopting the new practice outweigh the potential risks

Training and Support: whether there is effective training and ongoing support available

Incentive and Regulation: whether the new practice is specified by a governing authority or comes with inducements

It would be helpful for administrators and managers to consider these factors when planning the implementation of clinical supervision, as failure to take them into account could impact negatively upon adoption of the new framework by staff at all levels of the organisation.

*... we really need to train front line supervisors in supervision. Yeah I see that as a gaping need ... but my preference also is that the training provides them with a model they can readily implement. Because I think things can be too broad. I think you need a model that you can adhere to; to know that if you adhere to this model you are providing supervision.
(Manager, CMMH Service)*

Reference for this section: The Center for Substance Abuse Treatment (2009); The Bouverie Centre (Weir, 2008).

9.3 Consulting with Frontline Staff

Collaboration with workers is essential to a successful implementation outcome. Inviting ideas and opinions about decisions such as how supervisors will be chosen or assigned; what models and methods of supervision will be used; how evaluation processes will be carried out, and how problems will be resolved will encourage staff support and ownership of the supervision framework. In cases where supervisors are to be assigned rather than chosen by staff, it is important to clarify why this is the case, and to address any potential conflicts that may arise.

The Mental Health Coordinating Council (2012) specifically recommends the inclusion of both *supervisees* and *supervisors* in the planning process for the purposes of:

- ensuring both groups' needs are met
- cultivating a mutual understanding of the program's aims, objectives, structure and processes
- identifying potential constraints and promoting joint problem-solving

9.4 Creating Internal Policy and Procedures

A supervision policy provides structure, direction, support and validation of supervision activities.

(Mental Health Coordinating Council, 2012, p.25)

Managers will need to create clear and straightforward policies and procedures, tailored to the organisation's context and culture, which establish the aims, structure and process of supervision. These Guidelines are intended to assist in that effort. The *Resources* section of the companion website also provides examples of existing policies developed by Moreland Hall, PenDAP, and Neami.

9.5 Prioritising Funding

Clinical supervision will not be sustainable if no funds are provided to support it. This is an understandably tall order in the context of organisations which struggle to cover costs beyond direct service to clients. In speaking with consultants (see List of Consultants) while preparing these Guidelines, it was evident that the CEOs and managers considered clinical

supervision a priority, viewing it as a foundational necessity of sound clinical governance. The funding was sourced from the organisations' budgets and, in some cases, supplemented by monies gained via tender submissions.

9.6 Recruiting or Selecting Effective Supervisors

The quality of clinical supervision in an organisation will be directly related to the quality of its clinical supervisors. To assist with the recruitment or outsourcing of clinical supervisors, refer to the clinical supervisor competencies in section 7.3.1. It is important to recognise that these competencies will not all be present in inexperienced supervisors, who may require mentoring or coaching in their new role, in addition to receiving training in clinical supervision. Also, the competencies should be viewed as learning objectives, rather than as absolutes for taking on the role of clinical supervisor.

At a minimum, clinical supervisors should have the following qualifications and competencies: relevant formal qualifications and professional backgrounds; extensive clinical knowledge and experience; appropriate training in clinical supervision; a satisfactory level of cultural competence, and the ability to attend to supervisees' needs with openness, empathy, curiosity and respect.

As with internal supervision, when services engage external supervisors, accountability processes must be put into place. External supervisors should be willing and able to provide regular feedback on supervision (e.g., quarterly or bi-annual reports) within the appropriate bounds of confidentiality. Workers should be aware of, and involved in, this feedback process.

9.7 Providing Ongoing Training and Support for Supervisors

Clinical Supervisors will benefit from ongoing training and support for their clinical supervision practices and, lacking that, may face frustration, high stress levels and fatigue, as well as potential burnout. It is not only for the wellbeing of supervisors that organisations should make arrangements for professional development, and support for the work of supervision; it is also for the wellbeing of supervisees and clients, and for the accountability of the organisation.

In some instances, supervisors may seek their own supervision, self-funded, and independent of their organisation; however, this is not always possible, and it should not be expected that they do so. In speaking with consultants to prepare these Guidelines (refer to list), they discussed a variety of strategies that are used to support supervisors in both sectors, including:

- supervision of supervision via line management structure
- supervision of supervision via external consultant, funded by the organisation
- supervision of supervision via peer group, in which the members focus on, and support one another in, their clinical supervision practices
- supervision-of-supervision (SOS) group facilitated by an external consultant, funded by the organisation

- provision of leave for professional development activities

An additional way of supporting supervisors is to provide them with evaluation and feedback on their work with supervisees (refer to section 9.8) as well as opportunities for formal recognition such as the bestowing of a title, certificate of appreciation or additional payment (HWA, 2010, cited in Mental Health Coordinating Council, 2012).

9.8 Monitoring and Evaluation

Organisations will need to oversee the work of supervisors in regard to administrative concerns (e.g., who is and is not attending supervision; number and duration of sessions; areas of concern and general satisfaction with the process), but they will need to accomplish this within the bounds of confidentiality appropriate to the clinical supervision relationship. While it is part of the clinical supervisor's role to explain confidentiality and its limits to supervisees, this should also be specified in the policies of the organisation, and the organisation should support supervisees' right to confidentiality.

Unless a supervisee breaches a code of conduct, fails in duty of care or is perceived to be in danger by his or her supervisor, confidentiality should be maintained. Any provision made for sharing of information between line managers and clinical supervisors (where these roles are held separately) should be discussed and negotiated with the supervisee, and its content and aims discussed in detail, prior to any disclosure. The organisation also needs to have a grievance process, clearly stating the protocol to follow, for supervisees who are unable to resolve problems with their supervisors.

To assist with monitoring and evaluation, the organisation should prepare a set of tools for (1) supervisors evaluating supervisees, (2) supervisees evaluating their supervision and (3) evaluating the framework as a whole.

For examples of areas to consider and questions to ask in evaluating supervisees, Visit: www.cfalender.com.

For examples of areas to consider and questions to ask in gaining supervisee feedback, Visit: www.cfalender.com.

The Mental Health Coordinating Council (Bateman, Henderson & Hill, 2012) recommends the following issues be addressed when conducting an evaluation of a practice supervision program:

- 1) The extent to which program objectives have been achieved
- 2) The extent to which the program has met the needs and expectations of supervisors, supervisees and the organisation
- 3) The impact of the program on work practice

9.9 Managing Problems that Arise in Supervisory Relationships

It is part of good clinical supervision practice to expect that issues will come up, related to such aspects of the work as practical problems (e.g., chronic lateness or failure to attend arranged sessions; inadequate preparation for sessions); theoretical or philosophical

disagreements; parallel processes (e.g., supervisor begins to experience the supervisee in the same way that the supervisee describes experiencing the client), or, an area of vulnerability that gets opened up for either party. It is best for the working alliance of supervisor and supervisee if they are able to address and resolve any problems or ruptures which occur in clinical supervision themselves. However, this may not always be possible.

If a supervisee finds himself or herself chronically disappointed in, frustrated by or defensive towards his or her supervisor, and the supervisor is unable to adequately repair the relationship rupture, a third party should be called in to help. Who that third party is, and what role they hold within the organisation, will vary according to organisational protocol, but it should be someone who is in a senior position, who understands the clinical supervision relationship, and who is trusted and perceived as helpful by both parties.

Problems may also arise in clinical supervision groups, in which case, it may be between group members or between a group member or members and the supervisor. This is usually considered grist for the mill in group work, but in cases where it cannot be resolved, the above protocol should be followed.

When a supervisory relationship is deemed to be beyond repair, the organisation will need to assess the reasons behind the breakdown in order to determine a way forward (e.g., will changing supervisors help, or is the problem related to particular traits and behaviours of the supervisee?).

9.10 Addressing Challenges to Effective Implementation

Organisational administrators and managers assessing their readiness for adopting a new clinical supervision framework, or improving an existing one, should collaborate with frontline staff regarding barriers they face in their particular service context, and ideas for overcoming them.

Roche et al. (2007, p. 246) outline common barriers to implementation experienced by services (also see sections 9.1.2 and 9.1.3):

1. Managers who do not understand the benefits or value of supervision, or are unwilling to devote time and energy to developing a program (NCETA 2005, cited in Roche et al. 2007)
2. Workers who do not understand the benefits or value of supervision, or are unwilling to devote time and energy to developing a program (NCETA 2005, cited in Roche et al. 2007)
3. Supervisors who are not adequately trained in the delivery of supervision (Peake et al., cited in Roche et al. 2007)
4. An insufficient pool of qualified and available supervisors (NCETA 2005, cited in Roche et al. 2007)
5. Conflict between frontline and managerial staff, whose roles are often blurred (Webb, cited in Roche et al. 2007)

6. A lack of common language and conceptual framework amongst supervisors, supervisees and managers (NCETA 2005, cited in Roche et al. 2007)
7. Funding shortfalls and limitations (NCETA 2005, cited in Roche et al. 2007)
8. Geographical distance between supervisors and supervisees (Campbell et al., cited in Roche et al. 2007)
9. A cultural belief that practical benefits of clinical supervision are limited (Cleary et al., cited in Roche et al. 2007)
10. A perception that expressing a need for supervision may be indicative of an inability to manage the job (Olofsson, cited in Roche et al. 2007)

9.10.1.1 Issues related to staff misconceptions and organisational culture

Many of these problems (numbers 1, 2, 5, 6, 9 and 10) can be addressed through an ongoing process of collaboration between administrators, managers, workers, and supervisors. Without management driving and supporting implementation policies and processes, they are sure to fail. It is the role of organisational leaders to ensure that priority is given to engaging staff, and working out a viable plan for clinical supervision, and that it is understood to be an integral component of ethical and competent clinical governance. As part of this dialogue, clear roles should be defined, and a conceptual framework decided upon.

However, in some organisations where little or no solid clinical supervision practice has been followed and staff habits are deeply ingrained, it may require months or years for the changes to be fully accepted and integrated. Managers should not expect to wait for every staff member to come on-board before rolling out a clinical supervision framework, but they should do their best to engage as many people as possible, to ease tensions, and to aid the uptake and follow through on supervision plans.

It's hard to know what the prevailing attitude towards clinical supervision is because it's the policy of our organisation. Participation is a reflection of policy, as well as individual supervisor and supervisee attitudes. I think for some people it's, "This is what I have gotta do or else I will get in trouble." Whereas for the more inexperienced it's like: "Phew, thank God. I need the extra support." (Manager, CMMH Service)

9.10.1.2 Geographical distance (number 8)

Where there may be few clinical supervisors available, accessing supervision via an external consultant, who either comes to the site or supervises via teleconferencing or videoconferencing, may be a viable and effective option. In the event that tele- or video-conference is used, the supervisor should also have direct face-to-face meetings, both initially and every few months, with supervisees. Other options that are gaining traction are the use of on-line chat rooms and e-mail correspondence, though these have their limitations, and guaranteeing privacy and confidentiality is very difficult, if not impossible.

9.10.1.3 Funding and resource constraints (number 7)

The following advice is offered by NCETA:

It may be appropriate for organisations to foster partnerships and share resources...It is important that organisations involved in such partnerships develop a memorandum of understanding that clarifies each organisation's responsibilities (e.g., administration, residence, managerial). Submitting tenders for additional funding is an additional option to consider (NCETA 2005, p. 14).

9.10.1.4 An insufficient pool of supervisors who are adequately qualified and trained in clinical supervision (numbers 3 and 4)

Organisations developing a clinical supervision framework must either source training for their existing staff, or outsource their clinical supervision to trained, experienced supervisors. Refer to *Geographical distance*, above, for suggestions on engaging external supervisors from other areas, if rural isolation is one cause of the understaffing. Also, refer to *Funding and Resource Constraints*, above, regarding ideas for engaging in partnerships with other services.

References for this section: NCETA (2005); Roche et al. (2007).

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