DRUG & ALCOHOL CLINICAL SUPERVISION TRAINING EVALUATION REPORT

Prepared for

NSW Health

Centre for Drug & Alcohol (CDA)

By

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EXECUTIVE SUMMARY

The National Centre for Education and Training on Addiction (NCETA) was approached by NSW Health, Centre for Drug & Alcohol (CDA) to conduct an evaluation of their Clinical Supervision Training Program aimed at senior clinicians in government funded drug and alcohol (D&A) agencies in NSW. The main objective of the evaluation was to examine the impact of the training on the provision of Clinical Supervision (CS) in the workplace. This report presents key findings from the evaluation.

Four training workshops were held in NSW in October and November 2005, two in metropolitan areas and two in regional areas. In February 2006, evaluation questionnaires were posted to all 89 clinicians who had attended the training and 45 surveys were completed and returned, generating a response rate of 51%.

The majority of respondents were female(68%) within the 36-55 age bracket (77%), comprising mostly nurses (58%), followed by psychologists (19%), D&A workers (14%), and social workers (9%), from government agencies. Less than half the respondents were administrative managers or supervisors (43%). On average, respondents had 7 years of work experience in their current organisation and 10 years of work experience in the D&A field. The type of services generally provided included face-to-face specialist treatment services, pharmacotherapy maintenance programs, outpatient services, detoxification programs, and brief counselling. Almost half the respondents reported that they currently provided CS to staff, usually being one-on-one, 30-60 minute sessions, held on a monthly basis. Most respondents perceived important benefits for their well-being, work practice, and client outcomes from having CS.

The training content, resources and delivery were well received by the majority of respondents. With respect to knowledge and skills gained from the workshop, the majority of respondents reported that the workshop facilitated their understanding of the principles, components and value of effective CS, the organisational requirements for the effective delivery of CS, as well as the issues relating to the specific application of CS in the D&A field. However, there was less certainty about having the skills and confidence to develop CS policy or take a leading role in

improving the delivery of CS in the workplace. This is to be expected given that more than half the respondents were not managers, so taking such a responsibility would be difficult. Further, it is unlikely that most of the respondents had previous skills or experience in developing CS policy. Nevertheless, nearly 70% of respondents reported that the workshop did help to provide ideas, skills and / or strategies to improve the provision of CS in their workplace.

There were no statistically significant differences in the provision of CS in the workplace before and after the training. Given the time lapse between the actual training and the evaluation (i.e. 3 months) during which the year-end holidays coincided, it was considered unrealistic to expect any extensive changes to have taken place within this timeframe. Moreover, many NSW D&A agencies were still undergoing structural and organisational changes which would have further delayed the implementation and / or evaluation of CS strategies. Nevertheless, nearly 60% of respondents indicated that some changes had already been made or were currently under review, which is a reflection of the positive effects of the CS training.

Most respondents (67%) reported systemic barriers that hindered workers' involvement in CS at work. These barriers included having an insufficient pool of suitably qualified supervisors, a lack of understanding of CS benefits by managers and / or workers, shortages in funding, geographical distances between supervisors and supervisees, and a lack of commitment to program development. More than 70% of respondents also believed that more could be done in terms of implementing effective CS, such as enhancing the understanding of CS benefits, increasing management support to CS policy and program development, providing appropriate training to potential clinical supervisors, and offering CS to all D&A workers designed specifically for their needs.

In conclusion, it is apparent that the D&A Clinical Supervision workshops have had a positive impact on the majority of clinicians who responded to the evaluation survey. The training has increased their understanding and practical knowledge of CS and has equipped them with the skills to implement an effective CS program in the workplace. However, as long as systemic barriers such as lack of management support and an inadequate selection of available supervisors continue to exist, the successful implementation of CS as an effective workforce development strategy will be hampered. These barriers will need to be addressed in conjunction with additional CS training designed specifically to meet the needs of D&A workers in the field.

INTRODUCTION

The National Centre for Education and Training on Addiction (NCETA) was consulted by the NSW Health, Centre for Drug & Alcohol (CDA) for advice and assistance in the evaluation of their Clinical Supervision Training Program for drug and alcohol (D&A) workers in government funded agencies across NSW. This report presents the findings of the evaluation.

Background

Increasing attention has been directed to Clinical Supervision (CS) as an imperative workforce development strategy in the health sector. CS is gradually being accepted as an integral component in the development and maintenance of professional proficiency. Accordingly, the NSW Health CDA recently developed a set of guidelines for the NSW Health Drug and Alcohol Program to:

- provide an organisational framework for CS
- facilitate a consistent, best-practice approach to clinical practice; and
- contribute to workforce development strategies in the D&A field.

In conjunction with the development of these guidelines, CS training was proposed for senior clinicians in government funded D&A services to support the implementation of clinical best practice standards and build on the professional capacity of the D&A workforce in NSW. CDA commissioned Access Macquarie Ltd. to design and deliver the training following a review of current clinical practice, which included key stakeholders' input and a training needs analysis. The needs analysis examined the expressed requirements of the workforce and current best practice standards of CS based on research literature and stakeholder perspectives. Recommendations derived from the needs analysis were taken into consideration in the design of the training package.

Aims of Clinical Supervision Training

The aims of the CS training were to:[1]

- provide D&A clinicians with training and professional development opportunities in CS
- enhance the effectiveness of clinical practice outcomes in the D&A field
- ensure the adoption of clinical best practice models by D&A workers in the area of psychotherapeutic interventions
- garner clinician support for the implementation process of the NSW Health Drug and Alcohol Program Clinical Supervision Guidelines when it is finalised and distributed
- ensure that responsibility for implementation of the Clinical Supervision Guidelines and CS best practice is shared across all levels of AOD clinical practice, and is supported by senior executives and management in the Area Health Services throughout NSW.

Clinical Supervision Training Content

Approximately half of the training content was applicable to *all* D&A workers and the other half comprised skills training geared towards clinicians who were supervisors. The training workshop covered a range of issues including the benefits of CS, goals and tasks of CS, legal and ethical issues, models and structure of CS, and review and implementation strategies.

The Role of the Evaluation

A comprehensive evaluation of the training program was conducted by NCETA to provide CDA with an overall appraisal of the short term and intermediate outcomes of the training program. It is important to note that the present evaluation was distinct from the immediate post-training evaluation conducted by Access Macquarie Ltd. (i.e. the trainers). Their evaluation was mainly undertaken for the purposes of examining the effectiveness of the training workshops in terms of its content, facilitation and logistics, to facilitate ongoing improvements of the training program in order to ensure that the CS training needs of D&A workers are met.

[1] NSW Health, CDA Specifications 2005.

The main objective of the training evaluation conducted by NCETA was to examine the impact of CS training in the workplace in the short term. The training evaluation involved collecting both quantitative and qualitative data from participants three months after the training took place. No pre-training or baseline data was collected.

Evaluation Components

The evaluation included impact and outcome measures and addressed the extent of organisational support for the implementation of CS in the workplace.

The purpose of the *impact evaluation* was to assess the 'shorter term' effectiveness and efficiency of the training program. Thus, the impact evaluation determined whether the program objectives were met by measuring the perceived learning outcomes and the reactions of the participants to the training. This component of evaluation was also partly covered by the assessment done by the trainers at the end of their workshops.

The *outcome evaluation* component involved assessing the intermediate effects of the training program. Specifically, the outcome evaluation assessed the extent to which the training informed CS policy and practice in the workplace and the nature of organisational support (i.e. barriers and facilitators) available to facilitate this implementation.[2]

[2] Initial plans for a second follow-up survey to evaluate the outcomes of the training in the longer term were cancelled due to difficulties in obtaining an appropriate response rate as a result of staff changes across agencies.

METHODOLOGY

The evaluation methodology was developed in collaboration with the NSW Health, Centre for Drug & Alcohol (CDA). The evaluation team at NCETA focused on examining the effectiveness of the training in the workplace.

Data Collection

Training workshops (n=4) were held during October and November 2005 and the evaluation questionnaires were posted out in February 2006 by CDA to all 89 participants who attended the training. Participants were given a total of three weeks to respond to the survey. Follow-up reminders were sent out via email or post in order to maximise response rates.

Questionnaire Design

The evaluation questionnaire was designed to measure not only the knowledge and skills gained from the training but also the impact of the CS training workshop in the workplace (see Appendix 1).

The intention was to gather both quantitative and qualitative data from the participants, so the questionnaire included a combination of objective questions measuring levels of agreement and a number of open-ended questions.

Items contained in the questionnaire addressed participants' perceptions of:

- knowledge and skills gained from the workshop
- usefulness of the workshop and resources
- benefits of CS
- provision of CS in the workplace *before* and *after* the training
- systemic barriers to CS in the workplace
- strategies to implement effective CS.

The survey also included a section on participants' demographics including age, gender, occupation, years of experience, services provided, etc.

Data Analyses

Quantitative data was analysed using the Statistical Package for Social Sciences (SPSS) software and qualitative data was categorised according to common themes identified among the responses.

RESULTS

Participants' Demographics

Response Rate

Evaluation questionnaires were completed and returned by 45 of the 89 participants who had attended the CS training. The overall response rate was 51%. Contacting all participants proved difficult, as several had moved on to other workplaces during the 3-month time lapse between the training session and the evaluation period.

Gender and Age

Most participants who responded to the survey were female (68%). As can be seen in Figure 1, the majority of respondents (77%) were within the 36-55 age group. This is to be expected as the training was aimed at senior clinicians.

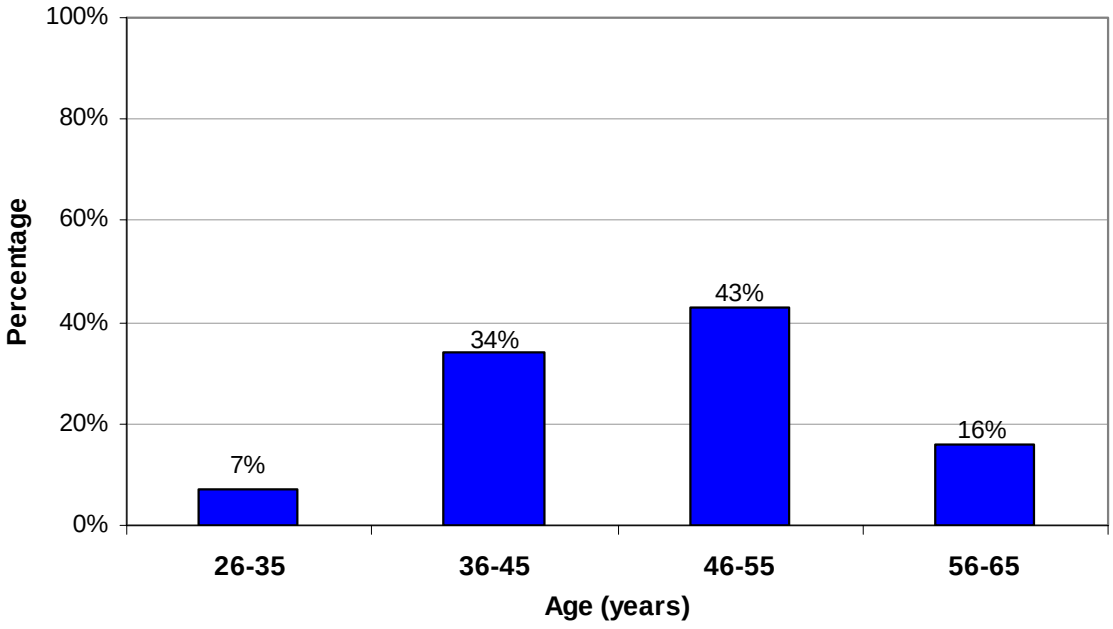

Figure 1: Proportion of respondents by age group (n = 44)

Profession and Work Arrangements

More than half the respondents were nurses (58%). Other respondents were psychologists (19%), drug & alcohol workers (14%) and social workers (9%) (see Figure 2). Nineteen respondents (43%) were administrative managers / supervisors. The majority of respondents (81%) worked full-time.

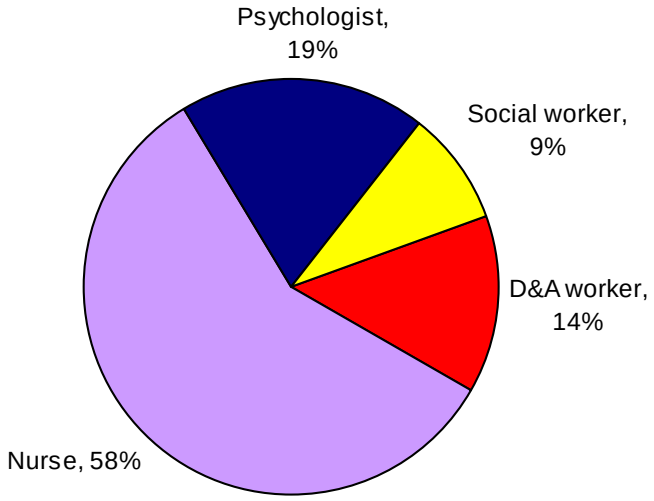

Figure 2: Proportion of respondents by profession (n = 43)

Length of Service

The median[3] length of time respondents had been working in their current organisation was 7 years (range <1-34 years). Most respondents (44%) had been working in their current organisation for less than 1 to 5 years (see Figure 3). The median length of service in the D&A field was 10 years with 46% of respondents indicating that they had more than 5 to 10 years of work experience in the field (range <1-36 years) (see Figure 4).

[3] Due to the wide variability in scores, the median is used as a more appropriate measure of average length of service.

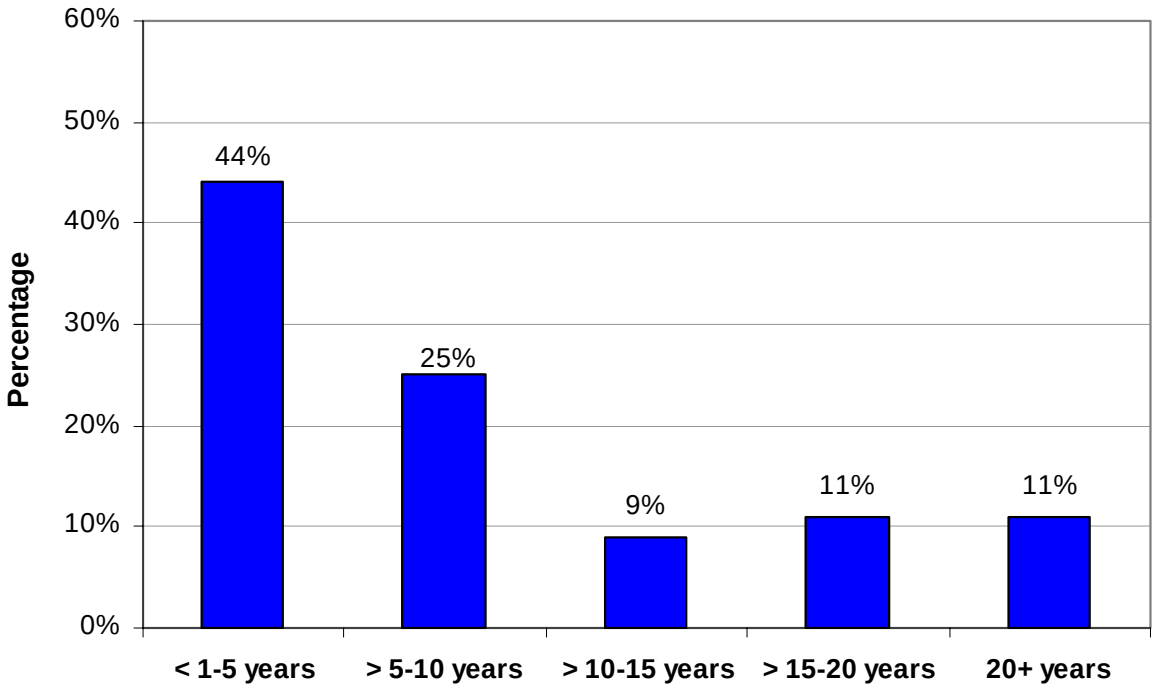

Figure 3: Proportion of respondents by length of service in current organisation (n = 44)

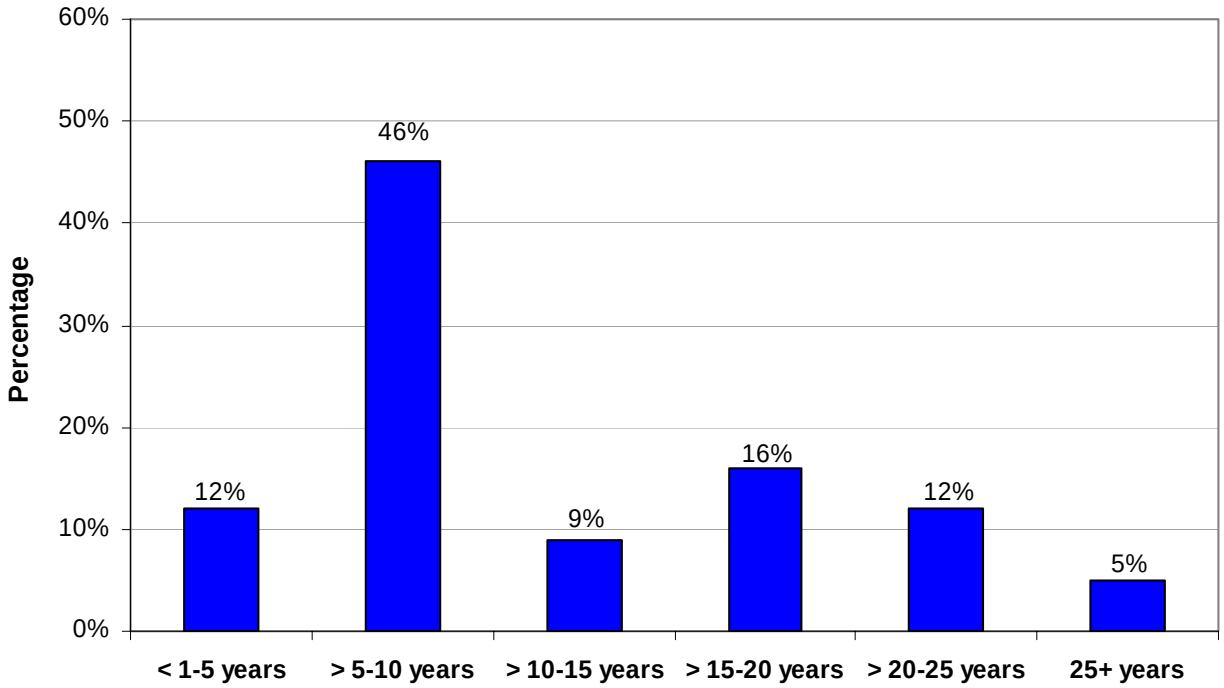

Figure 4: Proportion of respondents by length of service in the D&A field (n = 43)

Workplace Information

The majority of respondents (98%) were from government agencies. One respondent was from a non-government agency. Figure 5 illustrates the geographical location of respondents' workplaces. There were similar proportions of respondents working in metropolitan and rural / remote areas as the training workshops were conducted in 2 metropolitan and 2 rural locations.

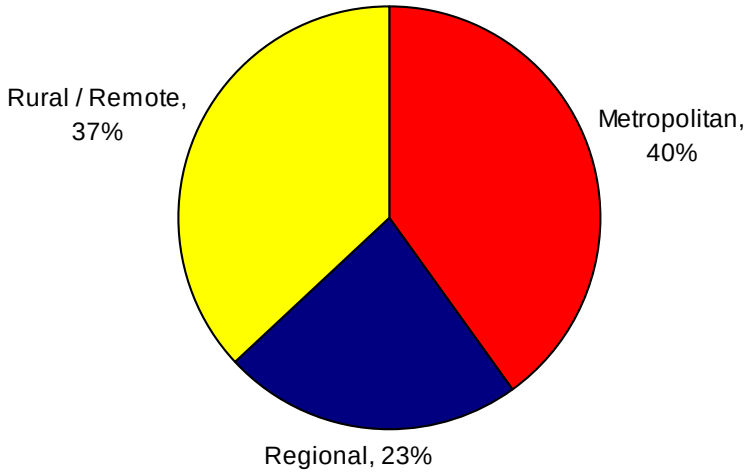

Figure 5: Proportion of respondents by workplace location (n = 43)

The type of services provided by most respondents' organisations included face-to-face specialist treatment services, pharmacotherapy maintenance programs, outpatient services, detoxification programs, and brief counselling (see Table 1).

Table 1: List of services provided by respondents' organisation

Services	*Frequency*	*(%)*
Face-to-face specialist treatment services	34	77
Pharmacotherapy maintenance programs	29	66
Outpatient services	28	64
Detoxification programs	24	55
Brief counselling	22	50
Diversion programs	16	36
Inpatient rehabilitation programs	10	23
Crisis intervention	9	21
Therapeutic communities	1	2
Accommodation	1	2
Other (group therapy, Aboriginal services)	3	7

Provision of Clinical Supervision

Almost half the respondents (48%) reported that they currently provided CS to D&A staff. Further, nearly 60% of administrative managers or supervisors were also providing CS to staff. The most frequent type of CS mainly provided was one-on-one sessions (see Figure 6).

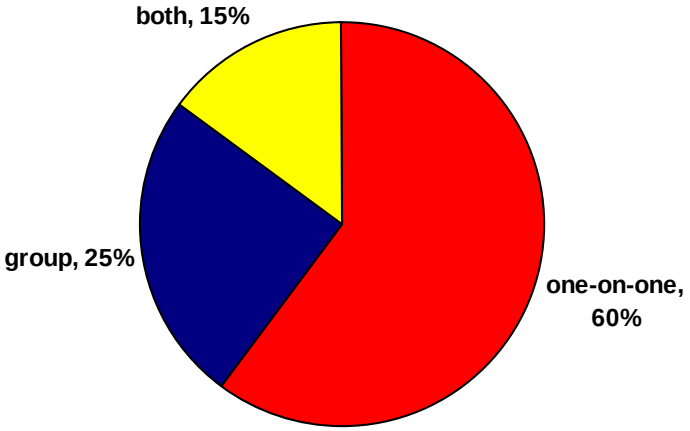

Figure 6: Type of supervision mainly provided by respondents (n = 20)

On average[4], respondents provided CS for 3 workers. Nearly 70% of those who provided CS indicated that they supervised between 1 and 5 workers (see Figure 7).

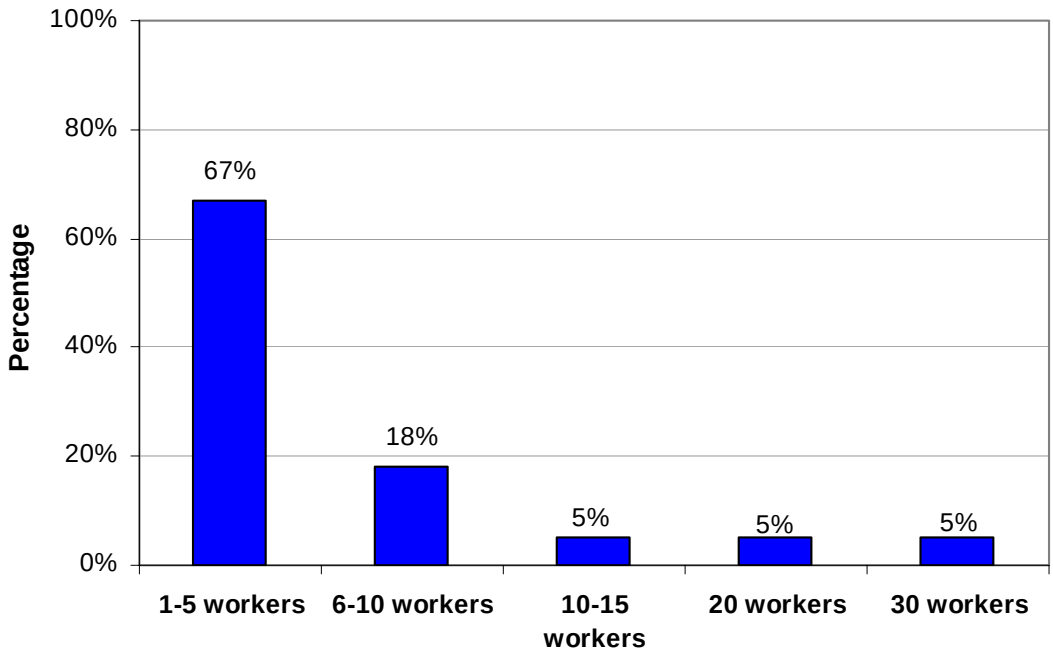

Figure 7: Number of D&A workers supervised by respondents (n = 18)

[4] The median is reported as the average to mitigate the influence of extreme values.

Most respondents (43%) indicated that supervisory sessions were held once a month on average (see Figure 8). Fourteen percent of respondents indicated that they held CS sessions more than weekly. This unusually high frequency of CS could suggest that some clinicians may have misconstrued the definition of CS to also include informal supervisory 'chats'.

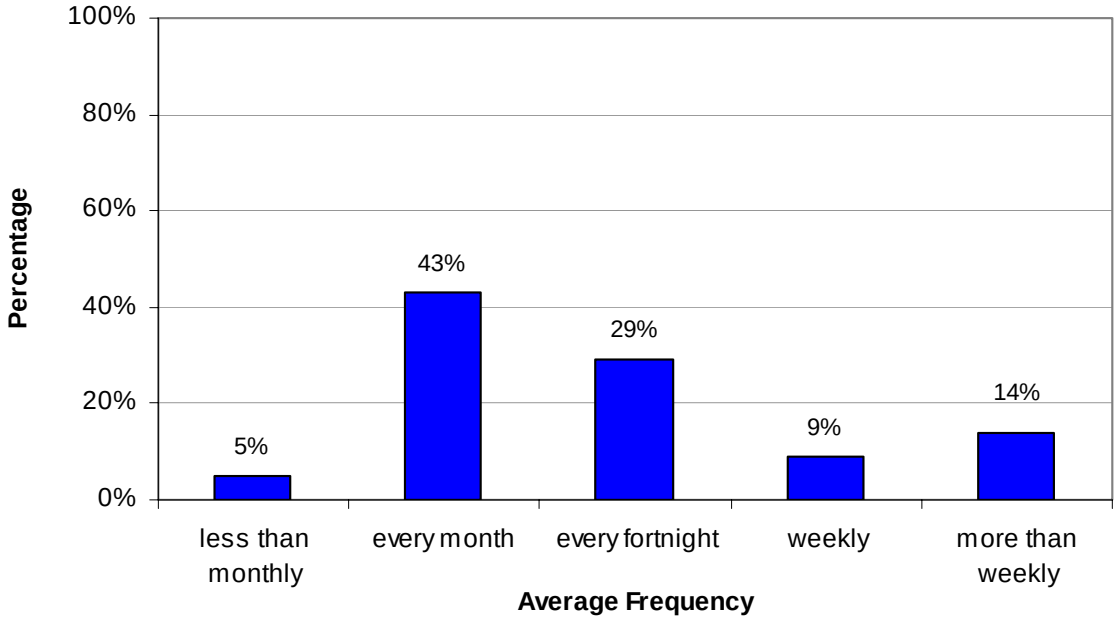

Figure 8: Average frequency respondents conducted their clinical supervision (n = 21)

Forty-five percent of respondents indicated that the average duration of their supervisory sessions was usually between 30 to 60 minutes (see Figure 9).

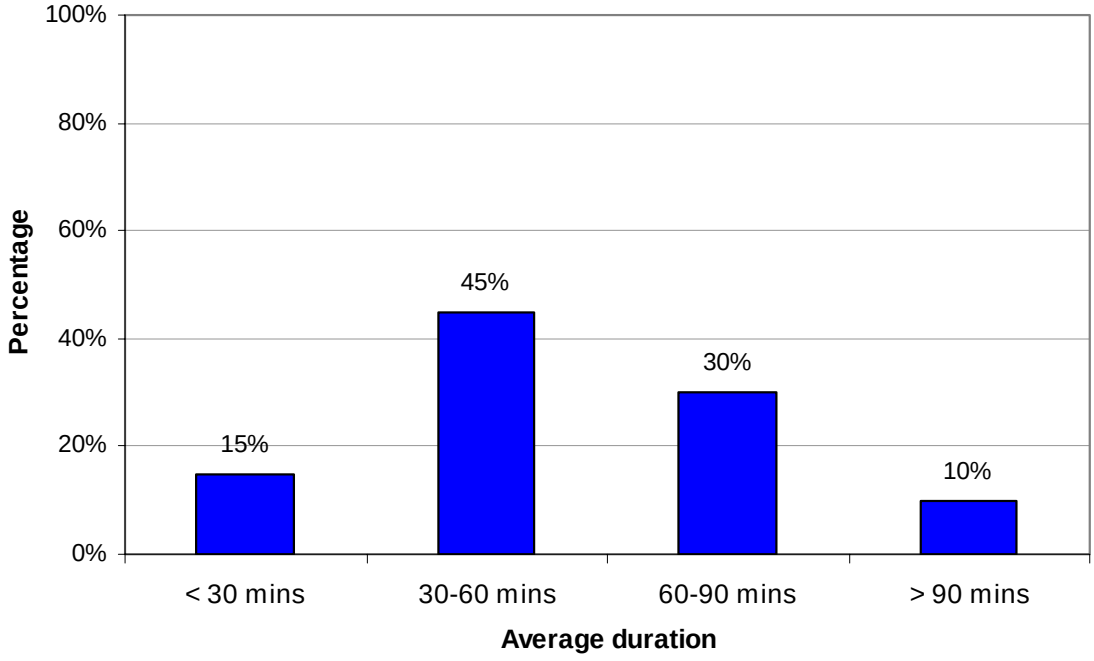

Figure 9: Average duration of respondents' supervisory sessions (n = 20)

Reasons given for not providing CS included:

- not being requested to do so
- having too many other job demands
- providing informal supervision instead
- having supervision sourced externally.

Qualitative statements by respondents:

"Staff regularly consult re clinical issues but it is not my job /appropriate to do clinical supervision!" – Manager (psychologist)

"No resources / direction from management / policy in place." – Clinician (nurse)

"I had not received training until now AND have not been asked." – Manager (nurse)

"Staff under my management already receiving supervision on a regular basis. Need to weigh up time and commitment to taking on supervision of others." – Manager (nurse)

"I provide informal supervision on a regular basis." – Clinician (nurse)

"My time is taken up with client load." – Clinician (nurse and D&A worker)

Perceived Benefits of Clinical Supervision

In a set of open-ended questions, respondents were asked to comment on the three most important benefits of CS for each of the following three dimensions:

i. clinical / work practice
ii. worker well-being
iii. client outcomes.

As can be seen from Table 2, the benefit most frequently cited as most important to their work practice was the opportunity for professional development (including building knowledge and skills). This reflects the respondents' awareness and recognition that CS can help improve their professional capacity.

CS was most frequently perceived to benefit worker well-being via the opportunity to debrief and reflect with one's supervisor, and helping to prevent or minimise levels of worker stress and burnout (see Table 3). Some respondents also believed that the

opportunity for professional development through CS was an important benefit for worker well-being. Of similar benefit were emotional support, guidance and encouragement offered during supervisory sessions.

Table 2: Clinical supervision benefits cited as most important to clinical / work practice

Benefit	*Frequency*
Opportunity for professional development (knowledge & skills)	23
Support strategy	12
Aids in development of ethical and professional work practices	10
Improves client care	10
Ensures quality assurance and control in clinical work	9
Maintains health and well-being (e.g. reduces stress & burnout)	8
Encourages reflective thinking about work practice	7
Ensures best practice approach	7
Clarifies boundaries / parameters / structure at work	6
Protects client and clinician	4
Opportunity to debrief	3
TOTAL	**99**

Note: Respondents could indicate more than one benefit

Table 3: Clinical supervision benefits cited as most important for worker well-being

Benefit	*Frequency*
Opportunity to debrief and reflect	26
Prevents or reduces stress and burnout	21
Opportunity for professional development (knowledge & skills)	18
Provides emotional support, guidance and encouragement	18
Increases confidence	7
Improves team cohesion	4
Enhances work satisfaction	4
Validates skills / knowledge	4
Improves morale	3
Clarifies roles and responsibilities	3
TOTAL	**108**

Note: Respondents could indicate more than one benefit

Benefits derived from CS frequently cited as most important for client outcomes were the promotion of best practice and evidence-based approaches and improvements to client care and management (see Table 4).

Table 4: Clinical supervision benefits cited as most important for client outcomes

Benefit	*Frequency*
Promotes best practice, evidence-based approach	16
Improves client care / management	16
Clinicians more informed about treatment options / approaches	13
Increases confidence in clinical skills / clinician	11
Better quality control	7
Ensures ethical and professional treatment	6
Better therapeutic relations	6
Provides accountability to procedures / policies / guidelines	6
TOTAL	**81**

Note: Respondents could indicate more than one benefit

Training Content and Delivery

The questionnaire examined participant feedback regarding the usefulness of the resources utilised during the workshop and also the general effectiveness of the training workshop. Overall, most respondents provided positive feedback on the training. Similarly, positive ratings and comments were received in the post-training workshop evaluation conducted by Access Macquarie Ltd.

As can be seen from Table 5, the majority of respondents reported very positive views about the workshop – almost all agreed (56%) or strongly agreed (40%) that the workshop improved their understanding of the benefits gained from CS. Eighty-five percent agreed that their needs were met from the workshop and 98% agreed or strongly agreed that the workshop was well facilitated.

With regard to the CDA Participant Handbook, 89% of respondents perceived this resource to be valuable and easy to use. Similarly, the NCETA Clinical Supervision Kit was also well received – more than 80% of respondents indicated that the NCETA Kit will be a valuable and easy to use resource (see Table 5).

Table 5: Training content, delivery and resources

Statements	*SD (%)*	*D (%)*	*Uncertain (%)*	*A (%)*	*SA (%)*	*n*
1. I felt my needs were met in the workshop	0	2	13	51	34	45
2. The workshop was well facilitated	0	0	2	37	61	44
3. The workshop improved my understanding of CS benefits	0	2	2	56	40	43
4. The CDA Participant Handbook:						
a. Will be a valuable resource	0	0	11	49	40	45
b. Appears to be easy to use	0	0	11	56	33	45
5. NCETA's CS Kit:						
a. Will be a valuable resource	0	0	15	47	38	45
b. Seems to be easy to use	0	0	19	44	37	43

Note: SD – strongly disagree, D – disagree, A – agree, SA – strongly agree

Training Impacts

The questionnaire also examined knowledge and skills gained from the workshop. As outlined in Table 6, the majority felt that the CS workshop gave them an understanding of:

- the general principles of CS (98% agreement)
- the components of effective CS (89% agreement)
- CS as a major workforce development strategy (89% agreement)
- issues relating to the specific application of CS in the D&A field (82% agreement)
- organisational requirements for effective delivery of CS (78% agreement).

The above results mirror the comments provided by participants in the post-training survey conducted by Access Macquarie Ltd.

There was less certainty in regard to policy writing skills with 34% of respondents indicating uncertainty and 21% disagreeing that the workshop equipped them with the skills and confidence to write a CS policy or operational guidelines within their organisation. One in four respondents was also uncertain about taking a leadership role in improving the delivery of CS in their workplace. Given that more than half the respondents were not managers or supervisors, these respondents may not have the responsibility or the experience in policy writing nor would they have the opportunity to take on a leading role given their non-managerial positions.

Table 6: Level of agreement regarding knowledge and skills gained from the workshop

Statements	*SD (%)*	*D (%)*	*Uncertain (%)*	*A (%)*	*SA (%)*	*n*
1. The clinical supervision workshop gave me an understanding of:						
a. The general principles of CS	2	0	0	58	40	45
b. The various components of effective CS	2	2	7	47	42	45
c. CS as a major workforce development strategy	2	0	9	53	36	45
d. Issues relating to the specific application of CS in the D&A field	2	7	9	64	18	44
e. Organisational requirements for effective delivery of CS	2	2	18	53	25	44
2. The workshops gave me skills and confidence to write a CS policy and operational guidelines for my organisation	7	14	34	38	7	44
3. As a result of participation in the workshop, I intend to take a leading role in improving the delivery of CS in my workplace	2	9	25	51	13	45

Nevertheless, 67% of respondents reported that the workshop did indeed help to provide ideas / skills / strategies to improve the provision of CS in the workplace (see Figure 10). The following themes arose from respondents' open-ended examples of how the workshop was useful:

- The need for and value of CS was addressed
- Strategies for the development and implementation of CS policy were provided
- The structure of CS was clarified
- Information regarding the development of contracts / agreements was supplied
- Strategies and information for supervisors and potential supervisors were given
- The supervision triangle was a useful facilitative tool.

These themes were also evident from the comments in the post-workshop evaluation conducted by the trainers.

The 11% of respondents who indicated that the workshop was not helpful also reported that their workplace had an effective program already in place prior to the training. This finding could suggest that more advanced training may be needed for about 10% of the workforce.

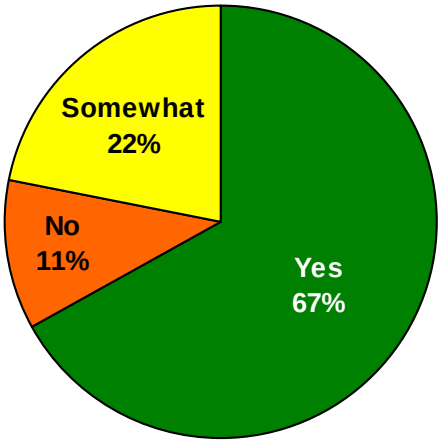

Figure 10: Perceptions regarding the usefulness of the training in improving the provision of CS in the workplace (n=45)

Training Outcomes

The evaluation questionnaire asked a series of questions regarding the provision of CS in the workplace before and after the training[5], in order to ascertain whether there were any differences which could be attributed to the training workshop.

Provision of Clinical Supervision in the Workplace Prior To and After Training

Nearly half (49%) the respondents indicated that their organisation offered effective CS, and 55% reported that a CS program was in place, prior to participating in the training workshop (see Table 7).

When asked to indicate the aspects of their CS programs that worked well, the following themes emerged from their qualitative responses:[6]

- sessions are held regularly; confidential
- characteristics of supervisor – external, experienced, supportive, non-political
- features of group supervision:
  - groups streamed according to skills and experience levels
  - structured sessions; clear goals
  - opportunity to exchange ideas and learn from each other

[5] Baseline data could not be collected before the training was conducted due to time constraints.

[6] 33 respondents provided qualitative responses for this question.

  - allows group discussion of cases and difference treatment approaches
  - team building; enhances team dynamics
  - peer support
- supervision contract – established timeframes and conditions of agreement
- choice between group or individual sessions or both
- supported by management
- validates skills and contributions

Qualitative statements from respondents:

"Clinically driven, management supported, adequate written resources, expectation of usefulness."

"Groups streamed according to skills and experience levels, fortnightly meetings, external supervisor – confidential, non-political."

"High standards of supervisor and clear goals. Good team dynamics."

"Regular meetings which were focussed and minuted with a flexible agenda."

Qualitative responses concerning the less effective aspects of the CS program were grouped by the following themes:[7]

- limited or no choice in the selection of supervisor and mode of supervision
- ineffective supervisor – unskilled; inexperienced (no AOD background); internal supervisor; trust issues
- timing inadequacies – insufficient duration; irregular; disruptions in scheduling due to work
- poor group supervision – trust issues; lack of individual attention; unstructured; group conflict
- geographical barriers – long distance travelling required to obtain supervision.

About 70% of respondents indicated that they did have access to a clinical supervisor, however only about a quarter (24%) indicated that the level of supervision was adequate to staff needs (see Table 7). In addition, just over half (53%) the respondents reported that clinical supervisors had the skills to deliver effective

[7] 29 respondents provided qualitative responses for this question.

supervision and 65% reported that staff received supervision on a regular basis. So even though most respondents had access to CS on a regular basis, and had clinical supervisors that have the necessary skills, it appears that the standard of supervision was inadequate for their needs, prior to participating in the training.

Table 7: Provision of clinical supervision in the workplace *prior to* and *after* training

Questions	*Prior to* participating in the CS workshop					*Since* participating in the CS workshop				
	Yes	*No*	*Somewhat*	*NA*	*n*	*Yes*	*No*	*Somewhat*	*NA*	*n*
1. Did/Does your organisation offer effective CS?	22 (49%)	8 (18%)	13 (29%)	2 (4%)	45	22 (51%)	9 (21%)	10 (23%)	2 (5%)	43
2. Was a CS program in place?	24 (55%)	8 (18%)	11 (25%)	1 (2%)	44	-	-	-	-	-
3. Has a CS program been effectively implemented?	-	-	-	-	-	12 (29%)	17 (40%)	10 (24%)	3 (7%)	42
4. When necessary, did/do staff have access to a clinical supervisor?	32 (71%)	4 (9%)	9 (20%)	0 (0%)	45	30 (68%)	5 (11%)	9 (21%)	0 (0%)	44
5. Was/Is the level of CS adequate to staff needs?	11 (24%)	14 (31%)	17 (38%)	3 (7%)	45	14 (32%)	11 (25%)	14 (32%)	5 (11%)	44
6. Did/Do clinical supervisors have the skills to deliver effective supervision?	24 (53%)	7 (16%)	10 (22%)	4 (9%)	45	22 (51%)	3 (7%)	11 (26%)	7 (16%)	43
7. Did/Do staff receive supervision on a regular basis?	29 (65%)	9 (20%)	6 (13%)	1 (2%)	45	24 (55%)	9 (20%)	10 (23%)	1 (2%)	44

Note: NA – Not applicable / don't know; Questions in past tense refers to circumstances before the training was conducted, and questions in present tense refers to the current situation.

Since participating in the training, respondents still reported similar issues regarding their CS program as they did before the training. Around half the respondents (51%) reported that their organisation offered effective CS and 29% indicated that a CS program has been implemented effectively (see Table 7). Furthermore, 68% reported having access to a clinical supervisor but again only 32% indicated that the level of supervision was adequate for their needs. Over half indicated that supervisors had the skills to deliver effective supervision and sessions were held on a regular basis.

Around a quarter of respondents (24%) indicated that there were several aspects of the current supervision program that worked well, including:

- having increased access to CS
- a wider selection of supervisors
- provision of external supervisors
- more frequently held supervision sessions

Regarding aspects that worked less well within the CS program since the training, 29% reported that their program remained unchanged or that more time was required to evaluate the changes made to the program. Others (18%) reported that the structural and staff changes created uncertainties for the CS program; management appeared to be unsupportive; supervision sessions were irregular or insufficient in duration; or a program was yet to be implemented due to workload and time restraints.

Qualitative statements from respondents:

"Need to have time to adapt to local needs in a changing environment – organisation structure not yet determined."

"Management didn't seem to be fully supportive of change."

"Not always as frequent as I would like – have been too busy clinically."

"Would prefer weekly or longer sessions fortnightly. Need more transparent planning process for future supervision and inclusion of supervisees in the process."

There were no statistically significant differences in responses pertaining to the provision of CS before and after the training. This is not unexpected given that participants were surveyed only 3 months after training, during which the year-end holidays coincided. Realistically, the impact of training can only be clearly observed after a much longer period of time (i.e. at least 12 months).

Changes to CS Program since Training

With respect to any changes made in the current CS program since the training had occurred, 14% reported in the affirmative, 43% indicated that changes are being planned, and 43% reported no changes made (see Figure 11). Some of the changes being planned included reviewing or developing the current CS policy and training more staff. Changes that had been implemented included having a wider selection of supervisors and increasing accessibility to CS.

These responses suggest that the CS training workshops had positively influenced nearly 60% of respondents to propose or make changes to their current CS programs.

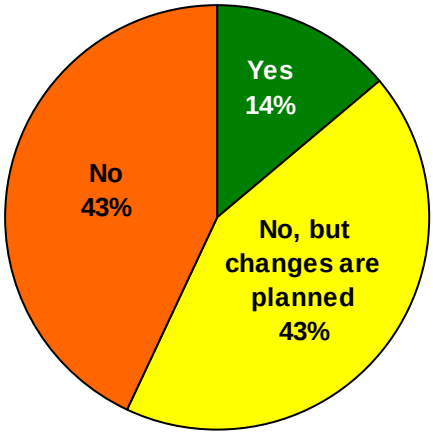

Figure 11: Participants' responses regarding changes to the clinical supervision program since training (n =42)

Barriers to Clinical Supervision

The survey also examined participants' perspectives regarding systemic barriers within the workplace that could affect participation in an effective CS program. Almost 70% of respondents indicated that there were systemic barriers to translating workers' intentions to participate into actual involvement in CS in their workplace (see Figure 12).

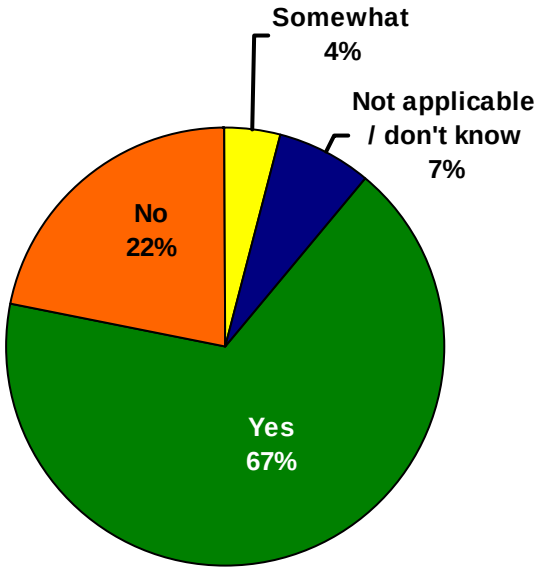

Figure 12: Participants' responses regarding systemic barriers to involvement in clinical supervision within the workplace (n =45)

The top systemic barriers in order of importance were:

i. an insufficient pool of suitably qualified supervisors
ii. a lack of understanding of the benefits of CS (by managers and/or workers)

Equal importance

iii. funding shortfalls
iv. geographical distances between supervisors and supervisees

Equal importance

v. a lack of commitment to program development.

Qualitative statements from respondents:

"I don't believe clinical supervision will improve due to lack of funding. Rather, a cheap version will be implemented to enable health services to 'tick the box' – done that."

"Management needs to support the providers of CS. It needs to be seen as an outcome of the agency. Does not get collected in any data process for some reason."

"The workshop was great - though there appears little opportunity to implement this systematically in practice."

Generally, respondents who reported that there were systematic barriers to CS in their organisation also indicated that there was no effective CS program in place. This was evident both before and after the training workshop. In addition, prior to participating in the workshop, *all* respondents who reported that the level of CS received was inadequate to their needs also reported that there were systemic barriers in the workplace. Since participating in the training, the majority (91%) who stated that the level of CS was inadequate for their needs and all respondents who indicated that supervision was not regularly conducted, also reported systemic barriers to supervision in the workplace. Clearly, these perceived barriers would initially need to be addressed before any effective CS program can be implemented.

Strategies to Implement Effective Clinical Supervision

The majority of respondents (73%) believed that there was opportunity to do more in terms of implementing effective CS in the workplace. Suggested strategies included the following:

- Increase understanding of the benefits of CS
- Increase management commitment towards the implementation and policy development of CS
- Provide appropriate training for supervisors and potential supervisors
- Offer the option of individual sessions
- Increase the duration of sessions
- Provide CS to all D&A workers designed specifically for their needs (e.g. dosing nurses, Indigenous workers, welfare workers)

Qualitative statements from respondents:

"Clinical supervision needs to be promoted more from management level. Some staff fail to understand the benefits. These are generally workers who have been in the workplace for a long time and haven't had clinical supervision through uni studies etc."

"Ensure supervisors have current knowledge of D&A policy, legislative requirements and key directions."

"Managers need to do the workshop and commit to implement a suitable program to address staff needs rather than put in place one program that all have to fit in."

"Access to current system is nurse-specific – there needs to be a more global access for allied health workers."

"Develop and implement a culturally appropriate supervision program for Aboriginal workers."

SUMMARY

The evaluation of the Drug and Alcohol Clinical Supervision Training Workshops found an overall positive impact from the training. The majority of respondents agreed that the training met their needs, the resources were valuable and easy to use, and the workshop was well facilitated. Most respondents also perceived that the training gave them an increased understanding and practical knowledge of CS, and equipped them with the skills to implement an effective CS program in their workplaces. Moreover, a large percentage of respondents reported that changes had been made or are being proposed for their CS programs, since participating in the training. Together, these findings indicate that the CS training has been effective in achieving its key objectives.

However, most respondents also identified barriers that were preventing their involvement in CS in their workplace. They also indicated that more strategies are required to ensure an effective CS program. As long as these barriers exist, the development and implementation of an effective CS policy and program will be hampered. Such barriers therefore need to be addressed in conjunction with the provision of additional CS training designed to meet the needs of all D&A workers in the field.

Training in and implementation of CS need to ensure that D&A workers and managers understand the definition of effective CS, the importance and benefits of CS, and the requirements for developing CS policy and implementing an effective CS program in D&A agencies.

APPENDIX 1

CLINICAL SUPERVISION TRAINING EVALUATION QUESTIONNAIRE

Clinical Supervision in the D&A Field:

Post-workshop questionnaire

This questionnaire relates to the Clinical Supervision Training Workshop which you attended in October / November 2005.

To maintain confidentiality, please provide an anonymous code on the first page of the survey using **your date of birth** and the **first four letters of your mother's maiden name**. If your mother's maiden name has less than 4 letters, use 'X' to complete the remaining code boxes.

> ***Example 1.***
> *The code for a person whose mother's maiden name was 'Smith' and who was born on 27th January would be **27SMIT**.*
>
> ***Example 2.***
> *The code for a person whose mother's maiden name was 'Howard' and who was born on 3rd February would be **03HOWA**.*
>
> ***Example 3.***
> *The code for a person whose mother's maiden name was 'Ng' and who was born on 16th May would be **16NGXX**.*

For more information about this survey, please contact:

NSW Health Centre for Drug & Alcohol

Doug Smyth ph 02 9424 5804

Tricia O'Riordan ph 02 9391 9338

National Centre for Education and Training on Addiction (NCETA)

Ann Roche ph 08 8201 7535

Chelsea Todd ph 08 8201 7543

Please return completed surveys to:

Attn: Doug Smyth/Trish O'Riordan

Centre for Drug and Alcohol

NSW Health

Locked Mailbag 961

North Sydney NSW 2059

E.g. 2 7 S M I T

Please complete your Anonymous Code: | | | | | | |

A: KNOWLEDGE & SKILLS ABOUT CLINICAL SUPERVISION IN THE D&A FIELD

Please read each statement carefully and circle the number that best describes your response.

A1. Knowledge & Skills Gained from the Workshop	**Strongly Disagree**	**Disagree**	**Uncertain**	**Agree**	**Strongly Agree**
1. The clinical supervision workshop gave me an understanding of:					
(a) the general principles of clinical supervision	1	2	3	4	5
(b) the various components of effective clinical supervision	1	2	3	4	5
(c) clinical supervision as a major workforce development strategy	1	2	3	4	5
(d) issues relating to the specific application of clinical supervision *in the D&A field*	1	2	3	4	5
(e) organisational requirements for effective delivery of clinical supervision	1	2	3	4	5
2. The workshops gave me the skills and confidence to write a clinical supervision policy and operational guidelines for my organisation	1	2	3	4	5
3. As a result of participation in the workshop I intend to take a leading role in improving the delivery of clinical supervision in my workplace	1	2	3	4	5

A2. Perceived Benefits of Clinical Supervision

In your view, what are the 3 most important benefits of clinical supervision to ***clinical / work practice?***

1. _____
2. _____
3. _____

In your view, what are the 3 most important benefits of clinical supervision for ***worker wellbeing?***

1. _____
2. _____
3. _____

In your view, what are the 3 most important benefits of clinical supervision for ***client outcomes?***

1. _____
2. _____
3. _____

A3. The Workshop & Resources	**Strongly Disagree**	**Disagree**	**Uncertain**	**Agree**	**Strongly Agree**
1. I felt my needs were met in the workshop	1	2	3	4	5
2. The workshop was well facilitated	1	2	3	4	5
3. The workshop improved my understanding clinical supervision benefits	1	2	3	4	5
4. The ***CDA Participant Handbook*** will be a valuable resource	1	2	3	4	5
5. The ***CDA Participant Handbook*** appears to be easy to use	1	2	3	4	5
6. ***NCETA's Clinical Supervision Kit*** will be a valuable resource	1	2	3	4	5
7. ***NCETA's Clinical Supervision Kit*** seems to be easy to use	1	2	3	4	5

B. PROVISION OF CLINICAL SUPERVISION IN YOUR WORKPLACE

PRE-WORKSHOP

PRE-WORKSHOP

B1. *Prior to* participating in the clinical supervision training workshop:

	Yes	No	Somewhat	Not applicable / don't know
1. Did your organisation offer staff effective clinical supervision?	❑ 0	❑ 1	❑ 2	❑ 3
2. Was a clinical supervision program in place?	❑ 0	❑ 1	❑ 2	❑ 3

If **Yes** or **Somewhat**

(a) What worked **well** and why? ……

……

……

(b) What worked **less well** and why? ……

……

……

	Yes	No	Somewhat	Not applicable / don't know
3. When necessary, did staff in your organisation have access to a clinical supervisor?	❑ 0	❑ 1	❑ 2	❑ 3
4. Was the level of clinical supervision adequate for staff needs?	❑ 0	❑ 1	❑ 2	❑ 3
5. Did clinical supervisors have the skills to deliver effective supervision?	❑ 0	❑ 1	❑ 2	❑ 3
6. Did staff receive supervision on a regular basis?	❑ 0	❑ 1	❑ 2	❑ 3

POST-WORKSHOP

POST-WORKSHOP

B2. *Since* participating in the clinical supervision training workshop:

	Yes	No	Somewhat	Not applicable / don't know
1. Does your organisation offer staff effective clinical supervision?	❑ 0	❑ 1	❑ 2	❑ 3
2. Has a clinical supervision program been effectively implemented?	❑ 0	❑ 1	❑ 2	❑ 3

If **Yes** or **Somewhat**

(a) What works **well** and why? ……

……

……

(b) What works **less well** and why? ……

……

……

(c) Have any changes been made to the clinical supervision program?

❑ 0 No

❑ 1 No, but changes are planned *(please specify planned changes)* ……

……

❑ 2 Yes *(please specify changes made)* ……

……

***POST**-WORKSHOP*

	Yes	No	Somewhat	Not applicable / don't know
3. When necessary, do staff in your organisation have access to a clinical supervisor?	❑ 0	❑ 1	❑ 2	❑ 3
4. Is the level of clinical supervision adequate for staff needs?	❑ 0	❑ 1	❑ 2	❑ 3
5. Do clinical supervisors have the skills to deliver effective supervision?	❑ 0	❑ 1	❑ 2	❑ 3
6. Do staff receive supervision on a regular basis?	❑ 0	❑ 1	❑ 2	❑ 3

B3. Barriers and Facilitators to Clinical Supervision	Yes	No	Somewhat	Not applicable / don't know
1. In general, in your workplace are there any systemic barriers to translating workers' ***intentions*** to participate in clinical supervision into ***actual involvement*** in clinical supervision?	❑ 0	❑ 1	❑ 2	❑ 3

If **Yes**, please rank the **top 3** barriers from the following list, using the numbers **1 - 3** in order of decreasing importance (1 = 1st most important, 2 = 2nd most important, and 3 = 3rd most important).

☐	Lack of understanding of the benefits of clinical supervision (by managers and/or workers)	☐	Conflict between clinical and managerial staff (i.e., blurred administrative and clinical roles)
☐	Lack of commitment to program development	☐	Different conceptual frameworks (i.e., common language) among supervisors, supervisees and managers
☐	Lack of training for supervisors	☐	Funding shortfalls
☐	Insufficient pool of suitably qualified supervisors	☐	Other/s (*please specify*)
☐	Geographical distance between supervisors and supervisees		……..

	Yes	No	Somewhat	Not applicable / don't know
2. Do you believe there is an opportunity to do more (in regard to clinical supervision) in your workplace?	❑ 0	❑ 1	❑ 2	❑ 3

If **Yes**, please indicate what course of action should be taken to implement more effective clinical supervision.

……

……

……

	Yes	No	Somewhat	Not applicable / don't know
3. Did the workshop help to provide ideas / skills / strategies to improve the provision of clinical supervision in your workplace?	❑ 0	❑ 1	❑ 2	❑ 3

If **Yes**, please provide examples of how the workshop was useful.

……

……

……

4. Any other comments?

……

……

……

……

C. DEMOGRAPHICS

1. Are you a manager / supervisor (administrative *not* clinical)? Yes ❑ 1 No ❑ 2

2. Are you currently providing ***clinical*** supervision to D&A staff? Yes ❑ 1 No ❑ 2

If **Yes**

(a) Is the clinical supervision you provide mainly: One-on-one ❑ 1 Group ❑ 2

(b) How many D&A workers are you supervising? _____

(c) On average, how frequent are your supervisory sessions?

Less than monthly	Every month	Every fortnight	Weekly	More than weekly
❑ 1	❑ 2	❑ 3	❑ 4	❑ 5

(d) On average, how long are your supervisory sessions?

< 30 mins	30-60 mins	60-90 mins	> 90 mins
❑ 1	❑ 2	❑ 3	❑ 4

If **No**, please state reason/s.

……..……..

……..……

3. What type of organisation do you work for? ❑ 1 Government ❑ 2 Non-government

4. Which of the following services does your organisation provide for people with D&A problems: *(please tick all that apply)*

❑ 1 Face-to-face specialist treatment services
❑ 2 Pharmacotherapy maintenance programs
❑ 3 Inpatient rehabilitation programs
❑ 4 Detoxification programs
❑ 5 Diversion programs
❑ 6 Outpatient services
❑ 7 Crisis intervention
❑ 8 Therapeutic communities
❑ 9 Accommodation
❑ 10 Brief counselling
❑ 11 Other (*please specify*) ……..

5. How long have you been working for this organisation? …….years ……..months

6. How long have you been working in the D&A field? …….years ……..months

7. Please indicate the type of geographic location in which your workplace is situated.

❑ 1 Metropolitan ❑ 2 Regional ❑ 3 Rural / Remote

8. Please indicate your age.

Under 25	26-35	36-45	46-55	56-65	Over 65
❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6

9. Please indicate your gender. ❑ 1 Male ❑ 2 Female

10. Are you working full-time or part-time? ❑ 1 Full-time ❑ 2 Part-time

11. What is your occupation?

❑ 1 D&A worker
❑ 2 Nurse
❑ 3 Psychologist
❑ 4 Social worker
❑ 5 Doctor
❑ 5 Doctor
❑ 6 Other (*please specify*) ……

Thank you for your time, it is greatly appreciated.

Reminder – have you completed your anonymity code on the front page?

Please return completed surveys to:

Attn: Doug Smyth / Trish O'Riordan
Centre for Drug and Alcohol
NSW Health
Locked Mailbag 961
North Sydney NSW 2059