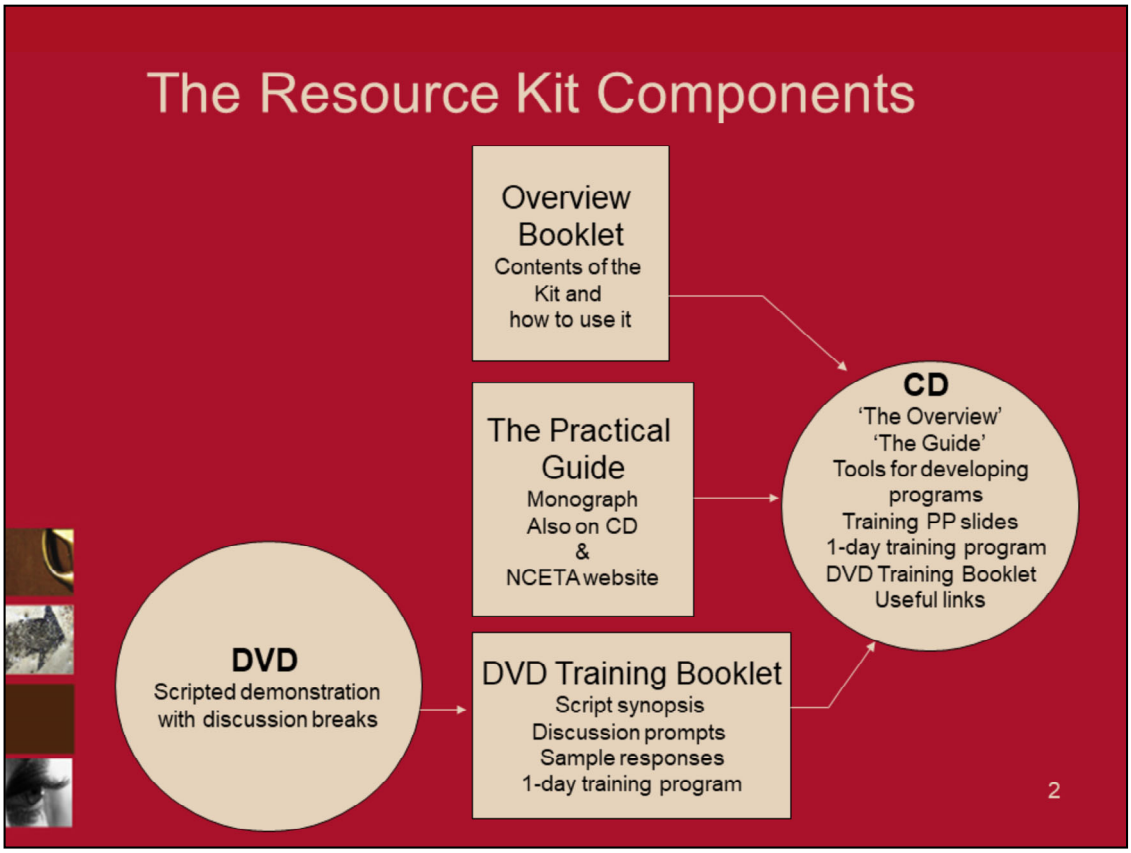
The National Centre for Education and Training on Addiction at Flinders University (NCETA), Adelaide, Australia has focussed in the recent years on ways to build the capacity of the workforce involved in dealing with alcohol and drug problems. The concept for the Clinical Supervision Kit came from our growing awareness of the need to provide more support to the AOD workforce.

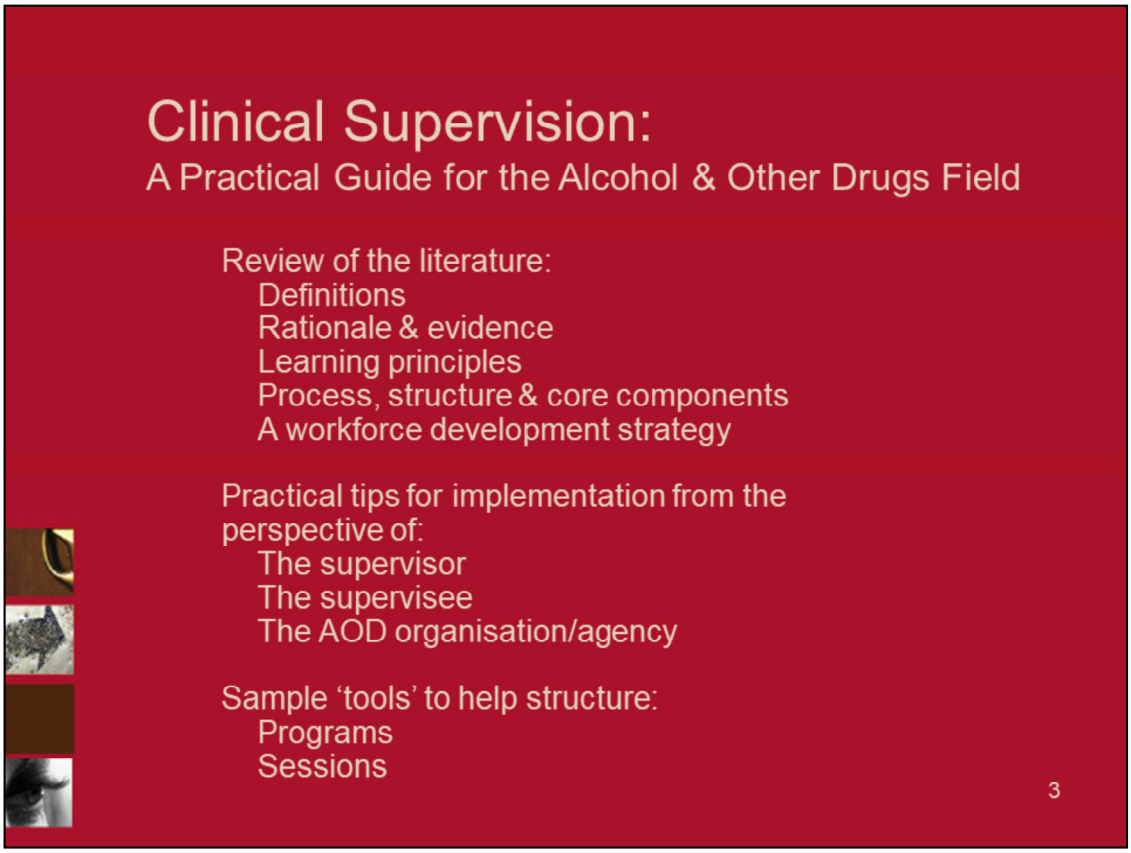
For those working in a clinical capacity it has become increasingly apparent that there was little support available in terms of structured clinical supervision. Moreover, it was clear from anecdotal reports that obtaining such support could be challenging and at times down right difficult. It was evident that several things were needed simultaneously. Firstly, there was a need to increase the perception and understanding of the relevance and importance of clinical supervision. Secondly, the resources to make clinical supervision feasible were needed, but first a clear understanding of what quality clinical supervision was, and how it might be provided in a resource-limited field such as the AOD sector, was the top priority. Finally, some clear Guidelines about what quality clinical supervision might look like and some assistance in training others to disseminate this information was also required.

In developing this Kit and in producing its component parts we have attempted to meet all the above needs. The kit is a 'tool', in and of itself, through which we hope to raise awareness of the importance of clinical supervision. The Kit provides content on the theoretical and conceptual issues entailed in clinical supervision from the perspective of a potential supervisor, supervisee and the organisation/s in which they might work. The Kit also contains practical resources to assist each of the above players to implement their preferred mode of clinical supervision. Finally, it also offers a set of training materials, complete with demonstrated simulations of supervision with guided instruction notes, to assist wide scale distribution and implementation of this important workforce development strategy.



This slide illustrates the various components of the Kit. The Overview Booklet, the 'Guide', and the DVD Training Booklet are also replicated electronically on the CD. The PowerPoint slides are located on the CD only (i.e. there is no hard/paper copy of the slides, allowing users of the Kit to select their own format if they wish to print the slides).

The contents of the 'Guide' are illustrated on the following slide. All parts of the Kit are based on the contents of the Guide.



The Guide is available as a monograph within this Kit or can be located on the CD.

'The Guide' is a comprehensive review of the clinical supervision literature as it pertains to generic counselling, with specific reference and extrapolation to the AOD field where possible. Practical recommendations are made for both establishing a clinical supervision program and for conducting supervision sessions. Sample worksheets are provided for use in structuring supervision sessions at the back of The Guide. The demonstration DVD, training program, and PowerPoint slides provided in this Kit are all based on 'The Guide'.

Part 1 of The Guide: "Background", provides an understanding of what is meant by clinical supervision, why it is so important, and how it relates to workforce and professional development.

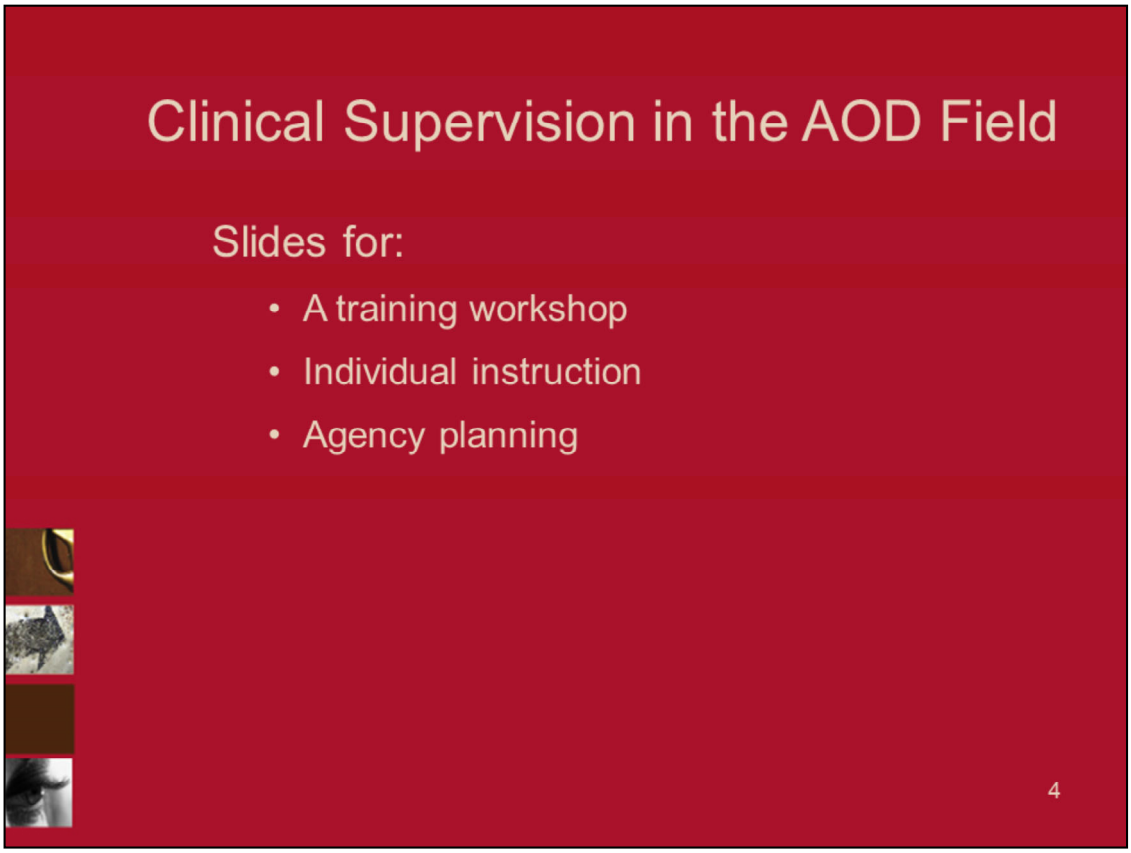
Part 2: "The Supervisory Relationship": Section 1 "The Supervisor" discusses the main foci of supervision, features of a successful supervisor, belief building, the content of supervision, principles of learning and supervision, training and observation methods, group work and training effectiveness.

Part 2: "The Supervisory Relationship": Section 2 "The Supervisee" outlines a number of key points that may help in developing a productive relationship with a supervisor. The topics covered in this section include what to expect, choosing a supervisor, belief building, planning supervision, training and observation methods, and remote supervision.

Part 2: "The Supervisory Relationship": Section 3 "The Organisation" includes the benefits and barriers of supervision, policy development, facilitators for programs, and barriers for programs.

Part 3: "Developing and Implementing a Program" covers the principles and processes of setting up a program, overcoming reluctance to engage with supervision, finding and cultivating supervisors, writing a supervision policy, evaluating what has been

put in place and forming partnerships.

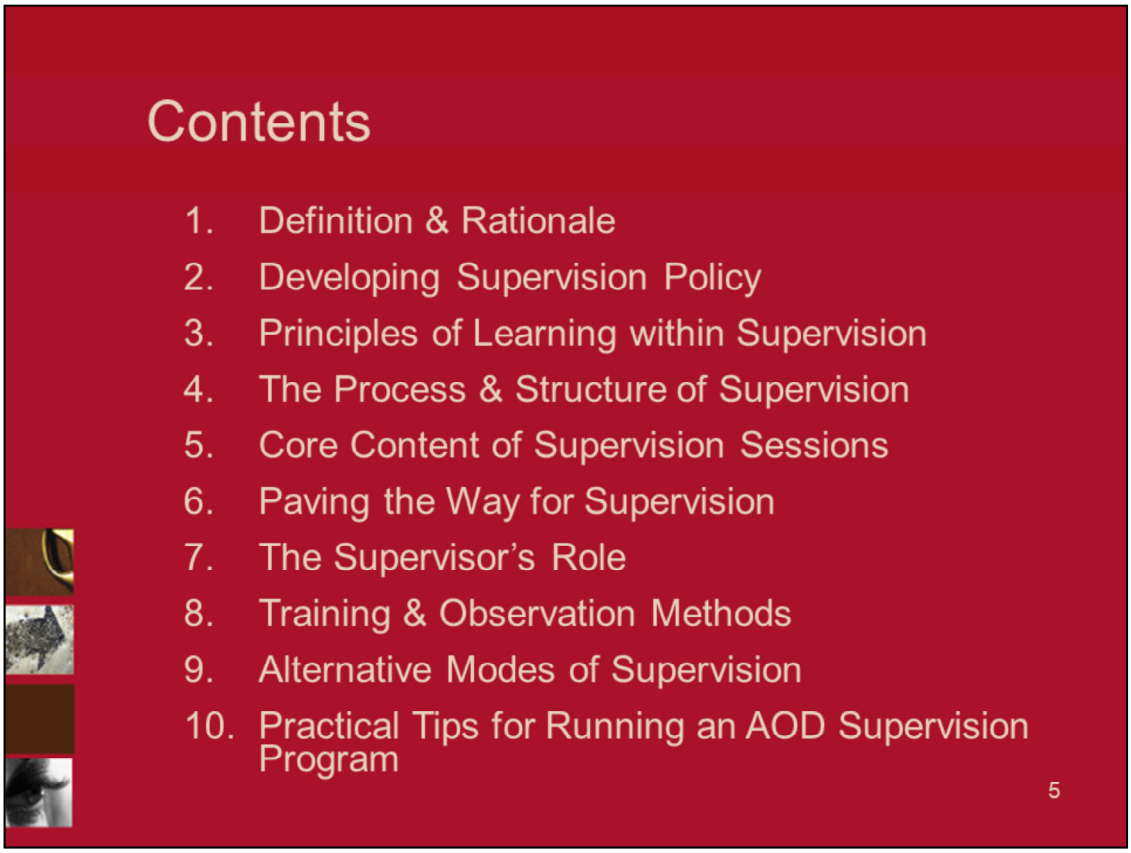


The PowerPoint slides can be used in various, complementary ways. Potential uses include:

1. The education and professional development of any interested individual; i.e. viewed alone in the first instance
2. Orientating a worker or supervisor to supervision
3. Assistance in structuring supervision sessions
4. Background briefing for a working group developing a supervision program
5. Structuring a clinical supervision training workshop/program.

These slides are designed to accompany a sample one-day training program (a copy of the training program can be found in the Training Booklet that supplements the demonstration of clinical skills on the DVD, in the Overview booklet, and on the CD).

These slides closely follow the content of 'The Guide'. However, you may wish to add to or modify the slides to reflect your particular training needs (e.g. type of personnel attending; special characteristics of your workplace; amount of time allocated for training). Instructions on how to modify PowerPoint slides can be found at the rear of the Overview booklet (Appendix II).

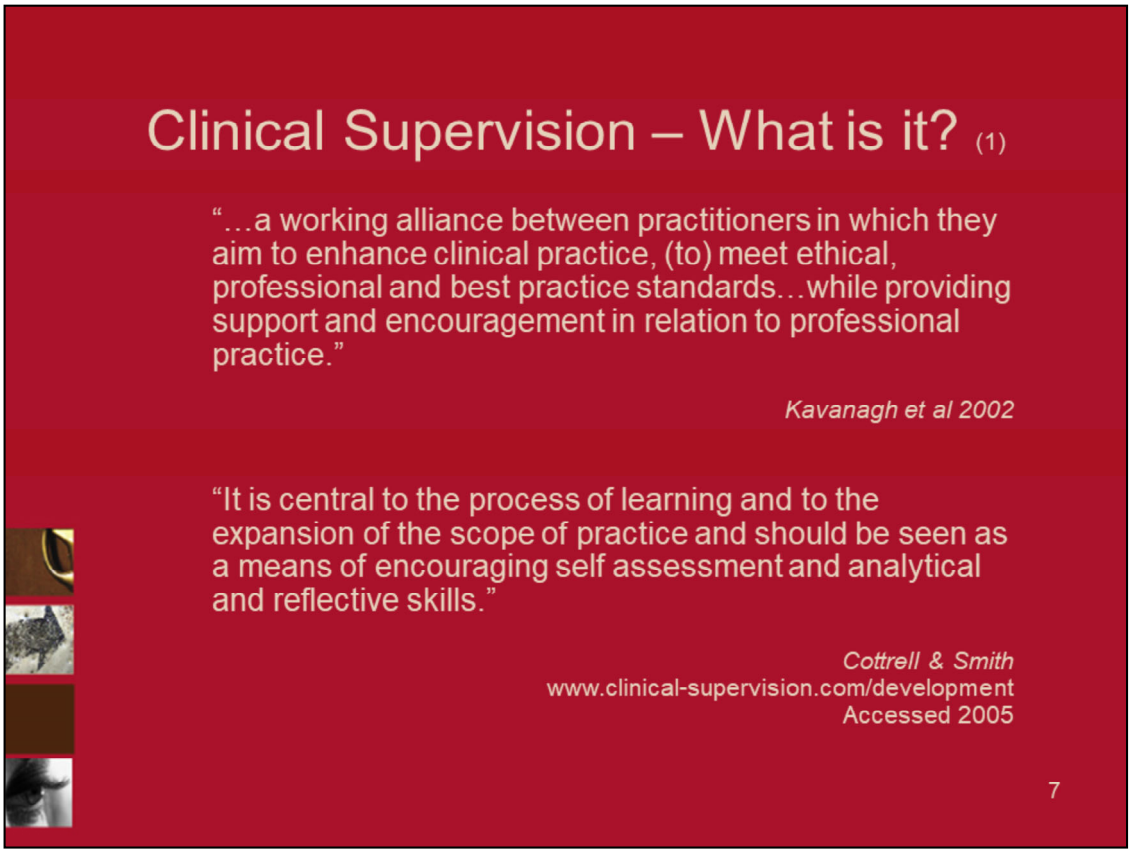


The PowerPoint slides are presented in 10 sections. These sections closely follow the segments of the sample one-day training program provided (a copy of the training program can be found in the Training Booklet that supplements the demonstration of clinical skills on the DVD, in the Overview booklet, and on the CD).

All 10 sections do not have to be used, or presented in a sequential manner. Rather, some parts of some sections only may be of relevance to your needs.

1. Definition & Rationale

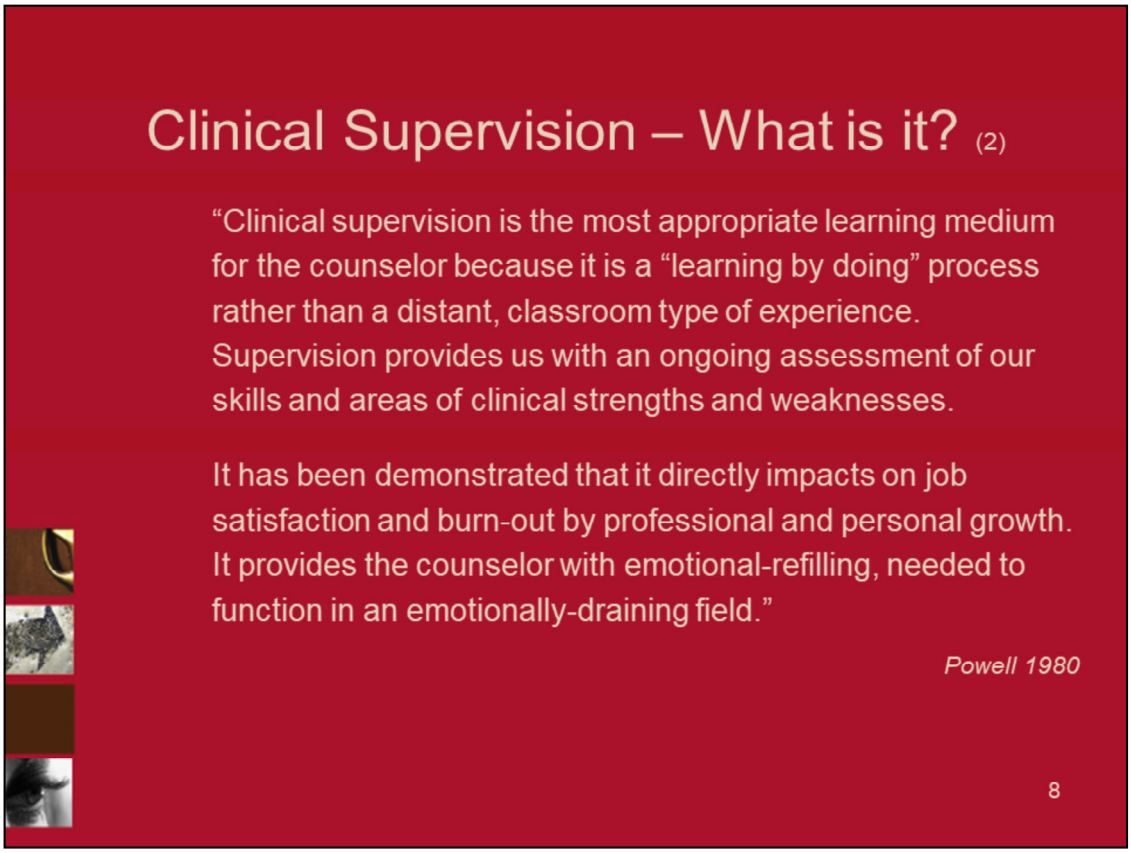
Clinical Supervision



The emphasis in this Resource Kit is on supervision with regard to the counselling of AOD clients. However, many of the principles covered are also germane to any contact with clients that requires good communication and relationship skills (e.g. dispensing pharmacotherapies to clients, exchanging syringes, administering a screening or assessment, giving harm minimisation advice).

Kavanagh, D.J., Spence, S.H., Wilson, J., & Crow, N. (2002). Achieving effective supervision. *Drug and Alcohol Review, 21,* 247-252.

Cottrell, S & Smith, G. The development of models of nursing supervision in the UK. *www.clinical-supervision.com/supervision.*



This quote introduces the theme that supervision is a form of 'adult education' based on the principles of experiential learning. This theme is returned to later, in more detail, in the section, "Principles of learning and supervision".

Powell, D.J. (1980). *Clinical supervision: Skills for substance abuse counselors* (Trainee's Workbook). New York: Human Sciences Press.

In a recent book on clinical supervision (Falender & Shafranske, 2004, p3) endorsed by the American Psychological Association, the following definition was given (some trainers may wish to make a slide of this quote):

"Supervision is a distinct professional activity in which education and training aimed at developing science-informed practice are facilitated through a collaborative interpersonal process. It involves observation, evaluation, feedback, the facilitation of supervisee self-assessment, and the acquisition of knowledge and skills by instruction, modeling, and mutual problem solving. In addition, by building on the recognition of the strengths and talents of the supervisee, supervision encourages self-efficacy. Supervision ensures that clinical consultation occurs in a competent manner in which ethical standards, legal prescriptions and professional practices are used to promote and protect the welfare of the client, the profession, and society at large."

Falender, C A & Shafranske, E P (2004). *Clinical Supervision: A competency-based approach.* American Psychological Association, Washington DC.

Clinical Supervision – What is it? (3)

- An in-depth regular exploration of the supervisee's work with clients in a systematic & planned way
- It integrates into practice:
  - self-understanding
  - relevant theory
  - up-to-date knowledge
  - skill development

9

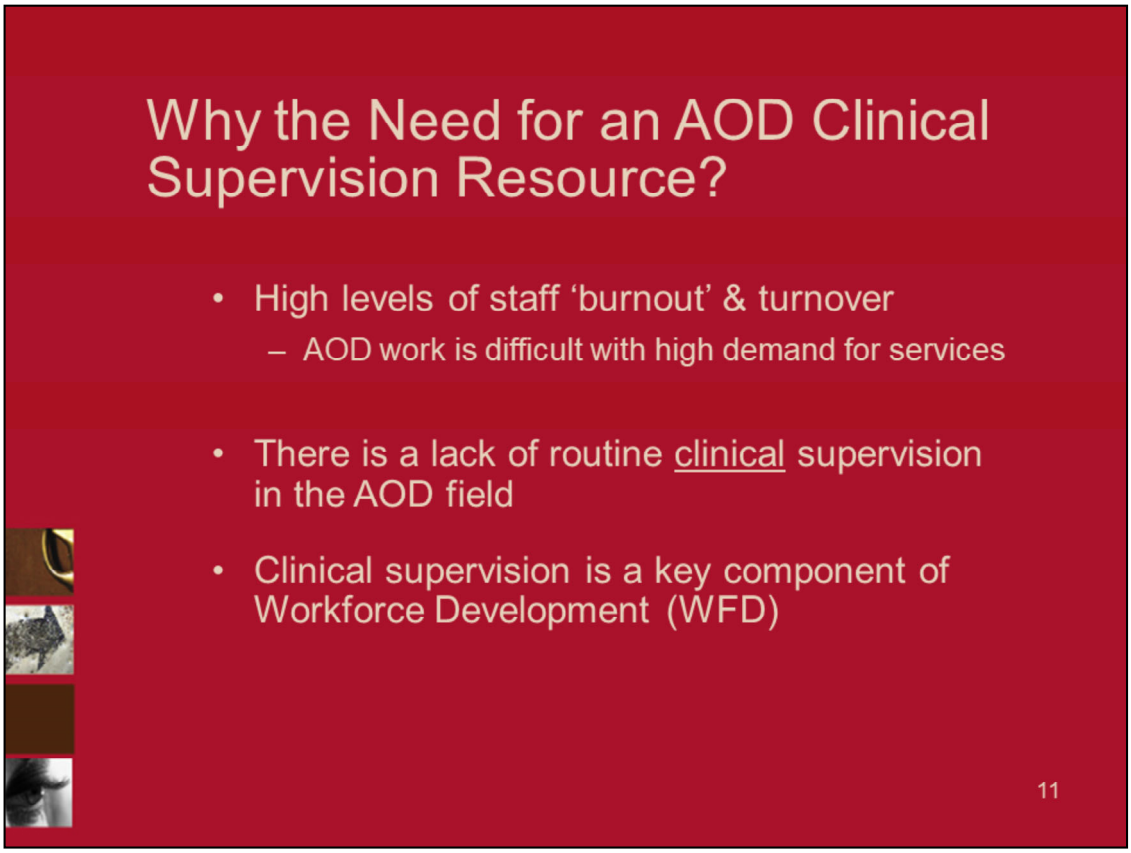
Supervision is not fulfilling its potential unless the clinician explores new perspectives and advances his/her knowledge and skills. Occasionally supervision can become a 'cosy club of complicity' in which no more than a superficial review of cases occurs.

It is acknowledged that clinical supervision will often be conducted by managers within organisations that have limited resources (the norm for many non-government organisations). On occasions both a worker and manager may be comfortable and satisfied with the dual roles of operational and clinical supervision, provided clarity is retained with respect to the different functions (i.e. both parties are clear which 'hat' is being worn at any given time).

However, there remains much potential for a blurring of boundaries between operational concerns and clinical/professional development. Therefore, the ideal situation is to have supervisors that are external to an organisation, and yet have some knowledge of the working of that organisation/agency (achieved as part of an orientation when contracted to provide supervision).

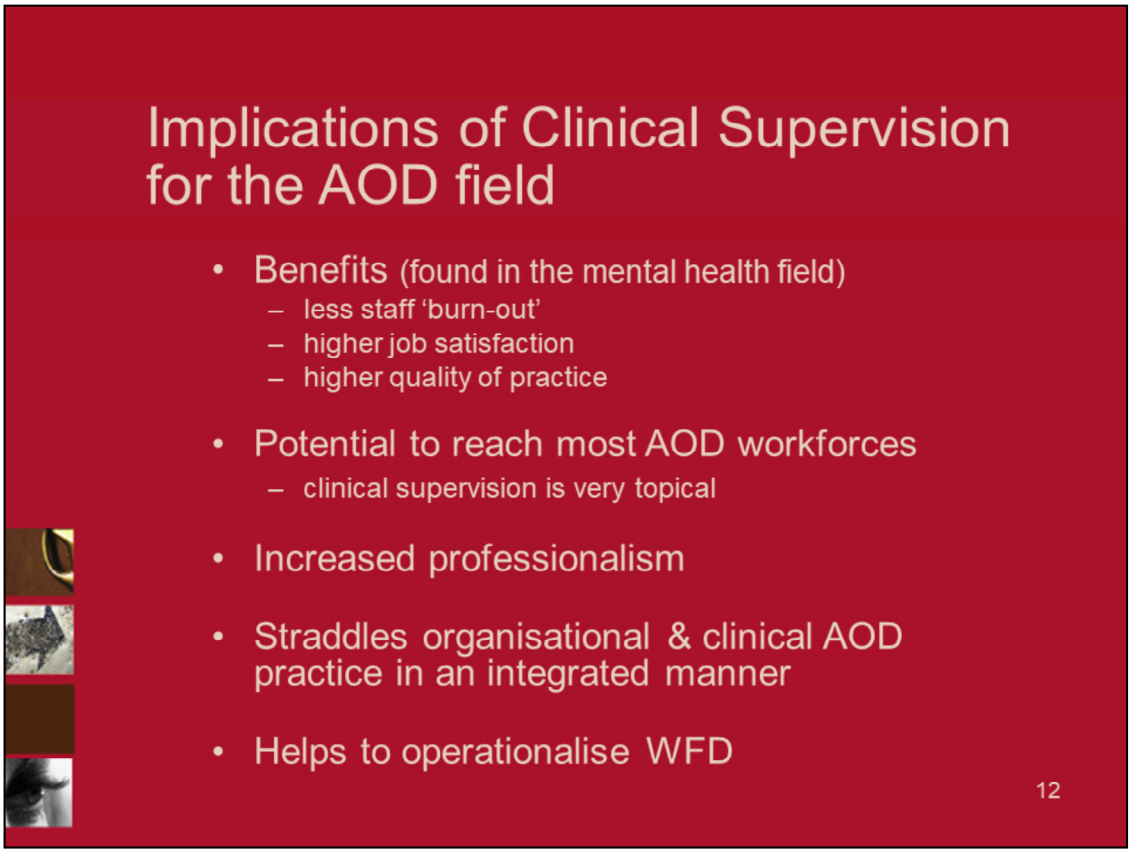
Whilst clinical supervision does not have as a primary aim the satisfying of worker obligations in an operational sense, greater adherence to organisational requirements may occur as a by-product of clinical supervision.

Hart, G.M. (1982). *The process of clinical supervision*. Baltimore: University Park Press.

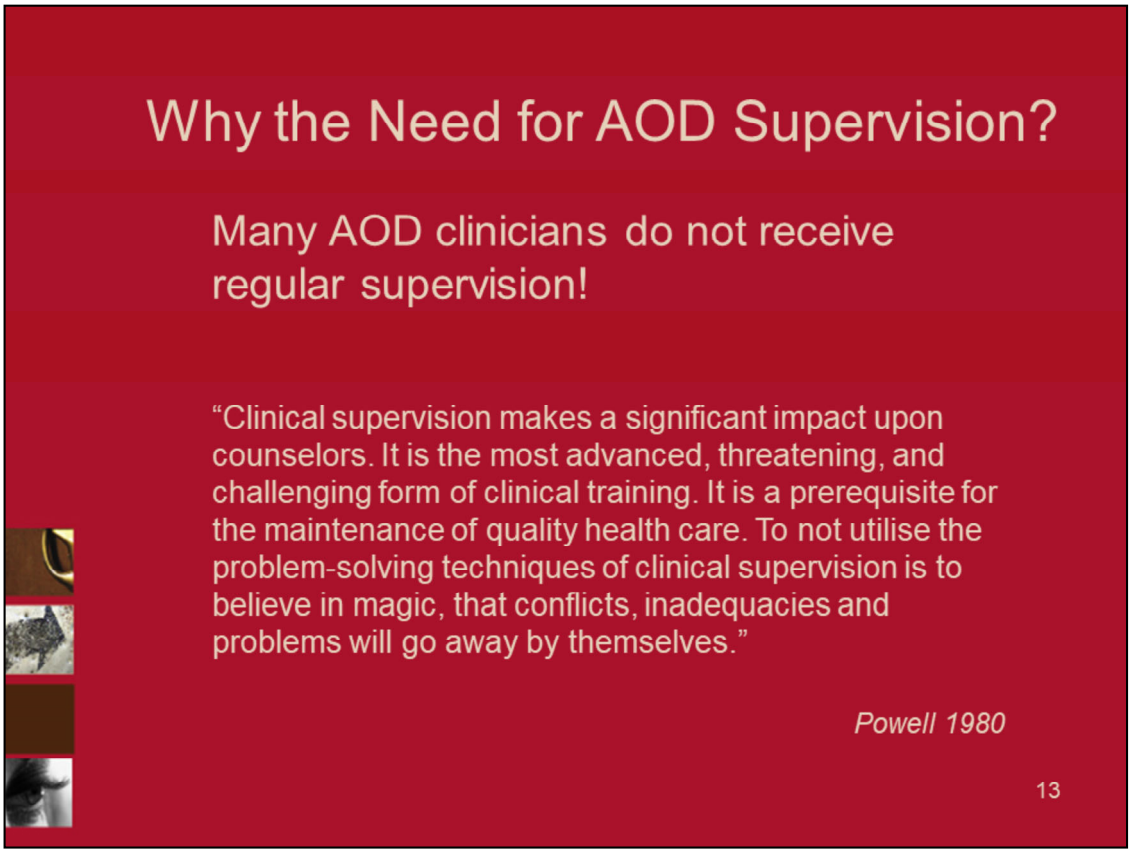


1. High levels of burnout, job dissatisfaction and turnover are endemic in the mental health field and in the AOD area.
2. The websites of some professional bodies contain information on the clinical supervision requirements of its members.
3. Workforce Development can be defined as:

   "… a broad term used to encapsulate a number of key factors pertaining to individuals, the organisations within which they operate and the systems that surround them. Workforce development is a multifaceted approach which addresses the range of factors impacting on the ability of the alcohol and other drug workforce to function with maximum effectiveness." (Skinner, Freeman, Shoobridge, & Roche, 2003, p.5). (See 'The Guide' in this Kit for further elaboration and references.)



1. The benefit of clinical supervision has been established mainly in relation to psychiatric mental health settings, and to a lesser degree in the AOD field.
2. There appears to be belated recognition in the AOD field that clinical supervision is essential to ensuring quality outcomes for staff and clients. The current interest in the topic suggests that program managers are ready and willing to establish supervision protocols and programs where they do not exist, and/or to make clinical supervision an activity distinct from line management/supervision.
3. Clinical supervision is an enterprise that helps to foster good communication and relationships between clinical and managerial staff. It is a win-win scenario in which clinicians feel that a duty of care is being exercised towards them and an opportunity for professional development provided, whilst managers can expect higher quality performance from staff and might possibly retain those staff longer.
4. WFD can appear to be a somewhat elusive, all encompassing, concept. Therefore, concrete examples such as the benefits of clinical supervision help to progress research into, and the application of, WFD.



The rationale for clinical supervision needs to be reiterated in various places that staff will access; e.g.

- an organisation's/agency's clinical procedures manual
- at staff meetings
- at training workshops
- during line-management supervision
- within initial clinical supervision sessions.

Powell, D.J. (1980). *Clinical supervision: Skills for substance abuse counselors* (Trainee's Workbook). New York: Human Sciences Press.

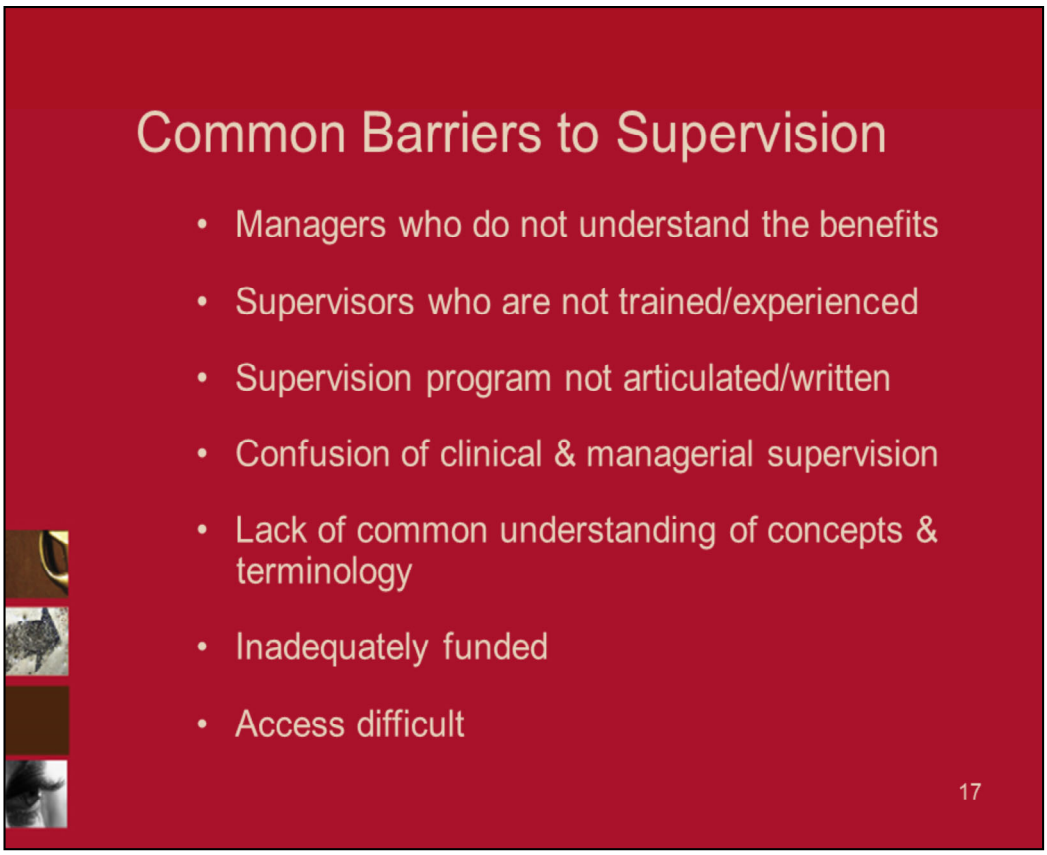
The claimed benefits are from research in the mental health field. It seems reasonable to generalise to the AOD field given that clinical supervision is a generic process, with only the details differing across areas of (overlapping) mental health.

Given that the benefits above are interrelated, it is likely that quality clinical supervision will consistently contribute to a whole ‘package’ of good outcomes. Having said that, supervision cannot be expected to be a panacea for workers in a dysfunctional organisation with other impediments to ‘best practice’.

2. Developing a Supervision Policy

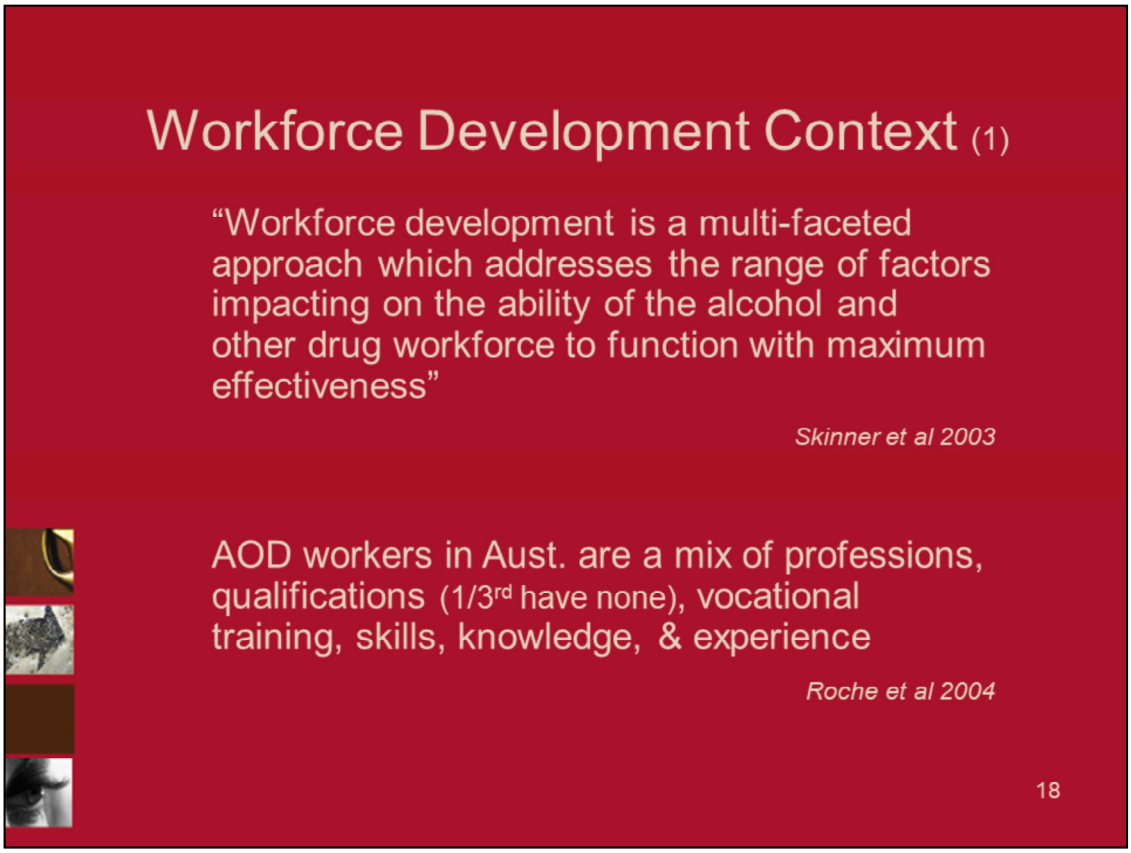
A Workforce Development Context

A supervision policy is best incorporated into an organisation's clinical procedures manual (or its equivalent), so that it is consistent with all related policy.



Many barriers relate to a lack of understanding of the value, goals and process of clinical supervision. A program designed to orientate managers to clinical supervision and to help them in developing a program of supervision is, therefore, of critical importance.

Supervisors for the AOD field may need to be recruited from other fields, and trained in groups, to ensure that they are familiar with the nuances of AOD work.

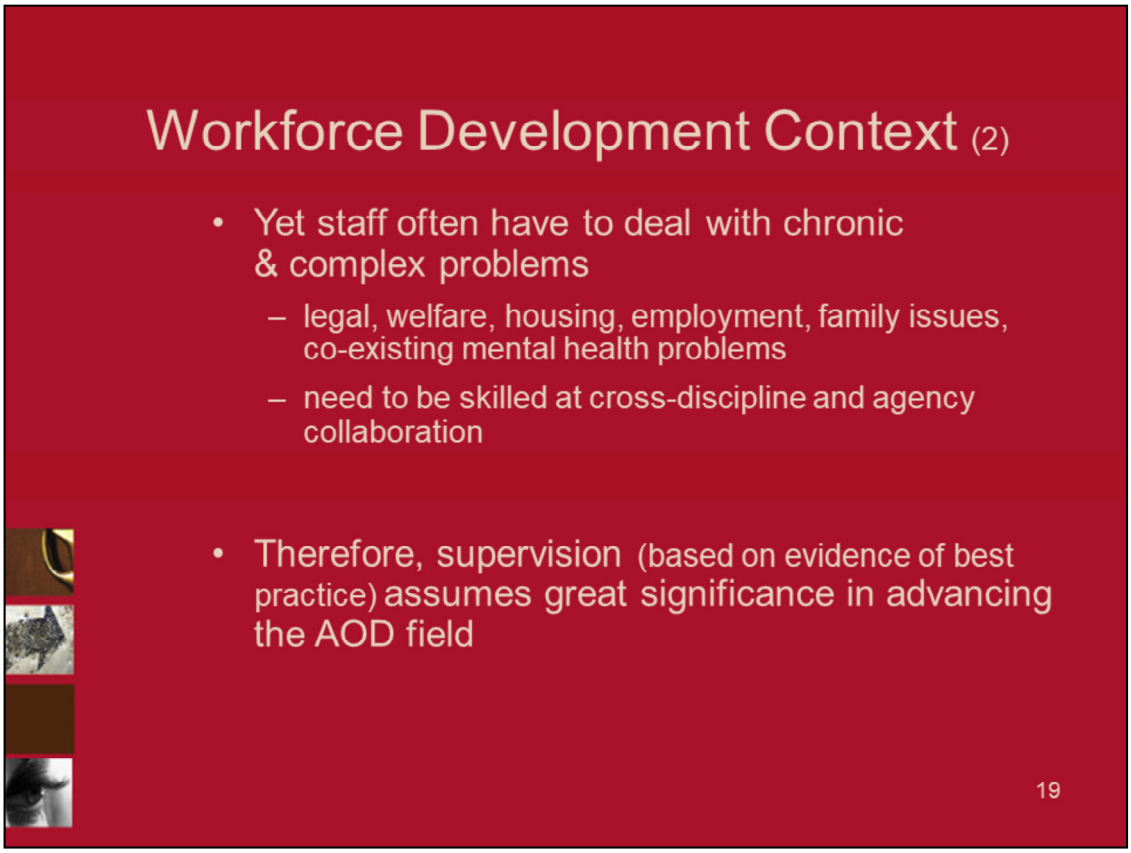


Clinical supervision is one aspect of a comprehensive approach to workforce development.

The varied nature of the AOD workforce will, in part, explain the lack of clinical supervision in the field. Quality supervision could go a long way in compensating for any lack of adequate training amongst AOD staff.

Roche, A., O'Neill, M., & Wolinski, K. (2004). Alcohol and other drugs specialist treatment services and their managers: findings from a national survey. *Australian and New Zealand Journal of Public Health, Vol 28 (3), pp. 252-258.*

Skinner, N., Freeman, T., Shoobridge, J., & Roche, A.M. (2003). *Workforce development and the alcohol and other drugs field: A literature review of key issues for the NGO sector.* National Centre for Education and Training on Addiction, Flinders University, South Australia.

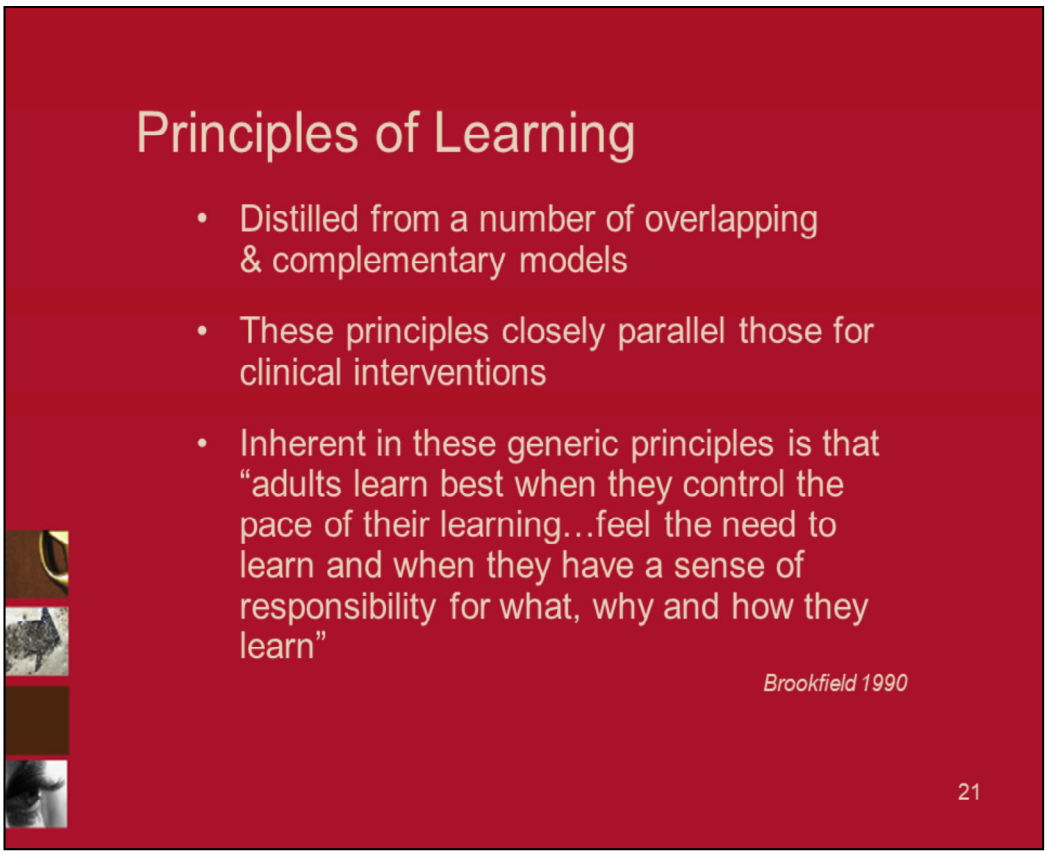


Given the extreme challenges of AOD work, clinical supervision is an imperative for optimal outcomes for the individual worker, the clients, the agency, umbrella organisations, and the wider community. That is, supervision is critical to a 'systems approach' in responding to AOD issues.

3. Principles of Learning within Supervision

Adult Self-directed Learning
Problem/Case based Learning
Observational Learning (Modelling)
Guided Skill Rehearsal

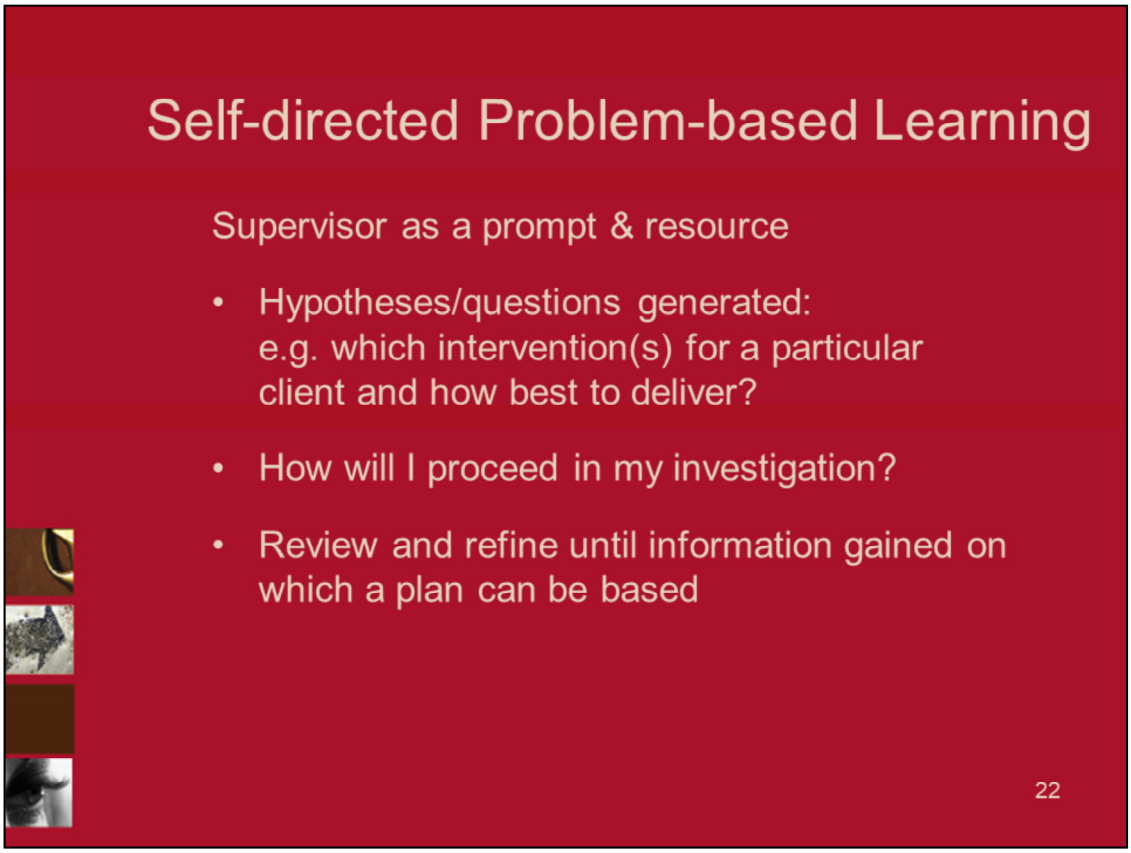
20



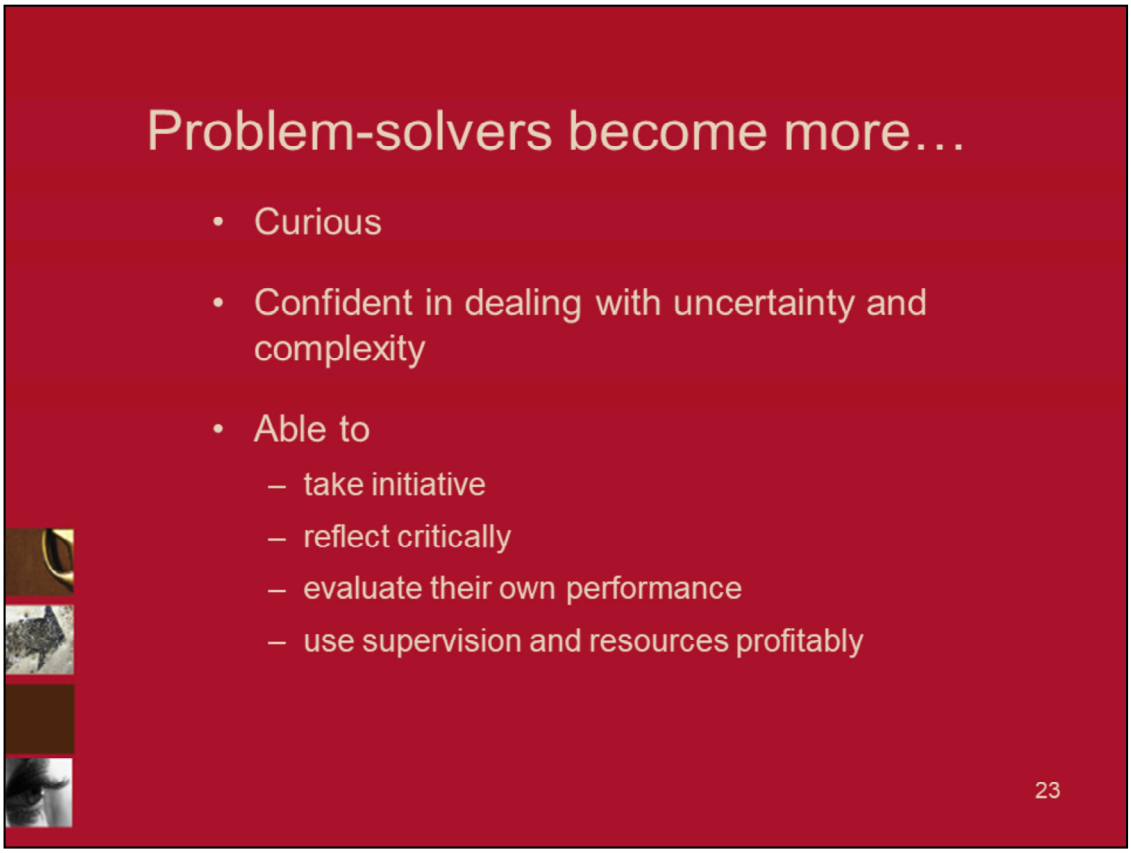
Common models are not mutually exclusive. An eclectic use of models and strategies is appropriate, provided all parties know what is happening and why.

It is interesting that the 'adult learning' principles first espoused three decades ago now appear to be incorporated into the education of children: i.e. when learners are highly active participants determining some of the content and processes involved in their courses, they acquire knowledge and skills rapidly and effectively.

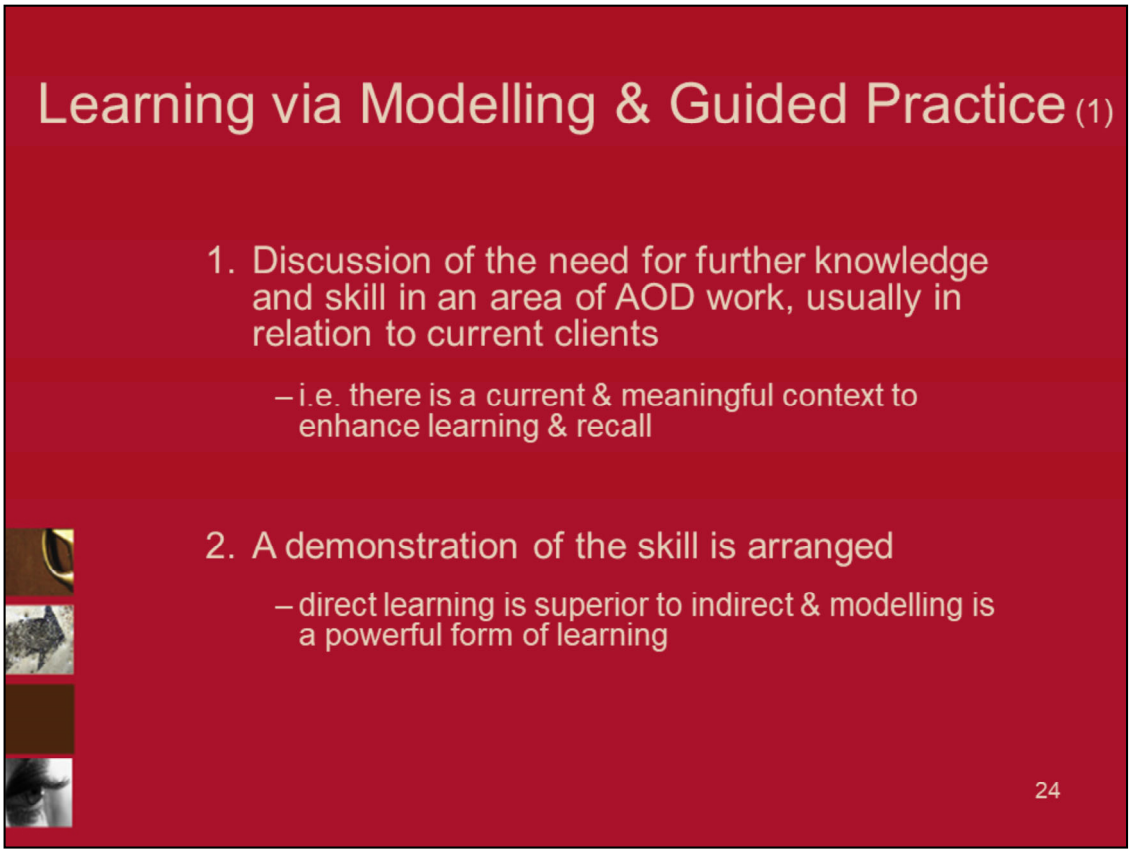
Brookfield, S. D. (1990). *Understanding and facilitating adult learning.* San Francisco, Jossey-Bass Publishers.



In a self-directed problem-based approach, the supervisor may initially play a critical role in helping the supervisee determine the focus of their inquiry in relation to cases, but having done that will then assume a less prominent support role as the supervisee then directs their own learning.



The claimed benefits of a problem-based learning approach parallel the evidence that problem-solving is a core strategy in equipping clients to initiate and maintain change in their AOD use, and to cope better in general.



Learning located within a meaningful context is sometimes referred to as 'semantic-based learning'.

The 'skills model': a detailed step-by-step guide (see Powell & Brodsky, 1998: Table 2.2 in 'The Guide').

The intention is not for the supervisee to replicate the supervisor's style, but to become aware of the key strategies to be employed.

Learning via Modelling & Guided Practice (2)

3. Supervisee is observed practising the skill ASAP
   - self-critique & feedback occurs immediately
   - supervisee applies skill to a client ASAP (ideally observed)

4. Skill acquisition enhanced with delivery over repeated sessions (rather than in one or two concentrated episodes)

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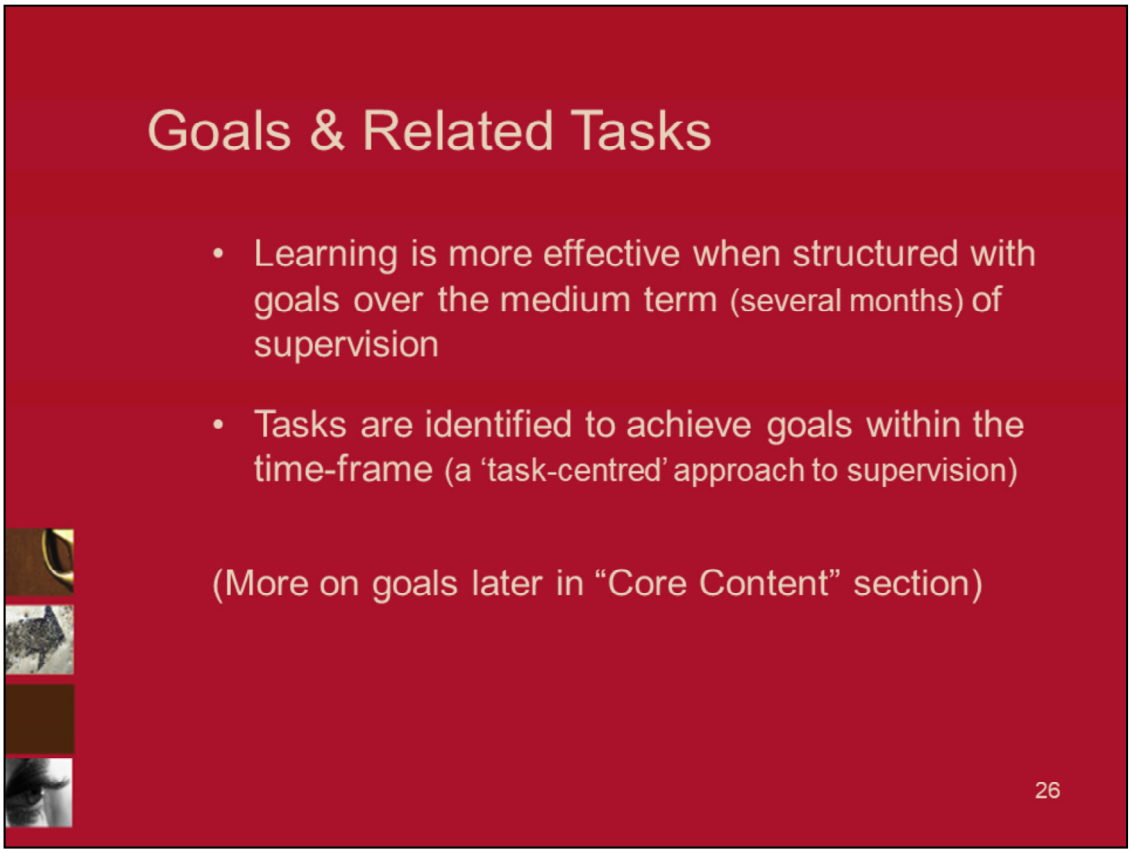
Immediacy of feedback and reinforcement is a powerful ingredient in effective and sustained learning.

Several rehearsals of short duration are likely to be more effective than one or two lengthy practice sessions.



It is unequivocal that a goal-centred approach can result in:

- clarity with regard to overall direction
- realistic time-frames
- a basis for reviewing progress (or lack thereof).

Tasks are more focused and generally more productive when they are closely linked to goals.

4. The Process & Structure of Supervision

A Developmental Perspective

Process Issues

Structural Components

27

A Developmental Perspective: (1)

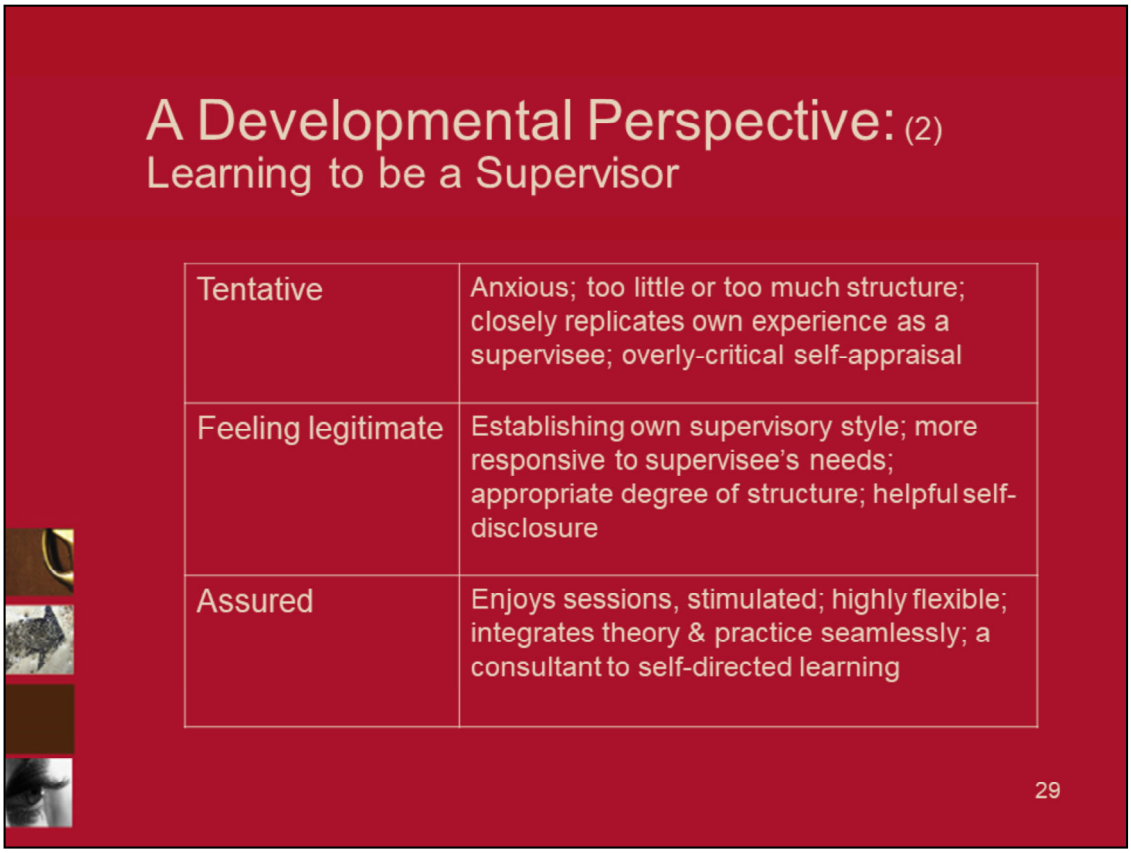
Tailoring sessions to the experience of the supervisee

Novice	Requires much support, guidance, structure, modelling, practice & feedback
Journeyperson	Confident of skills but occasionally overwhelmed by complexity/difficulty of AOD work; supervision may focus on feelings & coping with impediments
Independent craftsperson	Assured in skills; supervision largely an exploratory exchange of ideas for further development
Expert	Functions autonomously and knows his/her limits; will largely set the supervision agenda to increase self-reflective practice

Holloway 1995 28

This model should not be taken too literally. Like all models based on 'stages', it provides a convenient classification into stages that can help guide supervisory practice. However, development of any behaviour is on a continuum, and an individual person may seem to skip a stage, or recycle through stages, in a non-linear progression. Additionally, a complex case, critical incident, or the emergence of new evidence-based interventions, may lead to the most experienced of practitioners requiring the input and structure usually associated with a 'novice'.

Holloway, E. (1995). *Clinical supervision. A systems approach*. London: Sage.



This model is a summary of factors found in Table 1.1 (p 14) in:

Falender, C A & Shafranske, E P (2004). *Clinical Supervision: A competency-based approach.* American Psychological Association, Washington DC.

A link to the publisher of this valuable resource can be found at the rear of the Overview Booklet and the 'Guide'.

As for the previous slide, this model should not be taken too literally. The development of any behaviour is on a continuum, and an individual person may seem to skip a stage, or recycle through stages, in a non-linear progression.

However, the value of this schema is as a reminder that supervisors need training and support to develop full competency as supervisors. Not all new supervisors will display the characteristics of a 'novice' supervisor, but hardly any will be fully assured and display mastery of supervisory roles from the outset.

These issues must be addressed at the outset of a supervisory relationship to:

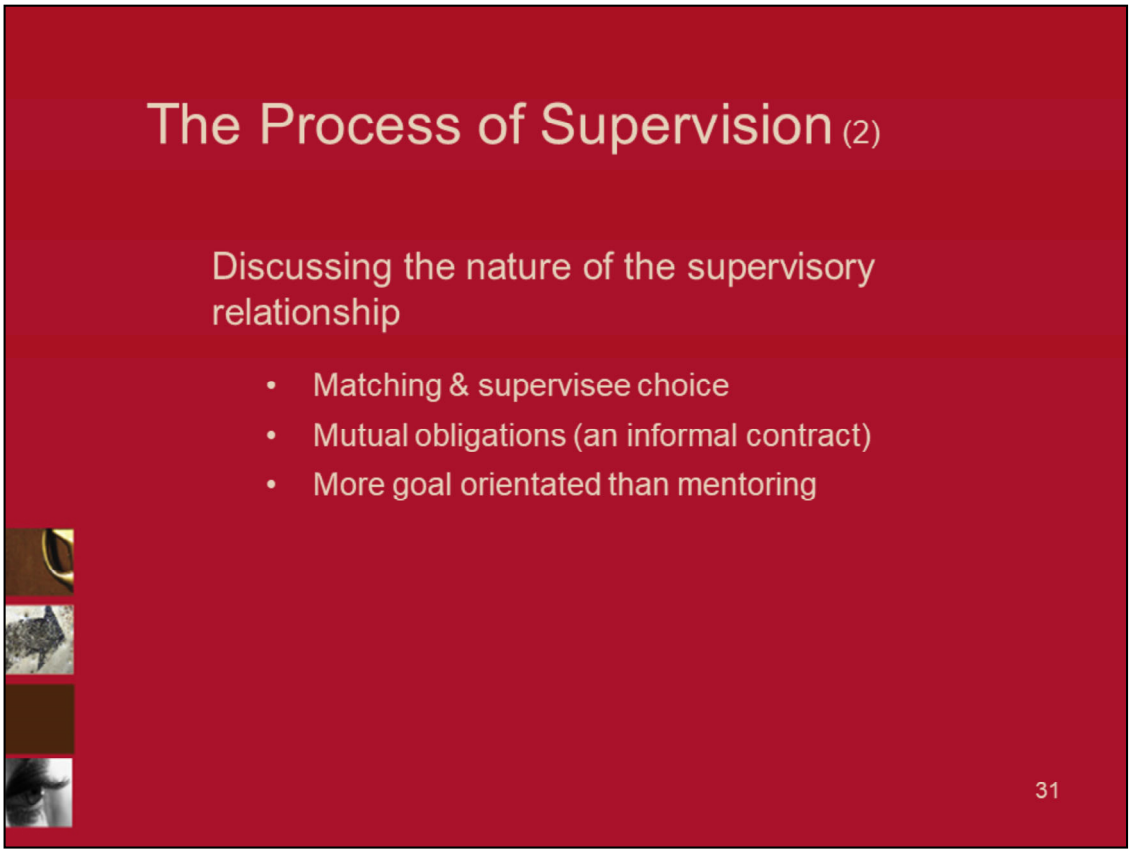
- minimise the possibility of misunderstanding and inappropriate expectations
- to maximise the potential of supervision by getting it on-track from the outset.

The same limits to confidentiality apply as for clinical work (i.e. mandatory reporting is required when there is imminent risk of harm, sexual misconduct or other unethical practice, on the part of the supervisee, supervisor, or client).

Operational matters within an agency are the domain of line supervision, not clinical supervision, which focuses on the clinical roles of the worker. Agencies should consider cost-effective alternatives such as group supervision.

Whilst the impact of a supervisee's personal issues on their work may be identified as part of clinical supervision, the supervisor must refrain from delivering therapeutic interventions. The supervisee should seek therapy elsewhere if necessary (the supervisor could help with a referral).

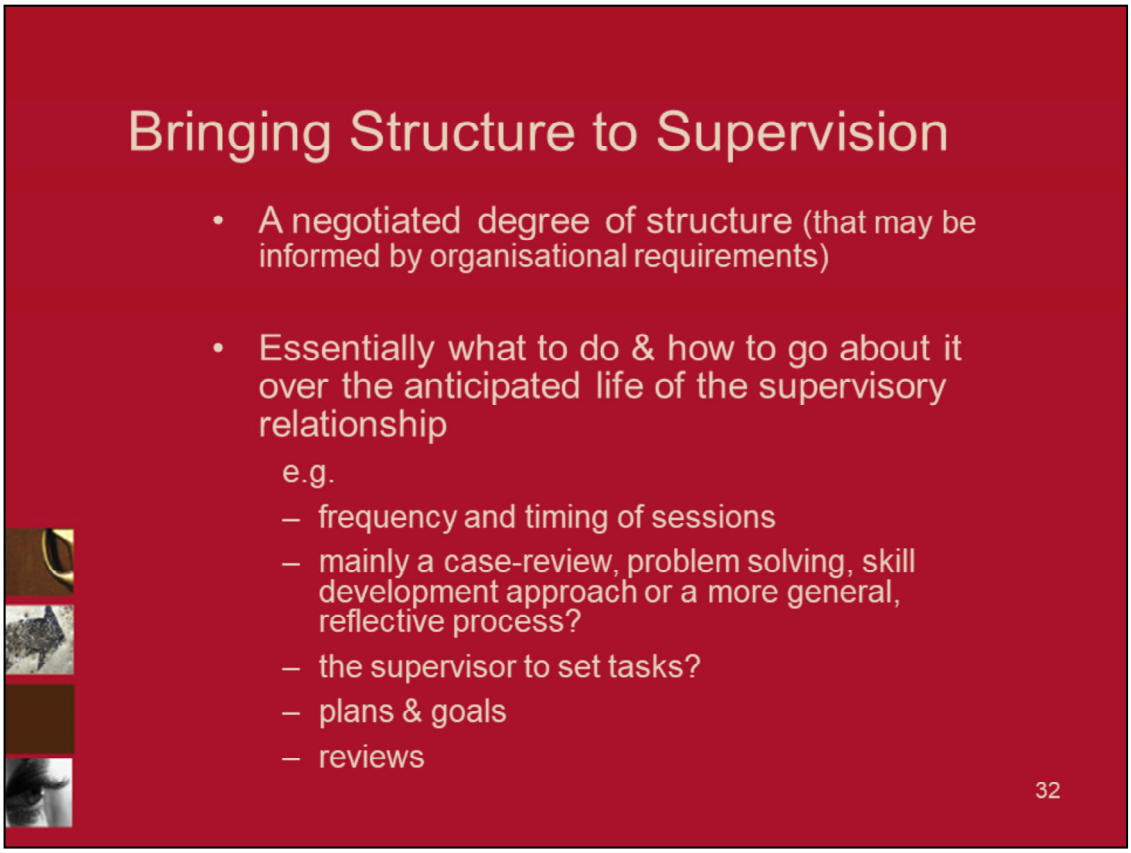
Procedures for disputes and grievances arising from clinical supervision should be detailed in an organisation's clinical operations manual. The general principle of resolution through negotiation and mediation applies before progressing to an official complaint and investigation.



The supervisee's right, and need, to feel comfortable in a supervisory relationship, and therefore to choose their supervisor, parallels that of a client's rights with counsellors. A good 'match' will be critical to good outcomes from supervision.

It is essential that both parties are clear about their expectations from supervision and their mutual obligations. Structuring supervision around a series of negotiated goals and tasks will help enormously in this regard. A supervisor and supervisee will decide together the extent to which they wish to formalise the structure of supervision and be bound to a 'contract'.

Mentoring is a closely related concept to clinical supervision (and , indeed can feature in a supervisory relationship to a limited degree), but differs in that it is a more fluid, unstructured, process that is more clearly rooted in the evolving relationship of the mentor and protégé. In contrast, clinical supervision is more anchored in formulated goals designed to advance the supervisee's skills and to immediately achieve better outcomes for clients.



A tighter structure to supervision will be of most benefit when a supervisee is inexperienced and has much to learn. Experienced supervisee's may appreciate a more flexible structure in which the opportunity to reflect and explore is the dominant feature of supervision.

All supervisee's will benefit from some flexibility in any 'program' of supervision so that they can respond to pressing clinical issues.

5. Core Content of Supervision Sessions

- Topics
- Competencies
- Issues
- Goals

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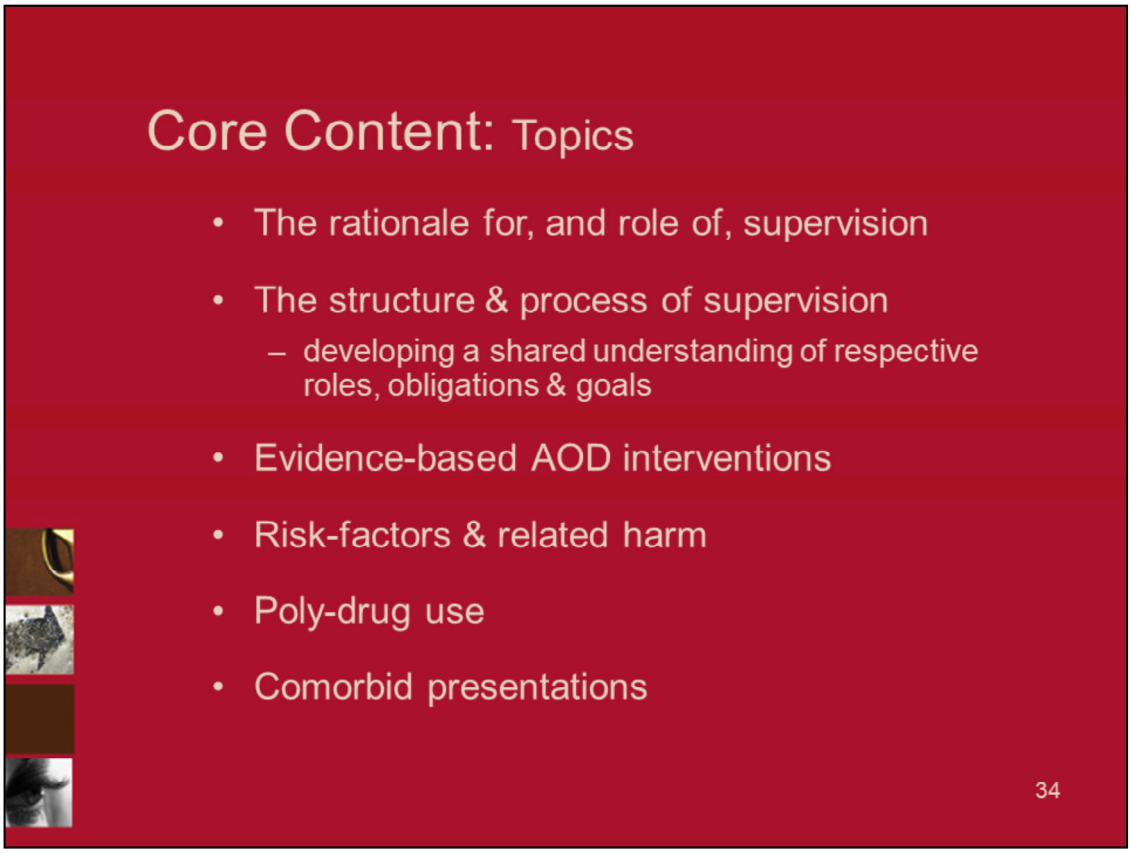


This is not a comprehensive list of possible topics, some of which will be determined by particular workplace and client contexts. The above topics are central to constructing effective clinical supervision in the AOD field given that:

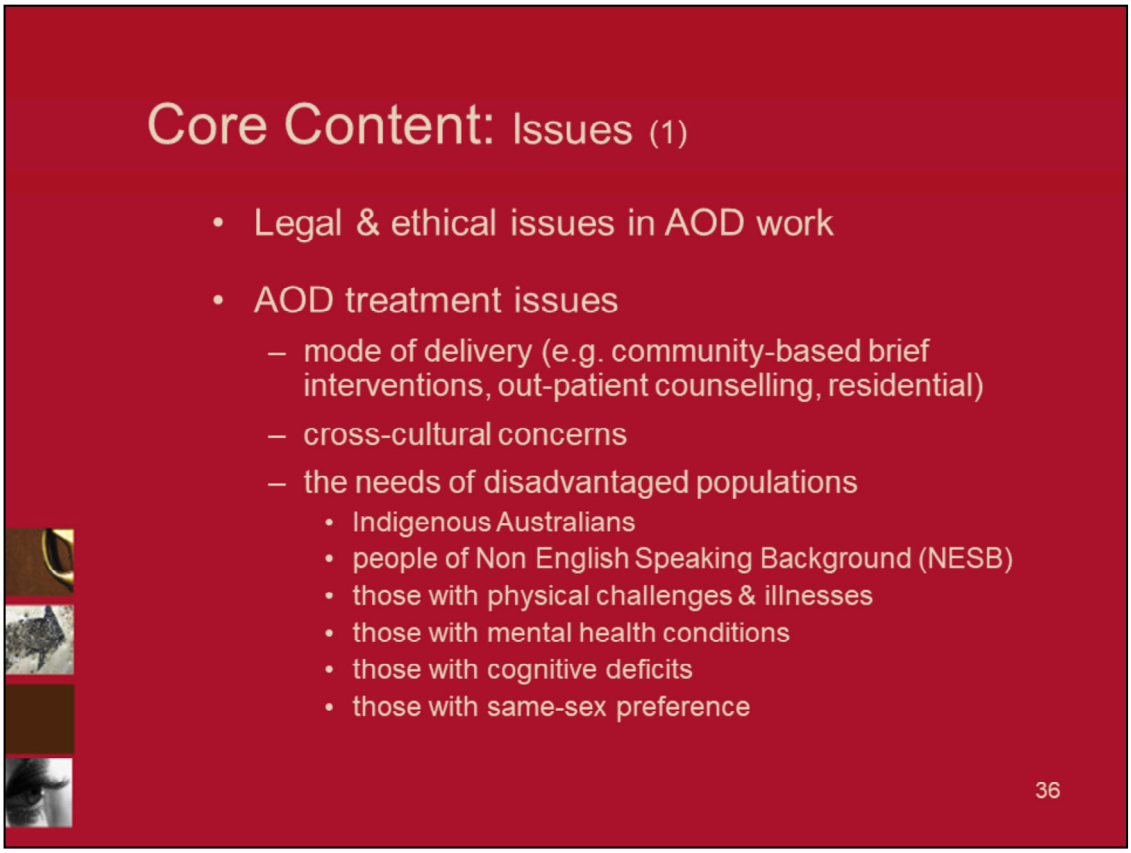
• evidence indicates which interventions are more likely to reduce AOD use in the short-term (notwithstanding the considerable limitations of most treatment outcome studies)

• a harm-reduction/minimisation approach now prevails in the AOD field in Australia (i.e. the emphasis is on keeping AOD users alive and well even when they continue to use); clinicians must be cognizant of, and vigilant in providing, immediate harm-reduction advice and facilitating access to practical aid

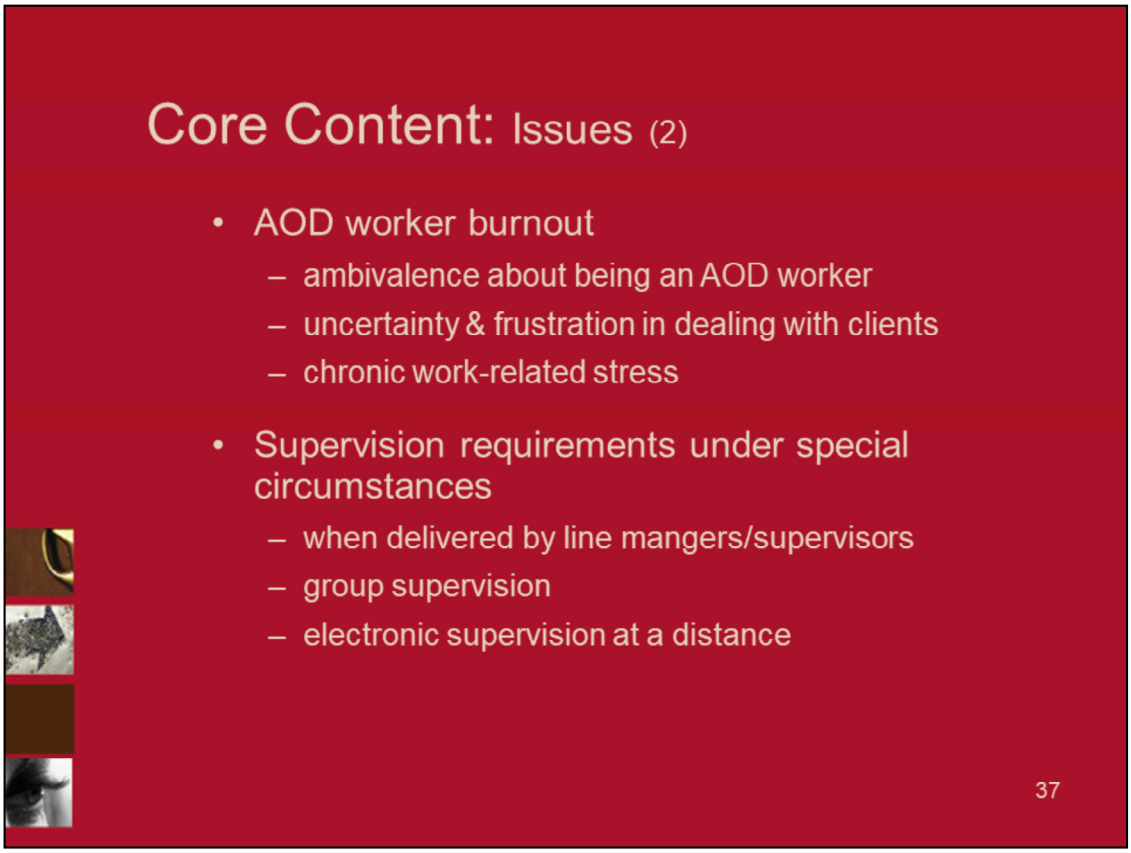
• poly-drug use amongst clients has increased sharply in recent years, complicating clinical presentations

• comorbidity is common in AOD clients (rates of depression, in particular, have increased sharply in recent years; anxiety states, paranoia, schizophrenia, and 'personality disorders' also co-occur frequently with AOD use).

Competencies may be identified by a supervisor and supervisee (in addition to those listed above) that reflect a particular theoretical orientation or therapeutic approach. Those provided above are considered minimal requirements for effective AOD work.



The list of issues on this, and the next, slide is not comprehensive, but it does include prominent examples. Other issues will arise in relation to specific workplaces (determining additional issues of relevance could be the basis of a specific training exercise).



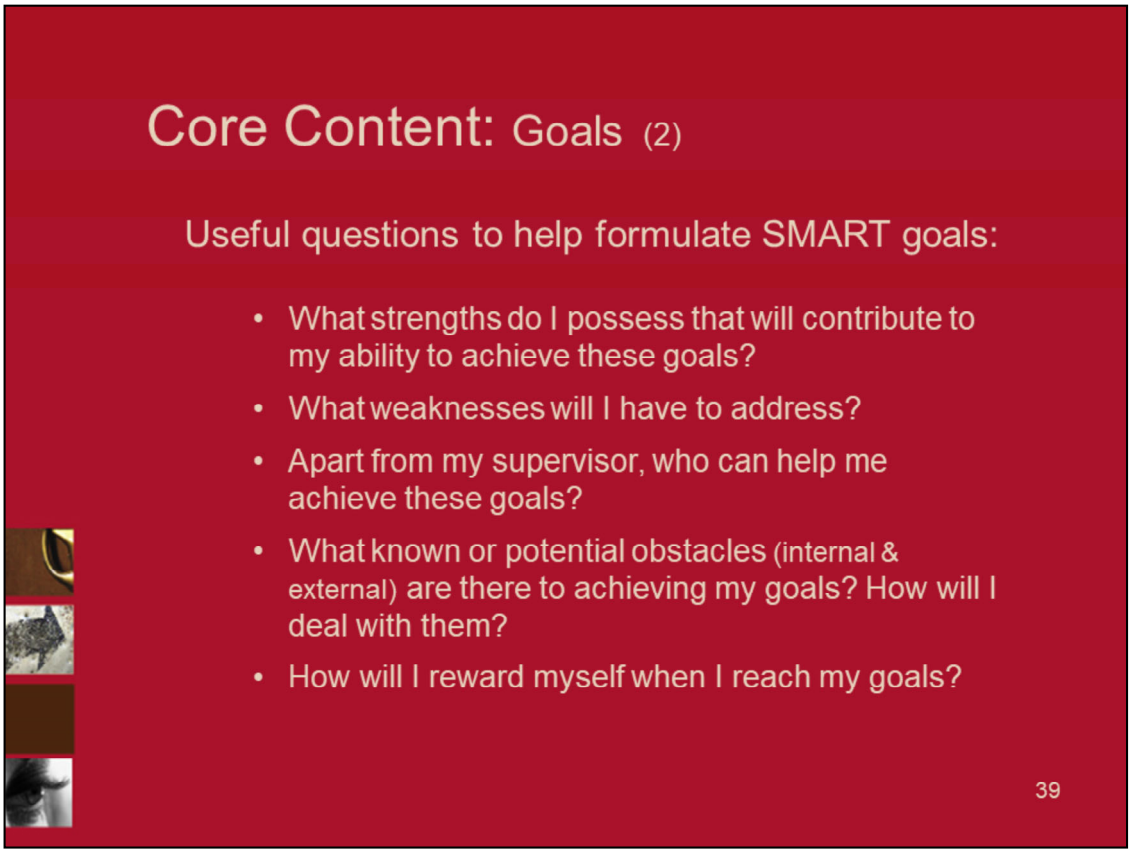
The list of issues on this, and the previous slide, is not comprehensive, but it does include prominent examples. Other issues will be easily generated in relation to specific workplaces (determining relevant additional issues could be the basis of a specific training exercise).

The supervisor should not assume that an AOD worker is struggling in their role (although it is unlikely that a worker will always feel on top of their case work given the challenges of AOD work). Open-ended questions will allow the supervisee to give an accurate report.

Supervision requirements under special circumstances is dealt with in more detail elsewhere in this training package.

Goals are ‘contracted’ in an informal sense; the term is meant to convey a sense of mutual agreement and obligation to strive towards specified goals. However, goals can be revised at any time as need, or inclination, dictate.

SMART goals for supervision directly parallels the framework used with clients.



A trainer could ask participants if they can think of any other relevant questions.

6. Paving the Way for Supervision

Preparing the Supervisee
Building Belief
'Matching'
Supervisee Characteristics

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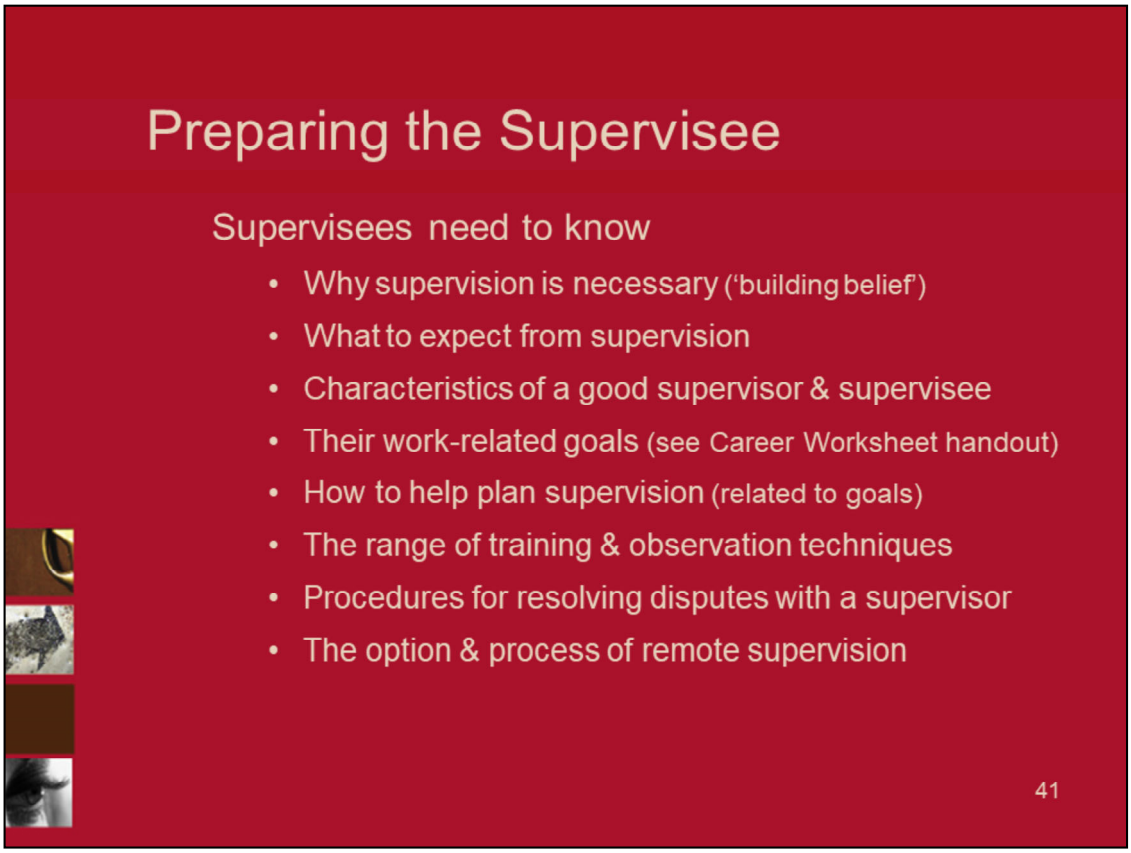

Much attention and effort needs to be given to preparing the way for supervision. A 'false start' based on a misunderstanding of the purpose and process of clinical supervision is very difficult to recover from (akin to therapeutic relationships).

The preparation should begin within an agency prior to clinical supervision beginning, via staff meetings, training sessions, line-supervision, dissemination of information, and discussion within the agency's clinical procedures manual.

As stated in the previous notes, much can be done within agencies to alleviate anxiety and concerns regarding clinical supervision before the supervision begins.

If over a few sessions a supervisee's concerns are not alleviated, it is possible that the match of supervisor and supervisee is not conducive to a good outcome, and discussion should be held around the possibility that a change of supervisor is desirable.

Building Belief in Supervision (2)

- Use active listening to explore resistance
- The reassuring technique of "feel, felt, found" may help

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

  Supervisor: *I know how you **feel** because I **felt** the same way when I was first supervised. I was working on placement in the local drug service and I **found** that supervision helped me a lot. I learnt skills faster and had support when things didn't go so well…*

- But don't fake it: if you have never been concerned about receiving supervision, then use a third-party example

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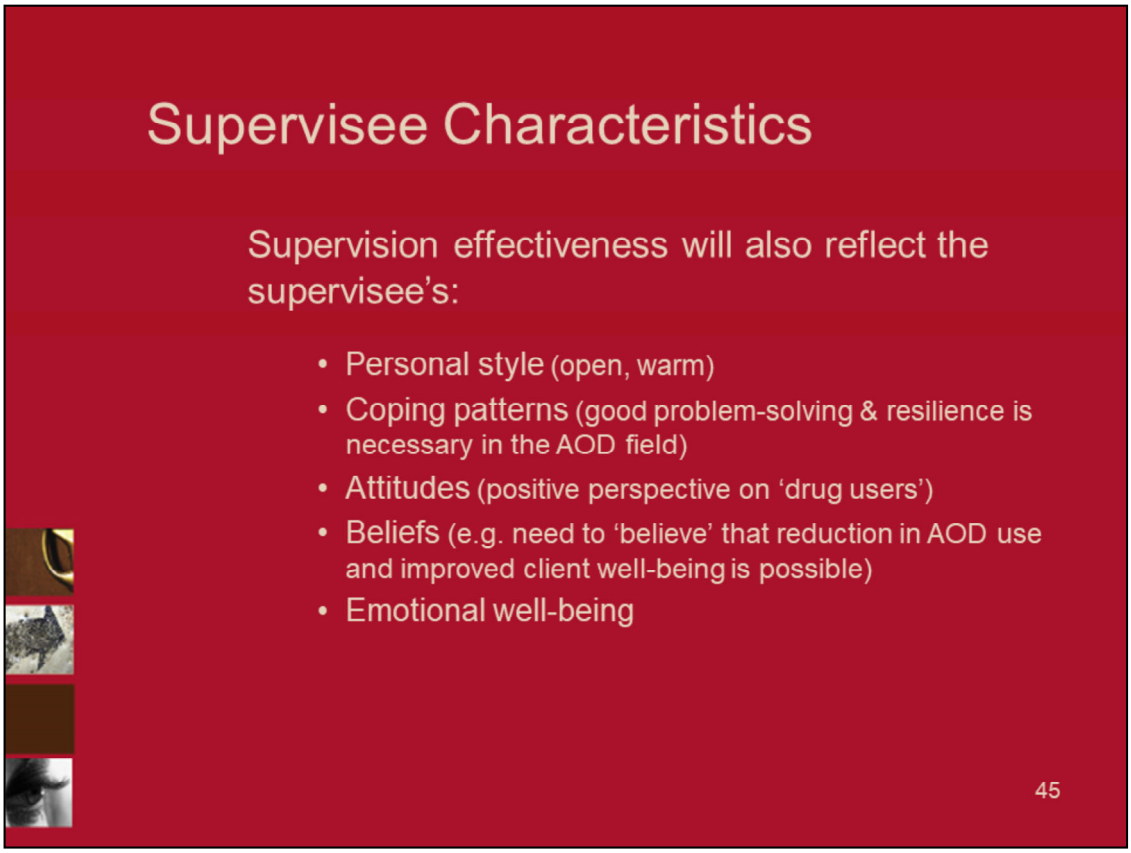
Sound generic counselling/communication skills on the part of the supervisor will generally reduce a supervisee's anxiety and concerns.

None of the above are immutable and serve as general guidelines only.

'World-view' encompasses beliefs concerning human interaction with nature, social relations, values and ethics, and the meaning of life (in general terms). Shared cultural experiences does not imply the need to belong to the same ethnic background. A supervisor whose training and life experience has included acquiring an understanding of multicultural issues and exposure to the practices of cultures other than their own, might adequately supervise people from diverse backgrounds. However, a supervisee who belongs to a minority cultural group may strongly prefer, if at all possible, to have a supervisor who shares their ethnicity.

Both supervisors and supervisees need to be aware of characteristics in the other that would lead to an incompatible match. For example, a supervisor may decide that they cannot adequately supervise a clinician wedded to an abstinence-only approach with AOD clients (or vice-versa), given tensions in the AOD field between abstinence-only models of intervention and 'controlled use', harm-reduction, approaches. This incompatibility might even extend to their respective drug-using histories.

A supervisee may have a strong preference for a male or female supervisor or for a supervisor of the same sexual orientation.



When a supervisee has personal issues that are inhibiting his/her functioning as an AOD worker, it would be appropriate, once trust is established, for the supervisor to gently address these issues. As stated earlier, the impact of personal issues on AOD work can be identified and discussed as part of supervision, but if therapeutic intervention is required, this should be obtained outside of the supervision.

7. The Supervisor's Roles

The Successful Supervisor
Skill Development
Support
Administrative
Evaluative

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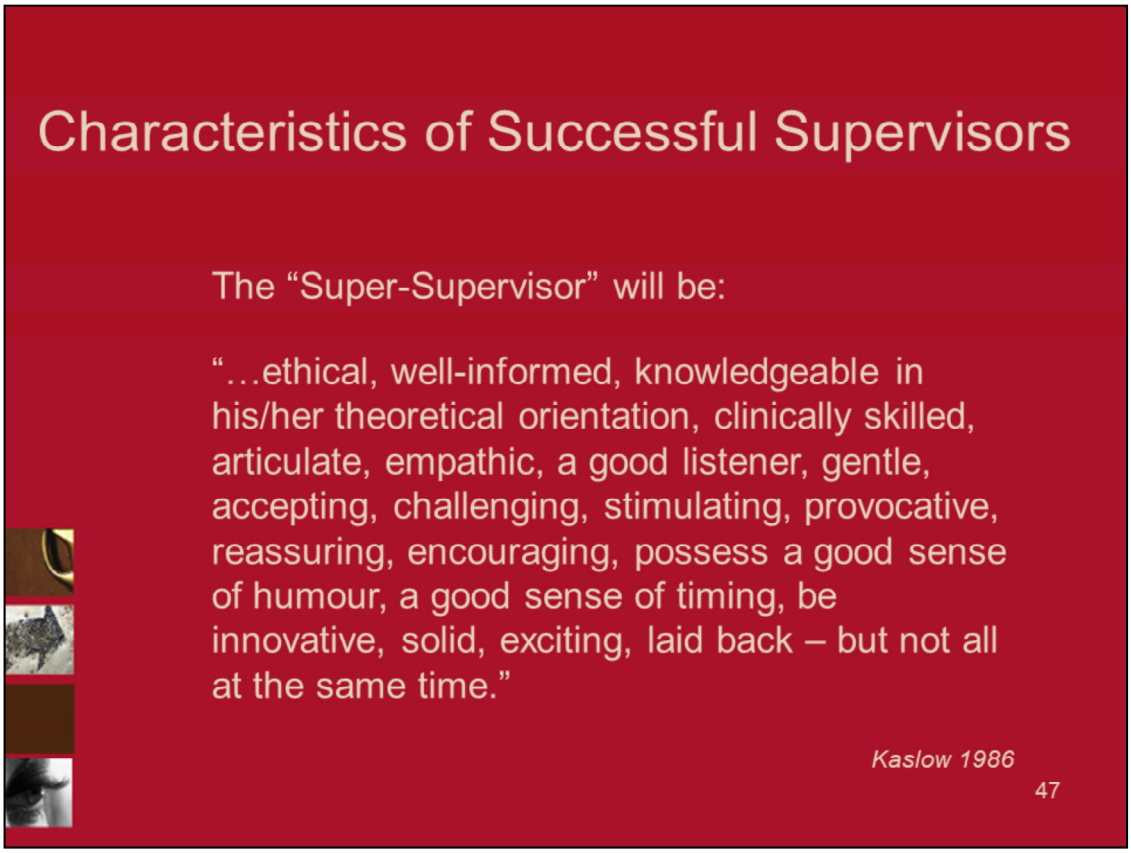

There is some merit in listing the ideal qualities of a supervisor, but this slide should also amuse an audience and may provoke some stimulating discussion around the issue of supervisors being 'mere mortals'. Indeed, a supervisor can acknowledge their limitations in a way that reassures the supervisee that there is no need to be perfect in order to achieve clinical competence.

Kaslow, F.W. (1986). Commentary: Individual therapy focused on marital problems. *American Journal of Family Therapy, 14*, 2-6.

Successful Supervisors are…

Available	Emotionally available - open,receptive, trusting, non-threatening
Accessible	Easy to approach and converse with, centred on the supervisees (who are more satisfied if they are given space to develop their own style)
Able	Skilful and an ability to impart current knowledge
Affable	Pleasant, friendly, reassuring

Powell & Brodsky 1998

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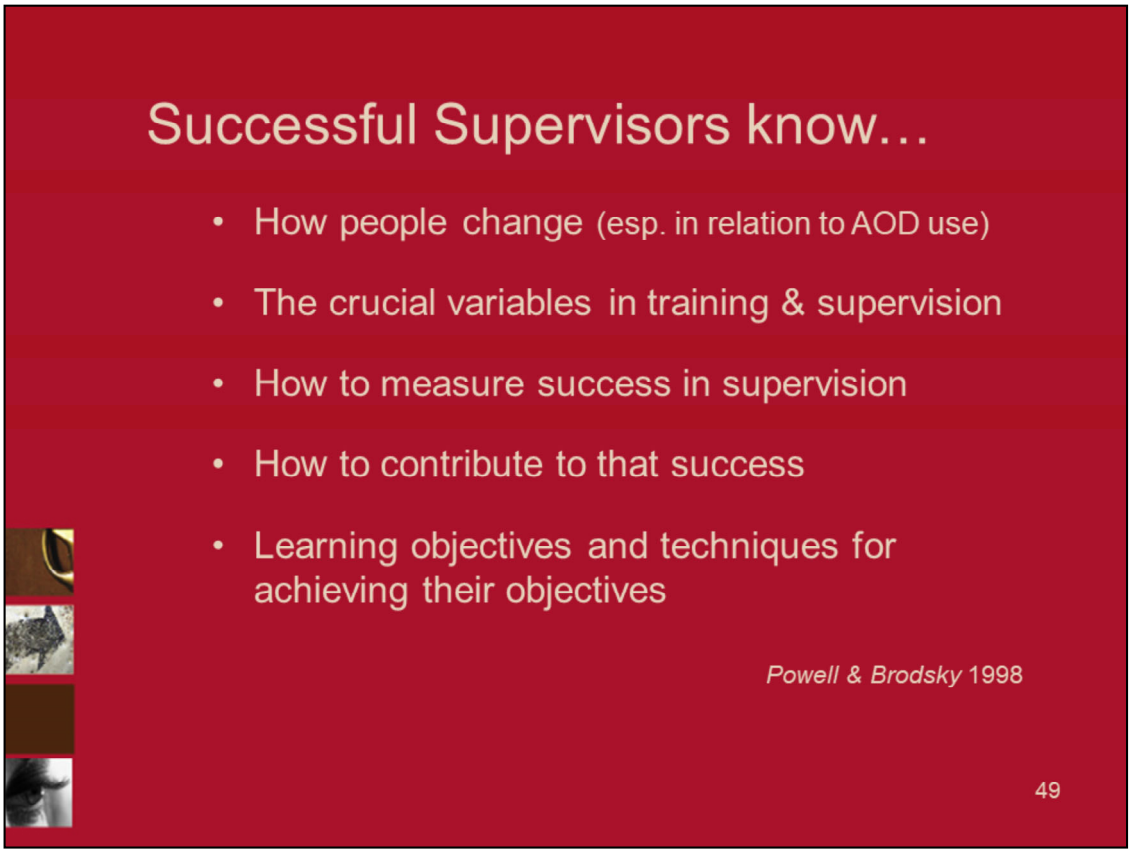
These characteristics really are the minimum requirements for a successful supervisor. It is hard to imagine that a supervisee would feel comfortable with, and confident in, supervision unless their supervisor was emotionally available, accessible, able and affable.

Powell, D.J., & Brodsky, A. (1998). *Clinical supervision in alcohol and drug abuse counseling: Principles, models, methods*. San Francisco: Jossey-Bass.



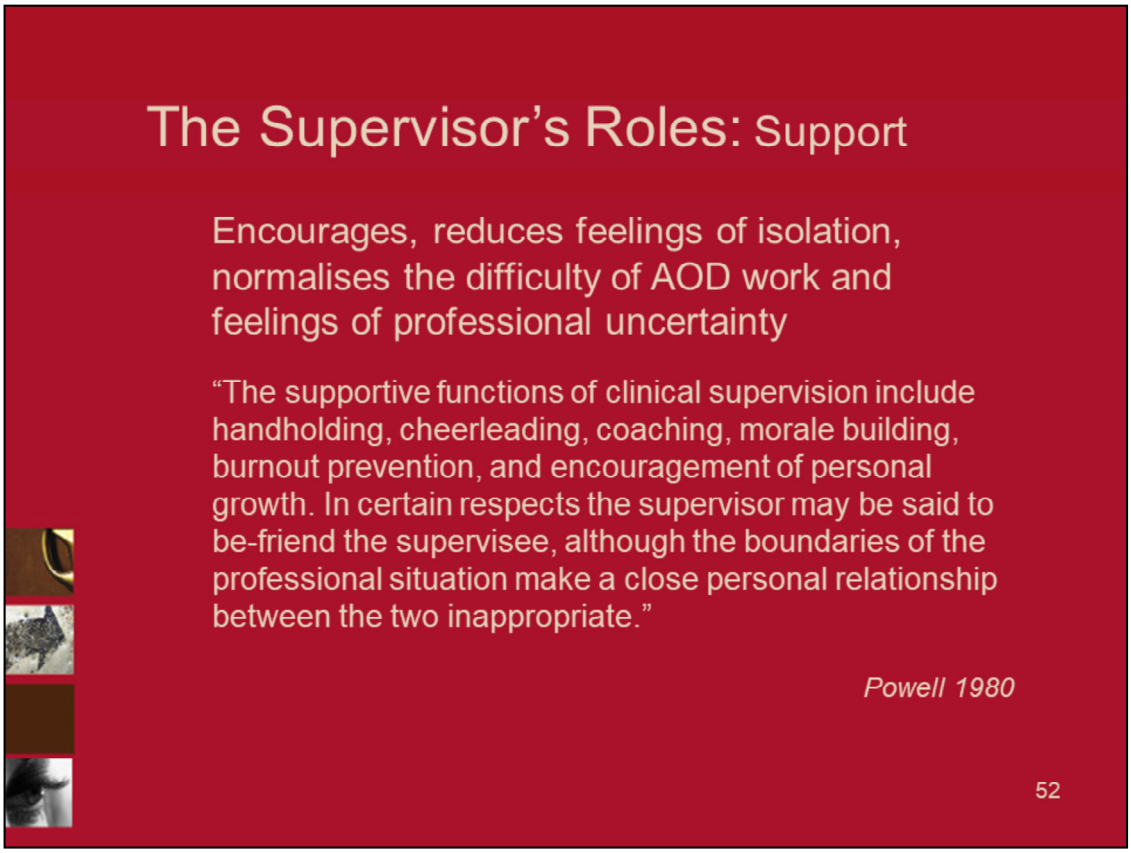
The above requirements are rather self-evident, but in fact require a high degree of knowledge and skill. Many supervisors will require training to be confident and competent in their supervisory skills.

Powell, D.J., & Brodsky, A. (1998). *Clinical supervision in alcohol and drug abuse counseling: Principles, models, methods*. San Francisco: Jossey-Bass.

A supervisor need only carry a small case-load to remain up-to-date with clinical presentations. Given quite rapid changes in drug-using patterns, current hands-on experience seems particularly germane for supervisors in the AOD field.

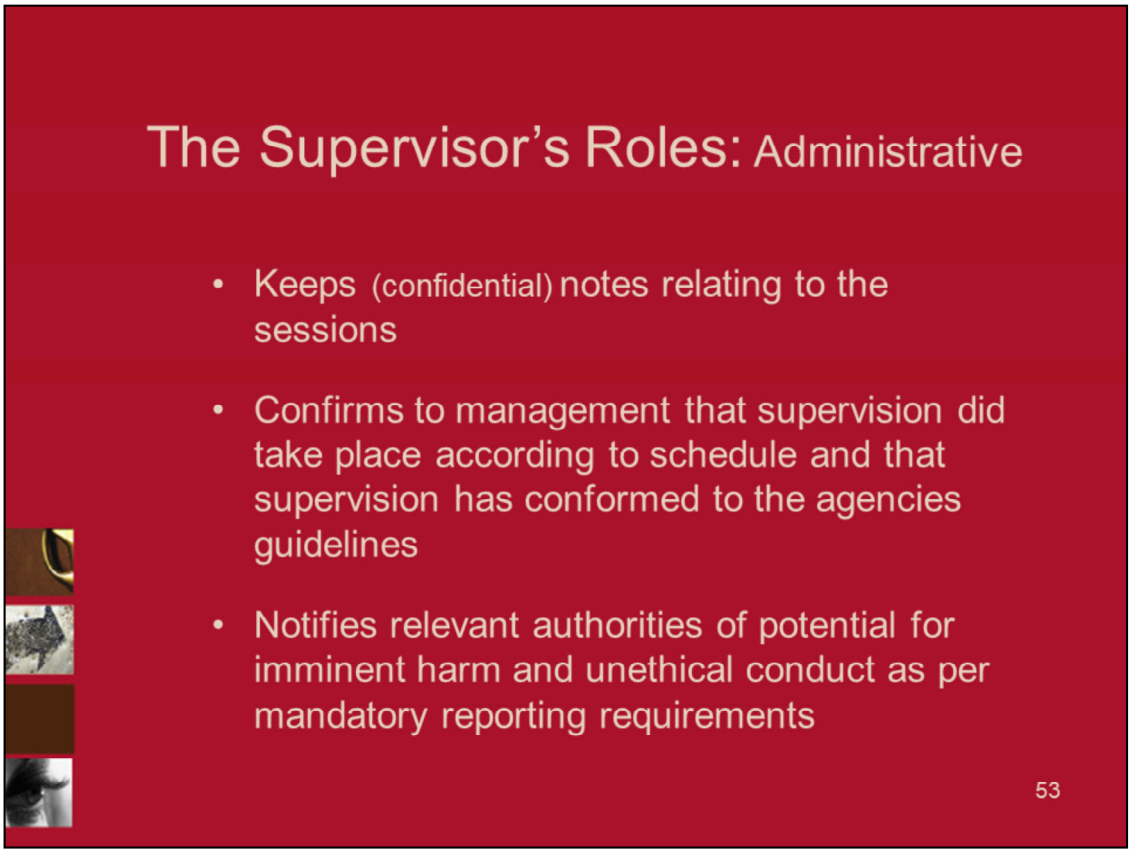
A large benefit of continuing to have a case-load is the need for the supervisor to also receive clinical supervision, thereby retaining a sense of what it feels like to be on the receiving end of supervision.

Clinical supervision has broad-ranging and diverse roles. It is a highly skilled activity. Some excellent clinicians will not necessarily be excellent supervisors.



Again, the parallel with a counsellor being supportive of a client is obvious.

Powell, D.J. (1980). *Clinical supervision: Skills for substance abuse counselors* (Trainee's Workbook). New York: Human Sciences Press.



The note taking need not be lengthy or detailed, but rather an aid to memory of areas covered and flagged for further consideration. The notes must be stored securely and only released to management with the supervisee's consent.

A log of attendance should be kept, as an agency paying for supervision of their worker(s) has a right to know that the contract is being fulfilled.

The supervisor's assessment of the supervisee's skills and progress is confidential, and would only be released to managers with the supervisee's consent.

A supervisor must be very skilled and sensitive in giving feedback to a supervisee. It is necessary to build a strong and trusting relationship before giving detailed constructive criticism. The golden rule of criticism is to focus on the good points of a performance first.

8. Training & Observation Methods

- Case Review & Analysis
- Role Playing/Modelling
- Co-facilitation of Clinical Sessions
- Indirect Observation

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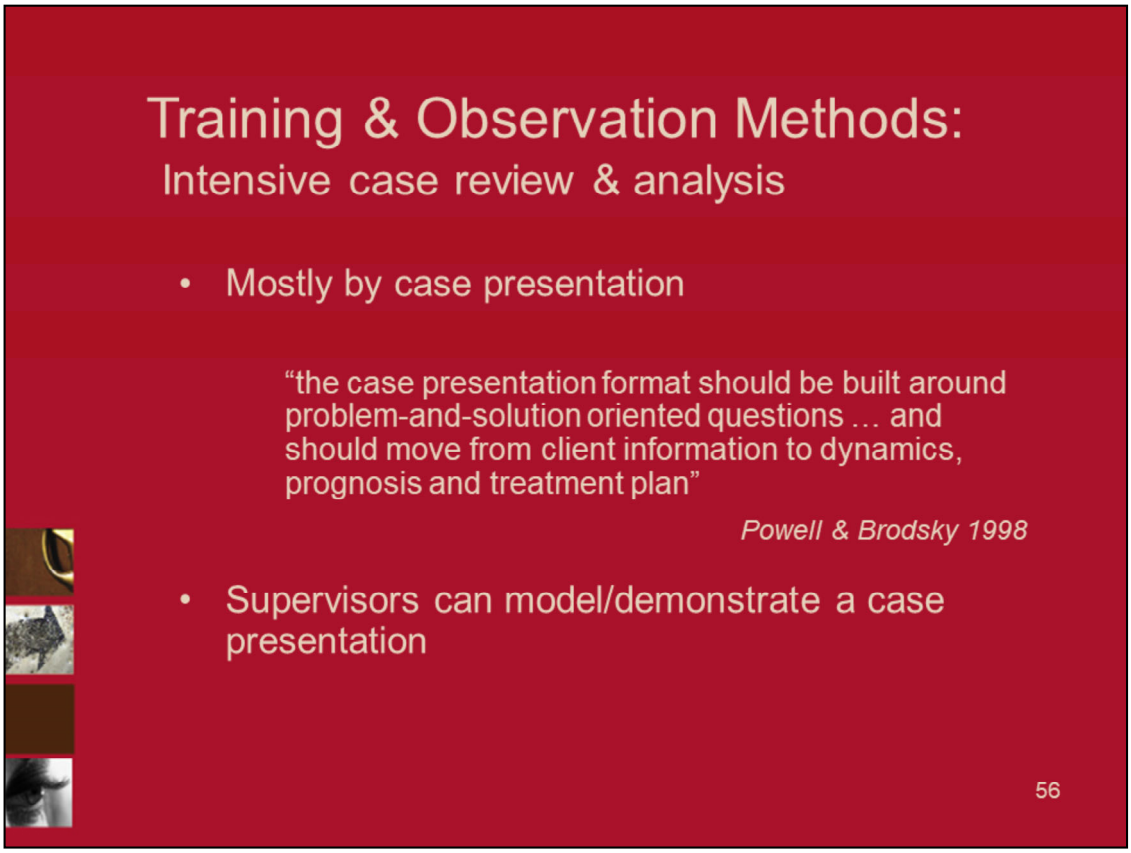
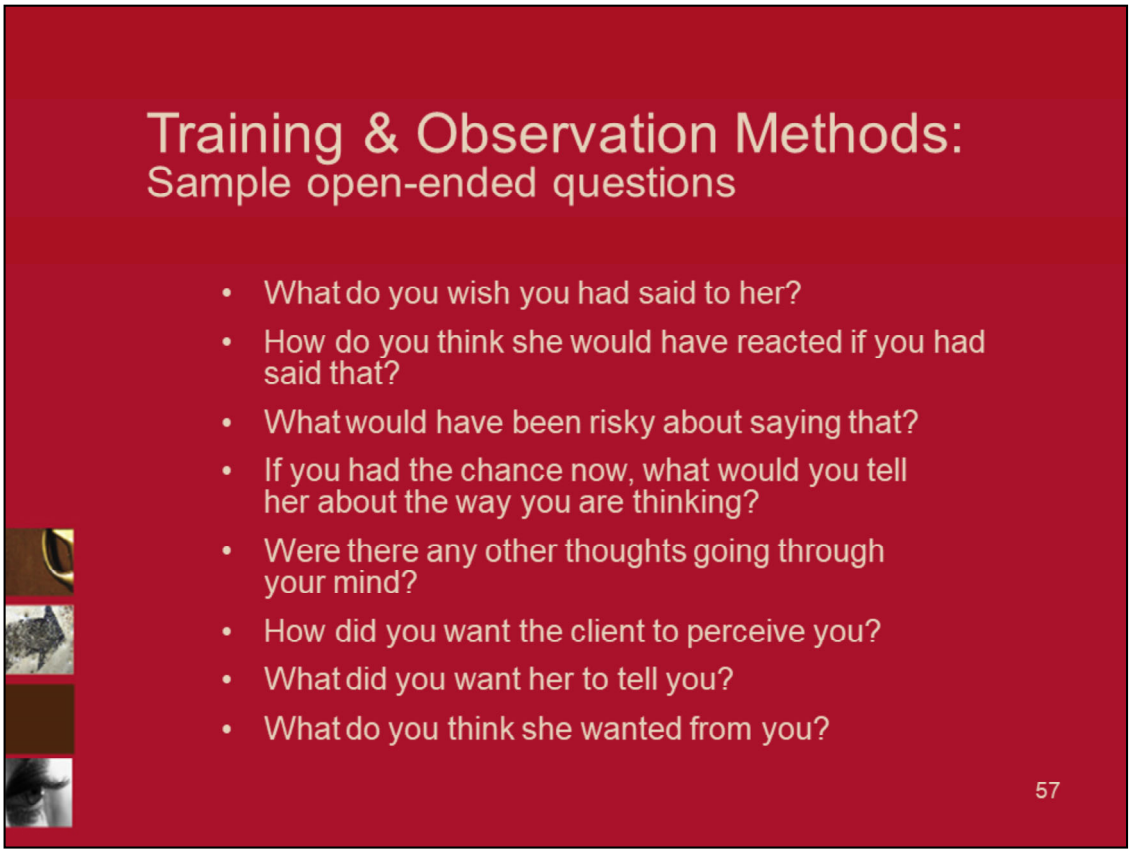
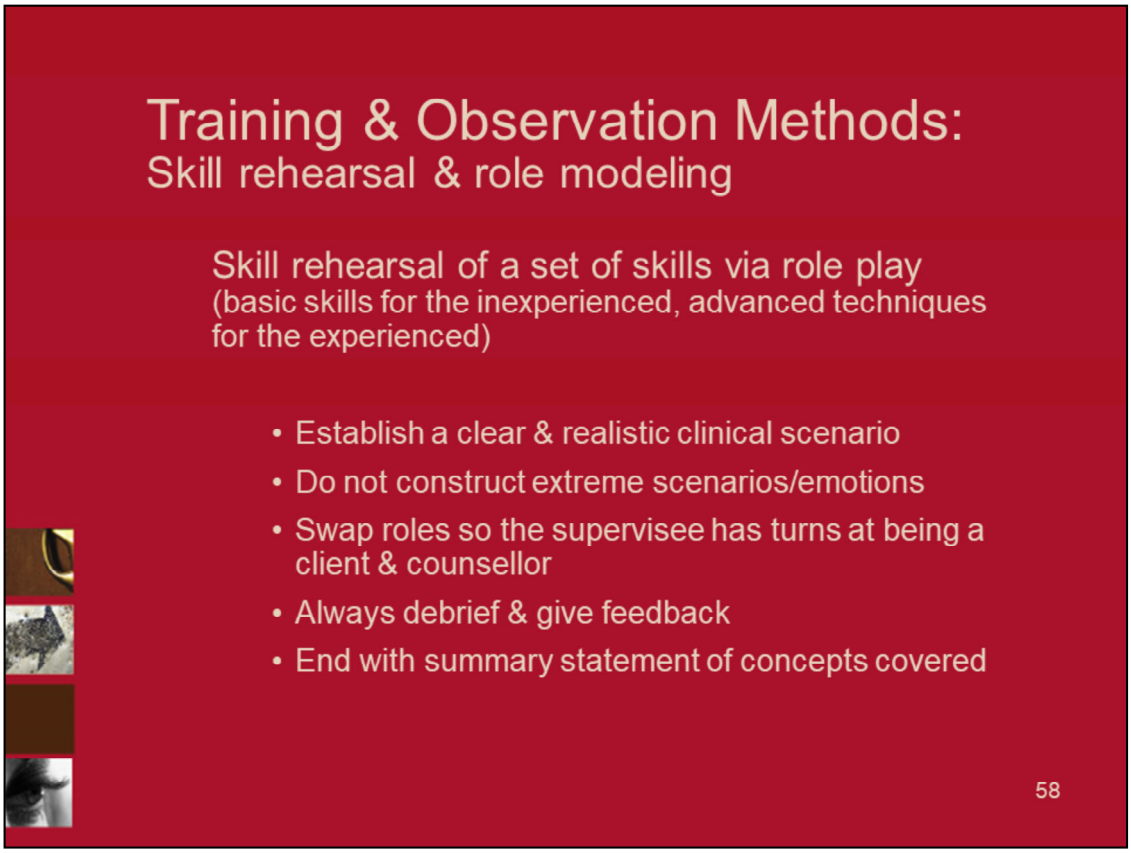


A case-centred approach to supervision is particularly useful for inexperienced supervisees. It provides a context for rapid acquisition of skills and allows for direct impact on current cases.

Powell, D.J., & Brodsky, A. (1998). *Clinical supervision in alcohol and drug abuse counseling: Principles, models, methods*. San Francisco: Jossey-Bass.



It doesn't matter precisely what questions are posed to the supervisee; providing they are open-ended in structure it will allow the supervisee to move into areas of concern and discomfort.



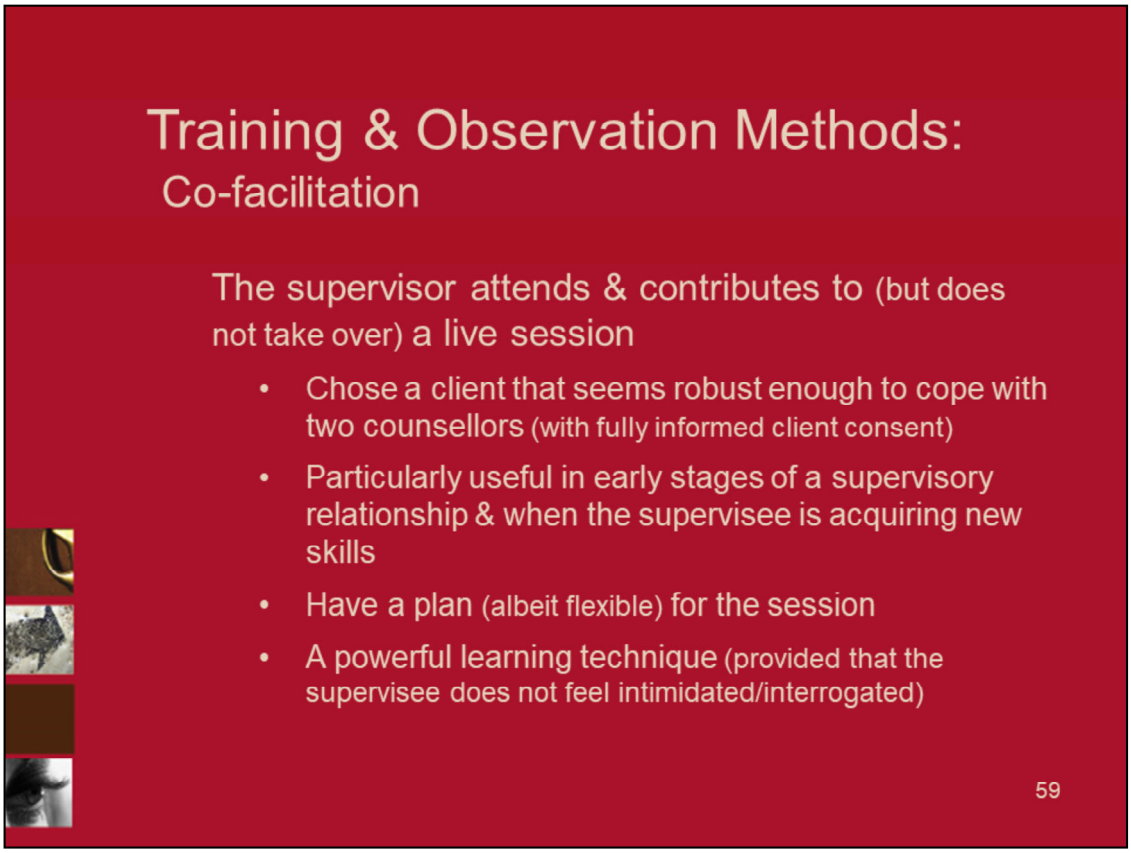
Ideally use a current case.

When constructing a hypothetical case, it is very important that “a client from hell” is not played. This is particularly germane to training sessions, where it is common for one or more participants to play extreme cases (sometimes reflecting a past client). Getting stuck with a resistant, ‘game-playing’ or aggressive client is not conducive to learning. However, it is possible to practice the micro-skills of communicating with challenging clients when necessary, by isolating a brief exchange.

Debriefing is vital to:

- maximising the benefits of the role play (much is learnt through collective debriefing when training)
- relieving any anxieties that resulted from the role play
- ensuring that roles are fully shed before moving on!

Role play (skill rehearsal) sessions should not end abruptly, but rather be fully integrated within a conceptual framework, introduced at the beginning and cemented at the end of the rehearsal segment of supervision (or training).



Co-facilitation is a potentially powerful technique to be used sparingly, and only when the supervisor is confident that both the supervisee and client will cope well with this unusual form of counselling.

It is also not to be used if a client seems to relish the prospect of having more than one counsellor on his or her case, or is likely to try and manipulate the complex dynamics inherent in a co-facilitated session.

Again, a powerful aid to learning that must be managed carefully. Scrutiny of every exchange between the supervisee and client could be an overwhelming, unfocused and taxing exercise, and quite likely counter-productive.

Consequently, it is better to establish loose parameters of inquiry before taping the session with the client, which may also help to structure that particular session (although flexibility needs to be retained, as a clinical session must never become secondary to a learning exercise).

The viewing of the tape with the supervisor should not approximate an examination. It will help for the supervisee to remain in control of proceedings by selecting parts of the tape that they wish to critique.

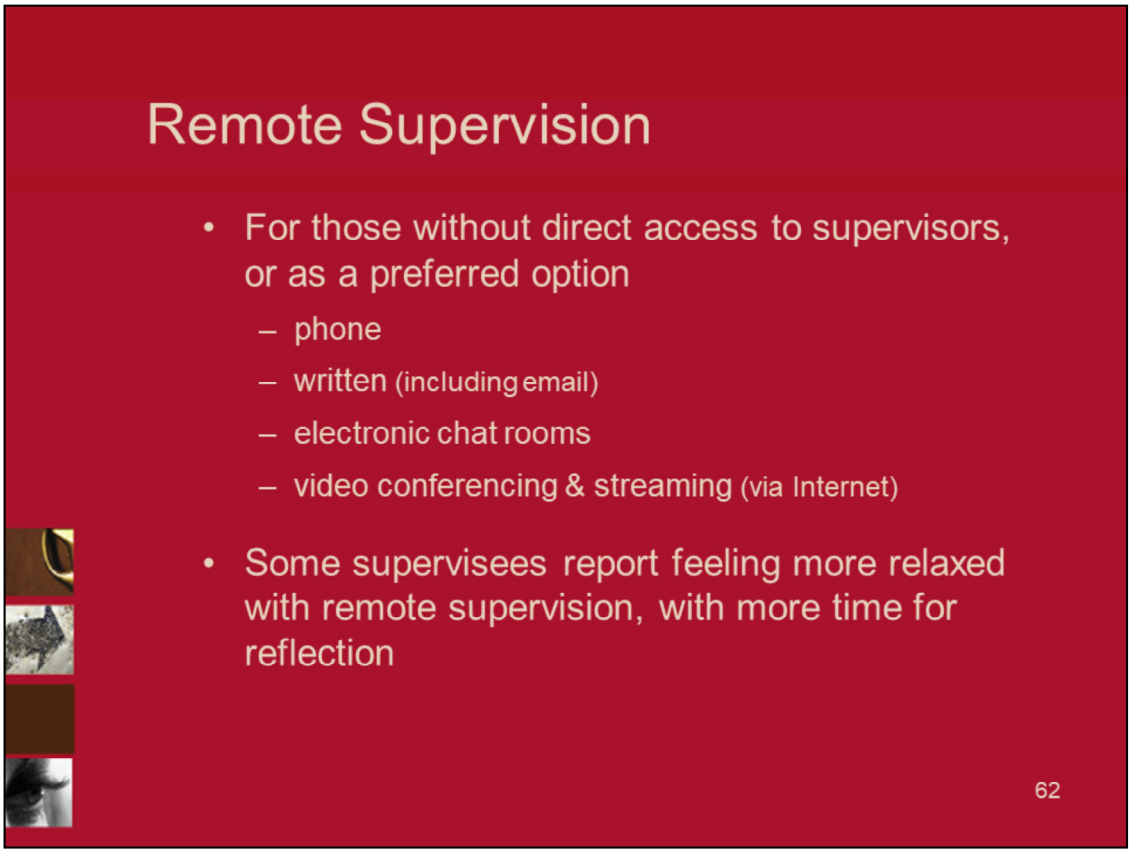
It is very easy for tapes to go astray. They must be well secured and disposed of in a disciplined manner.

9. Alternative Modes of Supervision

Remote

External

Group



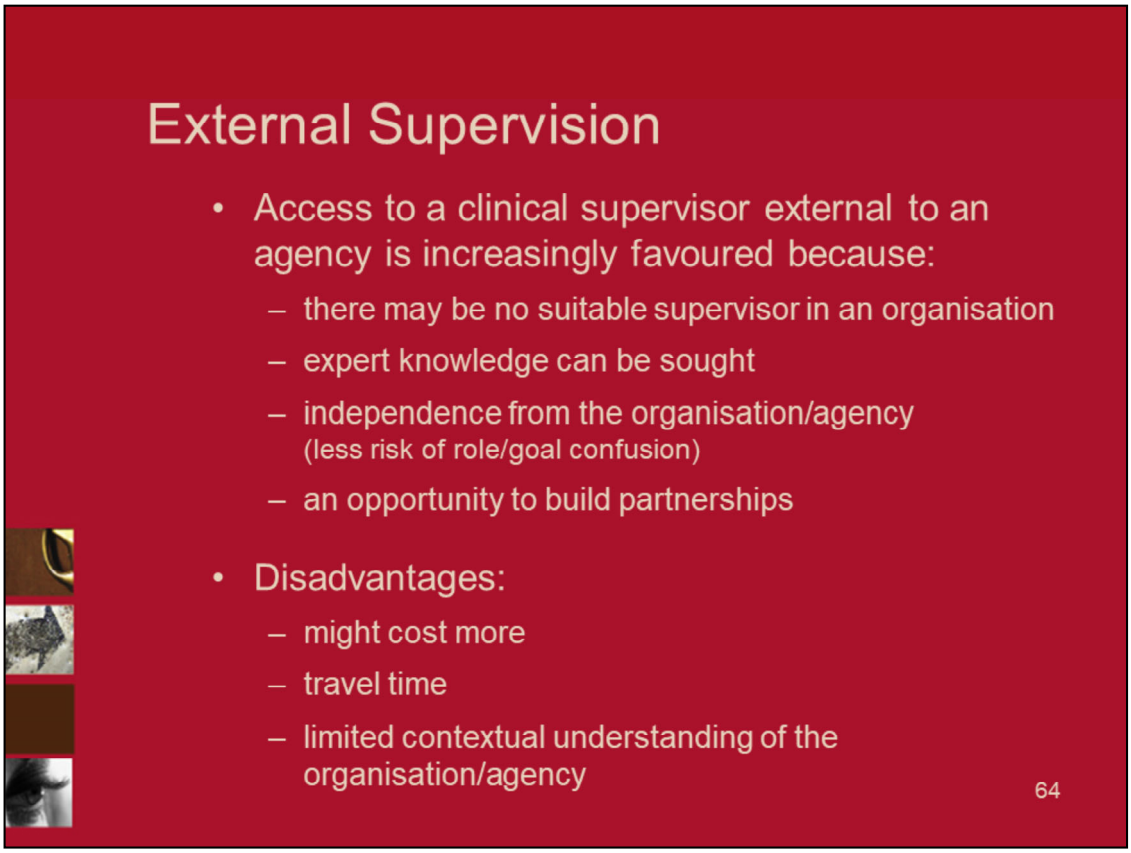
'Remote' refers not only to being at considerable geographical distance, but any contact that is not in person. Hence a worker may choose to receive supervision electronically when they could have secured it in person (perhaps for a variety of reasons, e.g. time constraints, cost reduction, anxiety).

It is also possible to have a supervision program that is a combination of sessions in person and by remote communication.

The general consensus is, however, that the complex interactions of clinical supervision are best served by face-to-face interactions.

Remote Supervision: Disadvantages

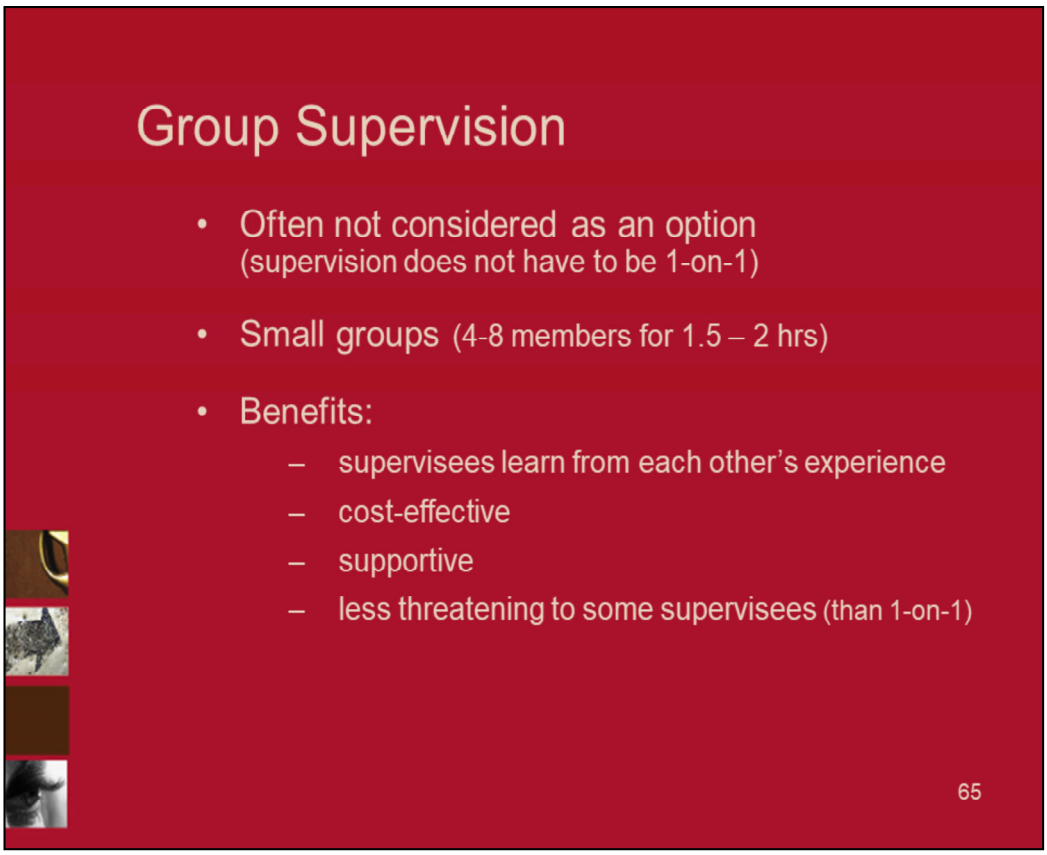
- Less interpersonal support
- Difficult to practise skills
- Advanced electronic communications still difficult to access in remote locations
- Security concerns



The consensus is that external supervision is the ideal format. However, it is acknowledged that many AOD agencies will struggle to afford the use of a consultant for this purpose. An alternative is to place a clinical supervisor on the staff in a part-time capacity for the express purpose of supplying supervision.

The limitation of an external supervisor knowing little of a supervisee's agency can be overcome, to a large extent, by a visit and orientation session to the agency. Relevant contextual knowledge of the agency can also be established through the accounts of the supervisee during supervision.

Too much knowledge of interactions within an agency may not be helpful, compromising the supervisor's independence. It is not a role of a supervisor to mediate or to help a supervisee in their dealings with their managers or fellow staff (again, a referral for such matters would be appropriate), although any stress and conflict being experienced, and its impact on their work, can be acknowledged.



It is a moot point as to whether individual or group supervision provides the most fertile opportunities for professional growth. Groups certainly have their advantages when all goes well, but as indicated in the following slide, there is considerable potential for problems associated with such intensive groups. Experienced and confident facilitators are necessary to run effective supervision groups, with the exception of peer-led groups for experienced clinicians who have already established a good working relationship.

It is hard to define a meeting as a group in a clinical context if it has less than 4 members; more than 8 members will lead to somewhat unwieldy dynamics in such an intensive context (although one cannot be too prescriptive, as a well bonded group of 8 -12 members may work adequately together). One hour is unlikely to be sufficient to cover pressing issues in a supervision group; more than two hours of intensive work may be too taxing.

When a member(s) is continuing to subvert the group after attempts have been made to modify their behaviour, it might be appropriate to terminate their involvement rather than for the group to suffer continued disruption.

Only very experienced, skilled and confident facilitators should attempt to oversee a supervision group.

A supervision group does not have to be a pure version of one of these formats to the exclusion of other styles of facilitation. During the evolution of a group, various approaches may be used, preferably negotiated with its members.

Adhering to a template for the processes involved in facilitating a supervision group will increase the likelihood of good outcomes, without denying the group an opportunity to negotiate their preferred modus operandi.

10. Practical Tips for Running an AOD Supervision Program

Developing
Implementing
Evaluating

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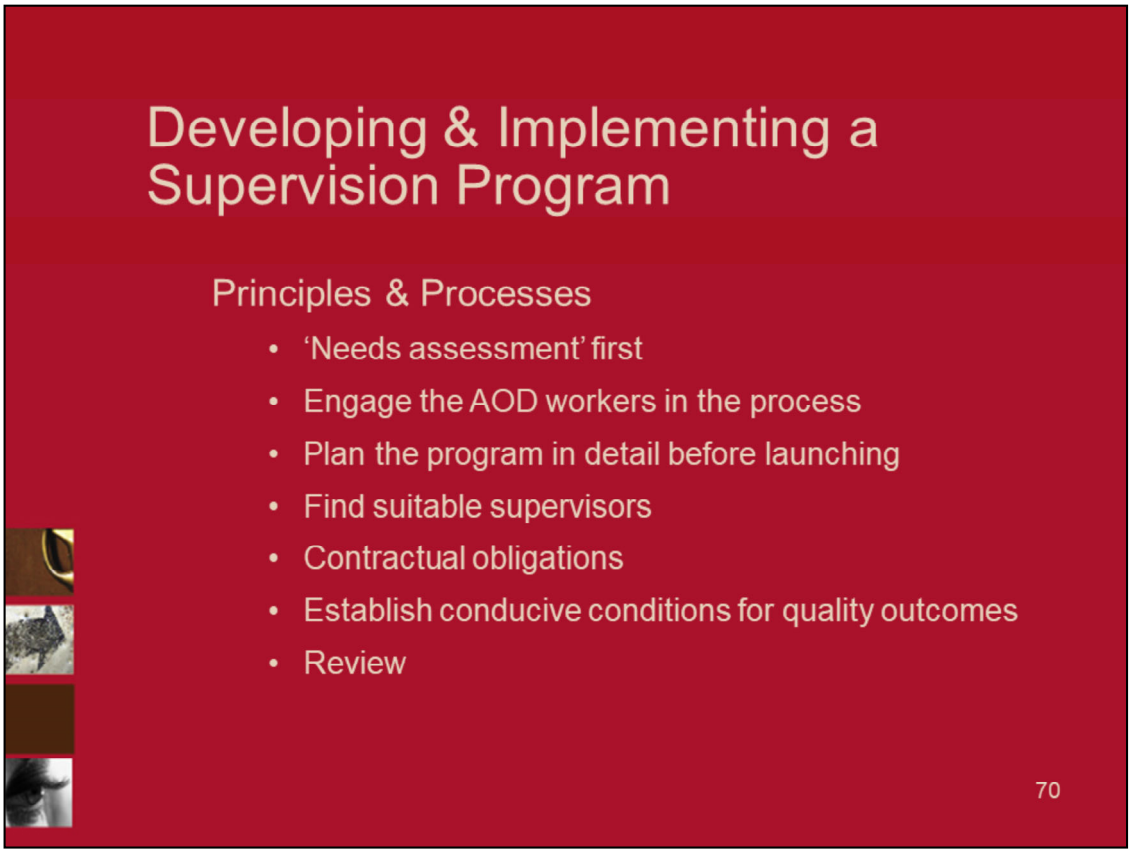
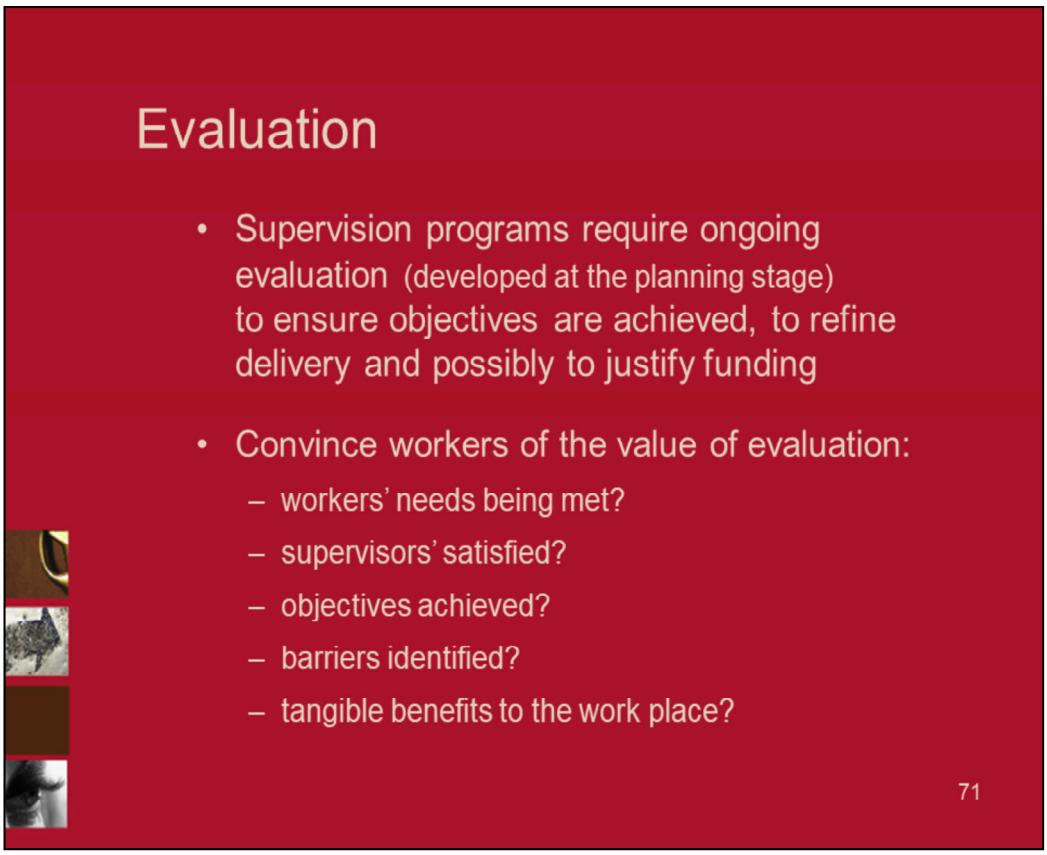


These are the same principles for establishing any new program, and if adhered to increase the chance of successful outcomes.

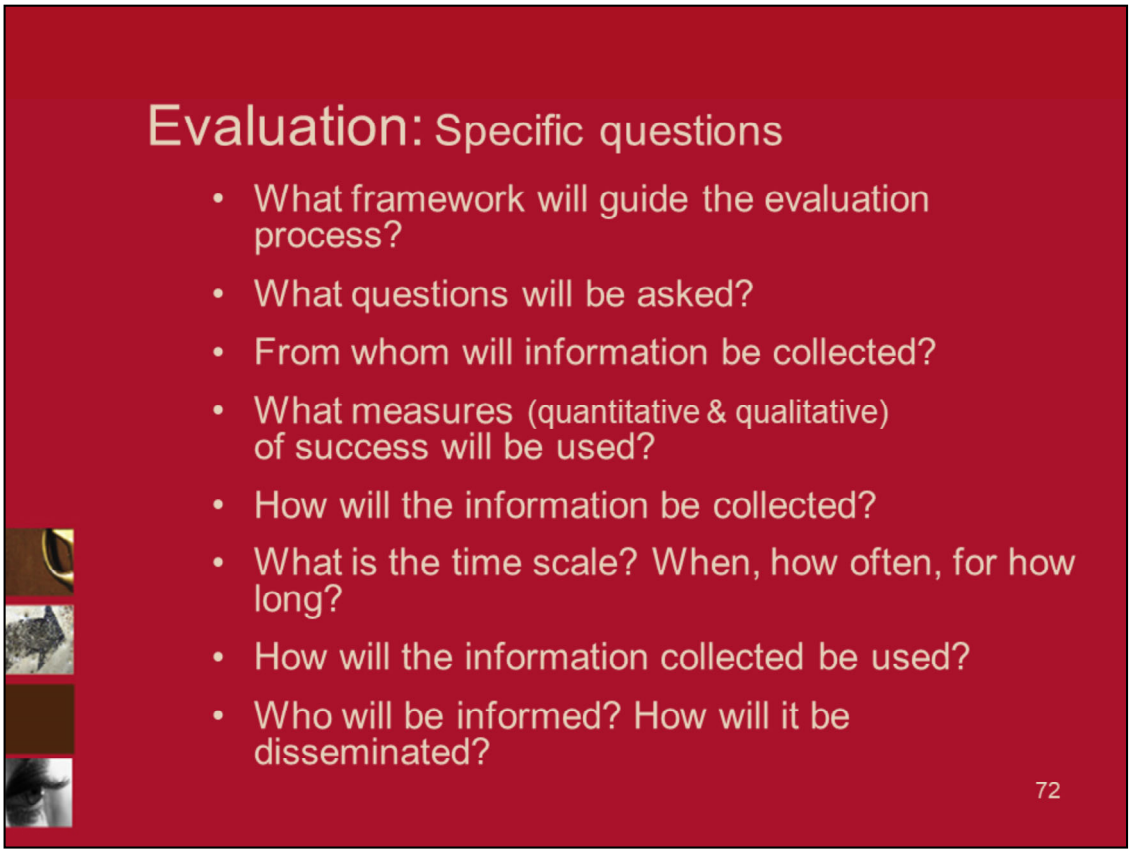
A needs assessment should occur after the staff have been given a clear rationale for the process, and a guarantee that a program will follow. Raising expectations, and then not delivering, is very bad for staff morale.

A critical factor is securing an adequate number of highly competent clinical supervisors (they can be in short supply). Search and recruitment of supervisors should begin early in the process, so that unnecessary delays are avoided. Clear contractual obligations consistent with your organisation's policy should be established with external supervisors.

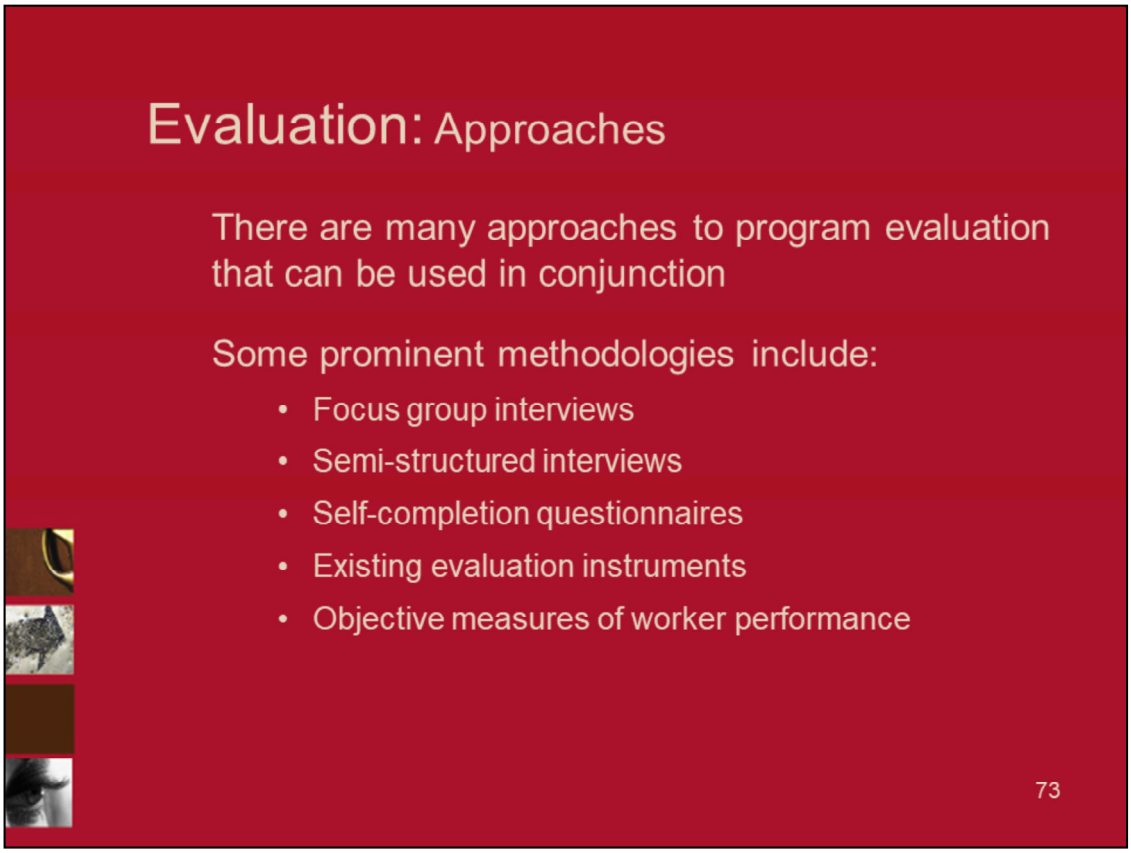


The main rationale for program evaluation is to determine whether a program is efficacious, and for implementing further improvements. An additional role of evaluation may be to justify further funding of a program. The use of external clinical supervisors can cost a considerable amount (e.g. fees, the need to cover the supervisee's absence, costs incurred in planning and setting up the program), unless some reciprocal funding arrangement is put in place. Therefore, it is vital that the program be evaluated from the outset to help further planning and justify funding

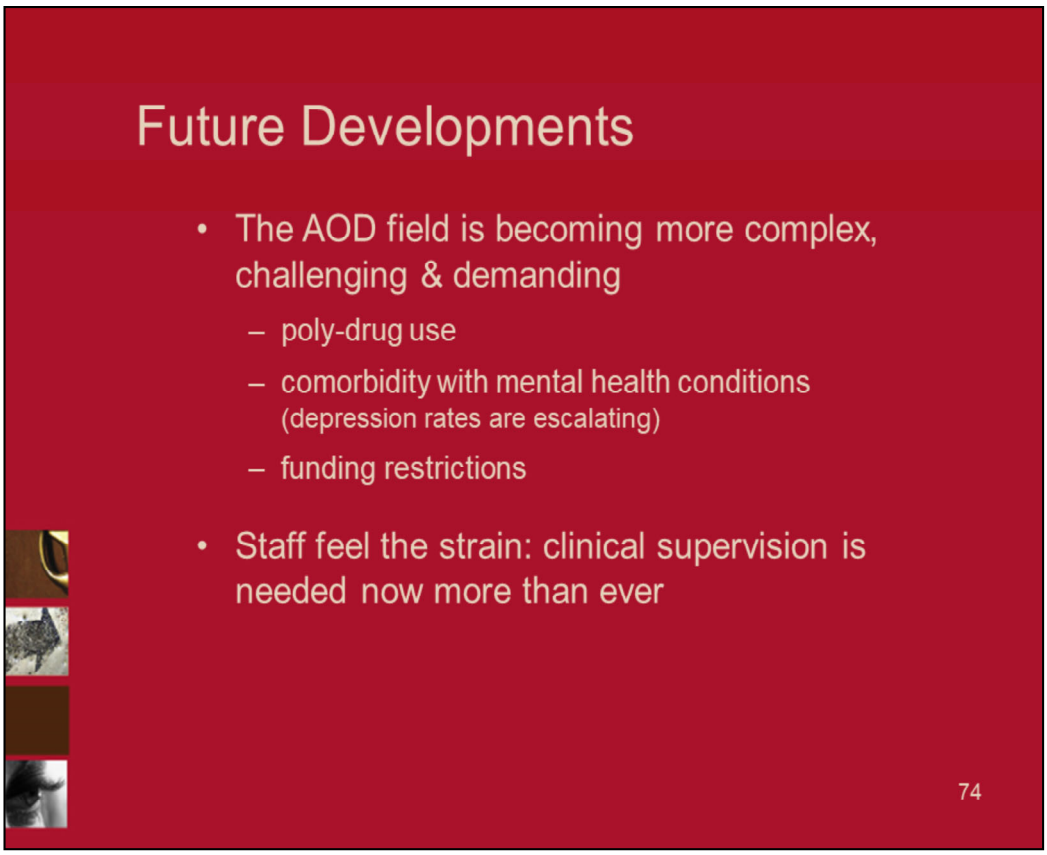
This is not to argue that clinical supervision should only occur if proven to be cost-effective, as it is a professional requirement that registered health workers receive clinical supervision. But, if tangible benefits of a program can be demonstrated, then the agency can justify a fully-fledged program without compromises.



These are standard lines of enquiry for the evaluation of any program. Managers/program officers could be asked to generate further questions specific to supervision programs as part of a training exercise.



It is not possible to train participants in any of the above methodologies in a workshop centred on clinical supervision. Evaluation workshops are required for those workers who will be involved in program evaluation but have no prior, or limited, experience in evaluation. Evaluation is a very skilled activity, and can be counter-productive unless some basic principles are observed (e.g. existing research/evaluation instruments need to have had their validity and reliability demonstrated).



The number of clients who use amphetamines and cannabis (not necessarily simultaneously), often in conjunction with alcohol, has increased sharply over recent years.

Comorbid presentations in the AOD field have been common for many years (depression, anxiety states/paranoia, schizophrenia, personality disorders), presenting a great challenge for AOD workers and other mental health services.

Clinical supervision can make an important contribution to current and emerging AOD issues and their effective management.

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