

# Clinical supervision in the Alcohol and Other Drugs sector as conducted by external supervisors under a social work framework: Is it effective?

A thesis submitted in fulfilment of the requirements for the degree of  
Master of Social Work

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## Declaration

I certify that except where due acknowledgement has been made, the work is that of the author alone; the work has not been submitted previously, in whole or in part, to qualify for any other academic award; the content of the thesis is the result of work which has been carried out since the official commencement date of the approved research program; any editorial work, paid or unpaid, carried out by a third party is acknowledged; and, ethics procedures and guidelines have been followed.

Signed:.....

Date: ...../...../2009

Marcel A. Koper

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## **Abstract**

In this thesis, I explore the impact and effectiveness of clinical supervision provided by external clinical supervisors, on workers from a variety of practice backgrounds in a residential rehabilitation centre, in the AOD sector. This thesis uses the framework of social work supervision, as defined by Kadushin (1985; 2002), with the administrative, educative and supportive elements. The research focuses closely on the latter two elements. For this purpose, I employ qualitative research methods, via a triangulation of methods, being guided by Participatory Action Research (PAR) and then conducting semi-structured interviews and focus groups as well as acting as a participant observer, to gather the data. The data was analysed using grounded theory.

This research was based upon a clinical supervision project that was fully funded and provided free clinical supervision by external supervisors, providing both individual and group supervision, for a period of 10 months. There were a total of 16 respondents with varied roles and training backgrounds as well as an additional six supervisors, interviewed throughout different stages of the project. The various roles undertaken by me throughout the research process provided essential viewpoints on supervision, as well as the place of boundaries and need for support. The power of such a large scale intervention is discussed and ultimately highlights and identifies the particular benefits of supervision in this research arena.

This thesis places clinical supervision in the context of workforce development in the Alcohol and Other Drug (AOD) sector. Thus, while this research elucidates a number of benefits and the factors involved with this experience, the clear separation of other modalities such as training, mentoring and Critical Incident debriefing are seen as integral additional avenues of support and professional development. This research concludes also with what the difficulties and hindrances were for people to continue with regular ongoing clinical supervision, and warrants the argument for interminable supervision in this setting.

This research points to an overall paucity of literature on efficacy studies, especially in the AOD context in Australia. This research significantly adds to this dearth and examines the factors unique to the AOD sector in Australia, as well as what factors make for effective supervision. The particular impact of external supervisors and group supervision are explored, which underwrites the forwarded concept of a customised supervision for this setting. By making explicit in this research what the efficacy is on those new to supervision, it provides greater clarity for future studies.

A number of recommendations are proposed as result of this research. New definitions of the supportive function of supervision and of clinical supervision are forwarded, as is a new look at the evolving history of social work supervision. This thesis highlights the impact of external supervisors and the unique contribution they offer.

## Preface

The opportunity to conduct this research came as a result of successfully co-writing, with the Program Manager and Program Director from the Basin Centre, a tender for a project that provided free clinical supervision by external supervisors for a period of up to 12 months. The external supervisors normally cost minimum one hundred dollars per hour. The funding body was the Alcohol Education Rehabilitation (AER) foundation. The 'clinical supervision project' I investigated provided both individual and group supervision, by external supervisors, for every willing worker, to a total of 30, for 10 months commencing in February 2005 and ending on the 30 November 2005.

In eight years of practice in the Alcohol and Other Drug (AOD) sector prior to this study, operating primarily as a counsellor, I was involved in clinical supervision as both a supervisor and supervisee. Particularly in the latter five years, I noted how AOD workers generally were not accessing clinical supervision and this aroused my curiosity. Upon investigation, I discovered a number of consistently cited reasons. High on the agenda was the considerable expense of clinical supervision, which the wages of the sector did not support. Other reasons were in the differing education and training backgrounds of workers in the sector, and the different emphases on clinical supervision. Limited promotion of the value or importance of clinical supervision in most AOD workplaces was another. Some workers placed little, if any value on supervision. There are no supervision-specific subjects offered in the AOD field qualifications (or welfare for that matter). The research was informed by my experience as a teacher in the AOD and welfare sector. One of the overarching features that stood out after discussion with people right across the sector was a general lack of understanding and experience of clinical supervision. Undeniably De Bomford's (2005) thesis confirmed my experience of this in Victoria, where he highlighted how the majority of workers in the AOD sector in Victoria were not receiving, and had little understanding of, clinical supervision. I found this perplexing, given both the complexity of this work and the challenging target group.

While completing a postgraduate Diploma in Social Science (Gestalt Therapy) at Swinburne University in Victoria from 2001 to 2003 I was strongly encouraged by the course trainers to receive regular, minimum fortnightly, clinical supervision. After following this recommendation in 2002, admittedly a bit hesitantly due to the potential financial burden, this for me has now become the norm. It took the actual experience of receiving regular clinical supervision to make me appreciate its potential positive impact. This positive experience I soon ascertained from other colleagues in the sector was not an experience in isolation. Others confirmed their personal experience of the ongoing importance of clinical supervision. My previous experiences of clinical supervision had been primarily with my line managers. This occurred sporadically and irregularly and was loaded with frustrations. There was a general lack of safety discussing my work issues with my line manager, who also had the task of performance management. Other colleagues concurred with this experience whenever I discussed it, and there followed confessions by some people who felt almost abused in their clinical supervision relationships with their line managers.

Concurrent with this experience was forward momentum for overall workforce development in this sector, heralded by groups such as the National Centre for Education and Training on Addiction (NCETA) and the Victorian Association of Alcohol and Drug Agencies (VAADA). In response to this I took part in the working party for Workforce Development coordinated by VAADA, the peak body for the AOD sector in Victoria. I became curious as to what the ensuing report would recommend. The report and process was funded by the Alcohol Education Rehabilitation (AER) foundation and concluded that supervision was a defined area of need that would aid workforce development. It then went on to outline a number of inherent benefits. My research question began to take shape in my mind, in that if significant people and groups were recommending clinical supervision for AOD workers, and given that there was little, if any, conducted, what then would be the impact and how effective was clinical supervision on AOD workers? Some people reported negative

experiences, whereas my experience was positive, and some did not even understand the very concept, then I wanted to know just what would be the impact if workers received regular clinical supervision.

AOD workers come from a variety of training and therapeutic backgrounds, including social work, psychology, nursing as well as those trained in Narrative Therapy, Gestalt Therapy, Cognitive Behavioural Therapy (CBT) or various eclectic modalities. To investigate clinical supervision in the AOD sector the study would need to represent this array of backgrounds. There was a need to know more than just what I gleaned from other people; I fully acknowledged that my experience and the anecdotal data gathered, was inconclusive and without any thorough backing. The literature review conducted to that stage pointed to a dearth of available literature on the impact of clinical supervision as well as AOD literature but in social work, the social sciences and psychology.

The counterbalance of my personal experience of clinical supervision occurred when I attended various different training days on clinical supervision. My attendance was partly to investigate further this key interest area of mine, but also for the personal gain of becoming a clinical supervisor. Finding any substantial training on clinical supervision was indeed difficult, especially in my home base of Melbourne. The aim of the initial training I attended, conducted by Dr Susan Lewis, in Melbourne, who is both a social worker and a psychologist, was to train managers to become dual clinical and administrative supervisors, as distinct to being an external supervisor only, and not needing to negotiate dual roles. I attended similar training at the Bouverie Centre in 2005, as part of their postgraduate certificate in clinical supervision, which was conducted with a similar premise. The managers with whom I discussed my developing research ideas, and who attended these training sessions, did not see clinical supervision as having any conflict of interest when delivered by them. Their general consensus was that clinical supervision was important for their staff, but not extremely, and that it was conducted internally due to the costs

involved. On the other hand approximately one-third of these managers felt that external supervision was beneficial, and had some experience of it.

In November 2003 I was employed at the Basin Centre through a 22 week funded<sup>1</sup> workplace exchange. From this experience I recorded in my final report that I observed a general lack of clinical supervision or relevant support. It was also a recommendation from the same report (Koper 2003, p. 3) that it would be appropriate for all workers to receive supervision because of their constant contact with the client group. The particular nature of a rehabilitation setting lends itself to constant contact with the client group. It is slightly different to an outpatient setting, where it is more common to have only one hour of contact a week. In this setting, there may be two counselling sessions a week, group work, as well as sharing of work and meals together.

The Basin Centre's staff cope with a plethora of stressors on a daily basis involving not only AOD issues with their clients, but also mental health, dual diagnosis, Acquired Brain Injury (ABI), involuntary clients (ordered by a magistrate), mediation between clients, behaviour management, sexuality and sexual issues, abuse, trauma, deaths of clients and ex-clients or a combination of all of these. The potential for vicarious trauma is high. Organisational issues and general counsellor and worker issues are also part of the range of difficulties faced and dealt with. All of these require skill, training, and expertise as well as support and supervision. This is a brief picture of the background of the Basin Centre, but in many ways the above issues are representative of the entire AOD sector.

My choice of theory and methodology is also partly informed by other life experience. My working history includes being a missionary for five years in a Catholic religious order, which included academic and informal theological training. Part of this experience was working on mission with different groups of 'stolen generation'

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<sup>1</sup> This was also funded by the Alcohol Education Rehabilitation foundation.

Aboriginal people in Darwin in 1996. It was there that I was constantly (only rarely verbally) and gently reminded of the colossal impact that making policy and decisions out of observing from a distance had. The 'White Assimilation Policy' was born of such a policy-making method. The Catholic Church made similar errors, though they attempted to at least engage the indigenous people and their culture through some missionary groups, naively enforced a western European style of Catholicism upon those they worked with. For example, if these people wished to be Catholic they had to do so in a Roman Catholic way including Latin<sup>2</sup> masses and the like. There was no tuning in from the 'inside' and minimalist enculturation attempts. The Aboriginal people from my Darwin experience taught me how to stop and listen, to attempt to see the world from their view. I am forever grateful. Simultaneously I was influenced by a theologian called Gustavo Gutierrez (1971), who developed 'liberation theology'. He posited that one could only theologise out of a particular cultural matrix. In fact one needs to be embedded in that culture, live it, breathe it, and this may include living with the poor, rather than spending time and then returning to the security of western comforts. His teachings influenced the choice of Participatory Action Research (PAR). It also influenced a leaning towards being a participant observer, and thus theorising from an 'insider' experience.

One of the original driving purposes of my research is that the findings go towards influencing governmental and/or agency decisions in respect to clinical supervision, especially when assessing the ongoing funding of similar agencies in the AOD sector. At the time of the study and still currently, there is minimal to no provision in the funding of positions in this sector for clinical supervision, especially for external supervisors, and certainly also not for the time out from a place of employment it takes to see the clinical supervisors. Those familiar with clinical supervision from any discipline, would have some understanding of the considerable and additional expense of paying for external supervision. Moreover, the historically modest level of wages in the AOD sector bears this out.

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<sup>2</sup> Prior to the second Vatican Council in 1962, all forms of the Catholic mass were conducted in Latin.



## Introduction to thesis

Clinical supervision has long been an integral component of much professional training as well as ongoing workforce development for social workers, psychologists, therapists of varying backgrounds and in latter years, nurses. Clinical supervision has risen to prominence in the last decade yet there is mixed reaction as to its importance and effectiveness. At the coalface of work in the helping, supporting and caring professions, clinical supervision is touted as a vital ingredient for worker retention, stress reduction, reduced absenteeism and professional development. However, despite such accolades, it is difficult to fully ascertain the connection of supervision with these outcomes especially considering the dearth of research on the efficacy of clinical supervision and lack of consensus even on the meaning of the term.

Recent literature and movements in the Victorian AOD sector have ranked clinical supervision as a key component of workforce development overall, due to its innate efficacy. There is a general lack of literature to support this locally and in the wider social work, social sciences, psychology and nursing fields. The reason for this begins with the problem of the understanding of the term, clinical supervision. This thesis seeks to bring some greater clarity as to the impact of clinical supervision and also seeks to contribute to a small but growing body of research on the matter.

This thesis explores the impact and effectiveness<sup>3</sup> of clinical supervision from the perhaps controversial perspective of engaging external supervisors to ensure its separation from line management supervision. That is, in a social work model of supervision (Kadushin & Harkness 2002), there is distinct separation of the administrative function from the educative and supportive functions. This thesis

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<sup>3</sup> 'Effectiveness' and 'efficacy' are used throughout the thesis, reflecting the language used in other studies in this sector. They are interchangeable with 'impact' and 'benefit', which are more commonly used PAR.

examines the separation of roles in the context of the Alcohol and Other Drug (AOD) sector, where the study took place in an AOD rehabilitation centre in Melbourne's outer east, at the Basin Centre, run by the Salvation Army. The respondents involved were from a wide variety of training backgrounds and have differing roles. In many respects they are a good cross-section of the diversity of experience and working backgrounds of the current AOD workforce in Australia.

In this study I ask a number of research questions to determine the efficacy of clinical supervision as conducted by external supervisors on respondents from a wide variety of educative, training and therapeutic backgrounds. Although I use research questions to help guide the research process, it is the intention in this study to be equally led by the data and uncover new information.

The first part of my investigation enquired as to the impact on workers of clinical supervision in an AOD residential rehabilitation setting. The questions were tailored to separately examine the impact on those new to supervision and the more experienced. Secondly I sought to determine what factors were associated with difficulties as well as benefits of clinical supervision. Thirdly I sought to understand the AOD-specific features and issues of clinical supervision particular to this setting, and their relevance. Finally I asked about the impact of having external supervisors provide clinical supervision and in this sense separating the administrative function from the educative, supportive and more clinical functions.

I conducted pre, mid and post interviews with ten respondents; I conducted focus groups with an additional six respondents on the same time-line. The external clinical supervisors employed in the study were also interviewed, making for rich and confirming viewpoints. The Participatory Action Research (PAR) utilised throughout the 10 month course of the study, combined with my role as a participant observer, were pivotal to ensuring quality outcomes.

In the first two chapters I conduct an exhaustive review which scrutinises the Australian-specific and international research on clinical supervision, relevant efficacy studies and AOD studies, from the social work, psychology, social sciences and nursing literature.

The third chapter outlines firstly the background to the study and then moves to the triangulation of methodologies employed so as to gain a number of differing but confirming perspectives. In the fourth chapter I detail how the data was gathered and elaborate on the use made of grounded theory for the data analysis in this study and its application alongside the other methodologies employed throughout the research.

Chapter five, six and seven examine in detail the findings as related to the research questions as well as what was discovered via a grounded theory analysis of the data. Chapter five provides an overview where chapter six moves to greater detail in focusing on the answers to the research questions. Chapter seven focuses specifically on new discoveries that were not direct answers to research questions.

In chapter eight recommendations arising from the research are discussed as are methodological discoveries. The chapter then moves to a deeper discussion of the findings and concludes with an understanding of the evolving history of clinical supervision and offers alternative definitions of supervision.

As with Hammersley (1995, p. 105), the pertinent object of this research is 'immediately directed' towards 'the production of valid and relevant knowledge'.

Finally I will introduce a scenario that I will return to in the conclusion, involving a person employed in an AOD agency in Victoria, in this case, an AOD rehabilitation centre. This person is Dominica (alias). She daily works directly with clients who discuss a myriad of issues from family breakdown, suicidal ideation, trauma-based issues, mental health, sexual abuse, emotional abuse, relationship disintegration as well as the tumult and debility of their dependency on their substance of choice. The

relapse<sup>4</sup> rate is high and the frustration and difficulty of re-engaging these clients is also taxing on Dominica and multiplied for the person who has the dependency. A critical incident in the course of a fortnight to a month, or news of a suicide or death, that may necessitate some level of debriefing would equally not be unusual.

After repeatedly working with these issues and attempting to support her clients, Dominica feels the need to offload some of this heavy material at the end of the day. She also wishes to talk about herself a lot more and not always about a client review or therapeutic skilling. Dominica never availed herself of debriefing after the recent critical incident. She feels unsure about offloading to her manager due to the general lack of trust and rapport she feels with him. He too seems stressed lately because of the tight funding regime and other organisational issues that he confides in her about. Dominica has been working a few extra hours without pay or benefit just to keep up with her workload. She has also been feeling for some time that she is losing interest in her job, as she feels stressed quite often, and notices her colleagues in a similar situation. She has been considering external supervisors for some time, but is weighing up the cost. Her manager said that she could have the time off for this. She has been recommended a couple of clinical supervisors, one of whom is relatively cheaper, and possibly not as experienced. The other is more expensive but has a greater depth of experience and has a solid background in AOD work.

Dominica investigates further and finds a supervisor who matches her training and her key therapy background interest. The drawback is that this supervisor is not very experienced in AOD work and is also expensive, considering her modest wages.

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<sup>4</sup> Relapse is a common AOD field term that means returning to their substance of choice in the form of dependency. A lapse is slightly different in that it is only a brief return to their substance of choice before they return to sobriety.

## **Chapter 1:**

### **Overview of supervision and the historical perspective**

#### **Introduction**

Social work supervision has been identified as one of the most significant factors in determining job satisfaction levels of social workers and the quality of service to clients. Indeed for many social workers supervision is one of the most highly valued characteristics of their profession. There are only a handful of recent texts that directly address social work supervision as its main subject (Kadushin & Harkness 2002; Munson 2002; Tsui 2005), and seemingly only one that investigates research into social work supervision at length; by Professor Ming Sum Tsui, Senior Lecturer in Social Work from the Department of Applied Social Sciences at Hong Kong Polytechnic University (2005). Tsui's book examines what research has been conducted on social work supervision (total 34 studies), including all studies to date, and makes a number of pertinent recommendations. In fact he wrote the book to 'bridge the gap between the demands of the field and the absence of literature' (Tsui, p. xiii). Tsui's (2005) book was influential in helping set up the initial parameters of this study.

A comprehensive search on the current range of literature on clinical supervision was explored, including social work, nursing, psychology, psychotherapy, school counselling, and counselling literature in general. Literature that specifically

addresses the Alcohol and Other Drug (AOD) sector was also explored. Clinical supervision in the nursing literature has proliferated in recent years, and as such are utilised considerably throughout the following chapters. The main and seemingly only text relating to the drug and alcohol sector is Powell's (2004) book, *Clinical Supervision in Alcohol and Drug Abuse Counselling*. A number of new and emerging articles and resources in the Australian context on clinical supervision are well informed and with sound research backing, and will be explored later in this chapter.

The following two chapters will for the main part primarily explore the social work literature. This is chiefly due to the clinical supervision project, upon which this research hinged, being purposely based on the social work model of supervision. The social work model of supervision separates the three functions of clinical supervision into the educative, supportive and administrative functions. In summary this thesis explores the impact and effectiveness of clinical supervision from a social work framework on people working in the drug and alcohol sector.

Definitions of clinical supervision and supervision in general are explored. Given the nature of this study, the review will dedicate some time to exploring the pertinent features of the salience or efficacy of supervision or lack of it, and what factors are associated with this. These factors entail the choice of supervisor, the cost of supervision and training of the supervisors. The study places clinical supervision in the overall context of workforce development.

Clinical supervision is primarily conducted in individual dyads but is also common in group or peer settings. The clinical supervision project based its model on covering both individual and group supervision. Thus a thorough exploration of group supervision was also conducted.

The term clinical supervision will be explored at the beginning of this chapter and following this the generic term of supervision will be utilised. Specific terms such as

clinical supervision, professional supervision or similar will be mentioned in the context of the study to which they apply. Literature on student supervision has been deliberately omitted as there is a clear delineation in the literature between workplace and student supervision. It is acknowledged that possibly some of those findings could be relevant; however it is not the focus of the research.

### **What is supervision?**

To supervise is to oversee or to view another's work generally. Some may say literally that it is to have 'super-vision' (Lewis 1999). Indeed I have encountered some very insightful and wise clinical supervisors. Others again may posit that clinical supervision is purely to check whether someone is correctly performing a particular activity or intervention or procedure, whether practice based or not. For different professions and different work backgrounds there are a variety of connotations. Some authors agree (Golding & Gray 2007; Mc Mahon & Patton 2002) that the goals of clinical supervision are to encourage reflection, understanding and self-awareness in the supervisee, and to enable problem-solving. Principally, the aim is to enhance clinical practice, and its effectiveness, in the best interests of the client.

Overall there is unanimous agreement in the literature on the absence of a universal definition of clinical supervision (Barriball, White & Munch 2004; Kelly, Long & McKenna 2001; Williams, French & Higgs 2005). Holloway (1995), Bernard and Goodyear (2004) and Munson (2002) all work through a cumbersome process to arrive at a 'working definition' of describing supervision. DeBomford (2005), in one of the few pieces of research in the Australian context on clinical supervision in the drug and alcohol sector, concluded that it was very difficult to find a useful and universal definition of clinical supervision.

Numerous studies reviewed by Tsui (2005) utilised a too generalised conceptual definition of supervision, making the construct of supervision too vague to operationalise and to test precisely. Munson (2002, p. 10) defines clinical social work

supervision as being only linked with the concept of 'clinical social work', which in itself has quite a specific definition.

Research from the mental health nursing arena indicates that provision of formal clinical supervision may be impeded by perceptions that informal or 'ad hoc' supervision equates with clinical supervision (Cleary & Freeman 2005, p. 490). Whether 'one of the most contentious issues in the literature is the lack of agreement on a clear definition' (Victorian Healthcare Association [VHA] 2008, p. 4), correct, is worthy of consideration. An alternative view is that the definition 'issue' is more indicative of the diversity of practice and professional backgrounds. However, across the board there are a number of common features of clinical supervision.

### **Common features of the multiple definitions**

Bernard and Goodyear (2004, p. 12), from a psychology background, suggest that supervision has two central purposes:

1. To foster the supervisee's professional development; (and)
2. To ensure client welfare.

The bulk of the literature would concur with this, yet it is how this is arrived at that differs somewhat. Sloan (2006, p. 11) describes three functions of supervision. They are the *formative* function of supervision, aimed at skills development; the *normative* function, concentrating on managerial issues and adherence to professional standards; and the *restorative* function, of providing support in an attempt to alleviate stress.

Williams, French and Higgs (2005) and Winstanley and White (2003), also from nursing provide summaries of the common features of the clinical supervision definitions. They both conclude similarly that it is:

- A focus on reflective practice and practice enhancement through self evaluation and development;



- A means to generate learning or increase knowledge; (and)
- Providing empathic support to improve therapeutic skills

### **Boundaries: what is and is not the realm of supervision**

What is the realm of supervision and what is not is sometimes difficult to distinguish. This includes the place of counselling, critical incident debriefing, mentoring and other workforce development activities. Of the latter two will be further discussion in the chapter. For example there is conjecture as to whether formal 'debriefing' is part of clinical supervision or is a separate therapeutic modality (Brunero & Stein-Parbury 2006). A critical incident (CI) is 'any sudden event which causes staff to experience strong emotional reactions which may interfere with their mental and physical state and their work performance' (Converge International 2008, Critical incident and management response, para. 1). The immediate or sometimes delayed response is what normally constitutes CI debriefing. The defining component is that it is generally a single session intervention, with follow-up when deemed necessary. If there are ongoing symptoms that affect a person's work performance or home life, then counselling is generally recommended.

Similarly Ennis, Cameron, Leszcz and Chagoya (1998) and Bernard and Goodyear (2004) discuss the blurry and difficult separation of counselling and supervision. Overall there is consensus that there are elements of counselling in supervision, but that these therapeutic interventions are aimed at supporting effective service with the client. Boundaries as to when counselling should be referred on must be defined.

Within the supervisory relationship itself, there is a range of understanding as to what is addressed and discussed in supervision. For example, although there is general acceptance of stress as a legitimate topic in supervision, 'how and to what extent a supervisor focuses upon it will vary' (Howard 2008, p.107). As to organisational issues, it is inconclusive whether clinical supervision is the ideal avenue for discussing these (Holloway 1985; Munson 2002). Similarly, whether

spirituality and its' application in practice is a topic for supervision is also varied in opinion (Grauel 2002b; Mann 1999).

Gregurek (2007), Heru, Strong, Price, and Recupero (2004) and Skerret (2004) recommend that the intimacy and content of the supervision, according to supervisor and supervisee style and needs, be defined at the beginning of the relationship with the possibility of a contract for this purpose. Furthermore, 'boundaries between supervisees, their agencies, and outside supervisors need to be negotiated' (Ungar & Costanzo 2007, p. 75).

This leads to the notion of boundaries, and how a potential supervisee understands the content and parameters within supervision. Boundaries have been historically hard to define (Stiles 2004), being not too dissimilar to clinical supervision in this respect, where people's definitions may have slight deviation and variations. Similarly, the AASW's code of ethics (2002) makes reference to and discusses the concept of professional boundaries but has no distinct definition of the term. The social work literature contains few in-depth discussions specifically about boundaries but deals rather with boundary issues, such as dual relationships (Reamer, 2003); for example, relationships that are both friend and supervisor. What follows is a brief discussion describing the concept and parameters of boundaries.

In exchanges between humans, there are implicit and explicit rules for interaction that maintain the fabric of culture and the integrity of each individual. We begin learning these relationship 'rules' at birth, and they continue to guide our interactions throughout our lives (Somers-Flanagan & Somers-Flanagan 2007). Relationship rules create boundaries within and around all human relationships. These boundary rules include the 'proper' amount of interpersonal space for various types of interactions including business, professional, service, sales, romantic, and familial. Other boundary rules include matters relating to dress, touch, food consumption, appropriate work and recreation, sleeping arrangements, and many other aspects of relating to others and ourselves. The notion of work-life balance and other ethical

issues with clients, including the line between the personal and the professional, are all part of what is commonly referred to as boundaries. Maintaining healthy boundaries around personal and professional relationships is an important component of burnout prevention, upholding professional fidelity and in the protection of clients (AASW 2002).

Personal boundaries are the physical, emotional and mental limits that define you as separate from another person. Having 'healthy' personal boundaries means accepting that you are a separate individual with your own emotions, needs, attitudes, values, limitations, strengths and weaknesses, and that others are separate individuals in their own right. Boundaries are where a person starts and stops. They include being able to say no or stop to behaviours that they do not like from others. It is equally about learning to stop personal negative behaviours. Self reflection is required to be able to know in what aspects of their life they may need to have stronger or clearer boundaries. People with healthy boundaries have respect for other people's feelings and beliefs, even when they are different from their own. Similarly, role boundaries are where a person starts and stops in relation to their job, their colleagues, management, work-life balance and work performance. Boundaries need sometimes to be an impenetrable brick wall for some; others need to learn a knowing flexibility. Too much rigidity and too much flexibility are not ideal. Maintaining good boundaries between supervisees and supervisors are crucial to the integrity of the supervisory relationship (Heru, Strong, Price, & Recupero 2004).

There was a lack of literature that named boundaries as their own topic or area of exploration in supervision. Much of the literature involving boundaries is often an exploration of coinciding ethical issues (Munson 2002; Sloan 2006).

The discussion so far encapsulates the essence of the common features of clinical supervision. In understanding the core and common features, just what are the different functions particular to social work supervision?

## **The difference between clinical and administrative supervision**

Kadushin (1985, pp. 27-28) confirms like others that;

Given the multidimensional nature of supervision and the different sets of theories associated with each aspect of it, the formulation of a theory of social work supervision is an unlikely undertaking.

However, in his 2002 text he is much more comfortable with the research pointing to the fact that supervision entails the 'administrative, educational and supportive functions' (Kadushin & Harkness 2002, p. 44). Informed by Kadushin, the current National Practice Standards of the Australian Association of Social Workers (AASW) also state that 'Social work supervision encompasses administrative, educational and supportive functions, all of which are interrelated' (AASW 2000, p. 1).

The administrative function provides frontline social workers with a context in which to perform their job effectively and to implement organisational objectives. Common tasks associated with this are staff recruitment, induction, monitoring and evaluating work, coordination, work assigning, and performance monitoring (Kadushin & Harkness 2002, p. 47; Tsui 2005, p. 15).

The educational function aims to improve the social worker's capacity to do the job effectively, by supporting workers to develop professionally and maximising their practice knowledge and skills. This involves teaching the necessary knowledge, skills and attitudes and involves 'detailed analysis of the worker's interaction with the client' (Kadushin & Harkness 2002, p. 129).

The supportive function goal is to ensure that ultimately social workers feel good about their job and are comfortable and satisfied, possessing a sense of psychological wellbeing. It is basically caring for the carers. The rationale behind this is if workers feel confident and are working on their wellbeing, then in turn they can communicate this same hope and wellbeing to clients. (Tsui 2005, p. 81).

Holloway (1995) succinctly formulates an intelligible understanding of the different facets of clinical supervision, and sees the distinction between the administrative and clinical functions of supervision. For Holloway, to understand the purpose and structure of supervision, it is essential to identify whether the primary context of a supervisory situation is clinical or administrative. 'Administrative or managerial supervisors have the task of overseeing, directing, and evaluating the work of clinicians, students and staff members' (p. 3) in an organisation. Responsibilities include recruiting, delegating, and monitoring work; being a managerial buffer, and acting as a change agent in the organisation (Kadushin & Harkness 2002, p. 130). Clinical supervision involves a main focus on the professional development of the supervisee and their skills within the organisation, with greater emphasis on the educative and supportive functions. The supervisee and clinical supervisor discuss clinical and professional issues as they relate to the professional growth of the supervisee. The ultimate long-term objective is to provide efficient and effective services to clients.

Powell (1998; 2004), in the only text of its kind on clinical supervision in the Alcohol and Other Drug (AOD) setting, also separates the administrative and clinical domains effectively. The administrative function is about helping the 'supervisee function more effectively within the organisation, with the overall intent of helping the organisation run smoothly' (2004, p. 5). Associated tasks in this domain are managerial requirements like case records, referral procedures, continuity of care, accountability, recruitment, performance evaluations and the like. The distinct difference of clinical supervision is that it focuses on the development of the supervisee specifically as an effective clinician. Areas dealt with are the counselling relationship, client welfare, worker support, clinical assessment and skills, worker style and other issues pertaining to the supervisee's professional and personal needs.

Powell also points out that: 'supervision is not therapy, but the relationship between supervisor and supervisee does have a therapeutic dimension' (1998 p.13). Powell

(2004), Cooper (1999), Edwards, Cooper, Burnard, Hannigan, Adams, Fothergill and Coyle (2005), and Bernard and Goodyear (2004) also add in an evaluative component to supervision, which Powell deems is 'essential if clinical work is to be accountable' (p. 14). This function entails providing feedback that is timely, constructive and non-judgemental.

Bernard and Goodyear (2004) distinguish an element of supervision being an 'intervention provided by a more senior member of a profession' (p. 8). Other authors (Hawkins & Shohet 1985; Holloway 1995) similarly add that a clinical supervisor is by definition a more 'experienced' person. This was not an important component in coming to a definition for the clinical supervision project but was inherent in some of the processes. The word 'senior' can have connotations of ageism or years of working experience. However it may be that a social worker of 20 years experience would receive supervision from someone with 10 years practice merely because of their high regard for their work in a similar field.

A few points will further clarify the boundaries of what constitutes clinical supervision for this thesis. This review comes predominantly from social work, psychology, school counsellor, nursing, counselling and psychotherapy literature, but the definition and understanding of clinical supervision in educational literature such as Pajak (2000) does not quite match, although it does have similarities. The understanding in Pajak's context is specific to teaching. However the above definition of clinical supervision may apply more to teachers who work with children/ students with challenging behaviours or have a large range of welfare issues.

Finally, the concept of ad hoc supervision (supervision on the run or as an immediate reaction to an adverse situation) is not part of the clinical supervision as understood throughout this thesis. Ad hoc supervision methods are difficult to show to be correct and optimal, but could be part of an overall clinical supervision program (Driscoll 2000, p. 47).

Below is a useful table reproduced from Roche, Todd and O'Connor (2007, p. 242) to help clarify the differences between line management (administrative) and clinical (involving the educative and supportive functions):

<b>Table 1. Differences between line management and clinical supervision</b>	
<b>Line management</b>	<b>Clinical supervision</b>
Managerial, hierarchical reporting process and quality control of an organisations performance	Concerned with skill development and quality control of an individuals practice
Concerned with evaluation and appraisal of all aspects of a practitioners performance for the purpose of appointment, promotion, dismissal and career development	Typically restricted to formative appraisals of the practitioners knowledge, roles, attitudes, beliefs and skills, with the potential for summative reports to management of the profession
May occasionally result in directives being issued to the staff member	Concerned with achieving optimal client outcomes via the provision of specific advice that the supervisee can decide to use to conduct independent practice

**Person-specific understanding of supervision: a broader perspective**

While Bernard and Goodyear (2004) suggest that a common formal definition should guide supervisory practice, it is equally inevitable that both supervisors and supervisees will have their own personal and sometimes idiosyncratic definitions (p. 14). This is based on both expectations and previous experience.

At any stage of a professional’s working life, one component of supervision may seem more important than at another time. For example, exploring professional

identity or the impact of gender on work performance, or organisational issues, may take precedence temporarily.

### **Definition of clinical supervision for this study**

The overall working definition of clinical supervision as the basis of this study is by Kavanagh, Spence, Wilson and Crow (2002):

Supervision is a working alliance between practitioners in which they aim to enhance clinical practice, fulfil the goals of the employing organisation and meet ethical, professional and best practice standards of the organisation and the profession, while providing personal support and encouragement in relation to professional practice (p. 247).

This definition of supervision is accurately understood in the social work framework of separating the administrative, educative and supportive functions. Indeed the study was purposefully set up to separate the administrative and clinical functions of supervision, with the former to become the specific task of the line manager and not the clinical supervisor. This separation of administrative functions is emphatically endorsed by Roche et al. (2007) from the National Centre for Education and Training on Addiction [NCETA] (2005) and Kelly, Long and McKenna (2001).

### **Clinical supervision: who for?**

For the last two decades clinical supervision has been synonymous with training in social work or psychology. It has been a common part of counselling training and ongoing professional development for some time now also. Towards the latter part of the 20th century nursing adopted clinical supervision (although there is some evidence that Florence Nightingale may have been the matriarch of supervision) and has taken it to new levels of professionalism. Allied health professionals also now avail themselves of clinical supervision (Community Health Services of the Eastern Metropolitan Region [CHSEMR] 2007). Different professions and training or tertiary institutions have their own histories in respect to clinical supervision. Some have



ongoing prescriptions for supervision where some only offer supervision during their training time. There is also now supervision for different roles, for example chaplaincy (Grauel, 2002b). There are also the beginnings of supervision for managers of welfare and community agencies (Victorian Health Association [VHA], 2008).

### **Historical overview of supervision**

Early insight into supervision is found in the evolving practice of consultation paralleling the medical profession's emergence in 17th and 18th century England. Grauel (2002a, p.4) investigated that there were three discernible levels of supervision which are now common to medicine:

- Close direct supervision (or 'over the shoulder');
- Close, indirect supervision (or 'on the premises'); (and)
- Distant, indirect supervision (or 'remote with monitoring')

It is reasonable to assume that the medical model was adopted by early social workers because they had many close connections with physicians (Munson 2002).

Grauel (2002a) in his searching of the literature on the history of supervision found that beyond this period it was social work, psychoanalysis and the different counselling approaches that had the greatest impact on supervision, with social work arguably the most influential.

### **Social work**

The roots of social work supervision can be found in America's northeast with the formation of Charity Organisation Societies (COS) in the 1880's. The upper classes got involved in philanthropic generosity in supporting volunteer services to the socially and economically disenfranchised. Tsui (2005, p. 2) makes the point that these upper classes would not have been supervised adequately and the support they received called be called more adequately, consultation rather than supervision. There was a lack of administrative type supervision at this time until these volunteer positions turned into paid positions. In general there are only a handful of references

to social work supervision before 1920 (Kadushin & Harkness 2002, p. 1). What can be surmised is that what began in social work in the early 1900's as inspection and review of programs, or effective and efficient administration of agency services, naturally extended itself to helping the social worker develop practice knowledge and skills and with the necessary emotional support. Thus the further two tiers of the social work model- the educative and supportive functions- emerged soon after.

The early twentieth century saw the practice of recruiting from the middle and working classes that ensured administrative accountability and offered personal support. Job orientation and training were carried out by the experienced and permanent agency staff (Kadushin & Harkness 2002, p. 4). The first formal social work education was probably conducted in 1898 in New York (Munson 2002). Due to high staff turnover, this training and the necessary nurturance became vital. By 1920 social work agencies linked to universities, and provided training supervision through practicums, tutorials or on-site field experience. Formalised training prompted inquiry into the nature of supervision and thus supervision became immortalised as an intentional social work practice (Tsui 1997). What also occurred is that while the learning was at universities, 'students learned social work practice at individual supervision sessions in their fieldwork placements' (Munson 2002, p. 115). These educational roots set the precedents for tutorials and individual conferences as the main formats for supervision of social workers.

By the 1930s supervision became more of a therapeutic process, being quite influenced by psychoanalysis. Supervision was reconceptualised as the lifelong development of the helping person. Social workers were especially drawn to better understand the motivation, thoughts, feelings and behaviours of the client and the social worker. Thus self-reflective and self-reflexive practice became paramount and self-awareness was a key ingredient. Simultaneously, staff supervision and student supervision became closely aligned; professional development as the core focus followed (Tsui 2005, p. 4). The separation from student and staff supervision did not occur until the 1960s when the clear differences were articulated.

In the same era, Virginia Robinson (1936) released the first book on social work supervision, but adopted a specific case work focus. The influence of the method of focusing specifically on casework combined with the psychoanalytic approach saw a style of supervision using parallel process where the goal for the supervisee was to explore and use the 'same skills to help their clients that their supervisors used to help them' (Tsui, p. 6). Supervision became a therapeutic process. A counterbalance to the psychiatric influence was Paige (1927, p. 307) who emphasised accountability in supervision.

The 1960s and early 1970s saw a period against supervision generally. The flavour was one of emancipation from supervisory control (Kadushin & Harkness 2002). In the 1970s there was a greater focus on accountability in agencies for the administrative side of supervision. The consequence of this was the discovery and growing interest in the need for a greater supportive function in supervision.

The last 20 years as described by Munson (2002) has seen social work operate out of 'Managed Cost Organisations' with a decreased 'emphasis on supervision of practice' (p. 88) due to supervision basically not being cost effective. Munson's (2002) tome on social work supervision is indicative of his stance on the importance of supervision. He finds one of the 'unexplained ironies of the social work profession' (Munson, p. 91), is that social work supervision should be at the core of the social work profession, but quite often gets put aside. Both Munson and Bernard and Goodyear emphasize supervision as a distinct and extremely important intervention in its own right.

### **Other disciplines**

As suggested earlier, the early popularity of psychotherapy leading back to Freud also coincided with supervision being a formal requirement for those in psychoanalytic training in the 1920s. It was not only social work that began to adopt

supervision on a larger scale at this time but also other helping professions including welfare (Bernard & Goodyear 2004, p. 210; Carroll 2007, p. 34). The second phase of psychotherapy supervision that emerged in the 1950s saw the burgeoning of counselling-based or psychotherapy-bound models of supervision. In the 1970s supervision moved to a more educative process with less emphasis on the counselling model. The work moved from 'the person doing the work to the work itself'. (Carroll 2007, p. 34). Thus there was a shift to practice, on the work proper and a clearer division between counselling and supervision. What emerged at this point were various different theories and models of supervision and a proliferation of research.

In looking to nursing, it is well known that Florence Nightingale encouraged the supervision of junior nurses by more senior nurses to improve their practical skills (Abel- Smith 1960 as cited in Sloan 2006, p. 3). However as with the psychotherapy literature, supervision began to flourish in the 1970s but was mainly targeted towards psychiatric nursing. In the last 15-20 years through nursing adopting regular clinical supervision, quality literature in this area has burgeoned. Yegdich (2002, p. 249) extols the notion that supervision has rapidly become the major force in nursing to improve clinical standards and quality of care.

Clinical supervision was originally introduced as a means of support to nurses in the workplace and has transformed since to being recognized as a way of providing nurses with opportunities for education, learning, and monitoring (Jones 2003; Malin 2000; Williamson & Dodds 1999). In Cleary and Freeman (2005), the definition of supervision developed from more of a pedagogical concept to embracing the ongoing need for professional development and support. Indeed, Yegdich (1996, as cited in Yegdich 2002, p. 257) again elucidates the difficulty of where the current focus of supervision should lie: whether through evolution over time or a wise reflection over the history to date, and offers another interesting angle; 'what is examined in supervision is the effect of the patient's suffering on the nurse's ability to respond, interact and think'.

There is some variance in the understanding across professions, yet there is an uncanny sense of similarity. The history of supervision revolves mainly around the concept of individual supervision. It is unclear when group supervision became the 'second most common type of supervision' (Kadushin & Harkness 2002, p.114; Tsui 2005, p. 119).

### **Group supervision**

The fundamental difference between individual supervision and group supervision is that group supervision by literal definition is an actual group of supervisees with a nominated supervisor. If the group met without a supervisor, then this dynamic would be referred to as peer group supervision.

Bernard and Goodyear (2004) define group supervision as;

the regular meeting of a group of supervisees, with a designated supervisor or supervisees, to monitor the quality of their work and to further their understanding of themselves as clinicians, of the clients with whom they work, and of the service delivery in general (p. 235).

Similar to the definitions based on individual supervision, this definition has quite a strong client and service delivery emphasis. Inskipp and Proctor (1993, p. 72) add to this, by stipulating that part of the potency of group supervision is in the feedback by colleagues, and that it is also aimed at building a counsellor's 'ethical competence, confidence and creativity'. The above definition of group supervision is applied in this research, yet the precedence of Kavanagh et al.'s (2002) overall definition of clinical supervision remains.

### **The place of group supervision**

In general it seems that the role of group supervision is often under-valued by health professionals (Ask & Roche 2006, p. 52), and may even be used less than in the past (Munson 2002, p. 201). McMahon and Patton (2002, p. 55) have a slightly

different view of group supervision. They suggest that group supervision is actually widely practised but has received much less attention. However, they claim that the first book written on group supervision was by Proctor (2000), suggesting that the popularity preceded any literature. Holloway and Johnson (1985) reiterate this point.

In social work literature, group supervision is generally seen as a supplementary, and sometimes a complementary form of supervision. The primary and ultimate objectives are the same as those for individual supervision. Tsui (2005, p. 123) states that it may 'require both supervisor and supervisee to open themselves up before they can benefit from the supervisory process'. As mentioned previously group supervision in social work is the second most common type of supervision (Kadushin 1992; Kadushin & Harkness 2002).

Elisabeth Shaw (2004), an Australian author/supervisor, has a challenging perspective with respect to clinical supervision. She considers individual and group supervision together, with a designated supervisor, as the cornerstone of professional development. Similarly Munson (2002) reiterates the complementary nature of both taken together, noting this as significant and the predominant form (p. 201). Group supervision has an efficiency such that it is often entered into because it seems to be the most practical, economical and time-saving way to accomplish supervision (Hawkins & Shohet 1989; Munson 2002; Powell 2004).

### **Advantages and disadvantages of group supervision**

The advantages of group supervision are numerous in that it provides a supportive atmosphere among peers, gains expertise from colleagues as well as the supervisor and can be a testing ground for an emotional or intuitive response. Group supervision also gives the opportunity to use action techniques, and if groups are being run, there is an evaluative opportunity to see how the supervisor deals with particular group issues (Hawkins & Shohet 1989; McMahon & Patton 2002; Munson 2002). Powell (2004) adds that this is an approach that is amenable to teaching methods, case reviews and possibly role playing.

Bernard and Goodyear (2004, pp. 236-239) are amongst the few authors that dedicate time to discussing the utilities of group supervision. They cite ten frequently suggested advantages of group supervision. They mention the economies of time, money and expertise and minimised supervised dependence. Further to this, they highlight that the opportunities for vicarious learning; the supervisee's exposure to a broader range of clients; having greater feedback for the supervisee in quality, quantity and diversity; and greater opportunity to use action techniques are of intrinsic value. Kadushin and Harkness (2002, p. 393) also add the exigent element of the group acting as an emotional support.

The disadvantages from a counselling perspective as suggested by Carroll (1996) are that it does not permit individuals to potentially get their needs met, especially if there are dominant group members or differing skill levels. The group supervision process often takes a while to operate optimally because of confidentiality concerns and confidence and trust with each other. Similar to focus groups, group supervision may also be diverted to interest areas for some but not necessarily for all. There are also potential negative group phenomena such as scapegoating, acting out of client dynamics or simply competition among group members.

### **Group supervision research**

Of the research on group supervision, Ogren, Jonsson and Sundin (2005) found supervisees' perceptions of attained skill were a result of attention to group process, psychodynamic processes, professional attitudes and theoretical aspects. Green (1999) also showed in UK nursing research that practice had been positively influenced by the group experience of clinical supervision, although only some of the participants could actually describe specific behavioural changes that had taken place.

Borders (2005), in a very comprehensive study of five years of clinical supervision research mainly in the American arena, cites four pieces of key research that attempt

to account for the dearth of research on group supervision. Of these studies she highlights the key role of peer feedback in group supervision, which is obviously unique to this style of supervision. Of equal importance is Borders' finding that there was an enhancement of skills outcomes for supervisees if a supervisor is present, as compared to peer supervision.

### **The impact of little to no supervision**

There is a growing body of literature and research that investigates clinical supervision but few papers that tackle the impact of little or no supervision. Bambling, King, Raue, Schweitzer and Lambert (2006) conducted a unique research project that had a control group without supervision, yet did not draw conclusions to suggest a major negative effect on those who did not undergo supervision. They did however highlight some benefits for those who received supervision. Bambling et al. summates that it was difficult to make further generalisations out of their study, but heralded it as a platform for further studies.

The most relevant study on the impact of a lack of clinical supervision was conducted by Edwards et al. (2005). They found that when community mental health nurses struggled to find time for supervision sessions then levels of reported emotional exhaustion as measured by the Maslach Burnout Inventory were higher. Addressing this problem from a slightly different angle, McMahon and Patton (2000) state that given the researched benefits of clinical supervision, serious questions can be raised about the cost of failure to provide adequate clinical supervision to career counsellors and to the profession as a whole.

Conversely, Ask and Roche (2005) tackle the notion of having little to no supervision with a positive slant; they focus on the AOD sector in Australia:

when the Alcohol and Other Drug field is permeated with quality clinical supervision, it will be an indicator that the level of professionalism that it so urgently requires across the board, is finally being achieved (p. 116).



## **The effects of poor supervision**

Similar to research on the impact of no supervision is the lack of literature available on describing the effects of poor supervision. Magnuson, Wilcoxon and Norem (2000, p. 193) surveyed experienced counsellors who identified overarching features of poor supervision. These features included:

- Lack of balance- overemphasizing some elements of supervision experiences and excluding others;
- Developmental inappropriateness- supervisors failure to recognize or respond to the dynamics and changing needs of supervisees;
- Lack of tolerance of differences- supervisors who attempt to mould supervisees into small replicas of themselves with no opportunities for innovation;
- Poor modelling of professional and personal attributes, including boundary violations, intrusiveness and exploitation;
- Lack of training- supervisors who conduct supervision without adequate preparation and professional maturity; (and)
- Professional apathy- supervisors who are not committed to the profession are not committed to the growth of supervisees or to future consumers.

Cooper (1998) points out how supervision can be quite an abusive process for many, where an examination of negative incidents revealed breakdown in the process of supervision, failure to protect new workers from harm and intimidating behaviour towards supervisees. Similarly Famularo (2002) recounts how she basically omitted truths or lied about how she was progressing because of a poor supervisory relationship. In her story there was also the added complication of her supervisor being her line manager. Likewise Priddy (now Moriarty 2004) in quite a personally disclosing story about her supervision journey, relates how she had role and boundary complications that led to a negative supervision experience.

The tight fiscal reality of community-based services has a direct correlation to line managers delivering clinical supervision. A recent study by the Victorian Healthcare Association (VHA) stipulates that,

While there is unanimous agreement that supervision by a line manager is problematic, in many workplaces and professions this appears to be the reality (VHA 2008, p. 3).

Line-managers often act as clinical supervisors and attempt to be 'all things to all workers'; often resulting in role confusion, ambiguity and a conflict of interest (Roche et al. 2007, p. 245). This points to one of the inherent outcomes of poor supervision. In the largest survey of the Australian AOD workforce undertaken to date (N = 1345), approximately two-thirds of respondents indicated that their organisation offered clinical supervision and nearly three-quarters reported that they had access to clinical supervision when necessary. But only about half thought the level of supervision was suitable for their needs and occurred on a regular basis (Duraisingam, Pidd, O'Connor & Roche 2006).

In the following chapter the other relevant research is explored as clinical supervision and its efficacy. AOD literature is explored as are Australian specific studies and recommendations.

## **Chapter 2:**

### **Research conducted on supervision, efficacy studies, Australian and AOD context**

#### **Introduction**

Following on from the previous literature review chapter, this chapter investigates what research has been conducted on supervision, by exploring efficacy studies, AOD specific research as well as Australian specific literature. This chapter further investigates the literature on the factors involved with supervision, the concept of external supervision as well as explores the prospect of interminable supervision.

#### **What research has been conducted on supervision in social work and the social sciences?**

With respect to social work, Tsui (2005) surveyed the literature in some depth. He found that the studies conducted on clinical supervision in social work have been minimal. In examining the methodologies employed for the studies actually undertaken on social work supervision, Tsui states that there has been minimal focus on client outcomes, as well as other problems such as lack of research on cultural traits and programmatic investigation. In his findings he concludes that most supervision research does not point to client outcomes despite the fact that 'efficient and effective service' (p. 16) is ranked as the ultimate objective of social work supervision. Similarly, Lambert and Hawkins (2001) concluded after their research and literature review that very little research had been conducted on client outcomes in relation to clinical supervision. This is not dissimilar to the wider social sciences conclusion about clinical supervision.

Tsui in his earlier studies into clinical supervision concluded that research into social work supervision was 'at an embryonic stage' (Tsui 1997 p. 49), and suggested a

need for more research in this area. Kadushin and Harkness (2002) assert that a social work model of supervision that is applicable to all job descriptions and working styles is a difficult task, and therefore difficult to research. Tsui (1997; 2005) concludes that this is one of the issues when researching supervision is that no specific model is either properly established or researched.

Bernard and Goodyear (2004, p. 298), in their review of the literature, have discovered that there are virtually no studies on any particular model of supervision. A large amount of literature on different supervision models for different contexts is set out in Hawkins and Shohet (1989), Kadushin and Harkness (2002), Westheimer (1977), Mc Mahon and Patton (2002). However Morgan and Sprenkle (2007) is one of the few attempts at defining a model that takes the common elements and factors from the different models currently being utilised and attempts define a core model to be properly researched.

Hancox, Lynch, Happell and Biondo (2004) conclude that while clinical supervision has been considered a major force in improving standards and the quality of care, there is limited research to prove this. They conducted a significant piece of research that highlighted how a thorough clinical supervision training program was effective in influencing the attitudes of nurses towards clinical supervision, and bringing about decrease in apprehension. People also felt more confident to provide clinical supervision after the training program. Hancox et al's literature review was consistent in finding that there needed to be adequate training and education for clinical supervision roles. Respondents gave feedback like 'now I am converted' (p. 205), as their previous understanding of supervision was either poor or non-existent.

Wheeler and Richards (2007), in their systematic and comprehensive literature review on clinical supervision, explored the ways in which supervision impacts on the supervisee. However, they found only two out of eighteen studies met the criteria to be classified as 'very good', an indication of the intrinsic complexity of supervision research. A key outcome of their review was recognition of the need to formulate a

clearly defined research agenda for supervision, which takes account of long-term supervision, experienced practitioners, methodological plurality including triangulation, and last but not least, the client. Although this is the most recent literature review conducted, it clearly indicates the same problems as Bernard and Goodyear (1998) outlined almost 10 years prior.

General criticism of supervision research includes problems of inadequate power, poor methodology, hypothesis-testing errors and an absence of outcome research (Bambling & King 2000; Ellis, Krenzel, Ladany & Schult 1996; Holloway 1996; Watkins 1998). Relatively, overall supervision research is in its infancy and there are complex factors of consistent approaches, definitions and understanding involved. It almost seems as though clinical supervision research has 'hamstrung' itself.

### **Studies and research on the effectiveness of supervision**

As stated previously, if the two main purposes of supervision are to foster the supervisee's professional development and to ensure client welfare, then the ensuing question as to the efficacy of supervision follows.

Kavanagh et al. (2002) in their literature review point out that the literature on supervision is 'heavy on opinion, theory and recommendation, but very light on good evidence' (p. 248). After their investigation they could only surmise as to the effectiveness of supervision with inconclusive words such as it is 'probably critical' (p. 251) and needed to be connected to training programs and the ongoing development of skills. They also point to how clinical supervision 'appears' to help in job satisfaction, aids the acquisition of complex clinical skills, and the carrying out of a difficult task in general.

There have been 32 published reviews of empirical studies into clinical supervision and counsellor training since 1988 (Bambling & King 2000), with most concluding that while we know a lot about the process and characteristics of supervision, particularly in the graduate training setting, little empirical evidence exists regarding

the effect of supervision on achieving measurable clinical outcomes for clients (Bambling et al. 2006).

In their investigations on the effectiveness of clinical supervision, Bambling and King (2000, p. 59) discovered that while the 'supervisory relationship is the most researched area of supervision', it is based primarily on the psychotherapy effectiveness research finding that the relationship is the means by which clients learn and grow. This they discover to be not always translatable to clinical supervision and that overall there is still little researched evidence to highlight the effectiveness of clinical supervision in increasing counsellor competence and client work. The question for them remains whether clinical supervision actually improves the clinical skills of counsellors and psychotherapists.

Rose and Boyce (1999, p. 11), in their research on effectiveness of clinical supervision from the American psychiatric literature found that it has 'previously been a retrospective, involuntary and externally motivated activity' and designed more for funders than to advance clinical practice. However their extensive literature review up to 1999 concluded that supervision is a demonstrated, effective training tool and is therefore considered a central mechanism for the learning and continual development of clinicians as well as a good source of professional support. How supervision affects client outcomes was inconclusive for them; they attest to the need to gain greater evidence of the effectiveness of the practice of supervision (p. 13).

Bernard and Goodyear (1998) similarly came to the firm conclusion that effectiveness studies were long overdue and simply had not been done. They also wished to determine what supervision approach works better than another. This would require comparative studies of supervisory models. Six years later they repeat their concerns in their 2004 revised text. Wampold, Mondin, Moody, Stich, Benson & Hyun-nie (1997) discovered that in the domain of psychotherapy, comparative studies are relatively common. However, supervision studies of this type have not

been conducted.

Bernard and Goodyear (2004) suggest another reason for the lack of efficacy studies on clinical supervision. Besides there being very little theory-driven research, there is potential danger to clients if a control group of those receiving no supervision were to be part of such a study. Bambling et al. (2006) seems to be the only available study to date utilising random control in addressing this latter concern. In their study, they discovered that supervision focusing on a working alliance can influence client perception of alliance and enhance treatment outcome (of depression specifically). However the intricacies of conducting such an elaborate and rigorous piece of research prove that following the previous mentioned recommendations, is a very difficult task indeed.

One of the many commonly attributed benefits of clinical supervision is job satisfaction. Schroffel's (1999) comprehensive study of 84 professionally trained workers on how clinical supervision related specifically to job satisfaction had mixed findings. The results demonstrated that workers satisfied with the quality and style of supervision exhibited greater overall job satisfaction and had specific preferences among four supervisory styles. Workers were generally more satisfied with their jobs when they were more satisfied with their supervision and liked their supervision better when it matched their preferred style. Interestingly Schroffel still recommended further effectiveness studies for clinical supervision.

In the psychotherapy literature, clinical supervision has traditionally been considered an important part of training and the professional development of therapists, being rated highly in the experience of trainees as well as practitioners in the field (Orlinsky, Botermans & Ronnestad 2001; Steven, Goodyear & Robertson 1998).

### **What are the benefits and why clinical supervision?**

The benefits of supervision logically flow-on from its effectiveness. It was Professor Tsui's conclusion that the quality of social work supervision directly and significantly

affects the quality of direct service to clients, as well as the retention and commitment of staff social workers (2001). The Australian Psychological Society ([APS] 2002, p. 6) has a similar basis for clinical supervision, where 'the client receives the best service and gains personal satisfaction'. This document continues to describe how complaints and legal action against the psychologist and the service organization or company are minimized as a result of clinical supervision, and therefore the profitability of, and goodwill towards, the service and profession is enhanced. This citation on clinical supervision lies within their ethical guidelines framework. Overall in psychology literature, the salience of clinical supervision seems to be unquestioned, being the 'primary component and most used method for teaching therapy' (p. 7).

The role of clinical supervision in the nursing workforce has been well established. A small number of studies have given an indication of a number of benefits as a result of experiencing clinical supervision. These benefits include increased feelings of support and personal wellbeing (Butterworth, Bishop & Carson, 1996), increased knowledge and awareness of possible solutions to clinical problems (Dudley & Butterworth 1994), increased confidence and decreased incidence of emotional strain and burnout, and higher staff morale and satisfaction leading to a decrease in staff sickness/absence and increased staff satisfaction (Butterworth et al., 1996).

Harvey and Schramski (1984, p.198) mention some of the benefits of supervision including improved consumer service, higher practitioner satisfaction, decreased staff turnover and lower training and administrative costs (also in CHSEMR 2006, p. 5). Other benefits range from general support for the supervisee (Shanley 1992, p. 345; Webb 1997, p. 38), discussion of clinical issues during supervision (Shanley 1992, p. 345), maintenance of high quality practice (Reeves, Cuthbert & Green 1997, p. 77; Webb 1997, p. 38), learning of complex clinical skills (Kavanagh et al. 2002, p. 248; Webb 1997, p. 37), improved job satisfaction (Kavanagh et al. 2002, p. 249; Milne and Westermann 2001, p. 452) and improved staff communication (Webb 1997, p. 37).



In school counsellor literature, McMahon and Patton (2000) conducted a piece of research on the perceived need for clinical supervision and discovered benefits in the areas of support, accountability, debriefing, professional, personal and skill development, counsellor development, and induction of those new to the profession. They state that the adequate provision of clinical supervision is a means of strengthening the practice of individual guidance officers and the school counselling profession. The logical inference for them was that client welfare and the quality of service to clients would be enhanced. (This was not specifically researched however). Further discussed benefits were reduction of professional isolation as well having the potential to 'mediate against burnout and serve as a mechanism for lifelong learning' (McMahon & Patton 2000, p. 340).

Ogren and Jonsson (2003) revealed that supervision contributes to greater skill, with the likelihood that this skill development enhances a supervisee's ability to manage key aspects of the psychotherapeutic process. Both the studies conducted by Ogren and Jonsson (2003, 2005) indicate that individual and group supervision improve counselling skills in a number of different ways.

Similarly Wheeler and Richards (2007) conclude in their comprehensive literature review of clinical supervision, that:

supervision has an impact on therapist self-awareness, skills, self-efficacy, theoretical orientation, support and outcomes for the client. The timing and frequency of supervision has some differential impact (p. 63).

Investigations via the social work framework, distinguish 'benefits' more formally as the 'objectives' of social work (Tsui 2005). Drawing from Payne (1994), Tsui elaborates by concluding that what social work supervision mainly strives for is enabling supervisees to deliver more effective care, to manage their own feelings, and increase the potential for their own self-management. From the supervisor's perspective, clinical supervision is ultimately about maintaining good standards of practice.

### **How important is clinical supervision perceived to be?**

Shaw (2004) asserts that the 'supervisory encounter is second only in importance to the clinical encounter itself' (p. 64). Hawkins and Shohet (2000, p. 5) suggest further that 'supervision is the equivalent [to counselling] for those that work at the coalface of personal distress, disease and fragmentation'. Such strong viewpoints emphasise the importance of clinical supervision, but there is mixed opinion generally in the literature as well as in professional association standards.

The AASW national practice standards for supervision have two statements that summarise the importance of supervision. The opening statement gives the first understanding, 'We believe that the quality of social work supervision is central to the development and maintenance of high standards of social work practice' (AASW 2000, p. 1). They suggest that there should be at least one hour of supervision per week, which for most community and welfare agencies seems appropriate and indicates the importance attached to it. A student social worker in Australia is required to complete two placements of 70 days with a minimum of one pro-rata hour of supervision per week, equating to approximately a minimum 28 hours. This is not paid for and is part of the student placement. The AASW also states that 'the primary purpose of professional supervision is to facilitate competent, independent practice and not to perpetuate dependency' (p. 2).

Registration with the APS is voluntary yet the membership exceeds 15700 (APS, 2007a). Those that are registered are mandated to accrue a certain number of professional development points each year. Supervision is not linked with this. Supervision is no longer one of the prescribed pathways for psychologists towards registration with the Psychologist Registration Board of Victoria since 30 November 2005. However, it is desirable 'for all psychologists to have access to professional expertise in order to maintain excellence within the profession' (APS 2007b). Gonsalvez and Mcleod (2008, p. 82) conclude that 'access to supervision is presented as a critical component of ongoing professional activity, not just a training requirement'. There is a separate registration process linked with minimum

standards and experience. Formal training for those wishing to be supervisors is under development (O'Donovan, Slattery, Kavanagh & Dooley 2008) in the psychology arena as a result.

In their document on professional standards, the Psychotherapy and Counselling Federation of Australia (PACFA), has a list of supervisor credentials. They mandate that as supervision presumes a level of competence beyond the most basic, supervisors should have been eligible to be clinical members of a relevant professional association for at least three years (PACFA 2006, p. 34). They further specify a minimum number of hours of supervision to be eligible for registration as a member where 'members must have completed a minimum 50 hours of supervision relating to 200 hours of client contact' (p. 32).

In a similar vein, the North Queensland and New Zealand Community Mental Health Nurses Association ([NQ-ANZCMHNA] 2000) have comprehensive guidelines and framework for clinical supervision. The latter stipulates the standards for general nursing as well as for nursing in particular settings.

The AOD sector in Australia has evolved enough in its own right to be genuinely nominated as a separate sector. This sector attracts people from different professions including social workers, nurses, chaplains, psychologists, counsellors, psychotherapists, and other qualifications and training backgrounds. The major funding body for drug and alcohol services in Victoria, the Department of Human Services (DHS), have recently implemented a minimum qualifications workforce development strategy (DHS 2004). The motivation was a concerted attempt to increase the professionalisation of the workforce. The AOD sector has nothing comparable to the comprehensive and prescriptive standards like the NQ-ANZCMHNA, for supervision and supervisory practice. In the available literature there are the beginnings of some excellent guidelines developed by NCETA (Ask & Roche, 2005). There are no other available references prescribed, or even strongly recommended guidelines currently on supervision. Powell (2004) mentions little of

stipulations or guidelines on supervision other than a brief overview of different associations in the USA.

### **Clinical supervision as a separate therapeutic modality - In the context of workforce development**

A few authors posit that clinical supervision should be seen as a separate and distinct therapeutic modality unto itself (Holloway & Johnston 1985; Munson 2002; Sloan 2006). This is clearly differentiated from clinical practice in general and separate from administrative or line management supervision. There are again authors in the field of social work in particular, such as Brashears (1995), who believe that clinical supervision as a separate practice modality creates a false dichotomy.

The Victorian Association of Alcohol and Drug Agencies ([VAADA] 2003) report, places clinical supervision in the overall context of workforce development, as do Roche (2002), Allsop and Helfgott (2002), Baker and Roche (2002). Bishop (2001) from the nursing arena, similarly places clinical supervision, if properly carried out, as central to supporting professional development. Similarly, clinical supervision in the psychology literature (Golding & Gray 2007) also place supervision in the context of Continued Professional Development or CPD. However supervision appears to be the most common form of CPD (Milne, Keegan Paxton & Seth, 2000). Similarly in social work, supervision is mentioned in the context of Continuing Professional Education (CPE). Social workers are required to accumulate points annually and supervision is an avenue for this (AASW 2006).

Saunders and Robinson (2002) elucidate the fact, 'that co-occurring disorders are now a norm of AOD service provision' (p. 234). As a result of this added complexity they continue to outline a number of supportive workforce development aspects such as training, mentoring and education. Supervision is a nominated strategy amongst these.

Other studies including Roche (2002) and Baker and Roche (2002) are consistent with the findings of the VAADA (2003) research and made strong recommendations for workforce development in the AOD sector. Workforce development includes other factors such as mentoring, job incentives, training opportunities, resource accessibility, career path options as well as supervision (VAADA 2003, p. 10). From this perspective clinical supervision is but one ingredient in the totality of the concept of workforce development.

In Australia and in the world generally, there are no separate bodies or associations set up specifically for clinical supervisors as there are for social workers, nurses, psycho therapists, counsellors, psychologists and allied health professionals in general.

### **Clinical supervision for what period of time? Mandatory supervision?**

In the early years of social work practice, supervision was a means of monitoring the work of volunteers. This evolved to extend to fieldwork supervision as part of formal social work training programs. With the influence of the psychoanalytic literature supervision further transformed into a life-long therapeutic process. This ultimately resulted in a social work debate between autonomous practice and interminable supervision. The advocates of autonomous practice maintain that a social worker with a Masters in Social Work and a number of years in practice should be allowed to practice autonomously without supervision (Tsui 2005, p. 7).

There is an argument that the period of time for which supervision is required has direct relevance to the importance that is placed on supervision and consequently makes indirect reference to the positive impact of supervision. Scant attention is given in the literature to whether clinical supervision should be mandatory (Carroll 2007, Tsui 2005). Some merely advocate the importance of lifelong learning and supervision. Others such as the British Association for Counselling and Psychotherapy (BACP) have set out quite strong guidelines for mandatory

supervision. Other schools of thought seek a point in a worker's career when they no longer need supervision, having reached senior or similar status.

McMahon and Patton (2000) and Milne, James and Sheikh (2007) emphasise the necessity of lifelong learning and thus lifelong supervision within psychology and allied health disciplines. As early as 1936, there was some debate around whether supervision should be jettisoned altogether (Grauel 2002a, p. 7). Kadushin (1992) suggested that interminable supervision was seemingly at odds with higher educated, autonomous professionals. The rationale was that in ensuring that social work was professional, supervision had become an impediment to professional status.

Spence, Wilson, Kavanagh, Strong and Worrall (2002) state that supervision represents one component of the lifelong professional development for practitioners. Supervision ensures that they maintain and update their skills in accordance with best practice and advances in knowledge. Spence et al.'s study found that practitioners, who did not receive follow-up supervision after being trained in evidence-based cognitive behavioural therapy interventions, were no longer continuing to use the techniques they had acquired.

Laufer (2005) researches the differing views as to whether lifelong supervision should be considered or not. She gathers various viewpoints ranging from whether supervision is effective for a period of time to the people believing in autonomous practice. She highlights how some authors are cautious about the potential for dependency on supervision. Laufer's conclusion is that there is great merit in lifelong supervision but this is dependent on the supervisee being able to change supervisor successfully as well as the style of supervision.

Feltham (2002) summarises the arguments for and against mandatory or autonomously chosen supervision. He reports that most countries and helping professions demand that supervision be mandatory only during training and the early

part of the career. If clinical supervision were to be mandatory, the possible disadvantages might include expense, infantilisation and ritualisation (Feltham 2002, p. 335). However, the BACP argues that lifelong supervision is a necessary safeguard and a likely enhancement of ongoing practice.

Powell (2004) reports that some of the associations in the USA mandated perpetual supervision and others did not. A few mandate ongoing supervision for registration purposes. Australia has no such prescription for any organisation, sector or peak body. The closest we come to this is the requirement to accumulate annual professional development points, with supervision as one of the options.

For other professions such as mental health nursing there are very good reasons for the mixed take-up of clinical supervision:

Despite a belief amongst nurses that clinical supervision provides an opportunity to reflect on and develop their clinical skills, it was considered to have limited experiential value and therefore there was a cautious attitude towards its wholesale adoption in practice (Cleary & Freeman 2005, p. 503).

This highlights how different settings have different needs and opportunity for clinical supervision, and the ongoing difficulty of a uniform concept of clinical supervision. Rizzo (2003) confirms this by saying that clinical supervision 'can mean many different things to various organisations and the people they employ' (p. 136).

### **Focus on the client or the worker or the organisation or position**

Kadushin and Harkness (2002) consider that the long term objective of social work supervision 'is to provide efficient and effective services to clients' (p. 44). Susan Lewis, a renowned expert in clinical supervision based in Victoria, suggests that the 'supervisory relationship is essentially about providing the best services for the client' (Lewis 1999, p. 13). Across the board this seems to be the common ultimate objective but how this filters down to the actual practice of supervision is not so obvious. Munson (2002), remarks that the content of supervision has evolved from a

psychological to a sociological orientation, in the sense that the emphasis has shifted from supervising the person to supervising the position. It is challenging to differentiate between the subtle differences as to the focus or orientation of clinical supervision at any time.

Payne (1994) identified 17 specific objectives of social work supervision in the literature. This can be condensed down to supervision for clients, supervision for supervisees, and for supervisors and staff (Tsui 2005, p. 15). The focus here is not so much these objectives but how the supervision is conducted, with what emphasis and what particular aim. For example, Williams (1997) puts forward a sound argument for supervisors to be knowledgeable about parallel processes, and have this as a focal point. From this focus, clients receive the greater benefit. A parallel process is the tendency for patterns to repeat at all levels of the system (Kadushin 1985). This is distinct from supervision where a supervisor may concentrate on how the negative influences from an organization are impacting upon them, and therefore how this is affecting their client work. The emphasis, though subtle, in the latter case has as its locus worker wellbeing as distinct from the prime focus of actual client work. One could argue that both have as the end goal, client wellbeing, but the initial emphasis is on worker support.

Maroda (2002) found that a supervisor's (and therapist's) gratification often plays a diminished role, if acknowledged at all. In their study of a relational approach to clinical supervision, Ganzer and Ornstein (2004, p. 447), arrive at a similar conclusion as to how 'therapist and supervisees all experienced personal growth and satisfaction from their participation with each other and with their clients'. This outcome or focus could have its initial emphasis on the client and may move to supervisor benefit and wellbeing, or vice-versa. The insights gained for the supervisor may flow on to better client work, yet the case in point is that this focus in supervision is mainly on worker benefit.

It is evident that the vast majority of literature in social work focuses upon client



outcomes, and less so on worker wellbeing. Harkness and Poertner (1989), in part of their three-phase study and historical overview of social work supervision, concluded that the emphasis had shifted from the client to the worker. Hence they attempted research by moving the focus of supervision specifically to client outcomes. The findings indicated that there was better service for this focus and that a mixed agenda may 'retard or defer the real or potential help that agencies provide' (p. 511). Following this, they set a strong research agenda to refocus back on the client and to attempt to define a model. Interestingly Kadushin and Harkness (2002) make no such strong assertions, and adopt a seemingly more balanced perspective.

There is much conjecture in the literature in the wider social sciences where the emphasis needs to lie for research as well as for evaluation of the impact of clinical supervision and its optimal use. Getz (1999, p. 491), who spearheaded a taskforce to establish standards for credentialing clinical supervisors, suggests as a result of her research that the focus needs to be on supervisor training and supervisor competencies. Central to client welfare is the importance of monitoring the supervisor, who greatly influences and affects the competency of the supervisee. Similarly, Ellis et al. (1996) in their methodological critique of clinical supervision research, have the underlying premise that if the research on supervision is enhanced, then there will be a logical flow-on to the supervisors, providing them with sounder and greater information, then on to the supervisee, all aimed eventually at the betterment of client outcomes.

For Neufeldt, Beutler and Banchero (1997), in their definition of supervision is that its purpose is the development of the supervisee as a professional psychotherapist. The fruit for them is in the client's external behaviours within psychotherapy, and in their life after psychotherapy. With the emphasis on the therapist, in supporting and up-skilling, the flow-on will be towards the client.

Carroll (1999) pertinently points out that it takes quite a skilled supervisor to support workers in their organisational context. Addressing parallel processes is deemed

crucial and often 'counsellors will do to their supervisor what the organisation has done to them' (p. 151). Despite supervision being for the client, neither clients nor counsellors exist in vacuums. Indeed they both belong to systems that impact on their work together. Similarly, religious vocations such as chaplains, priests and other workers in their settings, are well familiar with professional supervision (Mann, 1999). They are subject to counter-transference and parallel processes from the individual and from the communities/ organisations to which they belong.

Organisational issues in supervision are relevant to the extent that they impede the progress of treatment of the client (Munson 2002). Kadushin and Harkness (2002) devote an entire chapter to 'supportive supervision' (pp. 217-278), with the prime emphasis being on the social worker and their needs.

In some circumstances, supervision can have its focus primarily on supervisee support and even advocacy support. Typically a social work supervisor might advocate for their supervisee (Cooper 2002). Such advocacy may involve trying to ensure a person stays in their particular job or arguing for better working conditions. The supervision sessions would obviously be about support and empowering the supervisee, the emphasis being almost solely on supervisee support in this instance.

The literature overall is divided on where the emphasis needs to lie. This certainly makes for a common sense conclusion that there needs to be a particular focus for different situations and times. The balance need not sway between polarities. 'Tuning in' to the various factors and 'culture' (Tsui 2005; Bogo & McKnight 2005) of each working environment is essential.

### **Drug and alcohol sector literature**

Supervision in settings that involve issues of substance and alcohol abuse has become increasingly complex as knowledge and understanding of substances and alcohol has grown (Munson 2002). In turning to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) for evidence to represent this, some 15.6 per cent of the manual is dedicated to them. Munson (2002) recommends that practitioners

need to be more aware of dual disorders, especially the prevalence of depression, anxiety and other personality disorders. The complex and demanding nature of the work is linked to increased worker stress.

Rizzo (2003) is one of the few people apart from Powell (1998; 2004) who attempts to describe a model of supervision for the AOD sector generally. Rizzo, in this respect relies heavily upon Powell's 'blended model' (1998, p. 9) and does not show much deviation from him.

However Powell and other American authors are written for the American AOD sector. In the American context there is a particular difference with a strong emphasis on twelve-step programs that underpin bodies such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). The twelve-step programs are based on the concept that there is a disease called '*alcoholism*', and that if a person with this particular disease consumes alcohol, then the disease slowly but surely takes them over. They are unable to exercise control over alcohol or their respective lives as a result. This stands in contrast to the predominant philosophy of 'harm minimisation', to which the bulk of drug and alcohol services in Australia adhere. Harm minimisation adopts the viewpoint that people will and do use alcohol and drugs, and may or may not abuse them and form a dependency. While AA and NA have an integral part to play in the AOD sector in the Australian context, it is definitely not the dominant paradigm. Another divergence is the focus in the USA on zero tolerance, which as previously indicated has marked philosophical differences from harm minimisation.

In the AOD sector in Australia, clinical supervision has gained significant momentum in the last ten years. The Victorian context has seen widespread free provision of AOD-based clinical supervision training for senior workers via La Trobe University, accompanied by a comprehensive AOD-specific clinical supervision resource (Vivekandah, Moloney & Weir 2005). This was a result of the Victorian AOD Workforce Development Strategy – minimum qualification strategy (DHS 2004),

auspiced by the Drugs Policy and Services Branch, Victorian Government Department of Human Services. Resources and dedicated websites have subsequently been developed. Flinders University, via NCETA, has dedicated a website to Workforce Development. This is an innovation of Anne Roche, a leading researcher and expert in this area. A resource to build the capacity of the AOD workforce, called the *Clinical Supervision Resource Kit for the Alcohol and Other Drugs Field* has been developed. The booklet attached to the overall packaged resource referred to in other places in this paper is by Ask and Roche (2005). This resource provides background literature on how to implement a clinical supervision program in a working area/ agency and contains a number of informed recommendations on how to conduct clinical supervision.

However this resource (Ask & Roche, 2005), was appropriately given the title of 'practical guide' rather than claiming to be specific guidelines. Ask and Roche concede that the evidence on clinical supervision in the AOD field is scant, due to the general lack of research conducted. The evidence they draw upon for the resource comes from the wider body of supervision literature based in the social sciences.

Almost simultaneously, another resource *Workforce Development Resource Kit: A Guide to Workforce Development for Alcohol and Other Drugs Agencies*, was developed by the Network of Alcohol and Other Drugs Agencies (NADA 2005). This resource has an entire section on clinical supervision. The writers share the view that the separation of management and clinical supervision is quite distinct and important. They provide a strategy to source a clinical supervisor (external) specifically for clinical supervision (p. 26), which includes recruitment options. There is no mention of the nature of line managers providing supervision.

In August 2003 the peak body for the alcohol and other drug sector in Victoria, VAADA, published a research report that was a result of consultations with both management and direct workers in alcohol and other drug settings across Victoria.

The findings of this research highlighted an urgent need for supervision, particularly for promoting reflective and reflexive practices, and for providing support and guidance for workers in their daily activities. Similar reports on workforce development were conducted by other AOD peak bodies in other states of Australia. These studies were sponsored by the Alcohol Education Rehabilitation (AER) Foundation, the same body that funded the clinical supervision project that underpins the present research.

We need the capacity for reflection time and time for discussions. Currently decisions are made on the run and there is no time for reflective practice, our work is bushfire driven (VAADA 2003, p. 5).

This quotation within the report highlights the pressing need for supervision in the AOD sector in Australia.

### **Drug and alcohol sector specific studies**

One of the most recent studies conducted in Melbourne was by John de Bomford (2005). His focus was twofold: on AOD clinicians and their understanding of clinical supervision; and to what extent supervision was actually conducted in Melbourne for AOD clinicians. The size of the group was credible (N= 60) and taken from a sufficiently wide portion of the AOD sector to arrive at the conclusion that not only was it difficult to define what clinical supervision was, but there was an alarming lack of supervision.

Hohensil (1997), in a study that investigated the relationship of clinical supervision to job satisfaction for workers in the AOD sector in the USA, found that indeed clinical supervision did have an impact that was dependent on the duration and regularity of the supervisory relationship, and the degree of experience of the supervisor. This was a significant study of over 500 participants and was similar to the Australian context in one respect, in that this study also revealed the lack of opportunity for advancement in the AOD sector.

Hall, Amodeo, Shaffer, & Vander Bilt (2000) in their study of 303 social worker respondents in the AOD sector in New England, discovered the severe lack of clinical supervision having an AOD focus. Many of the respondents may have had clinical supervision that was not substance use focused, but a high overall population asked for more training in the area of substance use and related issues. The theorising as a result of this, led to recommendations to increase the coverage of substance use issues in social work curricula.

### **Should a clinical supervisor have an AOD background or training?**

The question arises as to whether a clinical supervisor should have AOD background or training. Roche, Todd and O'Connor (2007), are clear that this is quite important, as is Powell (2004). The former elaborates suggesting that 'clinical supervisors need a very broad skill base' (p. 244).

There is little evidence to suggest either approach. What the question does point to is the need to identify the skill set that is required to be a capable, 'good' and experienced clinician generally, as well as specifically in the AOD field.

### **What are the factors associated with supervisees' experience of supervision?**

The majority of the literature on supervisees' experience of supervision is on the supervisory relationship (Bernard & Goodyear 2004; McMahon and Patton 2002; Nelson and Friedlander 2001). There is unanimity that the supervisor/ supervisee match is critical to supervisory outcomes. That is to say the quality of supervision rests on the quality of the relationship between supervisors and supervisee (Cerinus, 2005).

Cutcliffe et al. (1998) assert that it is the supervisor's responsibility to create the safe and supportive learning environment required for optimum supervisee personal and professional development. Inherent in the definition of clinical supervision utilised for this study (Kavanagh, Spence, Wilson & Crow 2002) is the notion of a working

alliance between supervisor and supervisee that is based on trust and mutual respect.

Emphasis in the literature seems either to be on poor experiences of supervision or on the characteristics of a 'lousy' supervisor (Worthen & McNeill 1996; Nelson and Frieland 2001). These are similar to the previous discussion on the effects of poor supervision. Some of the research is limited to a supervisee's experience during training. Clouder & Sellars (2004) and Bernard and Goodyear (2004) describe power imbalances or misuse of power as other critical contributions to a negative experience of supervision.

Rennie (2003), conversely, cites as important, positive qualities such as trust and confidence, honesty, respect, understanding and the supervisor not being too opinionated. However there is a paucity of literature on what specific factors constitute quality supervision. Also significant is the choice of supervisors.

### **The importance of choice of supervisors**

A recent study of nurses in the UK (Edwards et al. 2005, p. 412) revealed that perceived quality of supervision was higher for those nurses who had chosen their supervisors, and where sessions took place away from the workplace. Sloan (1996), Webb and Wheeler (1998) and Sloan (1999) found that supervisees were more likely to disclose personal information in supervision when they had chosen their supervisor and when they were supervised by somebody independent of the setting in which they were employed. Bernard and Goodyear (2004) also endorse the importance of being able to choose a supervisor, especially when from the psychology background, supervision is 'not a voluntary process for supervisees' (p. 9). Kelly, Long and McKenna (2001) reported inconclusive findings in this respect.

Shaw (2004) advocates that optimally both supervisors and supervisees should have a choice in the process (p. 69). This better supports a supervisor/ supervisee match.

Cerinus (2005) found choice to be important especially so as to enhance trust and confidence, as did Williams, French and Higgs (2005).

Little more research or literature is available on this component of supervision. These factors discussed are relevant when investigating the effectiveness of supervision in enhancing or detracting from the supervisory experience.

### **The Australian milieu: Supervision**

Apart from the aforementioned literature and documents, there is overall an historical paucity of literature on clinical supervision in the Australian milieu. Kavanagh et al. (2002, p. 249) concluded also that research into supervision was a neglected yet important topic and were overwhelmed by the lack of it. Their conclusions, based on a wide literature review, used inconclusive words such as 'probably' when reviewing the claimed benefits of supervision, that it maintains and improves clinical skills and job satisfaction.

In an examination of the literature around the effectiveness of supervision in four disciplines, namely psychology, social work, occupational therapy and speech pathology, Spence et al. (2002), based in Queensland, come to a number of important conclusions. Firstly, while there is general consensus among practitioners of the value of supervision, in the majority of literature there is ultimately little in the way of empirical evidence to prove the efficacy of clinical supervision. Secondly for Spence et al., there remains 'more questions than answers relating to supervision and its effects on supervisor practice and outcomes' (p. 152).

in an extensive clinical supervision project in Queensland of over 273 professionals from across disciplines, Skerret (2004, p. 150) discovered that 'there is little research on how supervision impacts on client outcomes, supervisee practices, knowledge or job satisfaction'. Further there was a highlighted need for training and uniformity as to how clinical supervision procedures were conducted such as the need for contracts at the beginning of the supervision arrangement.



In the mental health nursing arena, Hancox et al. (2004) carried out a DHS funded project delivering training to 63 health care professionals on clinical supervision. It was discovered that through greater awareness and training in clinical supervision, nurses made a significant positive shift in their attitude towards clinical supervision. They were subsequently more receptive to receiving supervision, and felt greater confidence in their potential for providing supervision. The sample number of 63 and the limited time of the project led to recommendations to continue to research the area. However this study is important in a body of literature and research that is low on these sorts of projects.

Only limited research attempts to gauge the impact of supervision have been conducted in the Australian context, such as the recent exploratory study in a residential setting, by Rennie (2002) who found that clinical supervision increased workers' sense of support, clarified roles, understanding of clients, organisational requirements and increased teamwork cohesion. Studies led by Allsop and Helfgott (2002) conclude that supervision does not necessarily flow on to benefit client work, and that this is a problem that needs to be faced. Bambling et al. (2006) seem to be the only other available study on clinical supervision in the Australian arena.

Recently a document on clinical supervision was compiled by Community Health Services in the eastern region of Victoria (CHSEMR, 2006). No drug and alcohol agency or representative was part of this process however, despite AOD counselling agencies' presence in community health centres. The CHSEMR report is in response to the DHS's document, *Community health counselling: future directions and guidelines for quality counselling, Public Consultation Draft* (2004). The stipulation in that document was, that 'professional development and clinical supervision is to be mandated for counsellors in community health' (p. 4) and inspired the response. The recommendations refer to a number of innovative models for implementing clinical supervision programs. Most notably some of these suggestions are: organisation-funded external individual clinical supervision; formal inter-agency clinical

supervision agreements; establishing a group of roving independent clinical supervisors across agencies; and having a separate internal individual clinical supervisor, who is not the line manager. Lastly they propose a senior clinician model as well as facilitated peer group supervision facilitated by an internal or external supervisor.

### **Internal (line management) and external supervision: the issues.**

The concept of internal or external supervisors is not widely understood. Basically, internal supervisors can be also defined as those who are line managers or have similar responsibilities and also provide clinical supervision. External supervisors are external to the agency or to the line management system of that particular working area. The external supervisor may or may not be paid by the agency. It is not uncommon for an individual to pay for external supervision out of their own funds.

In the earlier exploration of experiences of poor supervision, there were a few examples of those receiving clinical supervision from their line manager or from someone who had managerial or performance monitoring administrative duties. Sloan's (2006) research insists that 'a practitioner who has no line management responsibility over the supervisee should provide clinical supervision' (p. 177). Ask and Roche (2005, p. xiii), who are known leaders in the AOD field in Australia, strongly suggest in a list of guidelines in their training book on clinical supervision, that a 'clear distinction should be made between clinical supervision and line management supervision'. They point to the basic difference being that clinical supervision is focused more on the workers clinical roles and performance, whereas line management is concerned with the evaluation and appraisal of all aspects of a worker's performance.

For most social work authors the notion of internal or external supervisors can be defined as separating those who provide the administrative function from those who provide the educational and supportive functions (Kadushin & Harkness 2002; Munson 2002; Payne 1994; Tsui 1997). These scholars assert that the educational

function should be separated from the administrative function because it is so difficult for frontline workers to discuss any potential errors or issues with supervisors who also have line management responsibilities.

Shaw (2004) highlights the relationship of supervisor/ line manager as the most problematic dual roles, compared to supervisor/counsellor and supervisor/trainer. She continues to outline a model of clinical governance that basically separates the functions and roles of line management, supervisor and supervisees. She further advances the idea by suggesting that supervisors and managers engage in an open and transparent fashion rather than separately. This is informed by the general practice that where workers access external supervisors, there is minimal contact between their supervisor and line manager. Shaw concludes that optimally both supervisors and supervisees have a choice in the process (p. 69) and that this is underwritten by clear communication.

Traditionally, for a lot of helping professions, supervision has been part of the line manager's responsibilities, based on the belief that they have more experience and skills than the people they supervise and that they have the ultimate responsibility for the work of their unit (Baldwin, Patawai & Hawke 2002). Baldwin et al. cite a role and power differential that would possibly produce anxiety and reduce the potential for frank discussion. Similarly, Swain (1995) adds a stronger emphasis on the 'fundamental principle of clinical supervision ... that it should be distinct and separate from management supervision' (p. 40), one of the reasons being that a manager also has disciplinary responsibilities. Cousins (2005) summarises the power a line managing supervisor has:

The reality is the supervisor does have power and no matter how much of a democratic style the supervisor takes, they make the final decisions and have a greater say to upper management (pp. 177-178).

Tsui (2005) describes how the supervisor acts as a middle person or mediator between the agency and supervisee. But in his understanding, he does not perceive

the supervisor to be a line manager conducting the supervision. For him there is inherent the issue of authority, and he concludes that this has received little attention in social work literature (Munson 2002; Tsui 2005). The concept of an external supervisor does not appear in his comprehensive research and literature analysis.

### **External Supervision; a mixed report**

There appears to be a paucity of theoretical or empirical literature dealing with external supervision in general. Itzhaky (2001) in his examination of the literature on this topic found that he was almost the only one endeavouring to undertake such a study. He examined differences between supervisors employed within the same agency and their supervisees, and those with external supervisors. The outcomes discovered that 'external supervisors were found to provide more confrontation when necessary and appropriate, and more expert-based authority' (p. 81). The recommendations included exhorting social service agencies to consider using external supervisors. Similarly, if agencies were to continue with the internal supervisors' model, due to financial constraints, efficiency or similar realistic and fiscal reasons, then greater training is recommended.

While little has been written on the subject, Ung (2002) suggests that there is an increasing tendency among health care workers to seek professional support from outside the place of practice. They aim to ensure that clinical supervision is separate from the line management structures where the emphasis is on 'evaluation of performance and productivity' (p. 92). Ung points to the clear advantages of clinical supervision where choice of supervisor is important and appropriate personal selection criteria may be met (2002). An external supervisor can also provide the opportunity to discuss clinical issues without organisational constraints; deeper listening and a wider focus may result.

It has been an issue for many such as Famularo (2002) and Copeland (2002) that receiving clinical supervision from a line manager or team leader, which includes educative and supportive components as well as administrative supervision, adds

complications of a lack of openness, due to power roles. Ask and Roche (2005, p. 13) stress that 'the clinical supervisor is not a line manager' and that each role- line manager and clinical supervisor- requires a distinct set of learned skills and expertise. The CHSEMR discussion paper (2006, p. 6) reports that the 'issue of a distinction or otherwise between organisational and clinical supervision has caused much discussion and debate'. The CHSEMR conclude that similar skills are needed for both management and clinical supervision, but that 'organisation-funded external supervision is seen as the *preferred* format' (p. 14).

There clearly was more to say in the nursing literature on the concept of external or internal supervision. For example, Abbott, Johnson, Dawson, Hutt and Sealy (2006), found that clinical supervision was primarily 'restorative', offering staff relief from the stresses of working in a very deprived and ethnically diverse area where the recruitment and retention of staff was an enduring challenge. In their project to remedy this, they began the process by drawing upon the expertise of external supervisors before training internal supervisors. The outcomes from the model were quite positive.

Copeland (2002, p. 236) found that both external and 'in-house' supervisors were exposed to dilemmas focused around issues of responsibility, confidentiality, boundaries, professionalism, relationships, contracts and ethical practice. The advantages for external supervisors were that they could be objective to organisational culture, and personally preferred this way of supervising. Supervisors were divided in their opinions about playing a more active, educative role within organisational systems. There was considerable support for the construction of more explicit relationships between supervisors and their employing organisation. Shaw (2004) had similar views.

Stone (2004, p. 72) concludes that 'the importance of regular professional supervision with an appropriately trained, objective and impartial supervisor for workers involved in direct welfare cannot be overemphasized'. The need for external

supervision, due to the line management in these organisations generally not understanding the need for and being adequately trained in clinical supervision, is an issue that can lend itself to the argument in favour of external supervisors. However Stone puts the realistic perspective of organisations or individuals not having the financial support for this. She ultimately flags the idea of group supervision being an adequate replacement. In her investigation with front line workers there was consistent feedback on the 'importance of external clinical supervision' (p. 76).

### **Training in clinical supervision**

Traditionally, across sectors there has been a lack of training for clinical supervisors and this is well noted in the literature (Ask & Roche 2004; Bernard & Goodyear 2004; Cousins 2004; Holloway 1995; Tsui 2005). Hoffman (1994, p. 25) calls this the mental health profession's 'dirty little secret'. There seems to be no identified pathway for workers towards clinical supervision. The Victorian DHS in 2005 identified clinical supervision as a key growth area, and subsequently as part of its workforce development plan offered training to leaders and interested people in the community health and AOD sector.

Notwithstanding the lack of training available for supervisors in general, internally in organisations there is often a lack of 'formal preparation for becoming a supervisor' (DHS 2005, p. 64) or a general lack of understanding of the concept of clinical supervision. It is not unusual in the literature to find studies of people either receiving supervision or training to become supervisors (Gertz 1999; Hancox et al. 2004; McFeely & Cutcliffe 2001). The recommendations from these studies are unanimous that training is beneficial for people's confidence and their general understanding of clinical supervision. Equally the findings from these studies point to clinical supervision for most being a new and unique experience. Thus some further feedback relates how participants are 'converted' to the need and importance of supervision after their training.

Bambling et al. (2006) suggest that in Australia supervision is considered an

important post-training professional activity and is not restricted to the graduate training setting. If a supervised therapist might reasonably expect to achieve greater clinical outcomes in client work than an unsupervised therapist (Steven et al. 1998), then what of an adequately trained supervisor providing this supervision? Similarly, Gertz (1999) concludes how important training is but how little has been done. Her conclusion was similar to Hancox et al. (2004) in highlighting how an effective training program increases supervisors' confidence and professionalism.

### **The financial component of clinical supervision**

Overall there has not been much literature examining the cost benefits or otherwise of clinical supervision on health professionals. Most AOD agencies in Victorian are funded by the State government's Department of Human Services (DHS)<sup>5</sup>. In the funding and service agreement for most AOD agencies in Victoria there is no money allocated specifically for clinical supervision. A small amount, less than one per cent, is allocated to workforce development. It is up to the discretion of the funded agency to allocate money for supervision, dependent on what they think is appropriate. It is not unusual to allocate a meagre annual amount between \$200 and \$300 for whatever professional/workforce development activity they choose, with the option of this going towards clinical supervision. The onus is generally on the worker to fund any additional professional development or supervision.

The average cost of supervision as recommended by the AASW on their website, [www.aasw.asn.au](http://www.aasw.asn.au), is \$120 per session. They recommend once per week for those with less than three years practice (AASW 2000, p. 3). Rose and Boyce (1999) mention the considerable 'expense of supervision' (p. 13) as does Munson (2002) who costs it from \$4000 to \$6000 per year (p. 21). He continues by stating how as financial demands for decreased administration costs become more important in social work education and work practice, supervision gets harder to justify. The irony

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<sup>5</sup> This information has been verified by the Eastern Collaboration of Alcohol and other Drug Agencies (ECADA) as of June 2006, all whom of which are on similar funding regimes.

he suggests is more, rather than less, supervision is needed.

Prior to 30 November 2005 there was a clear option for probationary psychologists to have a pathway of supervision for registration, which was a minimum of 100 hours. The costs soon add up here, especially if \$100 per hour is fairly common. As to the ongoing cost of supervision outside of probation, Green (2007) writes, 'Finally, of course, there are economic realities to be considered. The cost/benefit sums must add up' (p. 16).

Bogo and McKnight (2005) conclude that the dearth of literature related to supervision may be a direct result of cost-cutting measures in agencies. That is, supervision is an expensive exercise that seems to be the first to go when the fiscal squeeze is on. Of the other authors who comment on this issue, White and Winstanley (2006) come to the conclusion that, on average, the cost of giving peer, group or one-to-one supervision to any nurse represented about one per cent of an annual salary. When interpreted as a vanishingly small cap on clinical nursing practice necessary to reap demonstrable benefits, they recommend that 'it behoves Nurse Managers to comprehend clinical supervision as bona fide nursing work, not an activity which is separate from nursing work' (p. 628).

### **Supervision in different settings**

Finally it is important to note how tuning into different settings and the particular issues of that place are integral to the effective practice of supervision (Carroll 1999; Mann 1999; Tholstrup 1999). More pointedly, the culture of a place or organisation can inherently affect or even 'block effective supervision from happening' (Hawkins & Shohet 1989, p. 167). Conversely, from their experience of conducting supervision in a variety of social service settings, Hawkins and Shohet note how supervision best flourishes in culture where learning and development are seen as continuous lifelong processes, and even the most senior staff have ongoing supervision.

Supervision in religious settings (Mann 1999), in counselling agencies (Tholstrup



1999), or in organisations may differ from the particular cultural context of a residential rehabilitation setting. Tsui (2005) makes a recommendation that it is vital to recognise cultural contexts and should be researched when investigating clinical supervision. The concept of physical location, whether supervision is conducted on or off site can also be linked here as to how comfortable people feel to open up or disclose in different settings. Sometimes an organisational culture can lend itself to a lack of openness or safety. In such instances supervision could simply occur in a quieter more reflective space apart from the main working environment.

Powell's book (2004) points to the notion that clinical supervision is tailored for different fields of work, such as the AOD field in America. Further to this, authors such as Knight (2004) and Morrison (2007) specify the concept of tailored supervision in advocating for a trauma specific supervision, for those who work with sexual abuse victims. The reasons for a trauma specific supervision are that those who work with sexual abuse victims have a much higher chance of vicarious trauma.

A review of the supervision literature found no studies or research on clinical supervision in drug and alcohol residential rehabilitation settings – the location of the current research.

## **Conclusion**

In these chapters I have exhausted the literature dealing with all the relevant areas of clinical supervision that will contribute to the overall outcomes. These chapters began with the definition irregularities and resultant research recommendations, and moved to an overview of the history of supervision. The Australian studies and AOD specific studies were explored at depth as were efficacy studies and the factors and components involved in supervision. Group supervision and the notion of interminable practice were also investigated in depth. While social work was the prime basis for investigation in this chapter, due to the study being conducted from a social work model of supervision, the wider social sciences, psychology and notably

nursing were scrutinised. The following chapters outline the methodology employed for this study, and take into account some of the recommendations from this chapter.

## **Chapter 3:**

### **Overview of methodology**

#### **Introduction**

In the following two chapters I outline the qualitative approach undertaken to conduct the research. The general aims and objectives are presented, followed by outlining the research questions. The chapter begins by explaining the funded clinical supervision project at the Basin Centre residential rehabilitation centre on which the research is based and where it was conducted. Other processes prior to the research process are discussed in detail.

A full description of the 16 respondents how they were recruited into the study ensues. The methodology underpinning the research process of Participatory Action Research (PAR) is described at length as well as how it was applied in the study. The various roles undertaken are described, especially in the context of the role triangulation of being a participant observer.

The data arising from via the pre, mid and post semi-structured interviews and focus groups is outlined in detail as well as field notes. This part concludes with a discussion of the unique approach to the utilisation of Computer Assisted Telephone Interviews (CATI). The limitations and strengths as well as the reliability and validity of this study make up the penultimate segment, before the final data analysis section, where the usage of grounded theory in the study is described in detail.

#### **General aim of the study**

The general aim of this study is to explore in considerable depth the effectiveness and impact of clinical supervision on all levels of workers at the Basin Centre, an Alcohol and Other Drugs (AOD) residential rehabilitation centre, on the outskirts of

Melbourne, Australia. The study also aims to report with clarity the factors associated with clinical supervision.

### **Research Questions**

The research questions guiding my research are as follows:

1. What is the impact on workers of clinical supervision in an AOD residential setting, for:
  - a. Those new to supervision?
  - b. Those who have received supervision and/or are currently receiving supervision?
2. What are the factors associated with both the difficulties and/or benefits of clinical supervision?
  - a. Relevant to the supervisor/supervisee match
  - b. Gender issues
  - c. Style of supervision
  - d. Therapeutic backgrounds
  - e. Experience or insight provided by supervisor
  - f. Supervisors' own experience of receiving supervision
  - g. Other issues as identified during the research process.
3. What are the features and issues of clinical supervision particular to a residential rehabilitation program in the AOD sector? How does this impact on the supervision provided?
4. What is the impact of having external supervisors provide clinical supervision (and in this sense separating the administrative function from the educative, supportive and more clinical functions)?

### **Objectives of the study**

The objectives of this research are:

1. To describe and explore supervisee's experiences of individual and group supervision by external supervisors.
2. To identify the factors involved with effective/ non-effective clinical supervision.
3. To ascertain whether there are any specific AOD issues in clinical supervision. If so, to decide on the importance of discussing these issues in clinical supervision and also whether it is important for supervisors to have drug and alcohol knowledge.

### **Processes prior to the study: the supervision project**

The opportunity for conducting this research came as a result of successfully co-writing a tender with the Program Manager and Program Director from the Basin Centre for a project that provided free clinical supervision by external supervisors for a period of up to 12 months. The funding body was the Alcohol Education Rehabilitation (AER) foundation. This 'clinical supervision project' was organised to provide both individual and group supervision, by external supervisors, for every willing worker, to a total of 30, for 10 months commencing beginning February 2005 and ending on the 30 November 2005.

The choice of external clinical supervisors was to reduce the potential for ambiguity of roles if clinical supervision were conducted by a line manager or someone in a similar role. The participants<sup>6</sup> in this funded project were allowed to freely choose their individual clinical supervisor from a pool of screened and interviewed qualified supervisors. The selection of group supervision participants was organised by the Basin Centre's management. Groups were formed to account as well as possible for the heterogeneous skill levels and work areas.

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<sup>6</sup> From this point, mention of 'participants' is for any person engaging in clinical supervision for the duration of the project and the word respondent is for those within this project who volunteered for the research.

Permission was sought from management to conduct research potentially on all the workers, as part of a Masters of Social Work by research degree at RMIT. The Basin Centre management initially gave a verbal agreement, followed by a written agreement after acceptance into the Masters course at RMIT. This agreement was established in good faith and built upon previous good relationship.

Before the clinical supervision project commenced I made it clear verbally that I was conducting research via observation as well as interviews. I made it clear that this would form part of the data gathered to inform my findings. I articulated this in a forum which all workers attended, and then by e-mail and individual follow up. At the forum, the clinical supervision project was explained in detail as was the research process, including a clear and lengthy explanation of the concept and meaning of clinical supervision. I went to great lengths to guarantee all workers understood at some level the research process, as well as clinical supervision. This included tape-recording an initial group briefing for those who were not present<sup>7</sup>.

The clinical supervision project was coordinated by a Steering Group Committee (SGC), comprising the Program Manager (who also acted in the capacity of Team Leader of the counselling team), Program Director, Team Leader of Post-Residential Services, the evaluator and myself. Shortly after the commencement of the project the SGC nominated me as the Project Coordinator<sup>8</sup>. This role oversaw the running of the project, being very similar to a Project Management role, without the responsibility of budget monitoring. The Program Director was in charge of the budget monitoring and accountability to the funding body. However, when it came to asking questions and gaining permission for any research purposes, my role as researcher was subject to the general consensus method the SGC had in making decisions.

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<sup>7</sup> This tape is currently the property of the Basin Centre.

<sup>8</sup> There will be further discussion of this role later in this chapter

### **External observer with 'insider' knowledge**

Having spent six months 'observing', prior to the commencement of this project during a 22 week funded<sup>9</sup> workplace exchange that began in November 2003, I became attuned with the ethos, culture, organisational philosophy and general working knowledge of the Basin Centre. This allowed the research to be conducted less by a stranger, than by someone who was known to the workers and vice versa. The 'stranger in an office' (Ling 2007, p. 120) or stranger impact often associated with research of this nature was obviously lessened as a result.

This familiarity also enhanced understanding of internal worker issues, such as the tensions that exist between different working teams. Other problems included the sometimes delicate tensions that exist at times about being clear as to what therapeutic model the Basin Centre offered its residents. For example, sometimes there was a dialogic tension between the offer of the twelve step principles and those who did not adhere to it. As mentioned in the literature review chapter, the twelve step model originated from Alcoholics Anonymous (AA) and has abstinence as the *prime* goal, with the individual viewed as having a disease called alcoholism. Adherence to this model requires regular attendance at meetings and following the prescribed twelve steps. The Basin Centre has harm minimisation as its underpinning policy, most of which is dictated by funding sources. Harm minimisation has abstinence as a *potential* goal, but seeks to reduce the harm done by alcohol or other drugs in the areas of demand, supply and specific physical and social harms. Attendance at AA meetings is not compulsory under this regime.

Following the workplace exchange I maintained regular ongoing contact with most staff at the Basin Centre via phone or e-mail. Moreover, during the course of the research some familiarity was regained with the residents<sup>10</sup>, some of whom had returned since the workplace exchange time, 18 months previously. The reason for

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<sup>9</sup> This was also funded by the Alcohol Education Rehabilitation (AER) foundation.

<sup>10</sup> 'Resident' is the term used at the Basin Centre for a service user.

elaborating on this point is to stress the genuine difficulties for an external observer who previously may have had minimal or no contact with the Basin Centre. Residents need to become accustomed to you, and they have a need to feel safe from the outside world in their internal community.

The literature review recommended attempting to have supervisors all using the same model of supervision (Bernard & Goodyear 2004, Holloway 1995; Tsui, 2005) or at least come from the same training background to enhance the generalisability and rigour of the study. This proved difficult but was attempted. For example the AASW register of social worker supervisors was contacted as were other known clinical supervision professionals. A university faculty, who trained and operated from the same model of clinical supervision, was also contacted. The quality and depth of experience of supervisors who were eventually recruited was from my working experience, excellent. Time and supervision fee payments were factors involved as was the request by the Basin Centre to be able to provide supervision on-site.

**Table 2.**

***Timeline: Prior to establishment of clinical supervision project through to the end of the research process***

<b>Date</b>	<b>Activity</b>
November 2003	Workplace exchange X 6 months
October 2004	Grant application.
November 2004	Notification of successful grant.
November 2004	Application for MSW by research.
February 2005	Ethics application.
February 2005	Recruitment of supervisors.
February 2005	Recruitment of participants.
March 2005	First interviews.
May 2005	First focus groups.
July 2005	Mid-way interviews and focus groups.



July 2005	Clinical supervisor focus groups.
August 2005	Feedback of data from mid-way interviews.
September 2005	Clinical supervisor feedback to management.
October 2005	Clinical supervisor and management 'cafe' meeting.
October 2005	Survey of participants as to what they will do when the supervision project is finished.
End November 2005	Clinical supervision project finished.
December 2005	Final interviews and focus group.
December 2005	Final phone interviews for supervisors.
December 2005 – January 2009	Ongoing phone communication and visits to the Basin Centre.

### **Suggestions from the literature**

An extensive but incomplete prior literature review informed some of the parameters and processes involved with the methodology. The preliminary literature review made clear a number of factors that needed to be taken into account.

Firstly, among the dearth of literature available generally on clinical supervision as well as effectiveness studies, Bernard and Goodyear (2004) stated 'no one methodological approach is uniquely suited for providing the descriptive data' (p. 293) necessary for clinical supervision research. That is also to say that descriptive data was necessary as was their suggestion to attempt to have clinical supervision conducted under one model as previously mentioned. (Tsui 2005, p. 141) concluded also that in-depth qualitative methods were seldom used but were important.

Similarly to other authors (Holloway 1984; Lambert & Ogles 1997), Bernard and Goodyear also concluded that the acid test of effectiveness studies is in having client outcomes as a focus. They also admitted the inherent difficulty and that there was no prior study in this respect.

Given the plethora of different supervision models developed it has been a recommendation that at least one model of supervision should be tested, but tested apart from other models (Holloway 1995; Tsui 2005).

The recommendations from these previous studies were duly taken into consideration when designing the current research, as well as when recruiting supervisors prior to the research commencing.

### **Choice of research setting: rehabilitation centres in the context of the Australian AOD sector**

Nagy Hesse-Biber and Leavy (2006, p. 240) suggest it is 'imperative that you select a research site that will give you the information you need in order to address your research questions'. This study was designed to explore the impact of clinical supervision on all levels of workers at the Basin Centre. The Basin Centre's program encompasses counselling (individual and group), forensic work, 12-step programs, work therapy, chaplaincy, post-residential community linkage and support. The program has strong links with in patient and out-patient withdrawal regimes. The Basin Centre offers a 16-week program that has a particular emphasis on self-awareness, spiritual awareness and self-empowerment, with the option of gaining understanding and participating in the 12-step programs. Residents in the program are encouraged to participate in work therapy as well as individual and group therapy, all aimed at eventual re-integration within their local communities

There is great diversity in the AOD sector generally, and there is also a distinct diversity in respect to rehabilitation centres. For example, there is marked difference in their models and styles of operation, which includes duration of stay from 28 days

to two years. In Victoria, the 28-day style of rehabilitation centre is based on the Minnesota<sup>11</sup> model and has a strong 12-step emphasis, with lifetime abstinence as an integral goal. There is one such centre in Victoria, and the costs involved are significant.

'Treatment' in the AOD sector in Victoria has historically been understood to be distinct from 'prevention' and 'early intervention'. The Basin Centre in this respect is specifically a place of treatment. That is to say, it is for those with established AOD problems, who are dependent on their substance of choice. Prevention and early intervention are for those who are not quite dependant but for whom drugs or alcohol may have some problematic part in their lives. This is in contrast with the wider AOD sector that employs a range of working paradigms, with preventative and early intervention components integrated into their programs.

The age group of the clientele of the Basin Centre is primarily adults over the age of 25 (E. Holman, personal communication, February 3, 2005). My own experience of working with both young people and adults in the AOD sector is that working with young people can be significantly different from working with adults. However, the overall supervision process may be similar, as at times work with young people can be somewhat complex, difficult and taxing.

### **Research and not evaluation**

The clinical supervision project was funded to employ an independent evaluator. My role was to research the effectiveness of clinical supervision. The evaluator's role was to evaluate the program overall; here he employed a mixture of psychological quantitative measures and qualitative questionnaires. Ruben and Babbie (2005, p. 406) explain this difference by defining program or project evaluation as assessing

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<sup>11</sup> The Minnesota model is a strongly 12-step model following a 28-day regime of abstinence- based rehabilitation in a residential setting.

the 'effectiveness of programs in attaining their formal goals'. Some of the conclusions of the evaluation will be referred to in chapter eight.

### **Sampling**

Sarantakos suggests that the sample size must be 'as large as necessary, and as small as possible' (Sarantakos 2005, p. 170). Lee (2000, p. 44) states that in observational research the 'researcher must decide not only what is to be studied but where and when the observation is to take place'. He points out that observation necessitates being selective and purposive. That is to say there 'are no rules for sample size in qualitative inquiry' (Patton 2002, p. 244).

The sampling method utilised in the present research process was a stratified (Ruben & Babbie 2005) sampling method with some intentional or purposive (Bryman 2004) distribution of working areas.

### **Research participants**

There were a total 22 research participants (respondents), consisting of 10 interviewees, and a further six for the focus groups (who were not part of the interviewing process), as well as six supervisors. All 30 supervisees in the clinical supervision project were invited to be potential respondents by way of interviews or focus groups (Appendix A). These were conducted via an e-mail request that was distributed by the Basin Centre program manager as well as at the previously mentioned staff forum. It was highlighted to everyone that the method of selection for the study was that if they desired to be part of either focus group or interview, they would state their preference and their working area on a piece of paper. Inside that piece of paper they put their names. The paper was subsequently placed in a cardboard box under their specific working area. Pieces of paper were randomly selected from each box (working area) and afterwards the participants were informed of their status in either the focus groups or the individual interviews. Upon informing them of their status as respondents they were all issued the Plain Language statements (see Appendix B) and signed the ethics form (Appendix C). The sampling

method of purposeful distribution was utilised here in order to have a spread of participants over the different working areas. There was no intentional selecting for gender at any stage.

This process, from my previous working knowledge of the Basin Centre staff situation, ensured recruitment of participants with either no previous exposure to clinical supervision ranging to those, especially in the counselling team, who had some previous as well as ongoing experience of clinical supervision. If my main response came from one particular area of the Basin Centre then consequently my findings may only have been representative of that area. Again, if only counsellors volunteered, the possibility of most having had clinical supervision was higher and their feedback would have been specific to the counselling work, as opposed to the work therapy, post-residential care and other areas.

### **Response rate**

There was a 53 per cent response rate overall, with 16 of 30 responding. This rate was an important indicator to me of the freedom of choice people experienced in choosing to be part of the research process or not. What also can be deduced and was fed back anecdotally, is the importance of time in a busy work schedule for all the workers at the Basin Centre. Moreover, participants were fully informed of what was required of them and understood that participation was not simply a one-off questionnaire, but would entail a number of interviews throughout the year.

It worked out exceptionally well with proportionate distribution of new-to-supervision supervisees as well as the more experienced. There was also an overall bias towards females with a more than healthy representation of males (See Table 3). The respondents were from a wide range of work backgrounds, including management, counsellors, chaplain, work therapy (farmers), after hours and post-residential care workers. The number of 16 also lent itself to not having to inform anyone that they could not be involved. Six was the optimal number for a focus group with an option for up to eight.

**Table 3:****Distribution of respondents in working areas and experience of supervision**

Area of work	New to clinical supervision.	Had Administrative supervision or minimal clinical supervision.	Experienced/ familiar with clinical supervision
Counsellors (3)			3 (2f 1m).
Post-Residential Care (3)		1 (m)	2 (2f) (1 left before mid-way interviews)
Chaplaincy (1)	1 (f)		
Management (3)	1 (m)	1 (m)	1 (f)
Work therapy (1)	1 (m)		
Administrative/ Kitchen staff (3)	3 (3f)		
After Hours Support workers (2)		1 (f)	1 (f)
Total: (16)	6	3	7

The attrition rate of the 10 interviewees was only one as noted in table 3. This respondent gained alternative employment, citing clinical supervision as supporting this process. All the respondents attended the first focus group. The second focus group had one omission, but he/she provided some post-group verbal feedback. The same respondent did not attend the final focus group, citing self-care and an overly busy working schedule as the reason. This was inadvertently encouraging feedback, as self-care was a pertinent issue in the research and will be dealt with in the chapters discussing the findings.

## **Methodological triangulation**

For this study there was an intentional choice of method and data triangulation. Triangulation, or the use of multiple methods, occurs when researchers seek corroboration between two or more sources for their data and interpretations (Liamputtong & Ezzy 2005, p. 40; Sarantakos 2005, p. 145). This research was underpinned by a Participatory Action Research (PAR) component and was triangulated with an ethnographic approach, and through the utilisation of interviews and focus groups of both supervisors and supervisees.

Liamputtong and Ezzy (2005, p. 41) mention four distinct types of triangulation:

1. data source triangulation;
2. methods triangulation;
3. researcher triangulation; (and)
4. theory triangulation.

In this research a combination of the former two was utilised. There is potential for a fifth category in 'role triangulation'. This may be similar to the category of researcher triangulation, or 'multiple research gatherers' (DePoy & Gitlin 2005, p. 205), where a variety of researchers are employed in the research process.

During the course of the research process, there was the unique opportunity to view the impact of clinical supervision from various role perspectives:

- i. In the role as clinical supervisor;
- ii. As an SGC member (moving into Project Coordination role);
- iii. As a participant observer;
- iv. As an interviewer in focus groups and interviews; and
- v. As a supervisee under the tutelage of my thesis supervisor.

These are all very pertinent and relevant angles and will be discussed throughout this chapter. Balancing and negotiating all these functions was regularly supported by my role as a supervisee with my thesis supervisor. Furthermore, I also continued to receive additional external supervision for my job role of that time.

The entire research process was underpinned by a Participatory Action Research (PAR) methodology; thus a sixth role could potentially be as an action researcher. However this was already inherent in all the other roles.

### **Participatory Action Research (PAR)**

Action research is 'social research carried out by a team encompassing a professional action researcher and members of an organisation or community seeking to improve their situation' (Greenwood & Levin 1998, p. 4).

Lofman, Pelkonen & Pietilä (2004, p. 333) refer to action research as 'new paradigm research', which is understood to mean doing research with and for people rather than on people. Rice and Ezzy (2001, p.175) make the distinction between action research and PAR, writing that in PAR the instigator is likely to be from a different sub-culture and better educated and more closely associated with poor or disempowered people. The similarity between both forms is in the approach, but the distinction is that action research can be undertaken by and with people with power or in positions of power. In one respect the present study is action research because of the inherent power in being a supervisor and less so as project coordinator. However the study could equally be considered PAR in that I was from a different sub-culture in my place of work, in my understanding and experience of the potential positive benefits of clinical supervision, and in so far as the supervisees in a sense were the poor or disempowered. In the course of this study I link both together and conclude that action research is participatory because participants are collaborators rather than subjects. The definition of PAR I aligned my research with was analogous to Whyte (1991, p. 20):

Some of the people in the organisation or community under study participate actively with the professional researcher throughout the research process from the initial design to the final presentation of results and their implications.



The significance of establishing a definition for PAR relating to this study is underpinned by Mc Taggart's conclusion that PAR 'will still identify a confusing and meaningless diversity of approaches to research' (1997, p. 27).

The danger of ending up with 'research that is about action, but not action research' (Schatz & Walker 1995, p.168) is overcome in that the action was carried out during the project time, and the action has continued and in one sense is still continuing. Action during the project time consisted of delivering talks at key AOD conferences like the Australasian Professional Society on Alcohol and other Drugs (APSAD) conference in November 2005, where I began discussing the findings and how the study was carried out. A similar presentation was conducted at the Eastern Metropolitan Region (EMR) Harm Reduction Conference in October 2005, as well at the organisation that I worked for during and after the period of the study. The ongoing action is evidenced in clinical supervision being offered still at the Basin Centre and the outcomes of the research being promoted in the Salvation Army. Further attention to this point will be provided in chapters 5 to seven.

### **Choice of PAR**

My choice of PAR was for four key reasons:

- a) To enhance the study outcomes by providing a benchmark informed by the participants if any change was needed, and for future recommendations. To also glean from the supervisors their experience and perspective on the project and to feed this into the outcomes and recommendations.
- b) To empower the participants in this respect.
- c) As a form of inter-method triangulation.
- d) To continue to learn from the outcomes and apply that learning.

PAR was chosen because it is a recognised and relevant methodology to guide the process of the research. As well; it is a way of maximising response, and is a mechanism for any possible change that was identified and deemed necessary. Using PAR potentially mitigated the 'distinction between the researcher and the

researched' (Ruben & Babbie 2005, p. 439). The distinction could not fully disappear. This is most clearly demonstrated by the fact that in the study I did not take the role of supervisee in the actual clinical supervision project with the participants.

Part of the reasoning for choosing external supervisors was to attempt to reduce any potential power imbalance. Balancing the power factor was that all levels of power or authority, whether management or not, were supervisees.

PAR in its origins had a close affiliation with critical theory (Mc Grundy in McTaggart, p. 137) and sought to address problems of power and inequality. Rubin and Babbie (p. 440) cite PAR as often involving poor people, 'because they are typically less able to influence the policies and actions that affect their lives'. This informed my choice of PAR in that the workers are 'poor' in their ability to influence policy and funding structures for their positions. On a meta-level I wanted the participants to have some influence on how the overall project was shaped, and to glean from them what changes they wished to make, as well as simply discovering from them just what the impact the clinical supervision had.

All action research and action-based learning also has at its core, a style of acting or doing that is based upon the seemingly simplistic concept of learning from what one does as one goes, and then making appropriate changes, and then learning further from these. Wadsworth (1997 a; b) has championed this style of learning. On a macro level this research overall will contribute to learning about supervision and is inherently action based as this study is a platform for developing future studies.

### **Political reasons for PAR**

Most action research has an explicit political agenda to advance a cause and/ or 'improve the conditions and lives of research participants' (Neuman 2006, p. 25). The intention and purpose of my research was not simply about 'practitioners but for them' (Hough 1996, p. 27). I anticipated that whatever the findings, I would try to

ensure they got to relevant funding or research bodies. For example, upon successful completion, the AER foundation will make the findings of this study available on their website, Further, if the findings proved favourable, the political agenda would be to try and ensure that funding bodies would consider that clinical supervision should be provided as part of a funding and service agreement with the Basin Centre. If clinical supervision was only slightly beneficial or had negative impact this also would inform researchers and current bodies such as NCETA to reconsider the place of clinical supervision and its effectiveness as a workforce development strategy, and to conduct more large scale research into this.

### **PAR throughout the study**

As the nominated project coordinator for the duration of the clinical supervision project I was responsible for ensuring that the project ran well and kept to schedule. Underpinning this role was a PAR framework seeking to learn from what was happening throughout the research process and implement any changes deemed necessary.

The project coordinator role was not initially intended but emerged shortly into the project, as a very necessary and useful one. The SGC of which I was an integral member for the clinical supervision project, discussed this at length. Part of this discussion explored the possibility of inviting potential external members from associated agencies to fill the role. But the time shortage and lack of information on people with the relevant skills at such short notice supported the decision for my appointment. The time pressures from the funding body, the AER Foundation, were to begin the project and to commence to utilise the funds. There was also weighing up of possible conflict of roles. After lengthy deliberation, it was decided that the benefits of my prior skill base in project development and coordination, and the linking of my use of PAR would work well together. This view was also shared by my research supervisor.

After the mid-way interviews, I collated, coded and synthesised the data, via a grounded theory approach. This was fed back to all participants, and not just the respondents, via e-mail as well as hard copy where necessary (Appendix D). This step was taken only after receiving the respondents permission to do so at this stage of the project, with a full explanation that this was part of the action research component. Following the release of this report, participants were asked, again via e-mail, whether this matched their experience or added or detracted from it. There was no response to this request but the verbal feedback from people generally was that this reflected accurately what was happening and it was propitious that it had been acknowledged. As a result the 'double hermeneutic' effect (Giddens 1990) took effect and 'changed' the community. This was consistent with the Basin Centre's openness to change, and in many respects was like a parallel process, with the impact of clinical supervision bringing change. This process also corresponded with how I considered myself an 'interactive membership oriented' researcher, accepting (and the community being accepting of), intrusiveness (Angrosino & Perez 2000, p. 691). The SGC was also utilised in this process.

The impact of this action marked and confirmed a significant transition in workplace culture as will be discussed further in later chapters. The management of the Basin Centre, who were respondents in the research process, began to feel more empowered in their management roles and made a number of important decisions to ensure that this feedback was responded to with integrity.

### **Other PAR interventions during the research process: supervisors**

As a result of the various roles, I was able to intervene at various stages through the research process. By the mid-way point, the management team were confronted by the emerging theme of role clarification. They were feeling more like 'managers' than ever before. There was a reported sense of needing to take greater responsibility in their roles, where their staff were practising self care and saying 'no' to undertaking tasks that they normally would have done. Thus the weight of that task and decision rested heavier upon managers.

As a result they managers asked me as action researcher to request some recommendations or constructive feedback from the supervisors' focus group, who willingly obliged. I consented for three reasons. Firstly, because the management were respondents and needed the action-based support; and secondly this request was cleared by the SGC. The decision was also discussed with my thesis supervisor who consented to it, being consistent with the PAR approach.

Three weeks before the end of the study, the management also organised an extracurricular meeting with the supervisors. At the meeting a transcribed record of comments was taken via direct computer input. The venue, (the back of a local café), was not suitable for live audio-taping. Consequently this encouraged a stronger focus group atmosphere. In my roles as both action researcher and project coordinator my aim was to allow management to organise this themselves without my making any recommendation as to venue or otherwise. This was part of an emerging empowerment theme, and it was important that I be sensitive to it.

### **Inherent usefulness of interviews aligned with a PAR process**

The interviews alone served as a sounding board and reflective space, being very conducive to clinical supervision. Of themselves they became an action-based learning component for those involved in the interview process and the focus group components of the project. That is, having the interviews allowed people to take stock of what was happening for them and then to take positive action to make any changes that were needed. For example, in the focus groups the discussion on having greater regularity of group supervision led to decisive changes across the majority of group supervision sessions. My role was to ensure that some of the changes actually occurred after they were proposed.

### **Ethnographic approach**

Ethnography, quite simply, is the method of producing a written account of a 'particular group or institution or local culture' (Gillham 2005, p. 39). Ethnographic

methods (Hall & Hall 1996; Sarantakos 1998) require the researcher to 'tune in' as it were to the field of study. Whyte (1991) felt that he needed to become more of an insider when he used an ethnographic approach to investigate street gang leaders in Boston, USA, and got to participate in their activities (pseudonym for this study was Cornerville). Whyte eventually moved into Cornerville. The hallmark of the ethnographic approach in field work is, 'working with people in their natural settings' (Charmaz 2006, p. 27). A derivative of the field of ethnography is the role of participant observer.

### **Participant observer**

The central aim of this method is to generate data through 'observing and listening to people in their natural setting' (Gray 2004, p. 241), to be 'immersed' in the research setting and to report back from this experience. The role requires the researcher to be clear about their identity in the research arena, but the extent to 'which the researcher actively engages with the members of the setting is limited' (Nagy Hesse-Biber & Leavy 2006, p. 246). Bulmer (1984, p. 27) summarises the need in participant observation to 'co-operate with informants, establish trust, create empathy between researcher and subject, and be relatively open about what one is doing'. These criteria guided my approach.

Gray (2000) endorses a direct link with participant observation and action research, pointing out that one nicely leads to the other. Glesne (1999) describes a continuum of participant observation from mostly observing to mostly participating, which also can be the right context for the ensuing step of action research. Similarly, Charmaz (2006) and Jorgenson (1989) also remark how participant observation complements data obtained from research interviews as well as other data gathering methods.

### **My role(s) as participant observer**

The participant observer role could be viewed through the different roles as discussed earlier. As participant observer it was important to note the reflexivity of the following roles, acknowledging the existential fact that I am influenced by my own

socio-historical location in place and time (Ling 2007, p. 67), and that this will 'affect the data produced' (May 2004, p. 155). These roles enabled one to gain insider knowledge, where acknowledgement of the impact of the roles on the Basin Centre environment and the research process was duly noted. This was well supported by regular supervision from my thesis supervisor. As mentioned previously I was also able to draw on my previous experience as an employed full-time counsellor at the Basin Centre. The different participant observer perspectives were:

- i. As an outside eyewitness who observed the progress of the clinical supervision project and its impact by spending time at the venue;
- ii. As one of the clinical supervisors employed through the clinical supervision project; (and)
- iii. As project coordinator and SGC member.

On many occasions time was spent simply observing at the Basin Centre and immersing in the culture under study (Patton 2002). I would identify myself to the appropriate people such as reception and management, both before and upon arrival. This was to gain insight outside of the official times when I was there for the interview processes, and to establish an ongoing dialogue as to how people were experiencing clinical supervision and how effective it was. This proved to be important, particularly at the initial part of the research process, where general questions about clinical supervision were answered, including people trying to understand the basic concept of the term and its practice. This questioning gave the opportunity to actively provide education about clinical supervision and to explain the research and the processes being undertaken, and thereby to ensure quality data was gathered. Throughout the research I randomly asked people, both officially and non-officially involved as respondents, questions about how they thought the clinical supervision project was going. These contributed to my field notes. Bessant and Watts (2001, p.103) point out that 'subjects behave differently when they know they are being researched'. The ongoing dialogue with the participants during the research process was my attempt to reduce the possibility of this. Schutt (2006) weighs up the impact of identity disclosure and questions whether researchers

should always inform everyone all the time of their identity as a researcher. However, he also recommends gaining appropriate informed consent where possible, which is exactly what I did.

I also encouraged participants to ask me questions about the research process or clinical supervision at any time, which they often did. I also asked participants in general conversation 'How is the clinical supervision going?' or 'what have you noticed in respect to how clinical supervision is impacting on you and others?' Verbal permission was sought where necessary, to use their feedback as part of my observational findings. At no stage did I receive a negative response to my questions.

### **Practitioner-researcher: supervisor role**

To complement the 'insider' perspective of what it is like to work in this arena, I offered my services as a competent and trained clinical supervisor, so that equal insight into being an 'insider' from the supervisor's point of view might be achieved. Similar to the participant observer is the 'practitioner- researcher' (Gray 2004, p. 243). This role also certainly helped my understanding of and empathy with the supervisors' feedback and in my overall rapport with them. This was especially the case during the focus group of supervisors as I was able to listen from both supervisor and supervisee perspectives. In some respects the clinical supervisor role provided me as a researcher with a balanced look at the impact of clinical supervision. This is not dissimilar to hearing a person's feedback about one side of an argument and then spending time considering the other side of that argument.

The offer of my clinical supervision services was taken up by two participants in the clinical supervision project. A condition of the supervisory relationship was that they were not to be part of the research focus groups or interviews.



### **Support from thesis supervisor**

For the duration of the clinical supervision project I received regular fortnightly supervision from my thesis supervisor, and was often reminded as to how the ethnographic approach lends itself to reflecting on the use of self in the various roles being undertaken. The process of receiving independent supportive supervision also mirrored in some respects the intentionality of the separation of roles and functions of line management and clinical supervision. Further to that, the supervision with my thesis supervisor was integral in negotiating the different roles and the associated potential dilemmas. Her wisdom, insight, support, and encouragement to take on various roles were invaluable. She also helped me to remain objective in these roles where necessary. For example there were confidentiality issues of being privy to sensitive organisational information that management felt necessary to share during SGC meetings. The challenge was to maintain confidentiality of this information when acting as clinical supervisor.

In the next chapter I outline sources of data and how it was gathered as well as the ensuing process of analysing the data. The complementarity of the methodology and the use of grounded theory is explored at length also.

## **Chapter 4:**

### **Data sources and analysis**

#### **Data Sources and collection**

The data was gathered via individual semi-structured interviews, and focus groups and were complemented by field notes. All individual interviews and focus groups were conducted by me. There were 10 pre-interviews before respondents began receiving supervision; nine mid-way interviews and nine final interviews, making for a total of 28 individual interviews. All interviews were with the same respondents throughout. Further to that there were three focus groups with respondents and an additional two focus groups with the supervisors. The supervisors were also interviewed by phone in the same time-line as the final interviews.

All interviews and focus groups were held in the same week, except for the first focus group, which was held a few weeks after on 12 April 2005. The reason for this was for time efficiency for the Basin Centre staff and also to ensure that there was synchronisation of feedback from the different groups. The initial 10 interviews were conducted in the week of 11 March through to 18 March 2005 at the Basin Centre. The mid-way interviews were conducted from 14 July 2005, needing to be flexible for a participant who was about to go on leave, to 22 July 2005, with the majority of the interviews conducted in the week 18 to 22 July 2005. The final interviews were conducted the week after the final completion date of the clinical supervision project, from 12 December to 16 December 2005.

All the individual interviews and focus groups with respondents took place on site at the Basin Centre. The focus groups with the supervisors were conducted off-site.

The transcription of the majority of interviews was conducted via an independent transcriber. The transcriber also performed the 'live' transcription of the first two

focus groups, but was unable to attend the final one. His presence was announced at every interview and he was seated at the rear of the room so as to be as unobtrusive as possible. He was chosen for his speed typing abilities as well as my knowledge that he would keep the material that he was privy to confidential, and provide an accurate record of the session.

All interviews and focus groups were recorded via a mini-disc microphone. The confidentiality of all materials was iterated in the Plain Language Statement (appendix B), as well as explained verbally. The research was conducted in accordance with RMIT university ethical requirements.

### **Interviews**

Described succinctly, 'an interview is a conversation between people in which one person is a researcher' (Gray 2004, p. 213). Interviews have the potential to yield rich insights into people's biographies, experiences, opinions, values, aspirations, feelings and attitudes. There are a number of interviewing techniques and broadly speaking four types are utilised in social research paradigms. They are: structured, semi-structured, unstructured and the group interview. A structured interview attempts to control an interview through predetermined questions with emphasis on the respondent answering in accordance with the interview schedule. There is little scope for deviation in structured interviews. The continuum shifts to the other end in unstructured interviews, where the respondent is encouraged to answer in their own terms. In semi-structured interviews the questions are still normally specified but 'the interviewer has more latitude to probe beyond the answers and thus enter into a dialogue with the interviewee' (May 2001, p. 123). Both elaboration and clarification can be sought by the interviewer as well as the interviewee.

### **Interview format: semi structured interviews**

The interview format for all the interviews conducted in the present research process, was semi-structured. Supplementary questionnaires in a standardised format were filled out at the beginning of the project only. There were some slight

alterations to the questions between each interviewing round but they generally kept to the themes attached to the research questions. Each interview lasted for approximately 45 minutes with some being as short as 25 minutes, and the maximum length being close to 55 minutes.

Interviewing techniques such as open-ended questions, consistent with a grounded theory approach were utilised, interviewing one person at a time. An advantage of semi-structured interviews was that they allowed time to explore particular points. It also enabled me to provide further clarification and explanations (Sarantakos 2005).

For Gray (2004, p. 219) the validity of interviews is directly related to how the question content 'concentrates on the research objectives'. This I endeavoured to do by referring back to how the questions asked were related to my research questions. Prior to the commencement of the interviews, the questions were formulated, reviewed and revised, and then piloted (Bryman 2004, p. 326; Gillham 2005, p. 73). The questions were deemed to be clear and appropriate, allowing for suitable flow for the interview within the planned timeframe. I attempted to allow for flexibility and space to investigate answers that at times may have been skimmed over.

During most interviews, accompanying notes were taken and these were correlated with the transcribed interviews when the data was being scrutinised. Gillham (2005, p. 89) highlights how the trustworthiness of audio recordings of interviews is demonstrated by live transcription of observations. I was mindful not to labour too intensively on live note-taking as it can detract from the full attention needed to be given to the person interviewed. Furthermore, most of the interviews were time limited and did not allow for pauses for notes to be completed.

### **Why semi-structured interviews?**

Semi-structured interviews were chosen for various reasons. The semi-structured format provides greater opportunity for comparability, and allows people to answer

more on their own terms than in a standardised interview (Bryman 2004). It was this balance that was important. There was also a need for time efficiency with the interview schedules. It was necessary to limit the amount of time that workers were taken away from their core business hours and to fit into the Basin Centre's tight and often changing schedule. Closely associated with this was the need to ensure that all the findings were as much as humanly possible able to be used for the PAR component of the research while the project timelines were still running. It was well established that the funding for the project would finish in November of the calendar year 2005.

The semi-structured interview format was also chosen for intended richness and depth in the data, and to provide an opportunity for the participants to self reflect on their experience of clinical supervision. There was consistent feedback in the interview process to confirm the usefulness of the interview format as a self-reflective tool. An integral component of clinical supervision in my experience of providing as well as receiving clinical supervision has been the importance of connecting my thoughts and experiences via the process of simply talking them through. This process leads to greater overall self-awareness. Change is far more possible when one is conscious of what it is that possibly needs to change.

**The importance of choosing questions that would lead respondents to consider the importance, effectiveness and impact of supervision**

Designing and choosing questions that would lead people to consider the impact and effectiveness of supervision was challenging (see Appendix E). The question of whether supervision should be mandatory was such an attempt. The interviews generally explored the research questions as well as the commonly perceived and subsequently experienced difficulties and benefits of supervision. Some respondents found the very semantics of the word 'mandatory' difficult to fathom largely due to the lack of choice implied by the word, so on occasions I reframed 'mandatory' as 'strongly encouraged'. Overall the very strength of the term generally led to appropriate serious consideration of the value and effectiveness of supervision.

### **Interviews: How they were conducted**

Given my understanding of the difficulties of communicating in this large workplace, interview times were organised via e-mail. Some participants were also followed up individually on site, a few weeks before the clinical supervision project actually commenced. Just one week prior to the interviews there was a follow-up reminder by e-mail and individually where possible. This was anticipating that people can and often do, change schedules due to unforeseen circumstances that may arise in the daily running of a residential AOD rehabilitation centre. All potential participants, during the recruitment phase and throughout the clinical supervision project, were informed that they could withdraw from the research at any stage. This was done verbally, in writing via the Plain Language Statement as well as by follow-up e-mail. Further, all participants were given a letter of invitation, introducing the research and the potential time it might take to be part of the process (see Appendix A). I noticed that my reiterating that I had undertaken an official ethics process via RMIT provided most participants with some extra security.

The challenge at the initial recruiting phase for respondents was that it coincided with the recruiting process for participants in the actual clinical supervision project. For all staff, engaging in clinical supervision was strongly encouraged but not compelled by management. The management had the task of expounding the potential benefits of clinical supervision. However I ensured at this time and throughout the remainder of the research process that negative experiences or experiences that were not so helpful were treated equally.

The delicate balance of remaining neutral as a researcher in this early part of the process required considerable reflection and circumspection, particularly as AOD workers in Victoria, and especially the Basin Centre workers, have participated in so much previous research. So as not to look like another researcher conducting research to 'advance the researcher's career' (Engel & Schutt 2005, p.109), it was

necessary to inform the prospective participants also of the potential usefulness of their feedback, especially as to the PAR approach and the final outcomes.

Individual interviews were all attended with the only attrition being the one individual who gained alternative employment, mentioned previously. After every interview the opportunity to provide feedback was offered where this could be done via e-mail or phone. Only one participant on one occasion in the entire 28 interviews took up this opportunity, with a brief but informative e-mail. Sometimes during the interview process, the complexities of work at the Basin Centre impacted upon appointment times, sometimes favourably and at other times not so favourably. Sometimes people became so overwhelmed with busy schedules they had to cancel and reschedule their appointment times. At other times they decided to get their interviews 'over and done with' immediately when they saw me. This required some flexibility of time and space. The Basin Centre was very flexible and generous in their provision of interview rooms and time allowed for individuals to participate in the research. The interviews were all conducted in as relaxed and comfortable an environment as possible, to be conducive to self-reflection. Reiterating the confidential nature of the interviews was of paramount importance.

### **Initial interviews**

At the time of the initial interviews only two of the interviewees had engaged with their clinical supervisor and not yet in a formal capacity. As mentioned previously, respondents were deliberately interviewed on site for a number of reasons. The first reason was for a greater response rate, to avoid potential travel time and the known difficulties of getting off site. The other benefit of being on-site was that it gave me extra time to act in my participant observer role. This proved invaluable as people who did not choose to be part of the research process would often engage me or vice versa to provide their own feedback. This meant I was able to see the context and conditions of the work at times. For example, a respondent was interviewed on a Monday after a crisis involving a resident with whom they had close contact.

Ordinarily, to be respectful, the appointment may have been postponed. However in

this instance, when postponement was offered to this participant, they decided to continue, and thus I was able experience directly some of the background event that may have coloured the interview answers.

### **Mid-way Interviews**

By the mid-way interview point, most participants had a few months of clinical supervision and most groups had at least two to three sessions of group supervision. Again participants were e-mailed a few weeks beforehand to arrange interview times.

### **The Final Interviews**

The timeline for the final interviews was the second week of December 2005. This timeframe was chosen to ensure that the experience of supervision was still fresh but also to ensure that participants reflected upon their future clinical supervision arrangements, especially since the funding for the supervision project had ceased. The issue relating to the sudden ending of funding was raised as a potential concern by respondents at the mid-way interviews. This was a prior concern also addressed in the ethics application. The SGC spent time subsequently addressing this issue from a PAR response.

In the final interviews a question was added relating to the respondent's perception of the impact of the clinical supervision on their clients or client work. (See literature review recommendations and Appendix E).

### **Focus Groups**

In a focus group, multiple participants are interviewed together, as distinct from individual interviewing. Morgan (2007, p. 6) defines a focus group as a 'research technique that collects data through group interaction on a topic determined by the researcher'. The optimal number suggested is six to ten people (Patton 2002, p. 384; Sheppard 2004, p. 185). Focus group interviewing was historically developed from recognition that many consumer decisions are made in a social context, often



growing out of discussions with other people. For academic and research purposes, a focus group enables participants to hear and reflect on each other's responses and to make additional comments beyond their own original purposes. Focus groups generally employ convenience or purposive sampling (Barbour & Schostak 2005, p. 41).

Short (2005, p.104) demonstrates how focus groups have often been used in combination with established qualitative methods, such as interviews, as was the case in this research.

### **Focus group advantages**

One of the distinct advantages of a focus group over other methods occurs when a researcher 'doesn't know what all of the issues are surrounding their topic' (Nagy Hesse-Biber & Leavy 2006, p. 196) or wishes to extract or explore their topic further. Focus groups provide the 'flexibility for probing ...bringing out aspects of the topic that were not anticipated or may have emerged in individual interviews' (Ruben & Babbie 2005, p. 454). With members all present at once, there is also a time efficiency that enables in-depth exploration. As alluded to before, the 'interactions among participants enhance data quality' (Patton 2002, p. 386), and tend to be more enjoyable for participants. The extent to which there is a relatively consistent shared view or great diversity of views can be quickly assessed. Participants in a focus group have greater opportunity to pursue and saturate themes.

### **Focus group disadvantages**

The clear disadvantages concern the skills needed in managing the group and the flow of the discussion. Keeping people focused rather than allowing too much sidetracking and deviation from the topic matter, with the constraints of time, especially since the groups were conducted during business hours, was certainly challenging. As generous as the Basin Centre management was in providing their time, the appropriate reciprocal response was to be equally responsible with how the time was made use of. The skill that I had already acquired in running and managing

groups certainly helped. The power of the focus group is in their being 'focused'. For example, there was a tendency by the group to discuss workplace issues, such as communication across working groups in such a large geographical space, and then to go on to begin to problem solve such matters. I encouraged them to keep such discussions until after the focus group, for possibly a separate meeting.

Another potential drawback of the focus group process is that it may allow popular opinion to dominate and those holding minority views may be disinclined to speak up. This was not an issue in these discussions. Quite conversely, the group became an environment where everyone was encouraged to contribute. Interestingly, the presence of a manager in the group enhanced this aspect rather than stifling it.

### **Focus groups: How they were conducted.**

The focus groups were deliberately started slightly after the clinical supervision project began, so that respondents would have some relevant experience to talk about in respect to clinical supervision; albeit early experiences. Another reason was that the focus group was comprised of 60per cent of 'new to clinical supervision' supervisees.

The same questions and format were used in both the focus groups and the interviews. The focus group lent itself to participants disclosing information to me that might not be shared in a more formalised structure. Although the participants were acquainted with each other, it was not taken for granted that they knew each other well. The group was made up from different areas of the Basin Centre. Thus at first, the respondents were unsure as to how safe it was to disclose information, particularly given the presence of a manager in the group.

The boundaries of confidentiality and freedom to speak were discussed at length at the beginning, as suggested in Cameron (2000, p. 118).The respondents came to a consensus that what was said in the group would not be discussed outside the group. On one occasion, the manager present in the focus group wished to feed

back to the management group an issue that he thought might be supportive of the group. Verbal permission was sought from the group, by means of group consensus. This did not detract from the group discussion or safety of the group. It was not the intention of this focus group to be seen as a management feedback tool. For research purposes it was reiterated that the material from the group would be non-identifiable

Accompanying notes were kept to a minimum so as to stay in tune with the flow of the focus group. Bryman (2004, p. 329) states that the interviewer is 'supposed to be highly alert to what is being said', and that it is better not to be distracted by note-taking. The advantage of the previously mentioned live transcriber supported this approach.

## **Clinical Supervisors**

### **Recruitment and response**

Recruitment of the clinical supervisors into the research component of the project was primarily purposive (Sarantakos 2005, p. 164; Bryman, pp. 333-334). Purposive sampling is the selection of a population to best suit one's research aims. The present selection was initially conducted through a formal recruitment process, as would be undertaken for recruitment of new staff. During the interview phase of the recruitment process, the candidates were invited to be part of the research process. To avoid any sense of coercion, it was made clear to them that if they did not wish to be part of the research process it would not count against their employment opportunities. The overwhelming response was of support and a few subsequently fed back that this approach increased their interest in being a clinical supervisor on the project. The response rate was close to 83 per cent. This suggests something of the importance to the supervisors of meeting together, given their busy schedules. No financial compensation was offered for the extra spent attending focus groups for the research.

The ongoing response was enhanced by the use of Computer Assisted Telephone Interviews (CATI)s for the final interviews, thus enabling easier access. After the phone interviews I e-mailed a copy of the transcribed interview, whereupon all supervisors made some necessary corrections and returned their responses via e-mail. Once the changes were made, a corrected copy via e-mail was sent back again, at which point all supervisors were satisfied. This innovative and expedient form of CATI will be discussed later in this chapter.

### **Supervisors: their involvement in the research process**

All supervisors were asked whether they wished to participate; the response rate for the first-round interview was five out of six. In the mid-way focus group four responded and one decided to not respond, despite being followed up at least three times via e-mail and telephone. This supervisor decided to not respond to any further follow-up without explanation. However in the final interview a supervisor earlier had not responded to the initial invitation to be part of the research process decided to take part and was subsequently interviewed.

The supervisors were interviewed before, mid-way and at the end of the study, to parallel the respondents. They were initially interviewed as candidates for role of supervisors on the project. At this stage the research was explained to them, and they signed the Plain Language Statement (Appendix B) and the ethics form (Appendix C). They were asked some questions appropriate for both the supervision project and the research. Only three questions were specifically for the research purposes. This approach was for reasons of time efficiency and did not seem to interfere with the integrity of the answers. The supervisors' consistent high calibre and professionalism are what informs my observation here.

At the mid-way point the supervisors gathered for a focus group. Considerable flexibility was required; there were different workplaces, and some had long distances to travel. Rarely were there two supervisors on site at one time at the Basin Centre. Because of these geographical challenges as well as the only

available time being in the evening, the supervisors' focus group was conducted off-site, in a central location.

This focus group was also intended to provide space for a forum, where the group could share experiences, within the limits of confidentiality. As a number of the supervisors had little contact with other supervisory colleagues, there was the added benefit of co-support. The interest generated by the research process amongst the supervisors, combined with the general interest in potential outcomes, further justified a focus group. Time effectiveness for me, by gathering the supervisors together in one venue, rather than conducting five separate interviews, with the corresponding problems in organising their times, was also a key factor. Other general benefits of focus groups as mentioned previously applied. The supervisors' focus groups were also an enriching experience for me in that they confirmed some of the experiences I already had in my role as a supervisor. The collegial support and learning were also beneficial.

### **Field research and notes**

The final component of the data sources was field notes. Neuman (2003) cites Fetterman (1989), 'Good notes are the bricks and mortar of field research'. DePoy and Gitlin (2005, p. 202) cite two different types of field notes; '(1) recordings of events, observations and occurrences and (2) recordings of the investigator's own impressions' of events and feelings. The notes recorded for the present research were a mixture but mainly of the former. The process of the clinical supervision project was diarised chronologically, together with a diary of the research process. As mentioned previously, where possible the interviews were supported with accompanying notes, more with reference to particular emphases that the interviewee said or made non-verbally, as well as an abbreviated summary of what each interviewee said. Notes were recorded with observations from my role as participant observer. In this respect Emerson, Fetz & Shaw (1995, p. 4) highlight that 'field notes are accounts describing experiences and observations the researcher

has made', from their involvement. Similarly, phone conversations were recorded as they related to feedback about the research.

Minutes from the SGC meetings were relevant. These minutes were included largely because the SGC meetings had direct impact on the PAR component of the project. The intrinsic challenge was my overall lack of time to record my feelings and interpretations. There was a need to be available and alert in the research process, especially in the outside context of my full-time employment, job changes, and father/ husband roles.

### **Other methods employed: Computer Assisted Telephone Interviews (CATI)**

CATIs have been historically used for surveying sample populations rather than interviewing for research purposes. CATIs are traditionally recognised in Australia and internationally for their ability to provide timely and relevant data on the health of the population and this is their common usage (Ruben & Babbie 2005, p. 297; Wilson et al. 2001, p. 34). Therefore this interview format is better understood as a semi-structured telephone interview (Gillham 2005, p. 105) that is directly transcribed on to a computer in Microsoft Word format. The computer was used to directly enter the data on to a pre-formatted interview question page (see Appendix F). The most closely associated example in any text that I could access was in Berg (2004, p. 95), where he explains that in a qualitative version of CATI, 'the interviewer asks open-ended questions and types in full accounts offered by the subject'. This method is generally utilised for gathering data on a larger scale.

House and Nicholls (2001, p. 422) state that the 'primary objective of any questionnaire is to collect data while minimising error, bias and respondent burden'. The choice of how data was gathered here was to ensure this.

### **Why CATIs?**

CATIs were chosen for their time efficiency, due to the end of year deadlines for most of the supervisors involved, and my own time restrictions. As mentioned

previously the supervisors had a mix of employment options, with clinical supervision being one of up to five different modes of employment. This factor was prominent in the decision to go with a form of interviewing that would not impact on their time, especially because most had to travel significant distances to get to a central location for a focus group. Being paid \$100 or more an hour for clinical supervision and then having to spend extra unpaid time for travel to and from an interview was not economically expedient. As well, the practicality of being able to conduct these interviews from any phone, whether on site or not, allowed flexibility for time scheduling other final interviews with respondents, and better equipped me for a greater response rate. The supervisors were contacted via e-mail a few weeks prior to assess their availability.

Moskowitz (2004) revealed how disclosure of sensitive subject matter is more likely via CATIs than using pencil and paper methods. The variation of method here enabled what I experienced as greater openness and frankness in feedback in the semi-structured telephone interview format.

### **How the CATIs were conducted**

The interview questions were read out over the phone slowly and were directly transcribed on to the laptop computer. There was immediate clarification, by way of rephrasing or repeating back what was said, and this was written in summary form. This immediate clarification allowed the interviewed supervisor to agree or not agree with my summarised form. Each interview lasted from 20 to 45 minutes. I followed up by sending through an unedited copy of the interview to the individual supervisor via e-mail, which allowed for a further opportunity to add or omit whatever they felt was appropriate or fitting. The few omissions were generally because names were mentioned specifically or the supervisors did not feel the grammar read correctly. It was intentional to allow them to do this so as to ensure confidentiality and so that participants would safely remain unidentified.

### **Advantages of CATIs**

The unanticipated benefit of this method was that it allowed me to have slower interviews. It allowed for deeper reflection, and the supervisor's feedback was that they generally felt this to be a personally helpful experience. Certainly there was no need to later transcribe and thus had the subsequent benefits of financial efficiency.

Another definite advantage from my perspective was one of time economy, where telephone access was readily available and my laptop computer was simply carried with me wherever I went during the course of the week that I conducted all the final focus groups and interviews.

Through this process of conducting interviews there was an unintended benefit of being able to access a supervisor who previously had been unable to come to any of the focus groups, due to lack of time. Her supervisory role was only a small portion of her income streams. Further post-reflection on the other benefit of this method of interviewing suggests that the previous mentioned supervisor who did not attend the focus groups may have preferred this option. This is unclear but a genuine possibility. There is also some curiosity as to whether the dialogue and flow of answers and reflections gleaned from these CATIs with the supervisors was enhanced by the earlier rapport and engagement developed via the focus groups

### **Limitations and strengths of this study**

The generalisability of a study is the extent to which it can be used to inform others about persons, places or events that were not studied (Schutt 2006, p. 20). If one wants to generalise from the findings then authors such as Tsui (2005, p.140) suggest that a 70 per cent response rate is necessary. The response rate for this study did not reach that and restricts the generalisability of these findings. However, the site for the study fits Schutt's (2006 p. 160) criterion of the 'typical' over convenience. Equally this study would have greater generalisability had it been conducted on multi-sites.



The intention in selecting the venue was to optimise the possibility of having the eventual findings available for consideration by the wider AOD sector including AOD therapeutic communities and rehabilitation centres: both inpatient and outpatient withdrawal regimes, Counselling, Consultancy, Continuity of Care (CCCC) services, forensic<sup>12</sup> services, 12-step programs, to AOD chaplaincy as well as AOD counsellors and other support workers. It was anticipated that this research might generate knowledge that is useful beyond the AOD sector, for generalist counselling services, mental health services, or other relevant disciplines. The link between AOD work and mental health has been well established and researched (Allsop & Helfgott, 2002; Martin 2006). As noted above, the findings are not generalisable across these different settings.

If the intention is to have the findings speak to a wider audience then gender balance must also be considered. This is in line with recent DHS data that close to 68 per cent of workers in this field are female (DHS 2005, p. 13). Gender distribution in this study was similar. In social work in general in Australia there is a much higher proportion of females, close to 85 per cent (AASW National Office communication, December 2, 2008). Study on the impact of the researchers' gender proved veritably how gender influences outcomes and responses (Williams & Heikes 1993). Considerable attention was given to ongoing reflectivity during and after all interactions. Further attention could have been given to the monitoring of this in the present study. However, it is suffice to say that I found little to suggest that gender hindered or obscured the research process in any way.

The limitations of over-familiarity with respondents are noted, and the potential for reduced objectivity. However, the advantages of familiarity certainly enhanced the research process, and helped with understanding tight working schedules and generated a more relaxed atmosphere in the individual and focus group interviews.

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<sup>12</sup> Forensic in this respect can be simplified to mean working with those people who have problems related to courts.

Inherent in my role as a supervisor was power differential. This at first could be seen as inconsistent with a PAR approach seeking to empower people. Therefore, as mentioned, I chose not to supervise any respondent or to take on more than two supervisees. This decision was made in consultation with my thesis supervisor.

The potential limitations of the semi-structured interview format are that anonymity and confidentiality are more difficult to maintain, than in anonymous questionnaires. The other difficulty was that it took skill to avoid the tendency to sidetrack, free associate or deviate from the topic, and to keep the interview on track. Being aware of one's own preconceptions and values (Bowen 2006; Charmaz 2006; Schutt 2006) and how they might influence the research process was important. This was particularly a challenge given my prior positive experience of clinical supervision. However, on balance it was often reiterated to respondent's that their perspective could be as it was, whether negative, positive or neutral in stance.

In semi-structured interviews there is the potential for the researcher to influence or guide the respondent's answers, where a more structured interview format may reduce this possibility. The interview questions in the research had some deliberate overlap to counter this problem. The semi-structured format was used to prompt thinking rather than to guide responses.

It is argued that 'all research on health and social work involves areas of high sensitivity' (Sheppard 2004, p. 168). These interviews were no different in this sense and due respect was paid to sensitive topics such as how a person is experiencing supervision and reflecting on their own work and wellbeing.

Schostak (2006, p. 76) challenges whether a 'mere' copy, of the original interview truly, that has been transcribed, represents what the person is truly trying to convey. As will be explored later in this chapter, the data analysis involved matching the

transcribed interviews with interview notes, as well as re-listening to the interviews to compensate for this.

A common criticism of CATIs applies to telephone interviewing in general, in that you are 'interviewing live but you cannot see the person' and vice versa (Berg 2004, p. 93; Gillham 2005, p. 103). Any non-verbal elements are missed. Another criticism is in that there is no technology available for recording for in-depth transcribing. Some of the raw data is possibly not picked up. However the benefit of having a final product that the supervisors wished to convey, in my opinion, overcame the negatives. Given the sensitive nature of confidentiality in relation to clinical supervision this method was intrinsically more ethical in this sense.

### **Ethical considerations**

A resident whom I encountered in my workplace exchange at the Basin Centre had the saying, 'expect the unexpected' as a life philosophy. (Anon, personal communication, 2 July 2003), Kellehear's (1989) article similarly prepared me to be mindful of the ongoing ethical considerations through the research process, well beyond the life of the initial ethics application.

Stipulating what my various roles were at different times during the research process was an ethical matter I needed to be overt about throughout the research process. For example, this included the previously mentioned being candid with my roles as participant observer to management and staff at the Basin Centre. Through the course of the research process it was discovered that the prime ethical sensitivity lay in the area of confidentiality. This was confidentiality between me and my supervisees, and as well in the different communications with management, clinical supervisors as well as externally in sharing about any findings that were being discovered along the way. Discussing this with and gaining support from my thesis supervisor was extremely helpful in wading through this quagmire.

### **The particular or peculiar nature of confidentiality**

At the beginning of the study it was decided by the SGC that clinical supervisors should err on the side of maintaining confidentiality as if it were a counsellor- client relationship. The supervisors were also bound by the ethical practice of their training backgrounds, all being slightly different ethical frameworks. The clinical supervisors had different training backgrounds ranging from psychology, social work to other counselling qualifications.

The parameter in the supervisory relationship is the professional obligation to tell no-one about the content of the hour-long session. The only exception, where information can be passed on, is if the supervisee either presents with active suicidality, discloses being involved in serious crime, including harm to others, or reveals something about children in their care that might indicate the children are at risk of abuse.

If there was disclosure of practice that was unethical it would be reported to the program manager and be dealt with accordingly. The specifics of what would constitute unethical behaviour were the same as would apply to a social worker, as governed by the AASW Code of Ethics (2002). Being reported to the Australian Association of Social Workers (AASW), would be a result of such unethical behaviour. For those not attached to a professional peak body, the internal processes and policies of the Salvation Army would apply. Additionally the clinical supervisors were bound by Salvation Army regulations for ethical practice, as they were all directly sub-contracted by the Basin Centre.

As mentioned previously, in my role as clinical supervisor, anyone who was my supervisee would not be part of the interviewing process for the research. Given the overall information I was privy to, via interviews, participation on the SGC and from what I observed, this at times became a complex (yet achievable) task.

### **Confidentiality and PAR**

By way of conversations and mid-way focus groups involving the supervisors, it was discovered during the course of the study that the nature of confidentiality and appropriate flow of information to management was essential. This proposal was initiated by the supervisors but was equally a concern for management. The feedback was that the confidentiality clause hamstrung any potential to give even unidentifiable information as to how a particular person was progressing in relation to their work performance or general wellbeing. Two supervisors fed back to me that they felt quite passionate about this. My response from a PAR perspective was to e-mail to all management, after discussion at a SGC meeting, an article by Shaw (2004) that explored the necessity of freer flowing information between management and the clinical supervisors. The follow-up action was management organising the earlier described 'café' meeting with the supervisors to come resolve this matter. This is a typical example of how PAR moves from gaining knowledge into action – in this instance the management team.

### **Reliability and validity**

In a broad sense, reliability is concerned with whether a particular technique, applied more than once in the same situation, would yield the same result every time (Ruben & Babbie 2005). Reliability and validity are usually the domain of quantitative research but for this piece of research there were also important qualitative considerations to keep in mind. Thus far has there been a detailed account of the methodology undertaken for the research. Inherent in this was a description of the limitations of every form of methodology utilised. Issues such as gender have also been explored. The use of methodological triangulation discussed earlier was to help ensure reliability and to confirm the data from different angles. Ruben and Babbie, (2005, p. 181) advocate that triangulation be employed to deal with 'systematic error' in collecting the same information. Interviews alone would have provided sufficient qualitative data for an exploration of the impact of clinical supervision, but the decision to include other methods was to try to ensure some rigour in the outcomes.

The crucible of reliability and validity in this study lies in the careful negotiation of roles and different perspectives that informed the data. Suffice it to say that most researchers with the support of an experienced thesis supervisor could have done as ably. However within my supervisory relationship the trust that was built and the regularity of receiving supervision certainly supported my experience.

To ensure validity, interviews were conducted at the beginning, middle and end of the ten-month research process. If the interviews had been taken only at the mid-point for example, the data would not have reflected accurately the change over time. Moreover, what change happens in one point of time can be confirmed by what is occurring later on in the research process.

Grounded theory ultimately rests upon the interaction and relationship between the data and the researcher. This will always have a subjective component, where the results from another researcher conducting the research or scrutinizing the data may be similar, but may also have divergent areas of interest.

In respect to deriving reliable and consistent findings from the interviews, a researcher needs to be able to give some equal or fair weighting to what is fed back. Given the generally consistent positive feedback throughout the present study it also seemed imperative not to give too much weighting to the respondent/s who potentially did not share a similar positive experience. In fact, as a researcher it was a tremendous advantage to have such clear and straight, albeit sometimes challenging, thinkers among the respondents. However I attempt to fairly and evenly represent all the responses in the findings.

Finally, as Kellehear (1989, p. 63) describes, the ethics approval is not just a one-off process, but requires ongoing ethical sensitivity throughout the entire process. Given the sensitive nature of the topic of people's experience of clinical supervision, this had to be closely adhered to. As mentioned earlier the process of regularly discussing with my thesis supervisor any sensitive or potentially ethical matters was

integral to this. It is not difficult to imagine how an ethical dilemma or transgression could alter the data and research process, and thus affect the reliability and validity.

The pointy end in this respect was when I was asked specific questions by management in relation to whether people were receiving supervision, as well as when participants complained about management. This led to the need to delicately but clearly think through appropriate responses.

### **Data analysis**

Grounded theory was selected for analysing the data gathered in the interviews and focus groups from both respondents and supervisors. Field notes were also analysed. Grounded theory derives its name from the practice of generating theory from research which is 'grounded' in data. It is both an overall approach to research and a set of procedures for developing theory through analysis of gathered data. A definition of grounded theory by one of the founders of this qualitative framework, Anselm Strauss, (the other being Barney Glaser), is that it is 'theory that has been derived from data, systematically gathered and analysed through the research process' (Strauss & Corbin 1998, p. 12). In this method, data collection, analysis, and eventual theory stand in close relationship to one another. It is inductive and primarily humanistic in its approach. It is not specifically a method or technique, rather it is a style of doing quantitative analysis that includes a number of distinct features, such as theoretical sampling, and certain methodological guidelines, such as the making of constant comparisons and the use of a coding paradigm... (Strauss 1989, p. 5).

Grounded theory emerged as an alternative strategy to what were more traditional types of scientific enquiry that relied strongly on hypothesis testing, verification techniques and other quantitative forms of analysis and research of that time, which was predominantly positivistic. In the book that heralded grounded theory, *The discovery of grounded theory* (Glaser & Strauss, 1968), the central tenets of grounded theory were outlined. However in the following publications by Glaser and

Strauss, whether writing in tandem or with others, some distinct differences began to emerge. The result has divided grounded theory into at least two streams, each associated with one of the authors, Glaser or Strauss, and each with its own underlying 'epistemology and attendant properties' (Babchuk 1997, p. 1) .

The central differences between Glaser's and Strauss' version of grounded theory ultimately hinges upon both epistemological and methodological divergences. In summary, Glaser was generally committed to principles and practices associated more often with a qualitative approach. Glaser seemed to be of the view that grounded theory is inherently flexible and guided mostly by informants and their socially constructed realities. The process on the part of the researcher was not so important. He argued that Strauss had too many imposed rules and procedures for conducting grounded theory and the result was time ineffectiveness and possible confusion for the potential grounded theorist. Strauss wanted a detailed description and this was his prime concern. In Glaser's 1992 book on grounded theory, by critiquing Strauss, he attempts to reiterate the flexible use of grounded theory as an essentially flexible methodology, where the researcher should simply 'code and analyse categories and properties with theoretical codes which will emerge and generate their complex theory of a complex world' (p. 71).

The flexibility of the Glaserian school of grounded theory, and what Strauss also initially expounded (Glaser & Strauss, 1967), has been closer to the approach undertaken in this research. Like Charmaz (2006, p. 9) and for the sake of this research, I viewed 'grounded theory methods as a set of principles and practices, not as prescriptions or packages'. Charmaz continues that by moving away from a positivistic version of grounded theory, this opened up the gates for a 'diverse' range of use of grounded theory, in describing 'steps of the research process, rather than a prescriptive formula. Charmaz is one of a few authors who recommend different approaches to grounded theory together with Clarke (2005) and Goulding (2002).



The whole premise of qualitative research is to study a world that has interest to the researcher and that they may not otherwise have access to (Bowen 2006). For Glaser (1992, p. 22), grounded theorists begin their study 'with the abstract wonderment of what is going on that is an issue and how it is handled'. It is a process where the whole self is utilised and necessitates interest in the topic matter (Corbin & Strauss 2008, p. 13). Blaikie (2000) argues that research concerned with theory generation might require sensitising concepts but no hypotheses.

The development of the present research proposal began in exactly this way, by early investigation and saturation in the field of being a counsellor and clinical supervisor in the AOD sector. This ultimately led to the development of the research questions. It can be argued that having a pre-conceived set of research questions in this light might be similar to Strauss, where he believed that the 'research question in a grounded theory study is a statement that identifies the phenomenon to be studied' (Strauss & Corbin 1990, p. 38). Quite conversely, Glaser emphasises how the research problem emerges only as a by-product of the coding process and constant comparison. From this perspective there is some convergence between these schools in this study but overall there is a definite leaning towards Glaser as previously mentioned.

In grounded theory, the researcher is required to enter into the worlds of those under study in order to observe their environment and the interactions and interpretations that occur (Goulding 2006, p. 39). The researcher is expected to 'interpret actions, transcend rich description and develop a theory' (Schwandt 1994, p. 124). For Glaser and Strauss (in Charmaz 2006, p. 5), the defining components of grounded theory practice include:

1. Simultaneous involvement in data collection and analysis;
2. Constructing analytic codes from data, not from preconceived logically deducted hypotheses;
3. Using the constant comparative method, which involves making comparisons during each stage of analysis;

4. Advancing theory development during each stage of data collection and analysis;
5. Memo writing to elaborate categories, specify their properties, define relationships between categories, and identify gaps;
6. Sampling aimed toward theory construction, not for population representativeness; (and)
7. Conducting the literature review after developing an independent analysis.

From this viewpoint it is not hard to understand how grounded theory is also known as the constant comparison method. A key feature of grounded theory analysis is coding. The strength of coding stems from a concentrated and active involvement in the process. Data is acted upon rather than passively read. Coding means naming segments of data with a label that simultaneously categorises, summarises and accounts for each piece of information. This is the initial step in moving beyond concrete statements in the data to making analytic interpretations.

The basics of coding in grounded theory consist of at least two main phases:

- An initial phase involving naming each word, line or segment of data followed by;
- A focused, selective phase that uses the most significant or frequent initial codes to sort, synthesise and integrate and organise large amounts of data.

Sometimes there is no linear way of approaching this. There are different sorts of coding: open coding, axial coding, theoretical and selective coding. In open coding there is the breaking down, analysis, comparison and categorisation of data. Open coding lends itself to having incidents or events labelled and grouped together via constant comparison so as to form categories and properties. Axial coding is about the delineation of relationships between categories and subcategories and finally selective coding is best described as a process by which categories are related to the core category, ultimately becoming the basis for grounded theory (Babchuck 1997). Axial coding according to Strauss and Corbin (1998) is a strategy for bringing data back together in a coherent whole. This can be cumbersome and labour

intensive. Theoretical coding specifies a relationship between categories that have been developed in focused coding. They move the analytic story to a more theoretical direction.

From coding follows the process of memo writing. Memo writing is the intermediate step between data collection and the writing of a draft paper. At this point the main activity is to stop and write any ideas or thoughts related to the codes (Glaser 1998; Charmaz 2006). Memos are meant to catch thoughts, capture the comparisons and connections you make and crystallise questions and directions that ultimately are pursued. Grounded theorists look for patterns and the memo writing phase supports this.

The next phase is to raise a code to the concept of a category. Theoretical sampling and saturation comes after this. Categories are saturated with data and subsequently sorted to integrate the emerging theory. The result is that now the data has delineated properties of a category.

### **Grounded theory in conjunction with ethnography and PAR**

The complementarity of grounded theory and ethnography is noted well by Charmaz (2003; 2006), Dick (2003), and Locke (2001) and influenced my choice to utilising both together. The advantage of grounded theory is that it gives precedence to the process of what is occurring rather than a description of a setting.

On the surface, PAR and grounded theory appear quite different. Some of these apparent differences are real. Grounded theory tends not to be participative and is not per se a method for gathering data. The action tends to be someone else's responsibility. A deeper exploration, however, reveals some important similarities. In particular, both are emergent and shaped incrementally through an iterative process. In both grounded theory and PAR, data analysis and interpretation and theory building generally occur at the same time as data collection.

The main precedent that informed the combination of grounded theory and PAR was by Teram et al. (2005). Other examples are cited in Somekh (2006, p. 78) and Charmaz (2006). Dick (2000) is also quite an advocate for the combined use of these. While both grounded theory and PAR are distinct approaches to qualitative research, Teram argued and proved to some extent that the two methods can be 'integrated in order to empower clients to credibly inform health professionals' (2005, p.1131). Charmaz (2006, p. 512) also makes this direct link and advocates that grounded theory would 'foster [their] efforts to articulate clear links between practices and each level and, thus, to strengthen their arguments for change'. The workings of the integration of both worked out slightly differently at the Basin Centre in process as compared to Teram's project, yet the intentions were similar, in attempting to empower the respondents in change.

### **Interviewing and grounded theory**

Generally for a grounded theory study, interview questions are broad and open ended. They are also normally non-judgemental. It is also in the range of intensive grounded theory interviews to ask semi-structured, focused questions. While I pre-coded a number of the questions to initially aid me I found that they became good prompters for people to truly think about their answer. In fact I wonder as to how rich the data may have been had I not added these points in.

Interviewing focus groups are better tailored in some respects to grounded theory and add a richness to the data as it truly allows participants to follow themes themselves, and reduces any structure or rigidity. The focus group participants have the freedom to follow thematic interest areas. However this is tempered by the researchers' challenge of time and keeping people as sensitively as possible on the subject matter.

### **How Grounded theory was applied in the current research**

The data generated via the methodologies employed was substantial and consisted of the pre, mid and final interviews. Rennie (2002) echoes the sentiments behind

how I applied grounded theory in that 'grounded theory is attractive to those people who prefer to immerse themselves in data before jumping into theory' (p. 105). The analysing of the data was conducted manually, and went as follows:

- a) First, every respondent's transcribed interviews were re-read, then re-listened to, and confirmed with the accompanying notes from the interview time itself. Field notes were also scrutinised;
- b) Second, all respondents' transcribed interviews were individually manually colour coded in Microsoft Word format, including the separate responses in the focus groups;
- c) Third memo writing began and individual colour-coded comments were placed under different categories as discovered whilst slowly immersing myself in the data. NVIVO, a qualitative analysis software package, suitable for this purpose, was strongly considered for this stage of the research. However it was my preference to read over the pre, mid and post interviews and to slowly familiarise myself this way. Corbin and Strauss (2008) elaborate on the art and science of data analysis. While this chosen process may have taken longer it provided me with the opportunity to have a closer connection with the data. This was also important because of the connection between grounded theory and PAR. The sample size was adequate for this also. The colour coding enabled easier tracking of respondents from the first to the final interviews.
- d) Categories eventually emerged and what transpires in the following chapter is a full discussion of the findings as a result, 'the match between scientific categories and participant reality (Le Compte & Goetz 1982, p. 43). Quotes that represent the emerging themes are placed under each category.

The grounded theory analysing of the data began just after the mid-way interviews, as mentioned earlier. Lee's admonition that 'reduction allows categories to be expressed at a greater level of abstraction and generality' (2000, p. 110) was adhered to. For example, this process saw the range of categories and data fall from a combined twenty pages to four pages. The mitigating factor here was the need to

be able to feed back this data to the participants in a synthesised and readable format, and thus increase the potential for further clarifying feedback.

The remaining analysis of the data was conducted primarily throughout 2008. This allowed time to elapse for the data to settle with reflection, a change of employment roles from management and back to counselling again and finding the time to give it even deeper analysis.

### **Credibility of the grounded theory approach in this study**

The credibility of the grounded theory process was influenced by both Charmaz (2006) and Chiovitti and Piran (2003). Firstly, Charmaz (2006, p. 182) posits six criteria for testing the credibility of a grounded theory:

1. study has achieved familiarity with the setting;
2. the data is sufficient to merit claims;
3. systematic comparisons between observations and categories are made;
4. the observations cover a wide range of empirical observations;
5. there are strong logical links between the gathered data and analysis; (and)
6. the research has provided enough evidence for the claims to allow other readers to form an independent assessment and thus agree with what has been discovered and posited

In response to these criteria, it has been explained in regards to the familiarity with the setting of the Basin Centre, and the volume of data generated. The wide ranges of observations and comparisons have equally been addressed. The further claims are substantiated in the following chapter and that guided the process of data analysis.

Similarly, Chiovitti & Piran (2003), from a nursing discipline, outline the eight methods of research practice used to enhance rigour in the course of conducting grounded theory research. This for me has been an integral alternative perspective given the importance and prevalence of nursing literature in clinical supervision. For

them it was discovered that it is important to let participants guide the inquiry process; to check the theoretical construction generated against participants' meanings of the phenomenon and to use participants' actual words in the theory. Further they deem it necessary to ensure that the researcher's personal views and insights about the phenomenon explored are articulated as well as specifying the criteria built into the researcher's thinking. Specifying how and why participants in the study were selected, delineating the scope of the research and describing how the literature relates to each category which emerged in the theory were also essential for Chiovitti and Piran. This study meets these criteria also, for it to be called an authentic grounded theory study.

### **Previous research utilising grounded theory in supervision research**

There were very few studies in the literature involving the use of grounded theory in investigating supervision in some capacity. Examples of this were Neufeldt and Karno (1996) and Rennie (2002). Neufeldt and Karno utilised Strauss and Corbin's (1990) model of grounded theory. The method of constant comparison they utilised was carried out manually by going over the recordings and transcripts from five participants. Their process allowed them to 'refine categories and their properties and dimensions and to determine what statements belonged where' (Neufeldt & Karno, p. 5). This is a similar method to how grounded theory was applied in this research process.

### **Conclusion**

In these chapters I have outlined the qualitative research methods employed throughout this study of the effectiveness of clinical supervision in an AOD rehabilitation centre. I have substantiated the use of the various methods utilised to gain multiple viewpoints. I have argued that the various roles that I undertook were instrumental in gaining the data necessary for an in-depth exploration of this topic.

I recruited 16 respondents plus six supervisors into the study, all of whom mostly found participation in the research process personally rewarding and beneficial, but enhanced their own understanding of clinical supervision and self-reflection.

Grounded theory was chosen as the most suitable form for analysing the data, being guided by the tenets of Charmaz and Chiovitti and Piran. After analysing the data with grounded theory, the research questions were certainly addressed and the themes and categories discovered are elaborated upon in the following chapters.

The following chapters analyse the data gathered via a grounded theory analysis and intertwines the literature that becomes the findings of the research conducted.



## **Chapter 5:**

### **Overview of research process**

#### **Introduction**

In the following three chapters I will outline the findings from the data sources. Firstly I will present an overview of the research process; then I will provide answers to my initial research questions, and then I will progress to unfold the newer discoveries unearthed by a grounded theory examination.

In each section I will further discuss the implications of the different categories and incorporate the literature review findings where suitable. Given the uniqueness of this study and the paucity of research conducted on clinical supervision in this or similar settings, the findings are distinctive and informative. The chapter begins with an overview of the different stages of data gathering and a look at the pre, mid and end stages of the research. Then, moving into the main body of material, the particular impact of group supervision is elaborated upon.

The research questions are explored with in-depth analysis of the impact of clinical supervision on those new to clinical supervision, as well as the more experienced. The benefits and difficulties of supervision are explored as are the factors involved. Unearthing the particular AOD aspects in the research follows, including whether the supervisor needs to have AOD experience. Exploration of the research question segment ends with a detailed look at the impact of external clinical supervisors.

The grounded theory analysis then uncovers an overarching theme of boundaries, as well as role support and clarification, validation and support, and the inestimable value of self-care. The introduction of customised supervision for the AOD Sector is proposed. Clinical supervision is revealed to be highly effective in all these areas and a necessary as part of the support required for workforce development. The priority

of the supportive component of supervision is made evident. However the importance of supervision for individuals was offset by the high cost.

The research using grounded theory produced such a plethora of data and fascinating insights that there is not enough space in this thesis for it all to be described. What is labelled as categories and themes is based on several references from different people and has in this respect been saturated. The quotes included indicate the theme being discussed but are not the only ones on the subject. Chiovitti & Piran's (2003) imperative to make use of respondents' actual words has been adhered to; this adds a narrative effect and genuine feel to the outcomes. Data from the supervisors themselves was invaluable during the PAR process of the study, and is used for confirmation throughout. The respondents quotes will be identified as simply r1, for respondent one, or *fg2* in italics for focus group member number two and (s 3) for the supervisors.

### **The stages of change: beginning of the research process**

To ascertain the effectiveness of clinical supervision from this research there is detailed consideration of the macro viewpoint, the micro viewpoint and change over time. All are relevant and form an integral part of the methodological triangulation. The beginning of the research process saw the respondents at very different stages of desire for, and experience in respect to supervision. Overall, there was general positive anticipation but with some respondents unsure, some excited and others needing clarification of what supervision might entail. Those who were newer to supervision had heard of the concept and had been involved in discussions, but had never experienced it.

It is also clearly understood that they were willing respondents. Very early in the research process, the group supervision changed from six weekly to three weekly or fortnightly, due to the perceived positive experience and impact. Group supervision allowed for more frank discussion, particularly with external supervisors. This effect of this will be discussed below.

**Mid-point: supervision unfolding, the big debrief and movement into action.**

At the mid-point of the research process, supervisors and participants concurred that there was an 'offloading', or as one of the clinical supervisors described it, a 'vomiting' of material: as though they were catching up on a backlog of need for support, debrief and care:

When I first started I felt like I had four hours of material I needed help with and I had to be picky as what to choose as I could get frustrated sometimes... but now because I have it regularly, I sort of don't have more to talk about in the hour, and I'm not overloaded with stuff that I need to debrief. (r8)

Feedback given to the community as summarised from the mid-way interviews shows a level of concern by management and some respondents, as to how the organisational and role questions that were being raised were going to be resolved. On the other hand, management were equally optimistic that the issues being raised were ones that had needed to be dealt with for a long time. The managers receiving supervision helped to gain insight into the organisational issues as well as an overall picture and sense of what was happening at each stage of the research process.

This supported management in making any necessary changes:

It has stirred up issues that need to and are being addressed. It has unsettled some... gave them sharper awareness of what was going on for their clients, so they became much more clinical focused. (r2)

Some mid-way feedback revealed that people wished they could have had supervision explained better; some were annoyed at how management had tried to positively promote the benefits of supervision; others had some apprehensions. Such feedback was reassuring because it showed that the participants were trying to make their own minds up and were not being coerced into any pre-conceived conclusions.

Could something have been done at the beginning of the project to ensure people felt more comfortable with the notion and concept of supervision? (r3)

There was also some concern during this phase as to whether supervisees who had spent a lot of time offloading, knew about the other facets and resources a clinical supervisor could provide. However, action was underway, and language around a 'culture of learning' was starting to develop. This culture of learning was a constructive move away from the previous reactive nature of the work.

### **Regularity of supervision: a necessary evil**

Throughout the study there was overwhelming feedback, particularly from those new to supervision, that the individual experience of supervision became better as it went along. This was consistent with my own observations. In fact it took time for a number of respondents, especially those newer to supervision, to fully appreciate and understand supervision and what it could offer them. In this study, given the complexity of clients and demands of the work, the argument for regularity is partly proven by the profound need for support and a place to be relieved of burdensome material:

*I started off reluctant, but I'm happy to say it was very positive and it was very good for me and her and motivation to keep it going even though I'm leaving this place. (fg6)*

For me, I found it gained momentum as we went along. (r5)

One respondent, while reflecting on previous experience of supervision remarked along similar lines;

I just hope that people learn what clinical supervision is... that when I first had clinical supervision which was before this project, I didn't really know what it was and how it could help me and I thought it was more like counselling, and yeah it's just so invaluable, for those that want it. (r8)

A respondent noted that their supervisor was good for a period of time and met their need for support, but felt the need for change near the end. At the mid-way mark of

the study both the supervisors and respondents clearly noted the need for 'offloading' and the gradual move towards having a greater clinical focus:

About the half way mark I needed to be more specifically clinically minded and I think I needed something more than what she had to offer. I just realised I wasn't saying that as clearly as I could have. (r3)

In the final interviews a number of respondents described the difficulty and frustration in needing to unburden so much, which was also characterised as a need for debriefing. There was a phenomenon whereby they felt as though they caught up as it were, that the hour was sufficient, where initially it was not:

From the beginning of the project I mentioned earlier about feeling like I had four or five hours of data I wanted to get out during the session. I no longer feel like that and that's because I'm not carrying all that around, so that's marvellous. (r8)

So it's affected me positively, gone from something being a pain in the neck to something that I've enjoyed. (r7)

Especially for those new to supervision, the enhanced understanding of supervision came only with the benefit of time:

In the beginning I didn't feel like it was worth me having it, I found that it was taking my time from my work and I was a bit frustrated by that, but as time went on and problems emerged I found [supervisor] to be fantastic. (r7)

Regularity of supervision is a benchmark component in definitions of clinical supervision as seen in the literature review (Bernard & Goodyear 2004, p. 235; Duraisingam, Pidd, O'Connor & Roche 2006; Stone 2004). For Hohensil (1997) the regularity needed to match the duration, and the experience of the supervisor. Wheeler and Richards (2007) similarly mention that the benefits of supervision are related its regularity. The reduction in apprehension mentioned by Hancox, Lynch,

Happell and Biondo (2004) is also accounted for, and their notion of someone being 'converted' only after the experience is equally relevant.

Therefore, regularity of supervision is directly related to the cost of supervision (as will be explored later in this chapter). That also relates to what standard of supervision is received. If cost is prohibitive, then possibly a supervisor who is cheaper and less experienced may be preferred. So in fact regularity may have a bearing on who a person chooses and how a person truly understands the concept of supervision, especially if it takes the actual experience to fully appreciate it.

### **The experience of supervision as described at the end of the study**

In the final interviews respondents were asked a general question as to their overall experience of supervision. There was unanimous positive feedback similar to that from the mid-way interviews. If the feedback were placed on a continuum it ranged from 'being transformative' and a 'metamorphosis' occurring, to 'very helpful', 'validating' and a 'positive' experience. Any concerns raised in the mid-way interviews were mostly rectified by the end of the study. Some respondents were glad to have the supervision paid for, as cost is a significant factor and will be explored later in the following chapter. The semi-structured interview incorporating detailed and specific questions so as to prompt reflection, especially when the respondents are being interviewed in the middle of a busy work day, proved a success. It accentuated that some components of supervision were more significant than others:

There was a metamorphosis for me; it was just very transformative for me.

(r2)

I was happy because I wasn't being charged for that period. It was a positive experience with [supervisor] throughout the project and it continued to be after it, the new element in the project was the group supervision. (r9)

By the end of the study, most of those with no previous experience of supervision had a positive view:

It was a very positive experience, it was positive because firstly I wasn't really a hundred per cent aware of what supervision is all about, I'm a bit more aware about it now. I really did find it helpful to have that regular opportunity to talk to somebody. (r4)

Moving now from a general overview of the outcomes of the study, there follows answers to the research questions and the grounded theory analysis of the data. In unison with the PAR approach, seeking to empower individuals and, as discovered, the organisation as a whole, considerable use will be made of the feedback from the respondents who clearly describe the outcomes.

## Chapter 6:

### Direct answers to research questions

#### The particular impact and benefit of group supervision

Before setting out the responses to the research questions, it is necessary to elucidate the unforeseen benefits and impact of group supervision. To extricate group supervision from the impact of external supervisors' and the combined effect with individual supervision is a difficult task and is acknowledged. Nevertheless, in scouring the data from a grounded theory perspective, very early in the study, group supervision achieved pride of place. Indeed, the semi-structured question format utilised did not have separate questions for exploring group supervision. The questions asked were about respondents' combined experience of both group and individual supervision.

As pointed out earlier, the first focus group was conducted a short way into the project for two reasons. First, so there would be a captured sense of the early experience of clinical supervision project, and second to allow enough subject matter for the focus group to have accumulated. Early on in the first focus group, there arose a discussion of the distinct benefits of *group* supervision. The focus group setting, emulating the environment of group supervision, more than likely prompted this direction of the discussion. It was this discussion that caused all group supervision clusters to be changed from six weekly to two to three weekly. The early active response indicated the invaluable positive experience of group supervision.

The mid-way interviews and subsequent feedback to the community again underlined the innate benefit of group supervision, as a forum where people could be straight and honest, and a place to acknowledge other peoples work and become a driver of discussion and support. One controversial subject brought to the discussion



table was a perceived difference between those who are 'ex-users' and those that are not. The honesty and directness allowed and encouraged by group supervision was an integral component in the movement towards constructive change. The following quote sums this up:

The group supervision particularly supported a safe space to say things that we really needed to say to each other and to work things through and resolve some conflicts, and they're kind of the big things. (r2)

The final interviews resulted in an array of feedback highlighting numerous advantages of group supervision. These advantages come in the categories of: honesty, safety and directness; co-emotional support; sorting of differences; role support; and team building. Group supervision also had a particular impact on management especially within their group supervision cluster. The following quotes come from a manager who ultimately had to deal with the problems that were raised in the meetings. In the context of finding supervision validating but with some challenge personally, the honesty, safety and directness revealed in the group were key components:

The group, I could only say positive things, I think it was an extremely important team building exercise, It enabled the team to speak honestly with each other...and we talk through differences, and in an adult, sensible, un-emotive framework, and I would say that's true, the other experience of group supervision was that it gave us reflection, it would be one of the biggest elements that we attempted and achieved. (r10)

Team building:

*Group supervision I thought was really good, I found the dynamics to be really excellent, you get to know your workers a lot better, one female worker who I didn't really know at all I got to know quite well. (fg5)*

Sorting of differences:

It drew the counsellors and the post resi[dential] workers together and caused us to become aware of our mutual difficulties and this was helpful to the organisation. (r9)

Role support:

Group supervision I think shifted me from being a tentative manager to a positive manager, I guess it helped me find my strengths and maybe for the first time helped me see that other people saw me as the manager. (r10)

The following quote should be read in the context of having two ancillary supervision sessions organised by management as a direct result of discovering the intrinsic benefits of group supervision<sup>13</sup>. As well, managers felt empowered by the process. The first of the sessions was organised to combine the post-residential team with the counselling team for some co-group supervision. The other session was organised as a few days away with their group supervisor to deal with problems that had been identified:

That group supervision stuff, that was very powerful I think in helping us to get to know each other... I was just in awe of how that whole process led to our two days away planning. (r 4)

Ask and Roche (2006) and Munson (2002) mention the undervaluing of group supervision. This study conversely adds substance to the prime value of group supervision. The complementarity of group and individual supervision as mentioned by Shaw (2004) and Munson (2002) was not specifically referred to by respondents. However, clearly at different stages of the research, respondents mentioned a preference for one over the other at different times but overall fed back separately about individual and group. It is difficult to establish directly the complementarity but that is inherent in the outcomes.

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<sup>13</sup> As noted in the methodology chapters.

### **Difficulties of group supervision**

Group supervision in many respects caused upheaval, especially for management; at times the directness and honesty unsettled participants. The feedback generally was that it was a difficult but important process. As compared to the vast volume of positive feedback about group supervision, the negative feedback overall was minimal. As will be described later, negative feedback mainly regarded the overall difficulties of supervision. Of the group supervision specific difficulties, three respondents fed back that one cluster of group supervision didn't get off the ground properly, and the other two accounts related to unrest at the mid-point of the research and the lack of role clarity. This latter point highlights the significance of suitable membership composition of groups and the need for appropriate mix of skills and experience. Of the disadvantages noted by Carroll (2007), such as dominant group members or differing skill sets, there was no direct feedback, but rather positive feedback regarding the freedom for everyone to speak.

### **What was the impact on workers of clinical supervision in an AOD setting, for those new to supervision and those who have received supervision and/or are currently receiving supervision?**

This research question is best answered from a number of different but related angles. It begins with a detailed look at mandatory supervision and discusses what respondents planned to do when their free, but regular supervision ceased. This is followed by an exposition of the benefits of clinical supervision.

Overall, for those new to supervision, there was positive anticipation at the beginning, but a consistent lack of understanding as to what supervision is. The mid-way results were unchanged in that respondents were still uncertain as to how effective or useful supervision was to them. But there was a sense that they were warming to the idea. The final results were unanimous- everyone found supervision at varying levels to be supportive, effective and necessary. Half of these stated that staying with the process supported them through to understanding how important supervision was for them. The main context for understanding the impact is best

understood in the feedback as a whole, where particular reference will be made to those new to supervision as well as those more experienced.

As demonstrated in table 3 in chapter three, the proportion of respondents new to supervision and those with prior experience was approximately half and half. Of the respondents who were new to supervision, none were counsellors, and only two were managers.

Two interview questions demonstrated how important supervision became by the end of the study. Table 4 summarises people’s responses from the final interviews, where people were asked if they believe supervision should be mandatory or not, and what they will do when the project is over. If respondents found the word mandatory too strong, the replacement ‘strongly encouraged’ was used, without any prompting or suggestion by me.

The question as to what people might do when the project was over was asked twice: once in an extra-curricular questionnaire proposed by the SGC to prepare people for thinking about this, and six weeks later in the final interviews and focus group. Thus, when asked in the final interviews there had been ample time for some thought to be given. Similarly the ‘mandatory’ questions were asked earlier in other interviews and thus allowed prior reflection.

**Table 4: Mandatory supervision and ongoing supervision arrangements**

<b>Should supervision be mandatory? (<i>Interviewees and focus groups</i>)</b>	<b>No.</b>
• Strongly encouraged generally	9
• Mandatory for some: especially counsellors or those with direct daily contact or relationship with clients	5
• People need to have the right to choose (despite thinking that it should be mandatory)	2
• Mandatory for all	2

<b>Why/ why not?</b>	
• Cost as an issue	7
• Occupational Health & Safety matter	2
• Duty of care of the client	1
• Makes workers much more effective and accountable in their work	1
• Complex clients and complexity of work	2
• Due to confidential nature of work- need space for critical debrief of serious issues	1
• Need the skills development	1
• Prevent burnout and tiredness and optimise performance	1
• Supervisees have a strong need for support	2
o 'I believe that we as human beings often cover over our own inadequacies, our own fears, our own sense of lost in terms of some of the things that happen in our work' (r5)	
o 'Cannot take for granted that everyone can do their job' (r6)	
<b>What will you do now the project is over?</b>	
• Continue fortnightly at own cost	2
• Monthly if financial burden too much	2
• Group supervision possibility	1
• Management supervision team to continue group supervision on a regular basis	2
• Specific supervision for area of work	1
• Access when necessary	1
• 6-8 weekly	2
• Have a rest first	1
• Suggestion for other source for payment or ways on continuing supervision:	2
o the government	
o partner with another organisation	

The conclusion to be drawn from table 4 is that respondents considered supervision so important as to be mandatory or strongly encouraged. But the considerable expense of supervision was a greater concern. The consistent reply from respondents was that many thought supervision should be mandatory, especially for those in counselling or who had regular direct contact with clients. If the semantics of

the word mandatory were difficult to fathom, respondents replaced it constantly with the notion that supervision should be strongly encouraged.

Other reasons for strongly held views also went back to people considering supervision as an Occupational Health and Safety concern or under the banner of duty of care for their client group. These latter reasons indicate that the onus of responsibility for the cost may need to lie elsewhere including funding bodies or the organisation. Ongoing group supervision arrangements were the middle line that people drew. However, when respondents came to the ongoing cost, only two considered continuing on a regular basis, and others more infrequently, or were considering alternative options. Respondents cited cost and time together as inhibiting factors. Cost will be explored further in the chapter

These strongly held views on the importance of supervision may be useful for those considering jettisoning supervision in the realms of autonomous practice, as was explored in the chapter three.

### **Benefits of supervision**

The benefits of supervision were saturated under the headings of: validating, affirming and normalising; provided space and time for reflective practice and different perspectives; motivation, confidence and happiness at work (or motivation to work); and reduction in stress levels. These are stated in order of the importance placed on these themes and the number of responses from both interviewees and focus groups. The inter-connection of the above categories will be explored throughout this section.

### **Validating, affirming, role-confirming and normalising**

This theme would certainly come under the supportive function of the social work model of supervision. It was consistent through the midway interviews; accordingly what follows is feedback from the final interviews. In the final interviews, 12

references were made to how significant it was to be validated and confirmed and to have the work they perform normalised.

Supervision gave participants the freedom to be able to admit mistakes and own their humanness and to empathise with their clients. The consistency of feedback indicates the importance of this:

I think it's very hard for a line manager to admit that you're struggling in that, and for him to say he has similar situations, normalises, like what we do with clients, you're normalising the human struggle. (r2)

Definitely, yeah it's [supervision] given me confidence, although I'm always positive about my work... but to be able to talk about basic humanity; how people are going. (r6)

*Often you bottle things in and you're not sure whether to express yourself, and I've felt that what was validated was that they see you as a real person and see your struggles as well, so they see people being real and that was something that kept on coming through. (fg4)*

The self-confirmation and personal development that arose through being validated and affirmed was similarly noteworthy. It was observed often that there occurred the opportunity to discuss issues that normally may have not been given credence or time:

Supervision was probably the first time that I've had validated to me...that often my thinking is pretty much okay...So the individual supervision was more of a validation of who I am rather than exploring different things. (r10)

Its [supervision] very affirming for the individual because... it makes you feel that you're not alone, that other people have been faced with a similar issue and have been able to work through it. (r5)

*He validated my approach to the way I handled clients and cared for myself and cared for others because there were certain issues that I wouldn't normally discuss with people that I was able to discuss. (fg6)*

The impact ultimately was that it 'boosted confidence in their own professionalism and staff have felt valued' (r2). Indeed supervision had an impact on people's emotional lives, no more eloquently expressed than in the following statements:

*Supervision tops you up emotionally, but it can be really draining, and it's just a top up that you need. (fg1)*

Learning to relax...[supervisor] has encouraged me to take some time to relax and gave me some books to read without feeling that I've got other things to do. (r6)

### **Provided space and time for reflective practice and different perspectives**

What respondents frequently fed back was the importance and what a benefit it was to be able to reflect on their work and to have the time and space to do so. This component was something I noticed when interviewing, as well as while being a participant observer. That is, the interview itself provided a space for reflection. The previously mentioned extracurricular group supervision sessions were another indicator of the benefit of a space for reflection. The flow-on effect to client work should also be taken into account. The reflective space lent itself to people evaluating their work and some of the goals that they hoped to achieve through supervision. This contrasts with previous 'bushfire driven' (VAADA 2003) practice that was reactive to the chaos of the day. The overall advantage of reflective practice is well summed up here:

Supervision provided space, time, reflection, awareness that really supported good decision making I suppose, not making decisions on the run and making decisions from a place of knowing and understanding a bit more...It's completely sold me on reflective practice, and that would be something that I will forever take with me, it's a big lesson learnt. (r2)



Reflective practice for many was also role confirming and brought an assertive confidence:

She's [supervisor] pointed out to me that we are part of this program, and we need to stick together no matter how minute the problem may seem to others, but to us it's an issue and worth bringing up and dealing with it and I've done that with people since talking to her. (r7)

The evaluative component of supervision was also the result of having a supportive reflective space, and helped people to reflect on their achievements and goals:

Supervision gave us that opportunity as a management team to legitimately take time out and reflect and evaluate what we're doing. (r4)

My aim in terms of the individual supervision was time management, and I do believe that I am managing my time better so that's definitely happened. (r3)

The perspective that reflective practice brought to the dyadic relationship with clients and the resultant relief and 'healing' that it brought to respondents is no less noteworthy:

*It's about putting things into perspective, I beat myself up a lot feeling overly responsible, but I've been able to step back a bit and that has really helped me, by being told that I can't control how people react ... their actions lead to that, where as I would take responsibility for that. So it's about taking a step back and not burdening myself with that, putting things into perspective. (fg1)*

*[Supervisor] gave me clarity about this sense of grieving, not just about this one incident, but about the grief I go through every day watching these people go through this misery. It was in this sense that [supervisor] made me feel healed. (fg4)*

### **Stress level reduction**

Of the interviewees, five respondents mentioned how they felt less stressed and commented on how the resultant reduction in stress helped relationships at home.

The following quotes summarise this:

Just in being able to debrief and talk about things on a regular basis reduced stress. (r4)

I think stress was reduced slightly because there was another person to talk over issues with instead of my wife, and it was a non-staff person so I could discuss it a little bit more openly so I think in that regard, stress was reduced.

(r10)

For a few respondents the reduced stress also directly correlated to the previously mentioned opportunity to offload the accumulated burden of client problems. This is in the context that previously there was little opportunity for this.

### **Motivation, confidence and happiness at work**

Respondents consistently praised their experience of supervision insofar as it increased confidence and boosted motivation. Their resultant general happiness was a constant feature in the feedback:

I get excited by my supervisor, and inspired and energized, and I want to stretch myself. (r2)

The outcome helped workforce development issues such as finding the courage to engage in further education;

Its' just made me feel fabulous, the confidence to get out and as I said I'll use the Certificate Four as an example... I just would never have done that. (r7)

The increased sense of competence and confidence is self-evident in the following feedback. The link with effective decision making is striking:

Has been confidence boosting that you belong to a reputable intellectual stream. (r9)

I see myself as more competent now after the supervision...For the first time in a long time I've had people tell me that it's a sensible decision, instead of that's a good idea. (r10)

I think I am more organised. I've got a better routine at work. I'm more motivated and can see a way through the chaos. (r3)

The benefits of supervision as described above as well as in the literature review are clearly linked to preventing worker burnout (McMahon & Patton 2000), increased staff retention, positive team building and increased happiness at work (Ogren & Jonsson 2003; 2005). Certainly, reduced stress alone is significant. People being validated and feeling valued and more motivated to work was also established in this study.

### **Impact of work with clients: confirming**

The question of whether respondents perceived that there would be a flow-on benefit to the client group was engineered because of the recommendations from the literature review. Respondents found the question moderately difficult to answer throughout the study. This is not surprising given that respondents had a greater centre of attention on receiving support for themselves. Respondents found it difficult to answer from a client's perspective also:

There was none that I heard from clients [direct feedback], if we are looking specifically at that area...I don't think I could attribute any changes in that area due to supervision. (r5)

The question did connect to the importance of reflective space in practice, how people perceived their client work was benefitting. The educative function of

supervision and the need for greater awareness and resourcing for complex clients, especially in relation to their mental health, was highlighted:

I think because the process was changing me, that impacted how I worked, I think more in relation to greater awareness to the complexity of our client group. (r2)

We've created a regular assessment with dual diagnosis which has come from brainstorming with my supervisor how do we manage the epidemic of brain damaged clients? (r2)

One particular thing for example is that I asked [supervisor] about acquired brain injury cause I had my own basic understanding which was not out of whack, but she was able to give me more detailed information and some guidance... and we talked about how to relate to them. (r4)

We've explored what options we have as a service to support from other agencies outside of here, we've developed a very good relationship with [Dr...] at [agency] and ... that has been a direct by-product of raising dilemmas and concerns about how we do business and getting those external supports for clients. (r2)

However there was some doubt about the degree of support for clients due to the lack of clinical function. Some respondents could not properly answer due to their assigned role not having regular ongoing contact with clients. This underlines again how the supportive component of supervision was integral for a period of time but needed to move into the clinical for many:

I hadn't had supervision for some time and there was a build up of frustrations, so I needed to talk about myself as a worker here, and I managed that ...wasn't as clinical as what I needed. (r3)

The plentiful feedback on impact on client work of clinical supervision confirmed respondents' methods or helped improve their methods. This is by definition evaluative and highlights the connection between reflective practice and evaluating one's practice.

There were a couple of other times we talked about specific issues, and it really just confirmed my own, I guess, gut feeling of how to relate or how to deal with something like that, so that was really helpful. (r4)

More patience, and I think my approach, just getting beside the clients and certainly if they want to talk man to man about issues, and the other thing is, the residents get frustrated with themselves in areas or work, and instead of getting impatient with them, you just put them aside and encourage them. (r6)

It's really impacted my work, one of the standout things it has impacted is my confidence and my ability to be assertive with not just clients, but with staff and management as well...now I just do it, I just make decisions and do some of the things. (r8)

I was better able to stick to the script, the narrative style...A little bit more confident, not a huge amount but a little bit. (r9)

Field notes, which included phone conversations with different respondents, were consistently showed that respondents noticed that clients were being better cared for and their needs were being met more adequately. Moreover the modelling of staff receiving care themselves was well received and commented upon by the clients.

### **Where lies the focus of supervision?**

Clearly throughout the present study, the focal point of supervision was on the supervisee. That the logical flow-on was to clients was remarked upon by respondents:

We support people so they can flourish, so the more support I have, the more support I can give, and the more our mission can be accomplished. (r8)

I think it was more my issues, I think [supervisor] and I discussed my boundaries. (r7)

The literature review was divided as to where the focus needs to lie. In this study there is a clear shift away from client focus (Kadushin & Harkness 2002; Lewis 1999). For Bernard and Goodyear's (2004) the acid test of effectiveness was on client outcomes. This may be a difficult task, but maybe the focus needs to move from client outcomes to supervisee and their wellbeing. The difficulty with studies of client outcomes is methodological (Bambling 2006) for a start, let alone finding a place to research with an adequate amount of participants. To shift the focus back on to the worker is a challenging yet important paradigm shift. Rather than supervising a role, a worker is being supervised (Munson 2002). Ultimately, the explicit intention is that the supervision will have flow-on benefits to the client, thereby avoiding the danger of organisations becoming self-serving and losing sight of client needs.

### **What factors are associated with the difficulties or benefits of clinical supervision?**

The factors associated with the benefits of clinical supervision can be grouped in five categories: the training background, the experience of supervisor and the importance of choice of supervisor; the safety factor encapsulating the ability to be honest/ importance of safe space; being supported; and supervisor being conversational, a good listener and having genuine interest. There was little reference made to the supervisors' clinical knowledge being an important factor. Contrarily almost everyone commented on the topic of gender, as it was a specific interview question.

### **Training background, experience and importance of choice of supervisor**

In this study, the freedom to choose a supervisor, after examining the options of what was available, was vital. As mentioned in the methodology chapter recruiting was carefully conducted and quality supervisors were chosen. Indeed, having and choosing a supervisor who was from the same therapeutic background or training was a constant. This resulted in enhanced trust and confidence in the supervisors' training backgrounds:

It was someone who was Gestalt trained which matched me very well; that enabled me to trust him very quickly. (r2)

It's given me more confidence in the fidelity that I've adopted; narrative therapy. (r9)

Choice also proved to lead to problems and highlighted participants' need for someone of the same training background;

Maybe I held myself back at times because [supervisor] wasn't a [preferred professional background], but I think if I had my time over again I would have gone for a [preferred professional background]. (r3)

Respondents wished for supervisors from any therapeutic background that supported the benefit of reflective practice:

Just someone very interested in process and awareness really supported me to be interested in process and awareness, and I just see that as a crucial ingredient in reflective practice, to know what's going on not just as an individual but as an organisation. (r2)

The choice element in selection was a key feature, as was the ability to change supervisor. There were over 11 consistent responses in this regard. Respondents had the right to choose someone from either the same training background, someone familiar with their role or with relevant experience or understanding of the

organisational context. It is indeed an interesting discovery to note how supervisees need to know something of their supervisor before they make a choice:

What was crucial when I was looking for a supervisor was that they were [therapeutic modality] trained, so they were actually talking the same language, that he understood the therapeutic framework that I was working with. (r2)

It was important that I had someone who understood the Salvation Army and [supervisor] was a good choice in that regard. Now I'm down the track, having someone understanding the Salvation Army is not as important to me. (r4)

Probably the most important thing that seemed to come across for me was that my supervisor seemed to understand my position as a manager, having had a similar experience. (r10)

The thing I liked about it also was that before making your choice, you had the option to read some of their background, to decide who I am going to relate to. (r6)

*I didn't gel with my first supervisor. I didn't feel that I was heard or understood, so I was glad that we had a nice little pool to choose from. (fg1)*

This concurs with the literature review in that the right to choose was important and that supervisees prefer to choose someone from the same training background. However, what is different in this study is that having the choice of supervisor with the same background was emphatically the most significant factor.

### **Safety: honesty/ trust/ safe space**

The right to choose may have contributed to respondents feeling of security and the sense of safety that it brought about was a major factor in supporting people's



experience of supervision as was having a safe space to explore and to be able to be honest. Trust and safety are intertwined and the supervisors' skill at gaining trust (Cerinus 2005; Kavanagh, Spence, Wilson & Crow 2002), without being too obtrusive was commented upon here as well in the literature. This is evident in the following feedback:

I think the importance of trust, knowing that you're talking to somebody, sometimes when you talk to other staff, it doesn't stay with other staff, so confidentiality. (r6)

She didn't take me into other areas without my agreement. (r9)

*I feel like you can't speak up here sometimes because it will create waves but it was nice just to go somewhere and dump, and get strategies on how not to create a mess and that there are ways to say it without having all that feeling attached behind it. (fg1)*

Respondents placed a high value on being able to be honest with themselves, and for some, their survival in the AOD sector depended upon it:

*And I realise that I won't be able to continue working in this field if I am going to do that, so supervision has been huge in just getting honest. (fg5)*

### **Being supported**

Inherent in the supportive function of supervision is the attribute of receiving support. The support received by respondents in supervision in relation to their work, and in their personal lives proved to be essential and necessary. This was the case for the majority of respondents in the study:

She [supervisor] supported me intellectually; she's also supported me practically. I've talked about cases and she's questioned me on what I've said about the cases in such a way as to encourage me to follow other lines of enquiry. (r9)

I didn't want to go from my work life here which can be a pretty high stress level often, and I go there and it was calm and nourishing and supportive. (r8)

Given that the majority of roles in this study and in general in the wider AOD sector have strong support elements, it is not surprising that being supported as a parallel process is so vital. The benefit of being supported is self evident in statements such as the following;

*Probably support is number one for me, and as a result of it I feel more at ease. When coming into my work and professional role, we have an advantage as a support worker that we are our own boss, so with that you have to make a lot of judgment calls and know your clients really well. So it's nice to have that support to say, 'hang on, you're doing a bloody good job...I think I cried in all my sessions. (fg5)*

*Me too, me too. (fg1)*

### **Supervisor being conversational, a good listener and having genuine interest**

The basic counselling and life skills of genuine active listening were essential to respondents' positive experience of supervision. As well as the supervisor being interested in the supervisees' work, they showed interest in their family and personal life:

For me, [supervisor] was very conversational in her approach, it was almost that you weren't aware it was in a therapeutic type context, it was almost as if you're chatting with a friend, that's not really a friend but rather than... so I suppose that's about rapport with one another, rather than a doctor-patient type. (r4)

She certainly is very good at listening. (r6)

*Just the fact that they are interested in working with you, the person I had was very down to earth, and very interested in me. (fg2)*

## **Gender**

Quite succinctly gender did not seem overly important, despite almost every respondent commenting about it. A contributing factor here was that participants had the option of choosing their supervisor from the outset. Of the only two pieces of feedback from respondents who placed importance on gender, the following summed up the main felt influence:

I think the fact that it was female really helped me a lot, the fact that she was warm and easy to speak to. (r7)

## **Cost of supervision**

A few respondents commented upon the benefit of not having to pay for supervision for this considerable period of time. Both of the following comments are from people who had received clinical supervision on a regular basis prior to this study:

It was fantastic and the fact that it was paid for. (r2)

I was happy because I wasn't being charged for that period. (r4)

This cost, while defined here as a benefit, was a prohibitive element in deciding whether people would take up ongoing supervision. Given that such a small amount of any salary or funding agreement is allowed for supervision, as discussed in the literature review, then possibly the way forward is like as White and Wistanley (2006) recommend: that supervision become part of the work, and not separate from the work. That cost is a problem is understandable. Since people work to be paid, paying extra for supervision seems somewhat unfair. There may be a need to lobby funding bodies and to put forward the notion that supervision becomes an integral part of their funding and service agreement.

The difficulty of implementing a similar clinical supervision project is also mainly to be found in the cost factor. Other solutions, such as what the Basin Centre has undertaken, could be in the form of a co-responsibility model, with co-payments.

Other creative options such as the models forwarded by the Community Health Services of the Eastern Metropolitan Region, Victoria ([CHSEMR] 2006) are also a step in the right direction. However, there is an additional potential hurdle, especially for those newer to supervision, in the time that it takes to fully appreciate and understand the benefits of supervision. This problem will assume greater relevance as the AOD issues are explored in this chapter.

### **Difficulties of supervision: Time, supervisor seeing people from the same team, and location**

Difficulties of supervision were group into three categories: the impact on time; the supervisors seeing people from the same team; and location. The nexus of location and time was that some people had to travel to see their supervisors.

#### **Time**

Being able to find the time for supervision was a consistently mentioned difficulty. Also something commented upon by management was that they had to fill the gaps when people were off-line for the period of time taken to see a supervisor.

Management were philosophical however:

If it was part of the norm and the culture, the holes wouldn't be there because it would be expected. (r10)

Otherwise, it was mainly those new to supervision who commented upon time-scheduling difficulties. They found supervision beneficial but:

It would be better if it was once a month on call, or even once a fortnight but on call, when there's an issue [rather than a structured fortnightly session].  
(r7)

Preparation is an integral ingredient of supervision (Powell 2004; Vivekenandah, Maloney & Weir 2005). This difficulty needs to be weighed up in the context of the effectiveness of supervision. For some finding the time to prepare for a supervision

session was a problem, and when some sessions went for too long that too was problematic. On the other hand the travel time helped people with a preparation space for supervision. The pressure in this setting, and indeed the wider AOD field, to meet targets and keep competitive with limited and restrictive funding regimes is intense. Cost and time together are a potential enemy (Munson 2002). Agencies may be like new supervisees; they may need to experience supervision before they realise fully the benefits.

### **Supervisor seeing people from the same team**

Consistent feedback from respondents who saw the same supervisor if they were from the same team, was that this was fraught with tension. One supervisee commented that the supervisor would mention names of other people they were seeing. Even just knowing that they were seeing a supervisor from the same team made respondents uncomfortable:

Knowing that she was seeing a number of people, that did affect what I felt I could say about those people...I withdrew when I would have said otherwise, so her having contact with other people... and her talking about her contact with other people affected me. (r3)

One of the difficulties was that I knew she was seeing my manager, and I knew other people that she was seeing, and there was part of me didn't like that (r8)

This may just be the supervisor and their style of supervision, and boundaries that a supervisor keeps.

### **Location- where supervision takes place**

There was quite a mixed response in respect to the location of supervision. But certainly the feedback points to supervisors and supervisees needing to work out the most mutually beneficial suitable arrangements. Some respondents found having the supervisor coming on site a benefit whereas others found travelling off-site better. If

a preferred supervisor was located too far away, this would add to the time issue of supervision because of the added travel:

Because it was on site, there was no hassle of time management or fitting in with priorities. (r2)

It was great for me that it was off site, that was an accidental blessing, that I was actually off this property. (r8)

On a micro level, the room and space where supervision took place needed protection from noise and people;

I would have preferred to know that you weren't going to be disturbed by outside noises. (r5)

### **A difficult but important process**

There were points in the research, particularly near the mid-way point, which were very painful for both the organisation and the workers. However, when asked about those difficulties, the respondents were fairly philosophical in their responses- it was difficult but was an important part of the process and was beneficial for their growth:

*So supervision has given me courage to actually step forward and stuff up and make mistakes, so it's a difficult benefit. The more pain I've been through this year the more I've learnt. (fg5)*

It was a good difficult... it was like being cheered on to come up to the plate, saying this is what I know this is where your development needs to be, this is where you need to grow and that can be very confronting but I was ready for it. (r2)

### **AOD issues overall: 'AOD clients are a unique target group'.**

Unfailingly in the feedback, and as a golden thread through the course of the research, workers reported that their clients are a unique target group with complex

needs. It was not just complexity but a consistent related sense of heavy burden where personal chaos and trauma were frequently involved and discussed.

AOD specific knowledge was most important for the educative function in relation to AOD issues. There was minimal feedback however because many workers accessed enough training and were able to consult their experienced line manager for their educative needs. The clinical and supportive function for AOD issues revolved around having empathy and understanding of the AOD target group.

### **AOD characteristics prior to research process**

During the first-round interviews, just prior to the actual commencement of clinical supervision, respondents were asked whether they thought AOD issues were going to be significant and what they might be. Those that had had supervision previously were also asked how important AOD issues had been.

Following the social work model of supervision, and the breakdown into educative, supportive and clinical functions, the perceived issues most remarked upon were the need for education around withdrawal symptoms; the particular danger for relapse for those residents leaving for the weekend; and a broad category noted as 'addiction' issues or issues related to 'dependence'. An example is:

They get upset over something to me that might seem trivial but to them because this becomes their world it's a huge thing. (r7)

Three participants stated clearly that the AOD clients being such a unique target necessitates a supervisor need to at least have a thorough understanding of them and their problems. Combined with this was the need to understand the distinctive nature of a residential live-in setting.

Potential AOD issues arising in supervision evoked numerous similar responses, especially emphasising the unique nature and complexity of the AOD client group. Often the nature of lapse and relapse and understanding how to work with these with

the clients and how it affects the worker were brought up. The potential negative impact on the worker rather than the client was a concern that a number of respondents quite clearly indicated:

A lot of AOD workers are flying solo and working with really complex clients who have... entrenched defence coping skills and are...quite difficult to work with and have very little support. Lack of support was a common issue. (r1)

These responses led me to ask in subsequent interviews just what AOD-specific issues were arising, as well asking about the relative importance of the supervisor having knowledge about them.

### **Mid-way interviews and AOD issues**

The mid-way point of the research process, as has been mentioned, was a critical time in assessing the impact of supervision. In respect to AOD issues, six of the ten interviewees mentioned that few if any AOD specific or related issues were raised. Similarly, the focus group had little to say about AOD problems. The unique nature of the AOD target group was pointed out again, as well as the even more idiosyncratic nature of residential experience. There was a little feedback that if supervisors had greater understanding of the residential setting then this may have benefited the supervision process.

In discussion, it became clear that respondents believed it was important for people to be resourced *educatively* with dual diagnosis knowledge as well as the need for general AOD-specific education. Boundaries were mentioned specifically in the context of asking about AOD problems, in that it helped respondents to be clearer with personal and professional boundaries regarding their client group. There was some minor discontent over people hoping their supervisor was more AOD savvy, and conversely an appraisal of the positives of a supervisor having AOD experience. This was all in the context of so many people having a great need to offload a backlog of material as well as organisation and role problems being dominant. Thus,



AOD related topics were mentioned, but they were not in the foreground of people's experience.

### **Final Interviews: Common supervision issues for AOD workers**

The final interviews were decisive in that people attempted to deal with matters that were AOD specific. However the AOD specificity was never made clear by respondents, which in itself could be a research question worth investigating. The unique nature of AOD clients was unanimously affirmed in the final interviews. Questions that people commonly raised when asked about AOD-specific issues were as follows:

- Dual diagnosis (combined mental health and AOD problems). Acquired Brain Injury (ABI) would be a sub-section of this and was mentioned specifically; self-mutilation; anxiety and depression;
- Boundaries and being clearer about relational boundaries with clients;
- Grief and loss: suicide of past and present clients, relapse and the frustration involved in this;
- Overdose, withdrawal, relapse;
- The chaotic nature of their lives, family disruption;
  - We're not talking about people who have got a marital issue that both work and have three cars. We're talking about quite highly distressed individuals with many needs. (r8)
- Homelessness;
- The concept of addiction and addictive personalities; (and)
- Sexual abuse;
  - Though the sexual abuse has been the core issue with the drinking involved. (r9)

From the above list a comment that sums up this experience and the need to have a supervisor with AOD knowledge and experience and the daily experience of working with AOD clients is:

I needed to acknowledge that hearing about physical abuse, and sexual assaults and suicide attempts and slashin' up; this is a daily, weekly event in my work life, and its part of working with alcohol and drugs. (r8)

Overall, three individual participants mentioned the need for the supervisor to have AOD knowledge and experience. Notably one mentioned that it was only in the latter half of the research process that the AOD-specificity became relatively important. This is consistent with the shift from debrief, offload and support to seeking a greater clinical function. Otherwise the majority of respondents, including the focus group, did not mention AOD experience as being requisite or significant in their understanding of supervision. Simply knowing that a supervisor had some understanding was important for some and for others not at all important. Many realised that a supervisor was able to support the AOD specificity of the workplace, despite some supervisors having little or no prior knowledge of working on a daily basis with AOD clients. The supervisors confirmed both in the prior and in the final interviews that their AOD experience was not so crucial. One supervisor summed this up well:

The process of supervision is the same [for all]. (s2)

This deviates from Vivekandah, Moloney & Weir's (2005) and Roche, Todd and O'Connor's (2007) notion of needing an AOD-specific model of supervision in the Australian context, or Rizzo (2003) and Powell's (2004) version in the American context.

**What is the impact of having external supervisors provide clinical supervision (and in this sense separating the administrative function from the educative, supportive and more clinical functions)?**

#### **External supervisors: overview**

For all participants having external supervisors was central to a positive outcome. The security and trust they provided because of their objectivity was paramount. The

subsequent impact on line management, especially when they too received supervision, brought a healthy and welcome change for most. For some, there was no change to their line management supervision. However it was constantly noted that role boundaries became clearer for people to understand and navigate.

### **External supervisors: prior to the study**

Prior to the research process people were asked about their potential concerns as well as the possible benefits of having external supervisors. From those who had received supervision previously, the response was overwhelming, that external supervisors provide safety, confidentiality about organisational issues, access someone from the same therapeutic or training background, ability to vent uninhibitedly, and being able to talk freely about their relationship with their managers.

Among those who hadn't received supervision, there was the sense that this was a good prospect, especially if management supported the idea. There was also some concern as to whether the supervisor would understand matters of spirituality:

I'm not sure how it will work if someone doesn't share the same Christian faith experience and is unable to understand that faith element of my role. (r4)

### **External supervisors: mid-way**

By the mid-way point of the study, respondents were consistently high in their praise of external supervisors in regard to the objectivity they brought and the safety and trust that had been engendered. Respondents commented on how the supervisors were able to see that there was a culture of overwork and a need for active self-care. Respondents also regularly fed back that line managers had become clearer about their roles. Similarly supervisees were able to have more of their needs met externally rather than relying too heavily on their line manager. The significance for some was:

So important that I wonder if I had not brought it to someone I cannot imagine what impact that would have on me as a worker. (r8)

### **External supervisors: the verdict**

Flowing from the mid-way interviews were the core themes of objectivity and the trust/safety that external supervisors brought; being saturated with considerable volume of feedback. The external unbiased perspective was liberating for workers, as the external supervisors had no organisational agenda; and this consequently enhanced the trust and also gave greater credibility to what they offered:

I think somebody external doesn't have any vested interest anywhere, somebody external comes unbiased. (r4)

The objectivity didn't just bring an unbiased perspective but also brought an informed and helpful perspective, likened here to a family:

It's also like a dysfunctional family and then having it witnessed outside of the family so to speak. (r8)

The objectivity also brought with it a voice of support and care that was not always readily available internally.

While [supervisor] was my supervisor, one of our clients passed away, and she was helpful but that's not really talking about drugs as such but it's talking about the impact on me and she helped me with that. (r7)

### **Trust/safety**

The trust and safety that external supervisors provided contrasted with a background of former workplaces where there were internal supervisors, and how that situation did not breed trust:

I've been in other organisations where supervisors have been internal, and trust is a big issue; is it safe for me to really say what's going on, and I was able to be absolutely transparent and talk about anything. (r2)

Flowing on from the importance of safety and trust was how the freedom to talk, bred greater honesty, and this was a significant benefit for most respondents. That people felt secure that what they said went no further cannot be underestimated;

I was free to express, it allowed more honesty. (r3)

You can talk to people here, but you do find even though you say, can we please keep this between us, it's out, and it's been a major thing. I've discussed things with [supervisor] and known that it's not going to go further and have gotten it off my chest. (r7)

The freedom to express thoughts about managers or colleagues was a vital ingredient in this process;

It's liberating to be able to talk about some of the political issues that are within the organisation and being able to talk about staff members safely and know that it's okay. (r8)

The connection between these matters of objectivity, safety and trust is eloquently expressed here, by a voice that is typical of a number of respondents:

*And knowing she was completely independent from here was great. And I felt safe because whatever I said wasn't going to come back here, unless she told me it had to. So I felt like I could be completely free, whereas here I feel like I need to suppress a lot of things; you don't actually want it to go further necessarily. (fg1)*

## **Difficulties**

Having external supervisors was not without its difficulties. While many respondents commented that they experienced no difficulties from external supervision, and some even suggested they needed more external people involved, the external perspective at the mid-point of the study created a number of organisational and role difficulties that had to be contended with, as mentioned in the methodology chapters:

Questioning whether we should have had feedback to management or some kind of freedom of information at least in relation to issues or themes that may have sped up the process of resolving conflict or issues. (r2)

The main difficulty mentioned was that some respondents, at times, had to explain context and background information relevant to the setting of residential rehabilitation:

There were times that I had to give contextual information that was [separate from the experience of] an external supervisor, and often that seemed to take up a lot of the supervision time. (r10)

The importance of choosing and screening a supervisor was mentioned in the context of being asked about difficulties, where respondents could perceive that potentially an external supervisor might prove somewhat challenging:

I could see it as potentially a difficulty with a supervisor who either struggled with the organisation or had strong views about it, even unintentionally challenging some of the culture, which may or may not be able to be influenced or changed. (r10)

One of the key clinical features salient to clinical supervision is pinpointing the parallel process of how the workers, and or workplace, can be imitating the client group they are working with. This feature of clinical supervision if left to a line manager to identify and work with can become difficult, especially if they work in the same challenging environment. This is in the context of all respondents describing the inherent challenge of the AOD client group. This again was one of the standout key benefits of having external supervisors, to be able to bring this perspective on a whole organisational level. Copeland (2002) endorses this objectivity as does Itzhaky (2001).

### **Educative, supportive, administrative and clinical components: a review**

The primacy of the supportive component of supervision was a standout feature of the study. The supportive needs are intrinsically linked with the challenging nature of the distinct and unique AOD work. The support was also strongly related to the backlog of general debrief and support needed even after the mid-way point of the study. The educative function was mentioned to some extent but was outweighed by this dominant need for support and care. A general shift to the educative and more clinical functions came towards the latter part of the study, after the themes of role clarification, boundaries and self-care had been given the time and attention they needed. These themes will be explored in greater detail later in this chapter.

The administrative component of supervision was explored by asking about respondents' experience of their line management supervision. This was language that people could better understand. For some the impact of external supervisors changed their line management. For others there was little difference due to the nature of their working area. For those working in either a supportive or counselling role or who had regular confidential discussions with clients, the change in line management was noticeable and necessary. Managers themselves detected the change and remarked how if a manager conducted the clinical supervision it was a:  
dual relationship with ethic dilemmas... had they not had this support it would have been much harder to do, given the dual role of line manager and supervisor. (r2)

That is, the line-managers noticed their load lighten somewhat and were now being cared for and unbeknownst to them, the workers they were supporting felt better about not burdening them so much:

I have a lot of respect for [line manager], even though we disagree on some points but in using her as I have from time to time as a supervisor I put a load on her that she can do without. (r9)

Respondents, both management or otherwise, could now separate their supportive needs and focus on their roles more effectively:

I no longer need to take any external supervision stuff to my line manager, I've got a place to put it, so I'm much more practically focused on the task at hand, to what needs doing to the role I'm in...But I also believe that my line manager, see she's getting supervision too, that she's helped create more of a line management relationship with me as well. (r8)

I guess it's made me realise that I don't have to go to my line manager for every little thing that happens to me, sometimes you don't need that person in between, and just go straight to the top. (r7)

The separation of the functions of supervision confirms the findings of Holloway (1995) and Roche, Todd and O'Connor (2007) and was paramount in the positive outcomes. The significance of the supportive function of clinical supervision in this study points to a number of outcomes. Firstly that support and care of the worker is paramount. Certainly, Sloan (2006) defined one of the facets of supervision in nursing as 'restorative', in order to alleviate stress. Bernard and Goodyear's (2004) two central purposes of supervision may be more connected in light of this study, in that in order to ensure client welfare, fostering 'the supervisee's professional development' (p.12) comes first. This solves the 'egg before the chicken' for supervision in this respect. However this equally points to how clinical supervision, as revealed in this study, is best placed in the context of workforce development. That is to say, that a worker's professional development, including the meeting of the educative and clinical functions, can readily be supplemented by training, study or other creative options.

The following chapter further examines the data by a grounded theory analysis and elucidates new themes and categories. The next chapter ostensibly answers the research question of 'other issues that emerge from the research process'.



## **Chapter 7:**

### **Further themes that emerged from a grounded theory analysis of the data**

#### **Introduction**

This section discusses further themes that emerged via the grounded theory process and also answers the research question about 'other issues that emerge from the research process'. These new discoveries fall under the headings of boundaries; the semantics and components of supervision; and the power of an en masse intervention.

#### **Boundaries**

Boundaries have been the foremost central theme to emerge; relational boundaries with clients, with roles, with colleagues, or management as well as relating to self. Boundaries have been mentioned several times in this chapter already in the context of other themes; the negotiation of my role boundaries; the confidentiality boundaries within the research process; the boundaries of what actually constitutes supervision, as well as the content of supervision.

A sense of safety developed from achieving greater clarity in respect to these boundaries and this in turn contributed to the feeling of support. Many of the boundaries developed clearer definition as the study progressed. Clinical supervision directly correlated with an enhanced understanding and practice of boundaries. What follows expands on the theme of boundaries by exploring self-care; role support, and clarification; and supervisor role boundaries.

### **Boundaries in the study**

The role boundaries that I had to traverse began early in the research and were monitored all the way through. For respondents however, it was at the mid-point of the study, that boundaries were definitively recognised, especially in respondent's relationship to their colleagues, to their work and themselves. Whatever boundaries were named, it was a concept most workers were familiar with. One respondent commented that supervision had:

Helped me not to take on other people's problems. (r5).

This comment is indicative of how many respondents' answers were interpolated within their responses to questions being asked about AOD matters relating to their enhanced sense of personal boundaries that were often questioned by clients in their work. There was consistent feedback that they felt clearer about these boundaries.

On the other hand, what was discussed in supervision throughout the study had a great deal of flexibility as to the boundaries. Many respondents discussed organisational topics and stressors, their role limits, as well as family life and personal subjects:

So [supervisor] would ask about family things, ask about the personal stuff as well, just overall friendliness and warmth. (r4)

However permission was always sought before a possible deeper discussion.

[Supervisor] didn't take me into other areas without my agreement. (r9)

People setting boundaries also relates to a sub-theme of self-care, and challenging the culture of overwork.

### **Self-care (overwork vs self-care): the boundary of relationship to self**

Self-care is basically an individual paying proper attention to personal wellbeing. This includes needs and wants, and active self-care especially during periods of increased stress or time pressures. Inherent in self-care is the ability to say 'no'. Part

of active care may be to better manage time, addressing the 'work-life balance', and indulging in more activities that help a person to feel good. This is opposed to the concept of overwork when people work extra hours, see extra clients, take less downtime and avoid quality team-building activities. Another downside is the effect of bringing unfinished work home.

As to what is necessary self-care for each individual it is necessary to understand the right balance and boundary. Reflective practice that encourages self-awareness is a critical ingredient:

It's put self-care on the map as well, creating some awareness about care for the worker as an important concept, especially in an organisation that is very self sacrificing. (r2)

In essence, the relationship of supervision to self-care is expressed well here:

*Gave you time to stop and focus on yourself, rather than everyone else. (fg1)*

An element of the impact of supervision in respect to self-care, in a busy hard-working environment, is not working such long hours and slowing down:

*You need self-care... so I've learnt a valuable lesson which I've known all along, but you just need to slow down. (fg3)*

People don't work the long hours that they used to. (r8)

Indeed one participant reduced their working week from five to four days, where the self-care was well embraced. Another aspect of self-care is simply realising that you don't have to be continually happy:

*Through supervision I realised I don't have to be happy all the time. (fg1)*

The efficacy of supervision in regards to self-care, the work-life balance and reflecting on one's journey was evident very early in the study exemplified by one participant leaving the Basin Centre and admitting that supervision had played a

significant in the decision. A positive outcome of active self-care also occurred when a participant did not attend a focus group and subsequently fed back that she was practising self-care, given the strenuous nature of her work at that time. Other workers revealed:

I'm actually working reasonable hours and not a lot overworking which was my issue. (r2)

I think one of the other benefits has been to self-care. I've actually gone home with my desk in a mess the last two nights. It's awful to come to the next day but in the end, who cares. The urgent things catch up with you, and the unimportant things just float into the distance. (r10)

Under the issue of self-care, we have decided to start our management meetings later so we are not coming to work earlier, and scheduling them into our work plan rather than in addition to. (r10)

The impact of self-care within supervision was also shown by one worker's decision to move out from living on the work premises. The supervision experience helped distinguish the boundary between work and home life.

There was constant feedback that people were aware that others too were practising self-care, such was its contagious nature:

I've noticed people looking after themselves way better, many staff, many staff. I've noticed people being more verbal and asking for their needs and what they want more than ever before, that there's been this with management, this sort of looking after yourself, and this has been directly related to the supervision. (r8)

Respondents even began delegating and assertively asking for what they needed in their working environment. This is especially significant when coming from someone

new to supervision. One can only imagine the challenges for this respondent had they not engaged in supervision:

*One thing I have learnt from supervision as far as what I need to do in order to have my needs met is to be more forthright for asking to have more time with management. (fg3)*

It revolutionised my role. I delegated so much. (r2)

### **Role support: clarification, development and confirmation**

The impact of support on roles was not simply an outcome that the organisation was working on. It was clearly linked with supervision, by everyone. Respondents became clearer about their roles and about defining the parameters of their roles. Role support brought about restructuring of teams and separated functions such as the counsellors undertaking too much work and not needing to case-manage as well as provide counselling:

When does my role stop and when does theirs begin with post-residential counsellors? (r5)

This theme of role support emerged quite early in the study, principally during the first focus group and showed an early impact. By mid-way, feedback was unanimous that this was a dominant emerging theme. Respondents were questioning their roles and asking for clarification. Not long after, as mentioned, management organised a separate retreat, to discuss their role clarity and the whole operation of the Basin Centre in respect to roles.

The impact of clearer roles gave rise to respondents' commenting that they had much more free structured time in their daily work schedules. Role clarity for people helped them to realise that their roles were so much more than their titles:

[Supervisor] made that clear; that I'm not just a cook and my role extends further than that. (r7)

Supervision also changed how people related to each other as colleagues:

My relationship with some of the team has altered and become more professionally orientated, and less like friends at work, so I imagine that has impacted the team, and I see that as role modelling of how to be at work. (r7)

Supervision also supported people to develop their roles by way of study and other workforce development activities, such as the participant mentioned earlier who enrolled in a Certificate IV in AOD Work.

Supervision was also instrumental in providing clearer structure and boundaries for one line-manager's role. She noticed that problems that had been ignored or avoided were not previously being addressed due to perceived inappropriateness or risk, were now being attended to by the external supervisor. Not being able to explicitly identify or deal with such clinical issues with the worker, it was noted, had hampered the client work. Role support here was also enhanced by validation and normalisation.

The fundamental nature of clinical supervision, especially from a supervisor who, brings an external perspective, supports the supervisee to reflect on their current work role, as well as potential for other meaningful roles both within and outside the workplace. A supervisee may also come to realise the unsuitability of their current role:

Group supervision for the organisation has actually forced people to think about their place in the organisation, and where they fit, and do they like where they fit. (r10)

One respondent mentioned earlier resigned; less than two months after the completion of the official study, three more participants resigned. Two of them fed back to me that the supervision they had received was integral and supportive in their decision.

### **Supervisor role boundaries and sharing of information**

The impact of supervision on boundaries came to a crossroads over questions of confidentiality and flow-through of information. Even the supervisors raised this as a point that had been dealt with. They were concerned that if too much content stays with them, then change that could be beneficial may not happen:

Discussion and clarifications around these underpinnings could help to alleviate some of the ambiguities that will arise in any organisation that is working with distressed and disturbed individuals. (s1)

The questions gave rise to the extracurricular 'café'<sup>14</sup> meeting in early November 2005. Arrangement and clarification of appropriate boundaries that can be intermittently reviewed, was required.

Overall the sense was that they did the right thing in adhering to the original form of confidentiality as organised at the beginning of the clinical supervision project. However, a freer discussing of themes, issues and organisational progress was proposed for future programs. Shaw (2004) offers a solution here in suggesting that management and supervisors need to engage in an open communicative process, where managers can receive feedback from both supervisors and supervisees. This requires some openness and strength on the part of an organisation. Boundaries of the relationship with external supervisors need to be established at the outset and monitored throughout the contracted period. Shaw's method also keeps the administrative and clinical functions of supervision.

### **Boundaries: Supervision and workforce development options**

Workforce development and the theme of boundaries are tied up in the premise that boundaries warrant deserved attention. The outcome may be training or tailored group sessions (whether supervision or not) on boundaries. It could also be a fruitful training or orientation topic for workers. The ability of an external person to provide

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<sup>14</sup> This meeting was described in the methodology chapters

security, trust and objectivity is most favourable, to study outcomes. As with the regularity of supervision, boundaries also need to be revised and explored periodically.

One universally accepted component of supervision in the literature review was that supervision is an official and distinct relationship. However the parameters of the official relationship need to be redefined continually while the parties are in the contracted relationship. This redefinition will help both supervisor and supervisee, especially if there are difficulties or the relationship becomes strained. A contract that is mandated due to a line management relationship or for professional training purposes, may add further complications. Skerret's (2004) recommendation of contracts at the beginning of the process is sound advice.

### **The semantics and components of supervision**

At the beginning of the research process, and during the early recruitment of respondents, the question arose as to what clinical supervision actually meant. Supervision seemed to mean something different to almost everyone. Among the respondents, an assortment of people who had received clinical supervision previously, three had received at least monthly clinical supervision. Four had provided supervision; another had provided general debrief and support for staff, but this had never been categorised as supervision. Such a varied background combined with people's differing work areas and professional training made for a challenging landscape in which to arrive at a common working definition of clinical supervision.

Even with a common definition, it was respondents' past experiences of supervision or similar care, in different capacities or job roles, which informed their understanding. As mentioned in the methodology chapter I went to some lengths to explain and discuss the concept of clinical supervision particular to the workplace setting. This experience alone demonstrated the range in understandings, let alone what clinical supervision may mean for someone in a chaplaincy role for example.



For different people, in the first round interviews, there was quite some variance in the understanding of supervision. Supervision for the work therapy staff could mean:

Artificial insemination – in cows. According to my version of supervision, you have to be supervised correctly about the procedure? (r6)

For kitchen staff, supervision could mean:

So yeah I've gone to him or I've gone to the chaplain and spoken to them so I guess that's supervision isn't it? (R7)

People's prior negative experience of supervision also seemed to colour and influence their understanding of the concept:

Have I experienced any [previous] benefits? No, I could almost emphatically say no and in fact the Christmas cards that are sometimes received from the line manager at the end of the year actually said thank you for being a hearing ear for me in the supervision sessions. (r5)

Considering this experience, this respondent was looking forward to supervision from external supervisors and had a generally positive disposition. However, the comment indicates previous experience of supervision may affect a person's future perception of what might actually lie within the realm of supervision.

The term 'supervision' also conjured images of someone looking over a workers' shoulder, or teaching them how to cook a meal, even that someone with more experience exposing their lack of skill and other similar fears. Again, these interpretations were countered as well as possible. A few people involved in church communities and church-related work mentioned the concept of 'pastoral care' and that supervision seemed similar. As a result the SGC discussed at length alternative names for clinical supervision, but in the final analysis the term 'supervision' survived, and clarification was provided where necessary.

### **Other terms to describe components of supervision**

Respondents found other terms to describe their notions of what may constitute components of clinical supervision. Participants mentioned 'debrief', 'catch up' and more commonly, 'client review'. These had been commonly associated with supervision by their respective line managers. The distinction from client review was summed up well in the following remark:

Then we both decided it would be better if I found someone in the private sector because her supervision is of a different character than clinical supervision. It's a weekly review of clients with [line manager]. (r9)

### **Supervision and critical incident (CI) debriefing**

Interviewee six described an event that included him debriefing a critical incident (CI) for a colleague and following up afterwards. This was not his normal role. He looked on this as an experience of providing supervision, whereas it is more correctly defined as CI debriefing. The clarity of what constitutes the need for CI debriefing seems another concept that many organisations, and not just the Basin Centre, may not have had the time to explore fully. Nor are there clear boundaries and parameters.

Part of the realm of CI management is exploring of how the incident may have been prevented, as well as what interventions are appropriate and when. Some discussion of a CI may constitute part of the official supervisory relationship but the separation of and clarity of the different roles is paramount. CI debriefing also requires separate, specialist training.

However, regularity of supervision was central to the following respondents being cared for after a CI. Given the frequency of similar CIs, and respondents frequent exposure to traumatic events, supervision may be the ideal place for support and care:

I think at the same time we had two other residents self mutilate, and another one lapse as well, so it was pretty full on at that time, so supervision was really important to have to debrief at that time. (r8)

Worth clarifying is whether regular debriefing is the place of a supervisor and is the active follow up personal support that is often necessary, an essential ingredient of supervision? Can they be separated well? Supervisors are well versed in being able to refer supervisees to counselling where necessary, but the active follow-up support associated with CI debriefing is more assertive in nature.

### **The notion of tailored supervision**

However in surveying the difficult and heavy work that is common in the AOD sector, a useful step might be something similar to Knight (2004) and Morrison's (2007) concept of a trauma-specific supervision, but tailored for the workplace and sector. They suggest that without this trauma-specific supervision there is a much higher risk of vicarious trauma. This process would not preclude the need for an official CI debriefing at times.

On another note there was feedback from the chaplain and others, that spirituality should also be an integral part of supervision. They expressed disappointment about the decision to leave spirituality out of supervision. Their response sheds light on how supervision is tailored for a field as well as roles.

I made that judgment call of keeping the spirituality out of it [supervision]. I'll now probably go for the supervision first which will help me solve some of the problems I have with my role that chaplaincy can work in this place. (r4)

Other instances of customised supervision were separate group supervision sessions for certain teams, as well as for management. That was supervision with a distinct purpose and agenda with a pre-ordained outcome.

In light of this research, tailored supervision for the AOD setting, as well as an experienced and knowledgeable supervisor, would need the following:

- awareness that the supportive component is a prime need;
- general acceptance and understanding of the unique nature of the AOD field;
- awareness of the potential for vicarious trauma;
- knowledge of boundaries and flexibility in approach and focus;
- clarity about the boundaries of what does and does not constitute supervision;
- regular supervision is integral to a beneficial experience; (and)
- an awareness that a supervisor seeing people from the same team may have difficulties and should possibly be avoided.

All the supervisors in this study had supervised people from a variety of different training backgrounds, including psychology, social work and different therapy regimes, as well as a variety of roles. This diversity of experience certainly contributed to the outcomes of the study. An added bonus would be an understanding of what respondents found most useful. This process is paradoxically made simpler by a supervisor not necessarily needing AOD experience.

### **The flexible and changing nature of supervision**

As mentioned in the literature review, where the focus lies at any stage for a supervisor or a supervisee depends upon a number of variables including the supervisor's model or training, the supervisee's resilience, a supervisee's work/ life balance, the setting itself, organisational issues, and general levels of stress or dissatisfaction within a team. The particular efficacy of group supervision in this research supports the notion that the contemporaneous needs at any one time are the most significant. This is a more phenomenological approach.

Evident in this research is that workers in all roles have different requirements and needs at different times of their careers and personal lives. Therefore they are attracted to different forms of supervision. Some components of supervision held greater credence than at other times, such as the supportive component being such

a primary need. The supportive component never entirely went away, but as mentioned previously some respondents began to seek more educative and clinical functions.

There is little new in the difficulty of finding a commonly held and used definition of supervision. Bambling's (2006) meticulous research, as also discussed in the literature review, had a methodology that adhered to one definition of supervision and one component of supervision. Despite this consistent line, the outcomes were not overwhelmingly conclusive. Therefore, whether the difficulty of a common definition needs necessarily to be contentious (VHA, p. 13) is not the debatable methodological issue, but rather points to embracing the diversity and the need for flexibility in approaches to supervision. It also reflects the diversity and flexibility needed to match the AOD workforce, and the flexibility of boundaries as discovered in this study.

### **The power of an en masse intervention: affirmation of methodologies utilised**

As a result of the whole of the Basin Centre engaging in supervision, people felt more connected to their place of employment and also that their team fitted with the rest of the program. This was a particular feature in the feedback, where respondents reported enjoying connecting and communicating, especially given the geographical challenges of the work site but more interestingly, where work teams used to operate as silos. This confirms Webb's (1997) notion that supervision improves communication. The focus group setting paralleled the environment of group supervision and thus the formats supported each other. Group supervision also helped people from different teams connect within the Basin Centre, where they wouldn't normally connect:

*group supervision I thought was really good, I found the dynamics to be really excellent, you get to know your workers a lot better, one female worker who I didn't really know at all I got to know quite well. (fg2)*

Themes also emerged within the focus groups of people feeling normalised in the experiences they described and explored just in that setting. It enhanced respondents esteem in their work roles:

Now I have a sense where in this environment that work therapy is a valuable part of the program. (r6)

As mentioned previously, boundaries require self-reflection and thus self-responsibility. The effect of an organisation actively and bravely providing supervision for all staff was immense; however, the ongoing weight of responsibility, especially given the theme of self-care, needed to be shared, including the financial component. This resulted in the previously mentioned co-contribution offered by the Basin Centre.

Already at the mid-point of the research managers commented that a culture of learning was developing with greater scope for creativity. This confirms Hawkins and Shohets' (1989) discovery in the literature review, that supervision flourishes best in a culture of learning. Paradoxically in this scenario, it was the supervision experience that nurtured the developing culture of learning.

Finally, it was discovered by using PAR in this study, how PAR enabled, indeed almost forced, any problems that arose throughout the research process to be faced up to. It was very empowering for participants (Sarantakos 2005) that their issues were being heard and acted upon.

## **Conclusion**

In chapters five, six and seven, I have outlined the findings and interwoven the data with the literature via grounded theory analysis. One of the chief discoveries was that the pre-eminence of the supportive component of supervision was partly counteracted by the eventual need for combined educative and clinical functions. This finding was enhanced by the regularity of clinical supervision provided, as well as the combination of group and individual supervision. The outcome for new-to-

supervision supervisees was that all benefited enormously, but it took the actual prolonged experience to compel them to acknowledge this. Enhanced self-reflective practice, stress reduction, increased confidence and motivation, and just simply being supported were the outcomes for respondents who experienced supervision as effective. The importance attached to supervision was where supervision was recommended to be either mandatory for those who work close with clients or at least strongly encouraged. This was tempered by how people, despite these sentiments, felt that the ongoing personal financial cost was too burdensome. The significance of being able to choose a supervisor, preferably from a similar or the same training background was discovered to be important.

Clinical supervision, as we have discovered, leads to people to reflect on boundaries and encourages reflective practice. The research outcomes suggest that coming to a universal definition or model of supervision is not necessarily what is important. Separating the function of administrative supervision and utilising external supervisors was vindicated by the unique and effective impact of group supervision. Being clearer about the place and definition of the separate functions of supervision, especially the supportive function, is what is needed and will be further explored in the following chapter. This chapter concludes that the inherent boundaries of where supervision starts and stops, especially in relation to CI debriefing, needs to be explored. A possible solution offered, is tailored supervision. In fact, the unique and complex nature of the AOD sector demands customised supervision. In this setting a supervisor needs a flexible approach but not necessarily an in-depth knowledge of AOD issues.

As well as the importance of external supervisors, it was recognised that some level of open communication between supervisee, external supervisor and organisation, with appropriate levels of confidentiality, will help monitor and support different demands from time to time and will also provide for appropriate flow-through of information.

Supervision had a direct correlation with clearer boundaries in relation to roles, self-care and other workforce development options. Supervision improved role clarification and helped supervisees feel valued and normalised in their roles. It reduced stress and helped people to feel affirmed and encouraged. As to the flow-on to client work, although the clients themselves were not questioned, the impact was noticeable to respondents. The predominance of the supportive function and the need for support, points to the focal point for supervision being mainly on the supervisee, and the client benefitting from there.

In the following chapter, I discuss further recommendations in light of this study and propose how the history of clinical supervision is evolving. I also posit two fresh definitions that address some of the concerns and take into consideration the findings in these three chapters.



## Chapter 8:

### Recommendations and further discussion of the findings

This brief chapter highlights areas for further recommendations in areas of study and methods. It is to be interpreted in the context of this research being conducted in an AOD residential rehabilitation setting. In extending the discussion from the previous chapters, four further points arise:

- a. The history of social work supervision is still evolving
- b. Supervision is useful for a range of roles
- c. There are a number of possible strategies to soften the cost of supervision (and)
- d. Two new definitions of supervision are posited in light of this study.

#### **Recommendations: discoveries and future studies**

A number of discoveries throughout this study either point to future areas of study or are useful methodological benefits.

The concept of having no supervision in light of this study is a serious consideration (Edwards et al. 2005; McMahon & Patton 2002). A study of people receiving supervision with a random control group of those not would be a useful study.

The connection between supervision, boundaries and reflective practice is worth exploring and also points to possible future studies of the importance and definition of boundaries in relation to professional practice, roles and wellbeing.

The supportive component of supervision has been identified as a necessary focal point for supervision. While supervisees moved to accessing the educative and clinical functions of supervision, there is also scope for research that investigates the complementarity of support and extra skilling and development of the professional.

As explored in the literature review, previous studies have put a greater focus on skill development. A research study to nurture the support and development of skill, either through supervision or other workforce development activities such as mentoring or training, would complement this study.

Regularity of supervision was paramount to success in this study. This in turn leads to the prospect of future studies exploring how frequency of contact affects supervision. Intrinsic in this would be exploring the impact of weekly supervision instead of fortnightly or monthly. Factors such as the right to choose supervisors would be a vital ingredient in such a study.

The efficacy of group supervision certainly warrants further investigation to develop from being 'widely practised and undervalued' to being an integral element of supervision or workforce development. The cost effectiveness of group supervision, would justify the effort (Stone 2004).

Clinical supervisors consistently fed back that it was a rewarding and informative experience to meet in their focus groups as well as the other extracurricular encounters. Supervisors themselves were confirmed and normalised, where the ethos was co-supportive, much like to a peer supervision group. This points to the relatively unexplored concept of supervisors receiving feedback as well as the need for supervision of supervisors. This notion can be taken into consideration when screening supervisors to supervise, whether they have this extra support.

It was discovered in the screening process that only one supervisor had any official training in clinical supervision, despite the high calibre of the candidates. Most of the supervision training available in Victoria is geared towards line managers conducting the supervision. This points to the need for development of appropriate training or university-based courses of study for those acting as external supervisors.

Hall, Amodeo, Shaffer and Vander Bilt (2000) suggest increasing the AOD focus in social work curricula. This recommendation is endorsed by this study. This would suitably prepare social work students for the wide variety of employment options in the AOD sector.

Finally, further study that has the focus of supervision specifically on the supervisee seems the next step for future research. The difficulty of such a study is acknowledged, especially if client outcomes need also to be measured.

### **Methodological recommendations**

The antithesis of this research is to imagine the impact if no supervision had taken place. This does point to the potential benefits of a control group for similar studies.

The use of CATIs as a research technique as practised in this study is worth further exploration. Where time is an increasingly precious commodity conducting of interviews over the phone, via a semi-structured format, and typing the answers directly onto the computer was useful and effective. Follow-up could be conducted via e-mail to help ensure the answers as transcribed were accurate and truly represented the views of the respondent.

In reference to the official evaluation that was conducted as part of the supervision project, psychometric measures were initially implemented but were soon rejected by the project participants as too intrusive and time-restrictive. There was a stage that there was considerable negative response and some emotional upheaval as a result of this, but to the evaluators' credit, qualitative measures were employed thereafter. The final evaluation report (Kaa 2006) was confirming of the findings of this thesis. Overall, this confirms the earlier discussion of utilising methods that support the phenomena being studied as in this research.

## **Further discussion of the findings**

What follows is a deeper discussion of the outcomes from the previous chapters outlining the findings.

### **Evolving history of social work**

The contemporaneous practice of social work supervision needs to progress so as to keep up with the current diversity of the workforce. With fewer traditional 'social worker' positions available in the workforce in Australia, many social workers are employed in organisations where their training and experience are advantageous, but used in diverse roles. The AOD field in Australia for example employs social workers in a variety of positions including counsellors, post-residential care workers, support workers and the like. Referring back to the 'literature review', reveals that the historical roots of social work supervision as early as the 18th century, broke supervision into different functions rather than a prescribed way and definition. Similarly Wistanley and White (2003) and Williams et al. (2005) in the nursing literature, listed 'common features' in what seems an expanding body of knowledge, rather than coming to a commonly held definition or way of supervising. The evolving history of understanding of supervision in social work changed with the evolving focuses of practice, need and social worker identity. Kadushin's understanding of supervision over fifteen years evolved from him being of the opinion that a universal understanding of social work supervision was an 'unlikely undertaking' (Kadushin 1985, 27) to defining the different functions of supervision (Kadushin & Harkness 2002).

### **Supervision useful for a range of roles**

The outcomes of this study show clinical supervision was a very useful process in all the roles involved, no matter their previous level of experience<sup>15</sup>. This is shown clearly by people's attachment of importance to supervision as in table 3. The many references to management in this study also prove the benefits for managers of

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<sup>15</sup> See table 2 for the spread of roles and the previous experience for respondents with supervision

engaging in supervision. This is endorsed by Hawkins and Shoheit (1989). This makes sense, especially if management are looking after people who are daily facing and dealing with such difficult and burdensome issues.

Possible solutions to the prohibitive cost point to group supervision as a genuine alternative. The Community Health Services in the Eastern Metropolitan Region of Victoria on clinical supervision (CHSEMR, 2006) proposed models to implement agency-wide supervision: formal inter-agency clinical supervision agreements; establishing a band of roving independent clinical supervisors across agencies; and having a separate internal individual clinical supervisor, who is not the line manager. These are solid recommendations. Taken into consideration is that agencies have minimal funds for paid supervision as part of their funding and service agreements. Lastly the CHSEMR propose a senior clinician model as well as the possibility of having facilitated peer group supervision facilitated by an internal or external supervisor as alternatives. All these seem possible with a thorough and ongoing exploration of the boundaries and potential issues. The proposed organisation-funded external individual clinical supervision is optimal but for now, seems unrealistic and necessitates lobbying and advocacy from workers, management and agencies.

### **Clinical supervision redefined**

In the search for a definition of supervision, although it may conjure pejorative notions, in light of this study, I wish to propose two alternatives. My proposal is based on the separation of the functions of supervision and the discovery in this study that the supportive function of supervision took precedence.

First, some of the negative views of supervision could be overcome by simply renaming clinical supervision or supervision to 'supportive supervision'. The 'clinical' nature is removed and a caring adjective that is better aligned to the caring professions replaces it. The main features of supervision remain clear in the new

term. In rewording the base definition for this study by Kavanagh, Spence, Wilson and Crow (2002), my proposed new definition looks like:

Supportive supervision is a working alliance between practitioners in which they aim to support and enhance clinical practice. Providing personal and professional support and encouragement to the supervisee is an integral part of this; as is skill development; as are fulfilling the goals of the employing organisation and meeting ethical, professional and best practice standards of the organisation.

Secondly, in light of this study, the supportive component of supervision I redefine as:

In a safe and trusting relationship with a clinical supervisor, the supportive function of supervision is the co-exploring and reflecting of a supervisee's relationship with self, with others, their organisation, their role, their personal issues, with each other and their clients. Self care, work-life balance and boundaries are integral components of this. The boundaries of which, are part of the contracting period before the supervision arrangement commences and will require intermittent ongoing reflection.

## Conclusion

In revisiting Dominica's situation, as described earlier in the preface, after some deliberation on which supervisor to choose, she chose the one she preferred. She decided that if she was take clinical supervision seriously and concertededly attempt to deal with her problems of job fatigue, working long hours and generally feeling unsupported, then the expense of supervision was manageable for now.

After twelve months of regular (fortnightly) clinical supervision with this preferred supervisor that, she feels 'converted' to the inherent benefits of it. So much so that she is advocating supervision to other colleagues. Part of this advocacy has been to organise regular group supervision, as she had heard from a recent in-depth study in a rehabilitation setting, of the particular benefits of group supervision. She felt that this was the most cost-effective and convincing way to draw others into supervision with her. She has decided to employ a clinical supervisor with AOD experience for this purpose. However, from Dominica's experience of her supervisor not really having much in the way of AOD knowledge or experience, realises that this is not so important. This supervisor has been recommended because he has the right balance of support as well as is able to get people to confront not only themselves but can carefully challenge others.

Dominica is aware that not everyone shares her positive view of supervision, including her often animated entreaties about the importance of supervision. She fully realises that it took the experience of regular supervision to realise this. There were some occasional difficult situations she had to sort through with her supervisor, but she found that discussing these thorny issues as well as the boundaries and limits of their relationship useful. As a result she intends to establish these boundaries from the outset with the incumbent group supervisor.

Dominica now comprehends that through her experience of supervision that she has limits and can only do what is possible each day. She has learnt boundaries and

does not work extra hours any more. In fact she is much more balanced in her life generally, and has increased her sporting and social activities to support her career. She feels re-invigorated for her job, and thus she has the energy to establish the extra-curricular group supervision. The client work has not got easier and she is now discussing with her manager the prospect of getting immediate debriefing support, especially after another recent violent outburst by a client. She personally cared for herself after this incident and received support from her external supervisor, but could see the impact on her colleagues and thus the weighing down upon the team of which she is an intrinsic member. What Dominica remembered was that previously a large portion of her time in supervision was getting the support she needed. It was so normalising and confirming to get someone from outside her organisation to listen to her and give objective feedback about her practice. She was also able to discuss her personal needs. This need for support has never fully diminished, and is not as much of a priority. In fact her supervision has recently been quite clinically focused, where she has been working at increasing her understanding of her favourite therapy modality. Occasionally she finds a place in supervision to discuss the ongoing problem of organisational issues.

Dominica has formed a better quality line manager- worker relationship recently and is more of a support to her manager. She has even found the courage to ask him to stop sharing negative management and organisational problems with her, so she can focus on her client work. She has been stronger at asserting boundaries since she has been in regular supervision. Cheekily, she has even talked about her experience of external supervisors and how she has heard that even some managers access this type of support. There is a constant weighing up of the cost versus how important it is to her, so she hopes the group supervision will take off. Dominica also wonders what it would be like if all the organisation was to engage in supervision, no matter their role. She is currently part of a working group in her agency to investigate and promote other models of supervision. The most likely option at this stage is reciprocal supervision with another local agency, for those interested.



This research confirms my early experience of supervision; like so many respondents, it took the experience of receiving regular supervision to fully appreciate supervision. Supervision was very beneficial for respondents on a number of fronts and this confirmed for me how important it was to access the necessary support in a field that I knew and experienced to be uniquely challenging. The matter of ongoing costs concurred with my experience also. It has taken ten years to find the most beneficial, productive and ultimately cost-effective supervision arrangement. I am yet to be employed in an organisation that provides financial support for supervision, even on a co-responsibility basis. Admittedly, witnessing the power of the large scale intervention and the benefit to the entire organisation as a whole, was something that I would loved to have experienced in one of my work settings. As described earlier in my investigations of supervision, I discovered that supervision was heralded as an integral component needed in practice for workers in the AOD field. This research verifies this momentum for supervision in the AOD workforce, as advocated by VAADA, NCETA and other Australian authors including Ask and Roche (2007).

This thesis has been an important study to add to the paucity of literature in the AOD field on supervision and its efficacy. In this thesis I have discovered that clinical supervision, as provided by external supervisors, was not only effective but had a number of significant benefits. Two key features that contributed to the outcomes of this research were that supervision was provided by external supervisors, and that it incorporated both individual and group supervision.

The effectiveness of supervision in this setting was that it reduced stress and subsequently helped people to feel affirmed and encouraged, to the extent of being happy and motivated. People in management also benefited greatly from supervision. The flow-on effect to increased worker retention, reduced absenteeism and greater esteem in work roles is now easier to comprehend.

One of the main factors directly linked to a positive experience of supervision, was having the right to choose a supervisor and that this was someone who matched respondents experience and training background. Integral to this was the focus of supervision being primarily on supervisee wellbeing rather than on client outcomes. Negative factors were cost and time, and the combination of both together. Time is needed to attend supervision, and possible travel, as well as for preparation. The cost of supervision was most apparent when respondents weighed up future supervision arrangements.

The other key features in supervision were the support that people cherished; the safe place and right to freely speak; and the supervisor's warmth, genuineness and relaxed approach. Outcomes of this study were recommendations for alternative supervision arrangements including the notion of formal inter-agency clinical supervision agreements; establishing a band of roving independent clinical supervisors across agencies; and having a separate internal individual clinical supervisor, who is not the line manager. Lobbying funding bodies or seeking funding option from alternative sources are other options. Most significantly the option of group supervision, considering the particular effectiveness in this study, is an informed and useful alternative. The consideration of a paradigm shift of supervision as being an integral part of the work rather than separate is the ultimate goal.

As to the engagement of external supervisors, it was recognised that some level of open communication between the supervisee, the external supervisor and the organisation they are employed by, with appropriate levels of confidentiality, helps to monitor and support different goals at different times and will also provide for appropriate flow-through of information.

Supervision has a reciprocal relationship with boundaries. Supervision supported clearer boundaries for roles; relationships with clients; colleagues and the workplace. Enhanced reflective practice as a benefit of supervision supported this. The concept of boundaries warrants further attention in training and other modes of workforce

development modalities. Supervision by itself is effective for a worker in their practice, yet it is necessary to understand supervision in the context of workforce development, that it needs to be complemented with training, mentoring or workplace exchanges.

Social workers in the AOD field are now placed in multi-disciplinary agencies in a wide variety of roles. Social work students and social workers may benefit from understanding the evolving nature of supervision in the light of this study, supervision needs to be adaptable to the present issues of the workplace but also the evolving roles of a social worker. There is a need for AOD subjects in social work curricula, and social workers would well consider ongoing regular supervision after their training, if they were to gain employment in the AOD field.

Supervision that is designed to meet the specific needs of the AOD workforce is an important step forward. It demands that a supervisor is aware that the supportive component is a prime need; acceptance and understanding of the unique nature of the AOD field; awareness of the potential for vicarious trauma; knowledge of boundaries; flexibility in approach and focus; clarity about what does and does not constitute supervision; regular contact as integral to a beneficial experience; and an awareness that the one supervisor seeing people from the same team may have its' difficulties and perhaps should be avoided. Separation of the boundaries of other supports, such as the need for critical incident debriefing, is also to be considered. The skill set for clinical supervisors is a universal one and interestingly, it was discovered that a supervisor does not necessarily need AOD knowledge to be an effective supervisor in this setting.

Supportive supervision, the term proposed in this thesis, deals with the confusing semantics of clinical supervision. The apprehension that clinical supervision evoked and the misunderstanding of the term, was common in this study, and was also a problem in the literature. The flexible and regular provision of supportive supervision,

as specific to the AOD field is essential for the well being of workers, and ultimately to the clients they work with.

The social work separation of supervision functions also helps the confusion of misunderstanding clinical supervision. The separation of the administrative function of supervision enabled external supervisors to provide safety with an objective viewpoint. The other benefits of external supervisors, was that they were skilled listeners who attended to the respondents high need for support and enabled direct conversation among each other that helped effect change. The separation of functions also supported people in increased role clarification. Managers particularly benefitted, and were able to provide a better quality and clearer form of line management to their staff, as the clinical areas were adequately being cared for.

For those new to supervision, the regularity of the supervision received was instrumental in eventually feeling 'converted' to the need for ongoing supervision. Indeed, the regularity was a necessary ingredient. For all respondents, the theme of self-care and asserting their boundaries was paramount to their changing the way they practised, especially to not over-work. This resulted in a positive change of feeling energised in their work and roles.

Respondents in this study considered supervision to be so important as to be mandatory or at least strongly encouraged. Identified in the literature were other bodies and authors that either mandated ongoing clinical supervision such as the BACP or encouraged the concept (Laufer 2005). Mandatory supervision from external supervisors in light of this study necessitates that there are accompanying funds. I encourage a middle line, where the importance and effectiveness of supervision is taken into account, as is the knowledge that it takes the experience of supervision for many to appreciate this. The first steps are to consider the concept of supportive supervision and to encourage the different models of supervision, especially group supervision. This will incorporate the fact that AOD workers need a customised form of supervision. The next step is to explore funding options. The

need to clarify the boundaries of what is supervision and what are other elements of workforce development or avenues of support, such as critical incident debriefing are necessary. The bottom line is that AOD workers need regular support and work in a unique and challenging field. Supportive (or clinical) supervision is an effective practice that will be of significant benefit.

## **Appendix A: Research Invitation**

## **Research Invitation**

**Project Title :**

***‘Clinical’ Supervision in Alcohol and Other Drugs Settings: Is it Effective and What are Issues Particular to this Setting? Towards Developing a Model.***

Dear \_\_\_\_\_,

My name is Marcel Koper and I am an Alcohol and Other Drug Counsellor currently completing my Master of Social Work Degree by Research Thesis.

I am writing to you to seek your participation in completing a series of 3 interviews with me that would most likely take around 40-60 minutes each to complete. Included in the initial interview, I would also be grateful if you could complete a brief questionnaire with around 10 questions that would relate to the interview topics. I anticipate that the questionnaire will require about 10 minutes to complete.

I will include a brief explanation of both the interview and questionnaire process. So taking this into consideration the first interview may take maximum 65 minutes and the ensuing interviews between 40-60 minutes. Overall throughout the course of the project I anticipate that the overall time commitment would total approximately 3 hours of your time.

If you decide to participate in the Research, I will provide a clear Consent form and Confidentiality Agreement as per the RMIT University protocols and standards regarding research involving participants.

### **About the Project :**

The aim of the research is to examine and explore the impact of the ‘clinical’ supervision you may or may not choose to receive. It will also be a platform to provide valuable feedback for the overall project especially if changes need to be made. Supervision issues particular to this field are also hoped to be identified.

The research aims to identify and explore existing models of supervision in the alcohol and other drug sector. It also aims to provide recommendations for an appropriate model of supervision for this sector. Wider exploration will include a literature review on supervision in Social Work literature, psychotherapy literature, and other related social science and health disciplines.

My contact details are as follows :

**Mobile** : 0408 427 939

**E-mail** : S3112034@student.rmit.edu.au

Thank-you for taking the time to consider my request and I look forward to hearing from you.

Yours Sincerely,

Marcel Koper  
Aod Counsellor  
M.S.W. Candidate (RMIT University)



## **Appendix B: Plain Language Statement**

**Design and Social Context Portfolio**  
School of Social Science and Planning

**Plain Language Statement to be used in a research project involving human participation**

**Project Title : *'Clinical' Supervision in Alcohol and Other Drugs Settings: Is it Effective and What are Issues Particular to this Setting? Towards Developing a Model.***

Dear .....

My name is **Marcel Koper** and I am undertaking a Master of Social Work Degree by Research Thesis at RMIT University.

The aim of the research I am undertaking is to examine and explore the impact of the 'clinical' supervision. An examination of the factors associated with both the difficulties and/or benefits of clinical supervision as well as identifying supervision issues particular to the Alcohol and Other Drug (AOD) sector. Your participation may also be a platform to provide valuable feedback for the overall project especially if changes need to be made. This is a unique project in the AOD sector, particularly because supervision and associated research has been hardly done.

I am approaching you to participate in this research by being either one of ten interviewees or to be a member of a focus group (but not both). Participation is purely voluntary. You may freely withdraw from this process at any stage and request to withdraw any unprocessed data.

The 10 potential interviewees will be interviewed pre-project, mid-project and post project, making for a total of 30 interviews. Included in the initial interview will be a brief questionnaire. This series of 3 interviews with me would most likely take around 40-60 minutes each to complete. The questionnaire will take around 10 minutes to complete consisting of questions that would relate to the interview topics. Questions in the interview will be open-ended and will not be aimed at collecting personal or identifying information.

Focus groups of up to 8 other participants, not included in the interview group, are also being sought. They will be involved in a series of 4 group meetings running for an hour each, so a total of 4 hours will be required at 5 week intervals during the period of the project.

All documentation and data will be kept secure for a period of 5 years and only accessible by me. No detailed personal information will be recorded.

Thank-you for taking the time to consider my request and I look forward to hearing from you. If you have any questions do not hesitate to contact me. My Master of Social Work supervisor is Dr. Jenny Martin ([jenny.martin@rmit.edu.au](mailto:jenny.martin@rmit.edu.au) or 9925 3131). My contact details are as follows:

**Mobile** : 0408 427 939

**E-mail** : S3112034@student.rmit.edu.au

Yours Sincerely,

**Marcel Koper**

AOD Counsellor (Grad Dip. Social Science (Gestalt Therapy))

M.S.W. Candidate (RMIT University)

Any complaints about your participation in this project may be directed to the Secretary, RMIT Human Research Ethics Committee, University Secretariat, RMIT, GPO Box 2476V, Melbourne, 3001. The telephone number is (03) 9925 1745. Details of the complaints procedure are available from: [www.rmit.edu.au/council/hrec](http://www.rmit.edu.au/council/hrec)

## **Appendix C: RMIT Human research ethics consent form**

# RMIT HUMAN RESEARCH ETHICS COMMITTEE

Prescribed Consent Form For Persons Participating In Research Projects Involving Interviews, Questionnaires, Focus Groups or Disclosure of Personal Information

PORTFOLIO OF  
SCHOOL/CENTRE OF

**Design and Social Context**  
**School of Social Science and Planning**

Name of participant:

Project Title:

**Clinical' Supervision in Alcohol and Other Drugs Settings: Is it Effective and What are Issues Particular to this Setting? Towards Developing a Model.**

Name(s) of investigators: (1)

**Marcel Koper**

Phone:

**0408 427 939**

(2)

Phone:

1. I have received a statement explaining the interview/questionnaire involved in this project.
2. I consent to participate in the above project, the particulars of which - including details of the interviews or questionnaires - have been explained to me.
3. I authorise the investigator or his or her assistant to interview me or administer a questionnaire.
4. I give my permission to be audio taped  Yes  No
5. I give my permission for my name or identity to be used  Yes  No
6. I acknowledge that:
  - (a) Having read the Plain Language Statement, I agree to the general purpose, methods and demands of the study.
  - (b) I have been informed that I am free to withdraw from the project at any time and to withdraw any unprocessed data previously supplied.
  - (c) The project is for the purpose of research and/or teaching. It may not be of direct benefit to me.
  - (d) The privacy of the information I provide will be safeguarded. However should information of a private nature need to be disclosed for moral, clinical or legal reasons, I will be given an opportunity to negotiate the terms of this disclosure.
  - (e) The security of the research data is assured during and after completion of the study. The data collected during the study may be published and the project outcomes will be presented in my Masters thesis with copies available in the RMIT library. I may also present the findings at relevant workshops and conferences and in scholarly publications. Any information which may be used to identify me will not be used unless I have given my permission (see point 5).

## Participant's Consent

Name:

\_\_\_\_\_  
(Participant)

Date:

\_\_\_\_\_

Name:

\_\_\_\_\_  
(Witness to signature)

Date:

\_\_\_\_\_

Any complaints about your participation in this project may be directed to the Secretary, RMIT Human Research Ethics Committee, University Secretariat, RMIT, GPO Box 2476V, Melbourne, 3001. The telephone number is (03) 9925 1745.  
Details of the complaints procedure are available from : [www.rmit.edu.au/council/hrec](http://www.rmit.edu.au/council/hrec)

## **Appendix D: Mid-way point feedback to the Basin Centre**

## Synthesised summary of participants feedback (Interviewees and focus group)

### Summary of mid-way interviews

#### **Preamble**

This is a synthesized summary from all the mid-way mark interviews and the participants' focus group. Of those involved, four out of 10 interviewees have had no previous experience of clinical supervision. One original participant has since resigned. Three of the 6 members of the focus group (f.g. from here on) have had no previous experience of supervision. I have purposely not collated this feedback in any order of interview nor from working area purposely to de-identify the feedback as best as possible. Whilst slightly different in its interactive style the focus group generally followed a similar line of questioning.

#### **Overview**

Overall the reported experience from everyone was extremely positive, with one exception, whom did not have a negative criticism of supervision per se but felt that there was not much to say. It was suggested to this person to possibly try and engage with another supervisor. People reported a range of feedback from feeling that supervision was encouraging and empowering right to not being able to understand how they will be without it. People reported the supervision affecting their way of thinking about their work, in relation to ethical issues, gaining clarity, right to how they discussed personal matters and supervision affecting their home lives; all quite positive and beneficial. The particular importance of group supervision and its impact was also elucidated. Organisationally people felt as though it was helping to get their act together. In the course of the feedback, where I have been summarizing and it is not direct participant feedback, that part will commence with an \*.

#### **Benefits**

\*The benefits of the supervision were summarized in the following categories (beginning with the most reported and then down- please remember this is about what was reported and is not intended to devalue the beneficial items mentioned least. I have chosen a brief comment most pertinent to the category):

- **Debrief/ offload/ personal support:** the safety of the supervisory relationship and the place of positive feedback as well as debrief.
- **Organisation benefits:** Self-care being encouraged, people looking out for each other, changing of entrenched patterns and more
- **Better working styles/ greater confidence in work**
- **Personal insight/ self care:** getting my needs met
- **Team Benefits:** connectedness in teams, greater trust and honesty
- **Benefits outside of work:** has helped relationships at home and home space
- **Self reflective practice/ place to explore/ slow down:** The whole organisation has stepped back and asked if we can do things more effectively and differently
- **Boundaries:** including not taking on other peoples problems

- **Clinical work/ client work:** Been able to take incidences and really unpack them
- **Impact on residents (Clients):** Clients have been noticing. Important that clients see that the workers need support and care also- good modelling- humanising.
- **Financial benefits;** do not have to pay for this
- **Communication issues:** better communication and team work. \*The focus group highlighted also how the sheer geography of the place makes it difficult to communicate

\***The particular benefit of Group Supervision** was often referred to being a place where people could be straight and honest, and a place to notice other peoples work and a real driver of discussion and support. Such a hairy issue as a perceived felt difference between those who are “ex-users” and those that are not was raised as a result of this greater freedom.

### **Difficulties** (same process as for benefits)

- **Time restraints and time related issues:** when supervision occurs, hard to get there, extra thing to fit in an all ready full program.
- **People not seeing the value/ unsure at beginning:** what am I going to talk about? Felt like a guinea pig.
- **Over emphasis of importance of supervision:** not useful for everyone
- **Unhelpful to team dynamic/ other team issues:** I felt in the wrong place in group supervision
- **Raised issues and tensions:** Has raised issues, not all rosy. Caused the post- resi team to be unsettled.
- **Issue of people going to the same supervisor:** makes me bracket what I say
- **Lack of role understanding/ role issues;** changed the role of my job- do not like it
- **The term and concept of supervision:** Who supervises the supervisors and so on. Is this a term taken from counselling where so many previously have gone without it?

### **Factors associated with supervisor/ supervision process**

For the following I will list in no set order of mentioned importance.

- **Gender Important-** for 6 out of 10. Age specific issues important.
- **Supervisor, supervisee match.-** good connection
- **Choice of supervisor:** choice was important
- **Warmth/ non-judgemental attitude/ genuine interest-**Someone impartial and interested in me and the issue I present and not just the emotionality.
- **Someone with greater experience-**Have felt trained by my supervisor
- **Someone with Aod or residential experience:** \*especially for those with no experience in this area but otherwise not that important but more helpful.

- **Listening skills/ empathy/rapport:** Just good listening skills- listened very closely. Feel validated.
- **Confirming and affirming/ normalizing:** Normalising- helps get things into perspective
- **Personal sharing from supervisor**
- **Particular philosophical/ therapeutic leaning**
- **Spirituality insight important**
- **Place, time and regularity:** \*Was a particular issue of the f.g. Many groups changed their group s.v. from 6 weekly to three weekly. Some preferred on site and others equally off- site.

**Impact of having external supervisors:** F.g: fantastic- unanimous.

- **Safety and trust ;**Definitely would not be talking about this same material with an internal supervisor
- **Objectivity/ impartiality:** Provides fresh eyes and more objective feedback, genuinely asking, “Why are you doing that?”
- **Impact on life outside work:** Supervisor became my ‘debriefier’ instead of my husband
- **Communication benefits;** Has helped the internal communication
- **Impact on culture of overwork/ self care:** my supervisor has seen a few workers and thus has seen the impact of the overworking culture
- **Difficulties/ uncertainties:** Needs to be a performance component- unsure whether an external supervisor can provide this.
- **Line management supervision benefits:** Has helped the problematic issue of people being line manager and clinical supervisors together

## **Role Clarification**

\*Both the f.g and the interviewees were similar in their feedback here. People are being more supportive and there is more support on your work role.

### **Issues**

- Restructuring in the organization has happened as a result of the supervision where previously roles and boundaries have not been clear enough. The issue of “Where does my role stop and start?” was raised a few times
- In the past people have had to wear different hats and change roles- difficulties for relating with each other as well as how clients perceive and understand people
- \*People describing how the role change has been difficult

### **Benefits**

- \*People described feeling clearer and more supported in their roles and for a few has helped sort out where they were in the Organization.
- Helped to see individuals within teams

### **External supervision impact on roles**



- \*Whilst there was a reported no change to line management structure there was a feeling that management were more management and workers now felt the confidence to ask for help with definition of their roles.
- People more supportive overall

**\*Aod Specificity:**

- Overall the exploration of Aod issues was not highly important, but that the supervisor need have some Aod experience and knowledge.
- Understanding of rehab work and therapeutic community living seemed a bit more important. 6 of the 10 participants mentioned that there was little if any Aod specific or related issues raised.

**\*Did not expect/ other outcomes**

- People did not expect to restructure and felt that the reflective process is raising the issues that need addressing. Ongoing budgetary restraints were also highlighted in how “we have been running on a shoestring budget for so long”. Some people also reported feeling like they had more structured time now.
- The f.g made particular reference to the need for uniformity with policy and procedure and consistency around the way people work.

**Recommendations/ Suggestions/ concerns and thoughts/ feelings on what to do when the project ends.**

- \*Feelings such as “I have just bonded and really love this- I really hope something comes as a result of the actual project to prolong this” but without greater suggestion were common. No suggestions were really given.
- Worried about staff who have not been able to maximise this opportunity but accept that some people do not see the need for this.
- Could something have been done at the beginning of the project to ensure people felt more comfortable with the notion and concept of supervision?
- Raise the question: How often does each group need to meet? How often does individual supervision really need to happen? Differing opinions between the f.g and the interviewee. Regularity and ongoing need were a strong highlight of the f.g.
- Worried that the positive impact of supervision, when project ends may just go back to old ways. Universal feel from f.g that something needs to continue. A suggestion that the focus group gets together to help problem solve all of this
- At the end everyone needs to get a report
- Hope that someone finds the funding

## **Appendix E: Final questionnaire for respondents**

**Final questionnaire for the clinical supervision project**    Name:

***General Overview Question***

1. a. Can you please comment on your overall experience of clinical supervision throughout this project. How was it for you?

2. Has the clinical supervision you received impacted upon you and your work?

Yes

No

Unsure

Why/How?

2b) upon your team?

Yes

No

Unsure

Why/how?

2c) and the organisation?

Yes

No

Unsure

How/why?

3. Did you experience any benefits from this clinical supervision experience? If so what were they?

4. Did you experience any difficulties with this clinical supervision experience? If so what were they?

5a. Did the clinical supervision you received impact upon your work with clients? If so, how? If not why? Any reported feedback this way?

5b. How else has your experience of clinical supervision impacted upon you?

- Stress levels
- Motivation at work (or motivation to work)
- Happier at work
- Greater sense of meaning in job
- Competence
- Feel more supported and encouraged
- Clarity of role
- Others...

6. What were the factors that were most important to your experience of clinical supervision to date? Why? What was most important?

- ***Gender***
- **Supervisor, supervisee match.**
- ***Choice of supervisor:***
- ***Warmth / genuine interest:***
- ***Non-judgmental attitude:***
- ***Someone with greater experience***
- ***Someone with Aod or residential experience***
- ***Listening skills/ empathy/rapport***
- ***Confirming and affirming/ normalizing***
- ***Personal sharing from supervisor***
- ***Particular philosophical/ therapeutic leaning***
- ***Spirituality insight***
- ***Place, time and regularity***
- ***Others:***

7. Has there been any drug and alcohol specific issues (what are they?) discussed in clinical supervision and how important has this been in the provision of supervision?

8. a) What has the impact of having external clinical supervisors been? Benefits.



8 b) Difficulties associated with external clinical supervisors.

9) What has the impact been in respect to your administrative supervision arrangements? E.g. you line manager

10. Do you think clinical supervision should be mandatory? Why?

Yes

No

Unsure

11. Have you noticed any other outcomes? Those that you anticipated or did not anticipate?

12. What do you think you will do when the project finishes in respect to clinical supervision? E.g Carry on out of own pocket

13. Other questions as they arise.....(e.g. How important has supervision been in respect to other workforce development issues such as training, etc)

## **Appendix F. Final questionnaire for supervisors**

## **Questions for supervisors Focus Group – final Dec 2005**

1. a. Can you please comment on your overall experience of provision of clinical supervision in this project to date? How did it go?

2. What do you think/feel have been benefits from this clinical supervision experience for the Basin Farm?  
a) individually (i.e for individuals)

2b) upon the teams?

2c) and the organisation (as a whole)?

3. What do you think/feel have been the difficulties from this supervision experience for the Basin Farm?

a) individually (i.e for individuals)?

3b) For the teams?

3c) and the organisation?

4. What do think/feel have been the important factors in the experience of supervision throughout the project? Why?

- ***Gender***
- **Supervisor, supervisee match.**
- ***Choice of supervisor:***
- ***Warmth / genuine interest:***
- ***Non-judgmental attitude:***
- ***Someone with greater experience***
- ***Someone with Aod or residential experience***



- *Listening skills/ empathy/rapport*
- *Confirming and affirming/ normalizing*
- *Personal sharing from supervisor*
- *Particular philosophical/ therapeutic leaning*
- *Spirituality insight*
- *Place, time and regularity*
- *Others:*

5. a) Has there been any drug and alcohol specific issues (what are they?) discussed in supervision? How important has this been?

5b) Has this been important in the provision of supervision? Why/ why not?

5c) Please comment on any other themes or issues in the provision of supervision?  
(e.g client focus vs. worker focus, self care, role clarification etc)

6. a) What has been your experience with 'new to supervision' supervisees?

6b) Has there been a noticeable impact on them?

Yes

No

Please explain

7a) What have you noticed with those that are more experienced with supervision?

7b) Has there been a noticeable impact?

Yes

No

Please explain

8a) Did you notice any change in your supervisees in the following areas? Any other observations?

- Stress levels
- Motivation at work (or motivation to work)
- Happier at work
- Greater sense of meaning in job
- Competence
- Feel more supported and encouraged
- Clarity of role
- Others...

8b) Was there any reported changes in work with clients or in respect to client outcomes?

Yes

No

Please explain...

9 Have you noticed any other outcomes?

a) anticipated

9b) Not anticipated?

10. a) What do you think has been the impact of being external supervisors?

11. What are your thoughts now that the clinical supervision project has ended? Has there been any pledge to continue on with you in clinical supervision or reports of other arrangements?

12. Other questions as they arise...



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