A Study on the:

Supervision Needs of Multi Disciplinary Teams in Outpatient Mental Health Programs in Northwestern Ontario

by

Denise Cronin - Forsyth

A Thesis

Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements

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A Study on the: Supervision Needs of Multi Disciplinary Teams in Outpatient Mental Health Programs in Northwestern Ontario

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ABSTRACT

The central research question for this thesis is: What are the supervisory needs of front line staff from the perspective of members of multi disciplinary teams in Northwestern Ontario. The objectives of this research are 1.) to determine the process of supervision in multi disciplinary teams; 2.) to determine what works well in the supervisory process of multi disciplinary teams; 3.) to determine what does not work well in the supervisory process of multi disciplinary teams; and 4.) to provide recommendations that could enhance the supervisory process for members of multi disciplinary teams.

Qualitative research methodology in the form of in depth interviews with 14 front line mental health workers was used to collect data. The specific method of inquiry was a modified phenomenological study. Participants were asked to share their experiences of supervision in the context of multi disciplinary teams in adult mental health programs. Almost all respondents saw value in having didactic supervision with their supervisor, however for many this was not their reality. Front line staff, commented on the merit of one on one supervision, staff evaluations, trusting supervisory relationships, the importance of peer supervision and a formalized debriefing process. In the absence of traditional supervisory processes many of those interviewed found creative ways to get their supervisory needs met including the use of technology.

This thesis reports on issues pertaining to professional identity in the context of multi disciplinary teams. Several front line staff discuss the erosion of their professional identity as they became immersed in their role as therapist. My research also offers insights into these workers experiences as it pertains to implications for social work practice, policy and education.

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CHAPTER 1

INTRODUCTION

1.1 Rationale

The goal of this research is to complete a qualitative research study on the supervisory needs of multi disciplinary teams in outpatient adult mental health programs in Northwestern Ontario. My interest in doing research in this area is a result of numerous changes I have experienced as a social worker in a hospital setting in Northwestern Ontario. During the past six years I have witnessed the abolishment of our social work department. I once had a social work supervisor and for the past five years my supervisor has been a nurse. I have seen inpatient services converted to outpatient services, and the development of new multi disciplinary teams to implement what once were hospital based services.

From my experiences, these changes have meant that multiple disciplines are now being supervised by the same person or that members of the same discipline are being supervised by an individual of a different profession. Many of these front line managers are not knowledgeable or trained for the complexities of other disciplines. This speaks to the need for an increased understanding of the supervision of multi disciplinary teams, specifically, how the supervision needs of front line staff are being met. Shulman's (1993, p.22) research findings indicate that workers are satisfied with their supervisor when feedback on skills is obtained, when time is spent with the

supervisor on practice skills and when the supervisor is accessible to the worker. Shulman's research findings are not indicative of the current supervision trends in the health care sector. I will discuss and provide examples of this in the literature review.

The proliferation of community based adult mental health programs in Ontario has placed much emphasis on the role of multi disciplinary teams to deliver adult mental health services. The development of these new programs is changing the manner in which services are delivered and the way front line staff are supervised. These current changes do have serious practice implications for social workers. One of the most pertinent of these implications is how the supervisory function is fulfilled in the context of multi - disciplinary teams. Specific practice implications include:

a. Limited clinical instruction or the contracting out of this supervisory function (Baxter, 1993; Duffield, 1994; Read & Gehrs, 1997);
b. Greater emphasis on professional staff to develop clinical expertise without supervisory instruction (Bueno,1991b,8; Bradford & Cohen, 1994 cited in Asian, 1996,19);
c. Social worker and supervisor having a different theoretical knowledge base (Read & Gehrs,1997,17);
d. Limited professional mentoring (Levin & Herbert,1999, 30, & Farley,1994,211);
e. Loss of social work positions (Levin & Herbert, 1999,30);
f. Assimilation of professional roles (Read & Gehrs,1997, 16).

Ferguson - Pare (1992), Roehlke (1991), and Shulman (1993) all found that professional competency was positively correlated to a worker's satisfaction with their supervisor. Professional competency included practice skills and clinical expertise. Other researchers have argued that clinical expertise is no longer required because professionals can manage themselves and that clinical expertise is no longer required by the supervisor/first line manager (Buena, 1991b, 8; Baxter,1993; Duffield ,1994).

1.2 Researcher sketch

Throughout my undergraduate career as a social work student, I was indulged with scheduled weekly supervision. This was a learning experience; I was the sponge absorbing the theories and skills of the profession. When I began my career in child welfare, the weekly supervision initially continued. This regularly scheduled one to one supervision was the hallmark of my working experience. As my skills and comprehension of the child and family service legislation matured, this regularly scheduled time continued but the frequency decreased. My supervisor in this context had expertise in the field of child welfare and in her role as supervisor. She was knowledgeable, validating, supportive, accessible, and willing to provide feedback.

My own experiences as a supervisor goes back to the early 90's when I supervised two residential programs. One of these programs was a group home for teenage girls while the other was a group home for individuals with developmental disabilities. As a supervisor in these contexts I adhered to a similar framework in providing supervision. My past experiences had taught me the value of one to one scheduled supervision recognizing the changing needs of the staff as they matured in their positions. This knowledge of supervision was augmented with readings I had completed on traditional supervision frameworks and a graduate studies course on supervision.

My experiences working as a psychiatric social worker in an acute care inpatient psychiatric unit has challenged my supervisory frame of reference. I no longer have a supervisor, I have a manager. When I first began my position, I belonged to a social work department with a social worker as my immediate manager. Scheduled one to one time was infrequent. Staff meetings did

occur every two weeks with the social work team which included the discharge planner (who was a nurse), the native service technician, two psychiatric social workers, one medical social worker and our manager. The main points of discussion were administrative issues, upcoming events, training opportunities, and on occasion case reviews. The role of my manager appeared to be primarily administrative because along with managing the social work department, he was also responsible for two outpatient programs. Approximately eight months into this job the social work department was abolished. My new manager was a nurse who placed a greater emphasis on the inpatient acute care team which consisted of nursing, occupational therapy, psychiatry and social work. This was and continues to be a unique experience. The team meets Monday to Friday everyday in the morning to address the clinical needs of the patient. This is the formal means by which clinical feedback is obtained. One to one supervision with a member of the same discipline is non existent and this has been my experience for five and a half years. For supervision within my own discipline I rely on peers whom I trust. This may include the other psychiatric social worker on our team, the social workers in our outpatient mental health programs, or other social workers in community programs.

1.3 The political landscape in the health care sector

Baumann et al. (1996) state that downsizing constitutes a number of activities implemented by the management of the organization designed to enhance organizational productivity, efficiency, and effectiveness. It represents a strategy undertaken by administrators that effects the size of an organization's work force and the work processes used (Freeman and Cameron, 1996, 11). The recessionary period in the 1990's has resulted in dramatic changes in public sector strategic

planning and an increased need to implement cost cutting measures (Baumann et al., 1996, 5). Changes reflecting restructuring of the health care system include converting inpatient service to outpatient service, decreasing length of hospital stay and merging hospital departments (Baumann, et al., 1996, 6). In their efforts to cut costs, hospital administrators have expanded the scope of responsibility of first line managers (Acorn and Crawford, 1996, 26).

These cutbacks and the merging of hospital departments and in some instances other hospitals have translated into a shift from a vertical organizational structure to a horizontal one that places enormous responsibility on the first line manager (Skelton - Green and Sing - Sunner,1997,90). Included in this added responsibility is the supervision of multi disciplinary teams. These increased responsibilities also include supervising more than one unit, supervising staff from a variety of disciplines, and participating in hospital wide strategic planning, goal setting, and planning for effective and efficient use of human, financial and material resources (Mark cited in Acorn and Crawford, 1996, 26).

Borellino (1995) states that Canadian provincial politicians and bureaucrats have this country's health care system primed for major retooling. Fiscal necessities are forcing restructuring that has resulted in "... budget cuts, new funding techniques, and the closure of beds and entire facilities" (Borsellino, 1995, 24). In Alberta, "... chronic under funding is straining Alberta's ability to meet the needs and expectations of the citizens for quality care" (Anderson, 1998, 7). Concern about the Canadian government's reform plan of the health care system has been expressed by professionals and consumers of services in all the provinces. Despite these concerns, the

restructuring process continues (Borsellino, 1995).

Coupled under the umbrella of the restructuring of the health care system in Ontario, is mental health reform (MHR). This reform process is characterized by the closure of provincial psychiatric hospitals, the relocation of tertiary care centres, and a shift from institutional support to community based living with an increased reliance on adult mental health programs (Flemming & Parson, 1998,22). The core of mental health reform is to provide and develop a health care design "... which places consumer services and family members at the centre of the system" (Flemming & Parsons, 1998,22). A second belief that the Ontario provincial government advocates regarding mental health reform is that it will "...create a comprehensive and coordinated cost effective system of services" (Gangji,1995, 10). Much concern and ambivalence have been expressed by social workers regarding the implications of mental health reform and the sustaining power of community based agencies. This concern is founded on experiences from past Ontario provincial government initiatives that failed to produce adequate community based services after a significant restructuring process (Gangji, 1995,10). Social workers believe that if mental health reform is to be successful, "...comprehensive restructuring needs to support inpatient and outpatient services and be available throughout the region, enabling easy accessibility to services by all individuals"(Flemming and Parsons 1998, 23).

This current mental health reform relies heavily on community adult mental health programs. New programs and positions have been developed including the assertive community treatment teams (ACT), case management positions, and court diversion programs. With the

proliferation of new community based programs there is also a recognition of the increase in services provided by multi disciplinary teams. This literature review will cover the management of multi disciplinary teams in the health care system , and explore models of supervision within multi disciplinary settings.

1.4 Theoretical framework

Supervision theory presented in the literature review provides the framework that underlies this research. Traditional supervision models are presented and discussed. As well, newer supervision models that challenge the traditional frameworks are also presented. The main themes that emerge from the literature include:

a. the complimentary functions of educational, administrative, and supportive supervision described by Kadushin (1992);

b. Shulman's (1993) interactional perspective that conceptualizes the worker constantly interacting with other systems;

c. the first line manager's main function being to encourage effective task performance (Bunker & Wijnberg, 1998);

d. the changing scope and role of the first line manager (Acorn & Crawford, 1996 McGillas - Hall & Donner,1997 Flarey 1996, Pabst, 1991);

e. belief that clinical expertise is no longer relevant to the first line manager role (Duffield et al 1994; Bueno, 1991b; Baxter, 1993).

1.5 Research Questions and Methodology

The central research question for this thesis is the following: what are the supervision needs of front line staff from the perspective of members of multi disciplinary teams in outpatient mental health programs in Northwestern Ontario? The objectives of this research consist of: 1.) to determine the process of supervision in the context of multi - disciplinary teams 2.) to determine what works well in the supervisory process of multi disciplinary teams 3.) to determine what does not work well in the supervisory process of multi disciplinary teams 4.) to provide recommendations that could enhance the supervisory process for members of multi disciplinary teams.

A qualitative research paradigm was used because it is most compatible with my research goal and objectives. The participants in this study are all members of multi disciplinary teams and are employed by adult mental health programs in Northwestern Ontario. Face to face interviews were conducted with front line staff in order to obtain data from their perspective. I then analysed the data and documented my findings.

1.6 Contribution to the research

It is my intent that this research will be of benefit to front line staff and their managers in the health care field. Limited research currently exists in Canada on the supervision needs of multi disciplinary teams in outpatient health care (Duffield,1994, 30 & Acorn,1996,26). My hope is that this research can contribute to the current literature and provide some concrete recommendations that will help improve current practices.

1.7 Organization of thesis

The format of my thesis was adopted from Pauch (1996). Chapter two, presents a comprehensive literature review which provides the theoretical framework for my research. It offers the reader an understanding of traditional supervision models and how these models are being challenged by changes to the health care system.

Chapter three, describes the methodology used to explore my research topic. It includes the rationale for using qualitative research and phenomenology as a method of inquiry. Processes of data collection and analysis are explained.

The next chapter presents the findings of my research. In keeping with the phenomenological method of inquiry, these finding are rich in context and description embodying the essence of the participants' experiences.

Chapter five is the discussion chapter where my findings are compared to the current literature on this subject. Finally, chapter six highlights the implications of my findings for social workers and presents options for further inquiry on this topic.

CHAPTER 11

REVIEW OF THE LITERATURE

2.1 Supervision theory – A social work perspective

In providing a comprehensive definition of social work supervision, Kadushin (1992) states that it is beneficial to review five considerations that contribute to a comprehensive definition. "These include 1) the functions of supervision 2) the objectives of supervision 3) the hierarchical position of supervision 4)supervision as an indirect service and 5) the interactional process of supervision (Kadushin, 1992,19).

The complementary functions of the supervisory process as described by Kadushin (1992) include the administrative function, the educational function , and the supportive function. The administrative function is " ... concerned with the correct, effective, and appropriate implementation of agency policies and procedures ..." (Kadushin 1992,20). Educational supervision deals with sharing clinical information on social work theory and knowledge (Kadushin, 1992, 19; Middleman & Rhodes,1985,4). The primary focus of supportive supervision is to enhance worker morale and job satisfaction (Kadushin, 1992,20).

The short and long term objectives of each of these supervision functions include the following:

Administrative Function	a) Provides a context to the workplace that enables work to get completed effectively.
Educational Function	a) Assists workers with improving their capabilities that in turn will enable workers to be more effective. b) Assists workers to grow and develop professionally. c) Assists workers with maximizing their clinical knowledge so they can do their job more autonomously and independently.
Supportive Function	a) Enables workers to feel good about their job performance and the work being done.

(Kadushin,1992,20).

By accomplishing these short term objectives, the long range objective is then achieved: to "...effectively and efficiently provide clients with the particular service the particular agency is mandated to offer. The ultimate objective is, then efficient and effective social work services to clients" (Kadushin 1992,20).

The hierarchical position of the supervisor assists in defining the process of supervision. "The supervisor is responsible for the performance of the direct service workers and is accountable

to the administrative directors" (Kadushin,1992, 21). The supervisor is therefore a middle management position.

The indirect aspect of supervision encompasses the belief that supervisors provide service to the client through the worker (Kadushin,1992, 22). Through the supervisory process, supervisors review client cases, assess the skills required by the worker to meet the client's needs, and strive to ensure that quality service is provided (Kadushin,1992,22).

The interactive process of supervision is defined in the context of a relationship between supervisor and worker (Kadushin, 1992,22 ; Shulman,1993,11). This relationship is an interlocking social system that "... at its best, is cooperative, democratic, participatory, mutual, respectful, and open" (Kadushin,1992,22). A definition of supervision encompasses the five principles previously discussed. In fulfilling the responsibilities of the supervisory role Kadushin states:

> ... a social work supervisor is an agency administrative-staff member to whom authority is delegated to direct, coordinate, enhance, and evaluate on-the-job performance of the supervisees for whose work he is held accountable. In implementing this responsibility, the supervisor performs administrative, educational, and supportive function's in interaction with the supervisees in the context of a positive relationship. The supervisor's ultimate objective is to deliver to agency clients the best possible service, both quantitatively and qualitatively, in accordance with agency policies and procedures. Supervisors do not directly offer service to the client, but they do indirectly affect the level of service offered through their impact on the direct service supervisees (Kadushin, 1992,23).

Shulman (1993) concurs with Kadushin on the three primary supervisory functions. However, Shulman (1993) builds on this framework by discussing in more detail the interactional aspects of the supervisory process. The interactional supervision model conceptualizes workers as constantly interacting with a number of systems that are directly related to their job (Shulman,1993,15). Workers can be called on at any given time to be involved in these systems (Shulman,1993,15). This model implies that the interactions experienced by workers are always reciprocal (Slulman,1993,16). In other words, as workers interact with other systems, these systems interact with the workers, forming reciprocal relationships.

"Supervision is a key process in social work. Skilled supervisors are responsible for the protection of clients, for the advancement of social work practice, and for the professional development of the individual worker" (Goldstein,1993 cited in Shulman,1993,ix). Through the process of supervision, social workers are taught new technologies to assist them in providing quality service. It is also in this process that gaps in a social worker's knowledge can be identified and provision made to ensure professional growth and development.

Bunker and Wijnberg (1988) describe three guiding assumptions regarding the supervisory process. Firstly, they state that the main function of the first line supervisor is to "... promote and enable the effective task performance of professional workers in providing appropriate services to clients" (Bunker & Wijnberg,1988,45). Secondly they advocate that professional work in the human services is characterized by complexity, high uncertainty and systemic interdependence (Bunker & Wijnberg,1988,45). By this they are referring to the demanding and often problematic nature of the

work performed. Often in social work, so much of the work is beyond the control of the clinician (Bunker & Wijnberg, 1988,46). For example, clients may not always comply with homework assignments or they may participate in self defeating behaviours.

Thirdly, in the human services field, supervision usually occurs more in the multi level organization than a single level organization (Bunker & Wijnberg,1988,46). Bunker and Wijnberg (1988) believe that the supervisory roles become connective nodes in the organizational hierarchical structure. Each individual worker reports to a supervisor who in turn reports to their supervisor and this pattern continues to the next higher echelon (Bunker & Wijnberg,1988,47).

The generic supervisory model presented by Bunker and Wijnberg (1988) asks the question: "What contribution is required from the front line supervisor for a human service organization to be successful in achieving its intended outcome reliably over time?" (Bunker&Wijnberg,1988,49). They respond with four sets of statements that focus on the role behaviour of the supervisor.

Mutual empowerment and systems linkage constitute the first set of role behaviours. Front line workers need to be able to exercise professional discretion while providing service to clients. If the policies of the human service organization and the monitoring role of the supervisor curtail this professional discretion, it can lead to unmet client needs and a tenuous work environment with high job dissatisfaction for front line staff.

The second set of role behaviours include the supervisory functions that are required to manage complex task activities and working relationships in human service organizations (Bunker & Wijnberg,1988,51). These tasks include such activities as:

> "A. Maintaining and building performance capabilities in the organization, the unit and the individual. B. Shaping and facilitating current work activities" (Bunker & Wijnberg, 1988,51).

The third set of role activities focuses on the supervisor's active participation in the generation, distribution and use of administrative, technical, professional, personal and interpersonal information (Bunker & Wijnberg, 1988,51). The fourth set identifies ten clusters of task activities that need to be completed by the supervisor. These ten clusters include:

> "... articulating and continuously adapting the unit's service model, monitoring and managing the climate of the unit and the organization, fostering individual development of workers, developing teamwork capabilities and work group resources, participating in agency planning, representing the unit and its requirements to other parts of the system, coordinating work activities: inter - unit liaison and conflict management, clarifying goals and tasks within the case, promoting active problem solving efforts, and managing the unit's daily service operations (Bunker & Wijnberg,1988,51).

Bunker and Wijnberg (1988) present a generic model of supervision in human service organizations that is based on several guiding assumptions. They build on these assumptions by describing specific supervisory role behaviour. Bunker and Wijnberg (1988) also advocate active supervision. This refers to the management, and distribution of the unit's work. It also refers to providing consultation to workers, promoting team work and the completion of tasks. Active

supervision also promotes maintaining a supportive and rewarding work climate (Bunker & Wijnberg, 1988,46 - 47).

Hughes and Pengelly (1997) describe the position of the first line manager as "piggy in the middle".

> "In social work in particular, supervision has traditionally occupied a significant, though potentially uncomfortable, piggy in the middle position between management accountability and professional responsibility; between broad policy formulation and its application to individual situations; between the organization and its users; between prescribed procedures and the emotional impact on high risk work" (Hughes & Pengelly, 1997,23).

Other professional disciplines such as psychiatry and psychology practice other traditions from a supervisory perspective. Hughes and Pengelly (1997) point out that these disciplines practice "...case autonomy over individual case decisions and practice autonomy in organizing and prioritizing their work overall" (Hughes & Pengelly,1997,25). These authors argue, with hospital nursing "...managerial accountability has traditionally been emphasized at the expense of the profession without a regular supervisory structure" (Hughes & Pengelly,1997,25). The differences in professional traditions and practices concerning the function of supervision may become salient in the context of multi disciplinary teams (Hughes & Pengelly,1997,25).

Hughes and Pengelly (1997) advocate that clear boundaries need to exist in the supervisory relationship that will focus on the work and at the same time allow for agency and consumer influence. In establishing these boundaries, these authors address the parameters around and within supervision. The parameters around supervision consist of ten points. They include: the purpose of

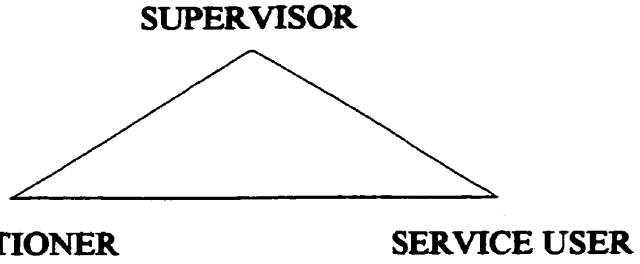
supervision, frequency and timing of sessions, interruptions and cancellations, the supervision room, confidentiality, recording of supervision, appraisals and individual performance reviews, the social - professional boundary, the boundary between supervision and other meetings, and dissatisfaction and disagreements. (Hughes & Pengelly,1997,34). These parameters speak to the logistics of organizing and arranging ongoing supervision.

The parameters within supervision consist of the following seven points. These include: power differentials, agenda setting, working concepts and skills, the personal - professional boundary, case records, methods and tools, and review and evaluation(Hughes & Pengelly, 1997,38). These seven points focus on what occurs in the face to face meeting with the supervisor and they recognize salient factors about the supervisory relationship such as the power differential.

Hughes and Pengelly (1997) also address the function of supervision. They concur with Kadushin (1976) who identified three main functions of supervision as being administrative, educational, and supportive. However, these authors also concur with such authors as Richar and Payne(1990) and Morrison (1993 cited in Hughes & Pengelly,1997,40) and add to Kadushin's (1976) list the supervisory functions of mediation and communication. Mediation in the supervisory context refers to "...recognizing the supervisor's role in negotiating with other organizations and with senior managers" (Hughes & Pengelly,1997,40). Communication refers to "...the supervisor's responsibility to channel feedback from practitioners to the organization on policy and practice issues" (Hughes and Pengelly,1997,40).

In describing the interrelatedness of the supervisory process between the supervisor, the practitioner, and the service user, Hughes and Pengelly conceptualize the work of supervision into two triangles. The first triangle represents the participants in supervision. These include, the supervisor, the practitioner, and the service user. The following triangle illustrates this point.

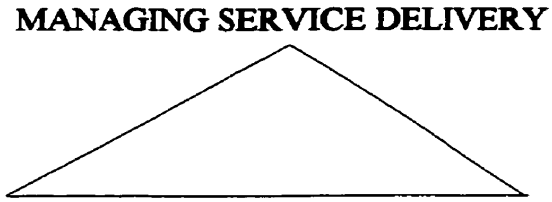
TRIANGLE OF PARTICIPANTS IN SUPERVISION



(Hughes and Pengelly,1997,41).

The second triangle these authors present represents supervisory functions. These functions are cited in the following triangle.

TRIANGLE OF SUPERVISORY FUNCTIONS



(Hughes and Pengelly,1997,41).

The three functions cited in the second triangle are linked to the participants in the first triangle. There is not a complete overlap with the respective corners of each triangle but a close relationship does exist. The application of these two triangles is based on three points. These include:

> "1.It is inevitably difficult, in any supervisory arrangement, to keep all three participants or all three functions in mind.
>
> 2. Nevertheless, the three corners are dynamically and functionally interrelated and cannot be regarded separately from each other.
>
> 3. Consequently, supervision and practice become unsafe if one corner is ignored or avoided for any length of time" (Hughes & Pengelly,1997,42)".

The supervisory triangles presented by Hughes and Pengelly (1997) strive to achieve balance between the three corners of each triangle and the interrelatedness of the supervisory process. Their model portrays the relationship between the three participants in supervision and the supervision function of each participant. This model also expands on Kadushin's (1976) and (1992) theory of supervision by adding the functions of mediation and communication.

2.2 Role of the first line manager

Within the health care sector individuals in middle management positions are often responsible for managing larger units of work that include multiple disciplines. Acorn & Crawford (1996) believe that a first line manager holds an integral managerial position in the health care organization (p 26). The scope and role of the first line manager has been transformed since the 1980's (Acorn and Crawford, 1996, 26; Hall and Donner, 1997, 14; Flarey, 1996, 16). Typically in

the 1980's 20- 25 workers were supervised by a front line manager with the primary focus being a specific unit of work (Pabt, 1991, 87-90). Pabt (1991) in an exploratory study found that in today's health care sector, manager to staff ratio can range from 1:12 to 1:63. These managers are often responsible for the operation of one or more units, staff supervision, standards for patient care, fiscal management and the management of the work environment (Acorn and Crawford, 1996, 27, Hall and Donner 1997,16).

Nursing professors McGillis Hall and Donner (1997) outline the changing role of hospital managers and describe the major functions of first line managers. According to these authors, patient care management, human resource management, and fiscal/operational management are the main functions of the first line manager . Mark (1994) and Nicklin (1993) add that the complexity and the importance of the first line manager role is increased when you also include in their functions the recruitment and retention of staff , and monitoring their workers' levels of job satisfaction.

Ferguson - Pare (1998) discusses the unprecedented changes in the Canadian health care system. She refers specifically to the structural changes from a hierarchical framework to a delayered team based framework. In this context she describes the role of the first line manager as, providing opportunities for staff growth and development, the creation of a positive work environment, maintaining relationships with individual workers, worker recognition through ongoing performance reviews, challenging work, and maintaining and demonstrating the managers' competence by teaching new skills and demonstrating professional competencies (Ferguson- Pare

1998,11).

Some authors have argued that clinical expertise is no longer relevant to the first line manager role as it becomes costly in human and financial terms (Duffield et al.,1994,54-63). Duffield's (1994) belief is that clinical expertise creates organizational costs because more experts or speciality staff will need to be hired in order to provide discipline specific supervision. This he argues is no longer required. This view is shared by such authors as Flarey (1996) and Drucker (1995) who advocate the use of business theory to manage health care. Baxter (1993) describes the first line manager role as that of monitor, disseminator, entrepreneur, disturbance handler, resource allocater, leader and liaison. What is interesting about the role descriptions of both Baxter (1993) and Duffield (1994) is the lack of emphasis on the first line manager providing clinical instruction. This lack of emphasis deviates from traditional management practices and supervision models in both nursing and social work.

This view is not shared by Shulman (1993), Kadushin (1992), Ferguson - Pare (1998), and Hughes and Pengelly (1997). Kadushin (cited in Shulman 1993,21) found in his research that supervisors and supervisees both agreed that the supervisors' ability to share information about social work knowledge and skills was primary to the supervisors' role and in turn enhanced job satisfaction for the supervisees. Shulman found similar findings. His research (1993,22) indicates that supervisees prefer that their supervisors spend more time teaching practice skills, sharing information from research that may be of benefit to the client group, and providing feedback on job performance. Heppner and Roehlke (1984, cited in Shulman, 1993,22), found similar findings in the

field of counselling psychology. Pincus (1986,cited in Shulman, 1993,22), found that job satisfaction and job performance for nurses is dependent on having positive communication with their supervisor and a supervisor who can teach and evaluate practice skills.

2.3 Supervisory relationships

Kaiser (1997) describes supervision as "... an involuntary relationship in which the supervisor is imbued with the power to make decisions or to take action that affect such things as hiring and firing, promotion, salaries or in the case of students passing or failing (p 7). Ideally, supervision provides practitioners a place where they can go where they can examine their interventions and interactions with the client (Kaiser, 1997, 7)The supervisory relationship ensures ethical practices are being followed, accountability maintained, and that the clinician is receiving support and evaluation. All of these functions need to be adhered to in the supervisory relationship if practitioners are to work with their clients with integrity (Kaiser, 1997, 8)

Accountability is described as a process of taking responsibility for one's behaviour and for the impact that behaviour has on oneself and others. It is a commitment to tell the truth and the commitment to take responsibility for one's actions (Kaiser, 1997, 14). This process ensures that clinicians are adhering to their code of ethics, codes of conduct, and are acting with integrity towards the needs of the client (Kaiser, 1997, 13). Evaluation of practitioners work ensures that competent work is being performed. This process makes judgements about the quality of the work being done (Kaiser,1997, 14). Through these supervisory practices the supervisor becomes directly responsible for ensuring the ethical and competent practices of the worker (Kaiser, 1997, 13).

Kaiser places much emphasis on the supervisory relationship because "...it is the medium through which supervision occurs." (Kaiser,1997, 3). She suggests that the relationship between supervisor and supervisee is based on three core elements that include power and authority, shared meaning and trust.

Power and authority is inherent in a supervisory relationship. Power refers to "... the ability to influence or control others and authority being the right to do so."(Kadushin,1992 cited in Kaiser,1997, 16). Essential in the relationship between supervisee and supervisor is that the supervisor not abdicate that power, nor abuse it (Kaiser, 1997, 16).

Shared meaning is the second core element in the supervisory relationship. It "... relates to mutual understanding and agreement between supervisor and supervise." (Kaiser,1997,19). A supervisory contract and approach to treatment are two components of shared meaning that can be used to make the supervisory relationship work more smoothly. A supervisory contract " ... can be defined as obtaining co - operation to work on a mutually agreed upon problem." (Connell, 1984, cited in Kaiser,1997, 19). The approach to treatment deals with the therapeutic interventions and beliefs about effective treatment (Kaiser, 1997, 19).

This encompasses the clinician's "...theoretical orientation, practical experience, and cultural and familial values and norms ..." (Kaiser,1997,19). It also acknowledges the parameters that exist within the organization as it pertains to counselling approaches." (Kaiser,1997,20).

Safety and respect are key elements to a trusting supervisory relationship (Kaiser, 1997, 20). Kaiser (1997) defines safety as "... the supervisee's freedom to make mistakes and to take risks without danger of an excessively judgmental response from the supervisor." (Kaiser,1997, 21). In this context the supervisee can show their vulnerability without negative repercussions.

Expressing a belief in an employee's ability and sharing with them the value of their work are both ways that a supervisor can demonstrate respect to their staff (Kaiser,1997,21). If a trusting supervisory relationship is to develop and be maintained growth promoting functions need to exist. In an ideal situation this function needs to be balanced with critical evaluation. Unfortunately, this can create a dilemma in the supervisory process.

Honesty, accountability, professional integrity and caring need to be present if a trusting supervisory relationship is to exist (Boszormenzi - Nagy, 1986, cited in Kaiser,1997, 21). Doherty (1995) suggests that if trust exists in the supervisory relationship that clinicians will practice 'practitioner's courage' whereby the clinician will push themself and the client past safety zones for purposes of client growth and professional integrity (cited in Kaiser,1997,21). This situation usually exists when the client has confidence in the supervisor and believes that the supervisor understands their work (Kaiser,1997,21).

The content of supervision is dependent on the context in which it occurs, thus having a significant affect on the supervisory relationship. The organization's philosophy and approach to therapy influences the supervisory contract and the shared meaning of that relationship (Kaiser,

1997, 22). For example, the organization may not make clear the job expectations to the practitioner or the supervisor may not have the knowledge to address the specific needs of the clinician. A final contextual issue that can affect trust in the supervisory relationship is the amount of power the supervisor has and how this power is utilized.

The supervisory relationship has a significant impact on the supervisory process. Staff supervision should be guided by ethical practices, the needs of the supervisee, quality service to the client and worker and supervisor accountability. Within the supervisory relationship there exists elements of power and authority, shared meaning and trust. Kaiser (1997) further adds that supervision occurs in the context of the organization and the community (p 23).

2.4 The changing role of the first line manager

Limited research exists in Canada that examines the outcomes of restructuring on our health care sector (Acorn 1996, 26 & Duffield et al.,1994, 30). Literature on the impact of downsizing is also limited but growing(Acorn 1996,26). What is known is that the scope and responsibility of the first line manager no longer has a narrow focus. The emphasis is now on the first line manager to transverse what was once a narrow portfolio of discipline specific activities to building and managing multi disciplinary teams (Skeleton - Green & Singh - Summer 1997, 100).

Ferguson - Pare's (1998) ethnographic study describes managers' and front line workers' perceptions of the qualities managers need to be viewed as leaders. The managers in this study had varying portfolios with respect to units they managed and the qualities they possessed. Despite

these diversities, five major themes emerged from front line staff with respect to their supervision needs. Staff reported that they needed their manager to give them support, recognition, involve staff in decision making, obtain input and feedback, and have a vision for the future (Ferguson - Pare 1998, 18).

Staff's perception of support in this study included a number of characteristics. These include advocating for staff, recognition for a job well done, taking a personal interest in staff, staff development, and providing a support structure such as quality improvement programs (Ferguson - Pare 1998, 18). Managers' perception of support emphasized "... the importance of organizational skills, people and communication skills and the ability to understand systems (Ferguson - Pare 1998, 18).

Recognition was described by the staff as considerate behaviour acknowledging staffs' abilities and the work they do. Managers' expectations regarding the recognition theme was that their staff are professionals with varying levels of education that should be competent and independent team players (Ferguson - Pare 1998, 22).

Receiving and obtaining input and feedback addresses the implementation of workplace systems, such as policies, procedures, and quality monitoring mechanisms (Ferguson - Pare 1998, 23). It is these areas in which staff feedback was solicited and where staff wanted to have input.

This study acknowledged the importance of collaborative decision making and how it contributes to staff empowerment. Within the workplace, managers reported creating an environment that solicited and acted upon input and decisions made by the team. Despite these efforts, factors in the hierarchical political environment such as decreased funding in health care, decrease in the quality of care, and lack of control, resulted in the staff and manager feeling disempowered (Ferguson - Pare 1998, 19).

This study portrays managers as using "... vision to involve staff in structuring their own work environments..." (Ferguson - Pare 1998, 23). Managers use their leadership abilities to motivate staff to see change as an opportunity and convey the need to pull together to support each other. The use of vision also assists managers in developing a work environment that supports professional practice and shared leadership.

Ferguson - Pare (1998) did comment on discipline specific supervision in her research. She noted that the first line manager with the same discipline as the front line staff had a significant influence on staff, particularly in the area of practice autonomy. She argued that when discipline specific leadership is absent from an organization it is connected to increased job stress, decreased job satisfaction, turnover and absenteeism (Ferguson - Pare, 1998, 9).

McGillis Hall and Donner (1997) in their research on the changing role of the hospital manager present several interesting findings. The qualities and skills needed to be effective in the first line manager role are: financial management, good communication skills, team building skills, staff motivational skills and the ability to adapt to change (Barker& Ganti 1980; Barrett 1990 cited

in McGillis & Donner, 1997, 16). The first line managers' superiors determined that the first line managers were not meeting the needs of some organizations. This was attributed to problems with employee morale, team functioning, management skill diversity, and adaptation to change (Dudhemin; Ferguson - Pare & Kemerer 1994 cited in McGillis Hall & Donner, 1997,17).

The current focus of the nurse manager role is the movement toward program management and interdisciplinary team structures (McGillis Hall & Donner,1997,18). This shift from the traditional nursing management role places new demands on the competencies of the manager. Kerfoot (1993) suggests that these changes foster interdepartmental and interdisciplinary partnerships. McGillis Hall & Donner (1997) suggest that a challenge of these partnerships will be competing expectations between patient care and fiscal management.

In keeping with the shift in focus of the nurse manager role, there are organizational changes in the health care sector that promote these changes. The shift in the organizational structure from a vertical structure to a horizontal span of control has some authors arguing that clinical expertise is no longer relevant (Duffield et al. ,1994 , 21). In fact, little research has been completed on the management of interdisciplinary teams(Duffield et al, 1994, 30 Acorn,1996, 26). McGinnis - Hall and Donner (1997) in their research, found that the first line manager should: stimulate creativity, establish an environment that facilitates teamwork and learning, motivate staff to assume increased responsibility, help in developing an employee's potential, facilitate employee awareness of organizational goals, communicate openly and directly with staff, and collaborate with peers. These tasks need to be complete in order to provide effective program management.

Read and Gehrs (1997) describe the realities of mental health reform and the implications for service delivery. Professional role redesign, rigorous staff selection techniques and cross disciplinary training strategies all represent a paradigm shift for hospital based staff who previously had very focussed and somewhat traditional perspectives of their role within the mental health care delivery system" (Read and Gehrs,1997, 20).Specifically they address the need to adapt to staff role changes, job transitions, and the development of new professional competencies. Rather than focus on a traditional professional role, i.e. social work, occupational therapy, nursing, where each discipline focuses on one aspect of patient care, it was necessary to focus on more expanded role definitions (Read and Gehrs,1997, 16).

These authors describe the amalgamation of two Southern Ontario hospitals that resulted in a program management structure for a community based mental health program. Within the context of this structure, the role of the program manager was to "... be responsible for program resources, high quality services, integration and coordination across all areas of mental health service, achievement of the defined goals and objectives and the creation of an atmosphere conducive to education and research" (Read and Gehrs,1997, 16). Strategies were implemented to ensure that staff receive appropriate training to enhance their skills and knowledge base. Partnerships were developed with existing community resources to provide clinical and educational support. Communication between team members was enhanced through the use of pagers, cellular phones, and voice mail. Computerized documentation systems were also established to record client records, workload measurement, and evaluation data.

In the redesigned health care system the first line manager's function is primarily to manage people issues (Bueno, 1991b, 8). In the new team, this manager may be responsible for the supervision of up to 100 people (full and part time), with approximately one half of the employees having less than nine months experience (Bueno, 1991b,8). Front line staff are expected to be clinical experts, as well as delegate and evaluate other staff effectively (Bueno,1991b,8). This is known as a self governance model, which refers to the belief that professionals "... can manage themselves, then perhaps the manager does not need to be a clinician who replaces staff while they are busy making managerial decisions (Bueno 1991b,8). Bueno (1991b) suggests that there are contradictions in the role expectations of staff. She elaborates that it is difficult for a manager to empower others with authority to make important clinical decisions when the manager is expected to be the repository of clinical expertise. What this author is saying is that front line staff in the redesigned health care system are to be the clinical experts yet historically this was the role of their manager. Because of this paradigm shift front line staff can no longer entrust their manager to provide them with clinical direction.

In terms of the role function of the first line manager, Bueno(1991b) states that there are relevant quantitative and qualitative expectations that need to be fulfilled. These include decision making skills (ie. budgeting), staffing, quality assurance, monitoring, and long range planning.

Self governance models place much responsibility on the staff to become clinical experts and to provide peer supervision. It appears that downsizing the health care sector has placed new responsibilities on the first line manager while deleting other functions from their role. Bueno

(1991b) states that eight to ten staff is usually the number one manager can supervise effectively. In today's health care sector the ratio of staff to manager is much higher.

How much or how little management is needed in the health care sector appears unknown. Bueno(1991b) does suggest that the amount of management required is dependent on a number variables. These variables include "...actual or perceived need for control; ability and willingness of staff to assume responsibility and accountability; functional diversity of the department or unit; manager competence; employee number and mix, and ability; and organizational or personal values in regard to status, chain of command, trust and discipline" (Bueno, 1991b, 7).

Aroian et al. (1996) present a business model of management entitled "manager as developer" which they argue can be implemented effectively in acute care, primary care and community care settings. With the shift from a hierarchal structure to decentralized units and the trend towards interdisciplinary teams and group decision making, these authors believe that leadership styles and skills are evolving in the workplace.

Bradford and Cohen (1994) developed the manager as developer model which is grounded in the belief that"... professionals must guide their own work, maintaining autonomy and responsibility for practice" (Aroian, et al,1996, 19). Staff ,they believe, do not require supervision in the traditional sense but the opportunity to develop critical and analytical thinking skills (Aroian et al, 1996, 19).

The manager as developer model is a process oriented model with seven major concepts. These concepts include: group decision making, tangential thinking, staff development, team development, staff autonomy, two way communication, and external influence (Aroian et al, 1996, 21). Group decision making empowers staff to share in the core decision making of their unit and to influence each other to work towards excellence. Tangential vision enables staff to look to the future in developing a vision. It is the process of setting goals to inspire staff to put forth their best efforts. Staff development pays attention to an individual's ability and creates opportunity to enhance that ability. This process involves regular monitoring and the assigning of tasks by the manager, in order to broaden the knowledge and skills base of the staff person. Staff development is a continuous process that requires providing feedback and coaching staff.

Team development is a collective effort that evolves as an individual develops. Methods are employed to teach the team to share responsibility for the running of the department or unit. Staff autonomy refers to the self directed action taken by team members to enhance the success of the unit. Two way communication is essential for healthy team functioning. This process emphasizes the open flow of communication among colleagues and among front line staff and their manager. The external environment does affect team functioning because the team is an open system affected by changes made in the health care sector.

The authors of this model perceive the manager as a catalyst, creating an environment of mutual influence encouraging individuals on the team to address each other and promoting the free flow of information and mutual problem solving (Aroian et al, 1996, 22). The key aspect of this

model is the ideal of promoting staff excellence by creating opportunities to enhance the skills of each team member (Aroian et al, 1996, 23).

Some health care sectors in the United States (US) continue to provide traditional social work supervision. The Henry Ford Hospital in Michigan is one such facility. The goal of the social work department is to foster an approach with staff that promotes teamwork, collaboration, and empowerment. This is accomplished through a department structure based on the concept of self governance. Self governance adheres to the principle of shared decision making with emphasis on the paradigm shift from "top down" decision making to "bottom up" decision making (Diamond & Marches, 1995, 45).

Within this department structure, the manager ensures that staff are aware of the core competencies of professional practice. These core competencies include, documentation of standards, understanding the structure, function and operation of the department, quality assurance activities, clinical service assignment, interdepartmental relationships, and community services (Diamond & Marches, 1995, 45).

A variety of methods of supervision occur regularly. Individual supervision is available based on the needs of the staff. Issues that can be addressed in this context include, focussing on practice issues, counselling skills, system problems and professional goals. Group supervision is also available through the social work team. This is a homogeneous team that consists of four to five members, that provide peer support through staff participation (Diamond & Markowitz, 1995,

p 48). This team meets once a week to discuss problematic cases and wider systems concerns. The goal of this supervisory process is to address problems and develop interventions to resolve them.

Direction and structure provide the basis for this supervisory process (Diamond & Markowitz, 1995, 48). Other concepts endorsed using this supervision framework are taken from Cohen and Rhodes (1977), and are listed below.

> Requisite activities and tasks for effective supervision that take into account concern for task, for people, and for competitive job orientations have been identified as: (a) setting individual and group objectives for task allocation and implementation; (b) implementing shared decision making; (c) directing group process; (d) planning work and case management; (e) developing communication networks; (f) evaluating performance; (g) motivating workers; (h)case consultation and professional support; (I) team building; (j) worker and client advocacy; (k) conflict management; (l) planned change at dyadic, team, and intergroup levels with particular attention to coalescing separate interests on behalf of employees and clients. (Cohen and Rhodes, 1997 cited in Diamond & Marches, 1995, 48 - 49).

It appears that through these turbulent times of health care reform, some larger health care centres in the US are able to continue to adhere to traditional supervisory practices. In doing so, these health care centres sustain a distinct professional identity and practices with clear role definitions.

2.5 The social work manager — a social work perspective

The role of the social work manager in a multi disciplinary setting is described by Rosenberg as "... the ability to support and cooperate in an environment of diverse expectations" (Rosenberg, 1987,81). The main functions of the manager's role include management of staff, education, and research (Rosenberg,1987,79). Rosenberg (1987) describes other critical functions that include the development of policy for multiple programs and the management of the human resource function.

Skills that the social work profession bring to the manager position include: an appreciation for client systems, an appreciation for service from the consumer perspective, skills in collaborative practice, knowledge and skill in group dynamics, social work values that appreciate all levels of staff and their contributions, and an understanding of the social effects of interventions on groups, clients, communities, and management (Rosenberg,1987, 82 -83).

Klingbeil (1987) concurs with Rosenberg on the attributes that the social work profession brings to the manager role. Klingbeil adds that social work also brings a bio - psycho social approach which from a management perspective would involve "... community organization and social planning both necessary ingredients in today's health care world" (Klingbeil,1987,45). Based on this bio psycho social approach, Klingbeil (1987) describes 12 roles and activities of the effective manager. These include the skills to:

1. Assume responsibility and insure that tasks are completed successfully
2. Balance many competing goals
3. Translate their vision, insight and imagination into action planning
4. Organize by creative coordination the human and material resources of the organization
5. Strategically negotiate differences and conflicts
6. Collaborate with and influence others
7. Advocate and broker for services, programs and resources
8. Innovate, create and develop programs
9. Implement goals through enabling structures
10. Influence in the political sense using timing as a necessary creative skill
11. Evaluate outcomes and adopt changes through dynamic processes
12. Prepare and empower others to create a dynamic and strengthened program/unit/department (Klingbeil, 1987, 46-47).

The clinical perspective of the bio psycho model is an essential ingredient in today's health care system because it looks at the aspects of illness and wellness from the viewpoint of continuity of care (Klingbeil, 1987,47). What emerges from these social work beliefs and practices is a more comprehensive and dynamic leadership style. " Social workers do make efficient and effective managers adding to these qualities a more humanistic managerial style" (Klingbeil,1987,46).

2.6 Group and Peer Supervision

Bernard and Goodyear (1992) believe that maintaining and improving professional counselling skills have been increasingly recognized as critical to learning in counselling supervision (cited in Benshoff, 1994, 1). Yet the availability for many professionals for"... regular counselling supervision by a qualified supervisor is very limited or frequently nonexistent." (Benshoff, 1994,1). Peer supervision or peer consultation (as it is frequently referred) is perceived as another effective supervisory approach that may increase the frequency and quality of supervision to professionals (Benshoff, 1994,1).

Peer supervision is an extension of group supervision (Kadushin, 1992, 482). Group supervision utilizes "... the group setting to implement the responsibilities of supervision." (Kadushin, 1992,404). The supervisor in this model assumes the leadership role to meet the educational, supportive and administrative functions of the supervisory process. Kadushin (1992) believes that the supervisor has an obligation to direct, guide and steer the course of the group process. This responsibility, he elaborates, can not be shunned because inherent in the supervisor's role is power and authority (Kadushin,1992, 422).

The goal of group supervision remains the same as that of individual supervision "... efficient and effective service to agency clients." (Kadushin, 1992, 405). A format for the group process is considered essential, that consisting of agenda setting and the completion of specific tasks. The group in this framework usually consists of four to five front line staff with similar training and education who deal with similar problems and provide similar service (Kadushin, 1992, 405). Kadushin (1992) believes that the group process is more effective when the group has clearly defined goals that are consistent with the group's purpose.

The group process offers many advantages. Kadushin (1992) states that more opportunities for learning become available such as films, role plays, and presentations by a specialist. Group supervision offers opportunities to present cases and work experiences as well as share common struggles and solicit feedback from colleagues (Fried Ellen, 1999; Benshoff, 1994; Kadushin, 1992). Case presentations are frequently used in group supervision and should be prepared and in line with the purpose and objectives of the group meeting (Fried Ellen, 1999; Benshoff,1994; Kadushin, 1992). Case reviews using group supervision are presented by the supervisor not the front line staff.

Emotional support from the group is an additional benefit (Fried Ellen, 1999; Benshoff, 1994; Kadushin, 1992). The group environment can offer support and validation for work completed thus enhancing the morale of the team (Benshoff,1994; Kadushin, 1992). It is an opportunity for mutual aid and an opportunity to learn from your peers. It is through this process that members of the group can acquire of sense of belonging (Kadushin, 1992, 406 - 407).

Therapists frequently work in isolation (Fried Ellen,1999; Kadushin, 1992). Group supervision fosters staff interactions. This can assist with encouraging peer group cohesion by providing an opportunity for staff to meet with some degree of regularity. Kadushin (1992) quotes the experience of a front line staff employed by a mental health clinic;

> A major plus of group supervision is the act of getting all of these autonomous people together. Unless we pass in the hallway, meet at the bathroom, or use the appointment book at the same time, we are 90 percent of the day, behind our closed doors. After group supervision started, there seemed to be a visible change in attitude and more people made an effort to stay in the hallway longer. (p 409).

A final benefit of group supervision is that it allows the supervisor to assess group members in the context of the group. By so doing, it provides the supervisor with an opportunity to assess member's clinical skills and knowledge and provide perspective on how members are functioning in the team.

Kadushin (1992) proposes disadvantages to group supervision. For some group members, the group process maybe perceived as less structured and focussed. Secondly, some participants may be concerned that their skills and knowledge may not be adequately represented in this context thus generating how their skills compare to those of their colleagues. There is also concern that because of this their colleagues may receive more positive attention. This can then foster hostility and competitiveness within the group (Kadushin,1992, 413). A third concern is that new group members may have difficulty fitting into the group process because of already defined roles and subgroups. Fourthly, the group can detract from members developing their own therapeutic plans

resulting in group members becoming dependent on the group to provide clinical direction. Finally Kadushin (1992) expresses concern for participants who cannot accept critical feedback. For these individuals, the group context would not be appropriate.

Group norms for group supervision are important. Kadushin (1992) believes that group norms should be agreed upon by the group and may include such things as;

> 1.To allow everyone to have his say without undue interruption.
> 2.To listen carefully and attentively to what others are saying.
> 3. To respond to what others have to say.
> 4. To keep one's contribution and response reasonably relevant to the focus of what is being discussed. Group membership requires a measure of deindividuation, some setting of one's own preferences in order to maintain the integrity of the group.
> 5.To share material and experience that might contribute to more effective professional development. (p 428).

Peer supervision is the process where mutual benefit is achieved by peers working together (Benshoff, 1944,1). Peer supervision is defined as "... a process by which a group of professionals in the same agency meet regularly to review cases and treatment approaches without a leader, share expertise and take responsibility for their own and each other's professional development and for maintaining standards of (agency) service." (Hare and Frankena, 1972 cited in Kadushin, 1992). Within this model, peers have a responsibility to assist their colleagues, however what their colleagues do with the feedback is their colleague's decision. As the definition implies, this process is without an authority figure resulting in more staff autonomy and independence (Kadushin,1992, 483).

Peer supervision is more effective with members with the "... approximate level of competence." (Kadushin, 1992,484). If this does not exist Kadushin (1992) believes that some members may be reluctant to participate in this process because they believe that their peers know less than they do therefore these members cannot learn from their peers. Fried Ellen (1999) believes that peer supervision is a worthwhile process for all members in the group process. She advocates that this process is essential in helping members see their own issues which can impact on the best interest of the client (p 6). Peer supervision is believed to be a proactive way to get peer input on difficult cases and it operates on the premise that "... people who are willing to discuss their work, in general are trying to preclude making some sort of mistake." (Fried Ellen, 1999; 6).

One cautionary feature of this model may be rivalry for leadership (Kadushin, 1992, 483). In these situations one or two members may want to control the group, thus elevating themselves to a position of authority. This power dynamic will have a negative impact on the group's functioning thus affecting group cohesion and the willingness of group to freely share information.

2.7 Vicarious Trauma - Debriefing and The Role of Supervision

Pearlman and Saakvitne (1995) believe that it is important "... for therapists who work with trauma survivor clients to have ongoing supervision and consultation for their work." (p 359). Supervision is not perceived as a luxury but as a necessity to ensure the health of the therapist and to ensure the best interest of the client. It is an opportunity for the therapist to step back "... from his experience of the therapeutic work in order to have an overview of the process in the context of the particular client and his history and his character." (Casement, 1991, cited in Pearlman &

Saakvitne, 1995, 377). Through this supervisory process it is imperative that therapists receive education about their own "... awareness and attunement to the effects of vicarious trauma." (Pearlman & Saakvitne, 1995, 365).

One of the roles of supervision should be to assist therapists with developing strategies for self care and self protection. This can occur in the context of professional help, personal techniques, organizational policy and procedures. What is important is that the therapist be given a forum to debrief and discuss the effects that secondary trauma has on themselves and their work.

Saakvitne and Pearlman (1996) describe the experiences of hospital workers who developed a group that enabled them to cope with the effects of secondary trauma. The framework for the group was based on three assumptions. These assumptions included; "(1) no therapist is immune to the effects of secondary trauma, (2) prevention of secondary trauma lies in the membership of the team, and (3) the higher the intensity of exposure to trauma work, the greater the need for a team."(Saakvitne & Pearlman, 1996,143). Within this framework,

> Team members regularly pose questions about secondary traumatization that include: (1) How are team members being engaged? (2) How do they feel about it? (3) What will we do about it? Therapist self care is expected and the team reminds members of this if they neglect this responsibility .... Overwork is discouraged. The feelings of team members are considered important (Munroe et al., 1995, 228 cited in Saakvitne & Pearlman, 1996, 143).

This team approach provides a safe and trusting atmosphere where therapists can share their vulnerabilities and struggles without negative repercussions. It is an atmosphere that recognizes and validates the debriefing process and the effects of vicarious trauma.

Pearlman and Saakvitne (1995) believe that the supervisory process for trauma workers is moving toward a more relational interactive model. This model allows the supervisor and the therapist not to know but to explore together the acquisition of skills and knowledge. These authors believe that less experienced staff or new staff may need or want "... a more didactic style at the beginning ..." (Pearlman & Saakvitne, 1995, 375). These supervisory relationships are based on the premise that supervisors must be open to change and being taught by their staff in order to teach and facilitate their growth (Pearlman and Saakvitne,1995,375).

Along with assisting the therapists in recognizing and coping with their own vicarious trauma and countertransference, the role of the supervisor is also to recognize the effects that the therapist's vicarious trauma is having on the client (Pearlman & Saakvitne, 1995,365). In so doing the supervisor can "... be alert to the effects of vicarious trauma on the client." and in so doing take the appropriate measures to address the situation (Pearlman and Saakvitne,1995, 365).

Pearlman and Saakvitne (1995) recognize that a difference exists between a new worker and an experienced worker in seeking supervision. They argue that inexperienced and new therapists have a license "not to know". In this context it is deemed appropriate for these individuals to seek out and ask questions. These authors believe that more experienced clinicians sometimes set unrealistic expectations of themselves and do not obtain the clinical support and debriefing that they require (Pearlman and Saakvitne, 1995, 377). In the latter situation, what the experienced worker needs to do is "... preserve an adequate state of not knowing if he is to remain open to fresh understanding (Casement, 1991, cited in Pearlman and Saakvitne, 1995,377).

There is merit to small group and peer supervision. Pearlman and Saakvitne (1995) propose that case reviews and rotating peer presentation are two worthwhile options. The case presentation enables therapists to present a case and all its relevant issues. It provides an opportunity for peers to teach from their own work but to also learn from their peers. By demonstrating an openness to presenting a case and discussing its issues therapists can also discuss and normalize issues of counter transference and vicarious trauma as they pertain to the information presented. This model requires that members of the team discuss the "...frame and structure that would enhance comfort for sharing struggles and feelings among group members." (Pearlman & Saakvitne,1995,375 - 376).

Rotating presentation structure is another peer option discussed by Pearlman and Saakvitne (1995). This peer model promotes self directed learning by staff in order to facilitate the channelling of information to the team and in so doing, enhancing their own professional maturity and that of team members. This process can provide new clinical insights to all involved. It can also address within this framework topics such as vicarious trauma, debriefing, counter transference and other significant clinical issues.

As illustrated, there is a role for supervision in dealing with issues of vicarious trauma, and counter transference. Providing therapy can invoke many thoughts, feelings, and reactions in a therapist. Figley (1983) believes that if these thoughts, feeling and reactions are not processed they can have serious negative consequences on the worker and the work environment. Figley (1983) attributes the impact of secondary traumatic stress on professional functioning to a decrease in

quality of performance tasks on the job, decrease in staff confidence, interest, job satisfaction, coupled with negative staff attitudes and staff demoralization. Withdrawal from colleagues, decreased quality of staff relationship, poor communication, staff conflicts, faulty judgement, overwork, and irritability are also described by Figley (1983) as additional consequences of the impact trauma can have on professionals. By recognizing and providing an avenue for professionals to debrief and receive support and validation the impact of vicarious trauma can be minimized.

2.7 Today's reality in the Canadian health care system

Profound structural changes characterize the Canadian health care system. During the past decade we have witnessed hospital mergers and closures, contracting out of services, and a shift from hospital to community based programming. All of these changes have had a significant impact on social work in health care (Levin and Herbert, 1999, 30). These changes have translated into functional social work departments being disbanded and replaced with program based teams consisting of multiple disciplines, often led by a person other than a social worker (Levin and Herbert,1999, 31). Levin and Herbert (1999) state that hospital social work has lost most of the mentoring, supervision, education and support that has been historically provided.

In their exploratory study Levin and Herbert (1999) addressed the changing role of social work in the Canadian health care system. The findings of this study indicate that program management is the management practice of choice in Canadian health care. The result of this new form of leadership has been that many front line social workers, their managers, and social work directors have lost their jobs. These study results indicate that social workers do not have access to supervision from

social workers and that supervision from peers has diminished. Concern was also expressed that nurses would usurp the role of social workers.

Further to these changes in health care, Keigher (1997) and Kadushin and Egan (cited in Levin & Herbert,1997, 36), have asserted that the curriculum taught on health care and social work no longer reflects the practice realities. They note that the mentoring and supervision traditionally available has largely disappeared.

Levin and Herbert (1999) describe with clarity and conciseness the realities of the changing role of social work practice in the Canadian health care system. The changing role of social work, the lack of supervision and mentoring, and the disbandment of social work departments will have a profound affect on social work practice in health care.

My research will address many of the issues presented by this literature review and it will provide additional insights into the supervisory process in adult mental health programs in Northwestern Ontario. In the following chapters I will document my method of inquiry, the processes of data collection, and my findings.

CHAPTER III

METHODOLOGY

3.1 The research questions

This is the central research question for this thesis: What are the supervisory needs of front line staff from the perspective of members of multi disciplinary teams in outpatient adult mental health programs in Northwestern Ontario? This includes objectives: 1.) to determine the process of supervision in multi disciplinary teams; 2.) to determine what works well in the supervisory process of multi disciplinary teams; 3.) to determine what does not work well in the supervisory process of multi disciplinary teams; and 4.) to provide recommendations that could enhance the supervisory process for members of multi disciplinary teams.

3.2 Research paradigms

My research questions and its objectives seek to put me, the researcher, and the participants in the context of the situation in order to better comprehend it. The separation between the subjects (the participants) and the object (the researcher) become diminished with "... the object becoming in the knowing process" (Olson, 2001, 5). This then allows the researcher to know the situation through the eyes of the participants (Chatman,1984; Mellon, 1990; Fidel, 1993, Westbrook, 1994; & Sutton, 1993 cited in Olson, 2001, 5). It is on these ontological and epistemological assumptions that my research is based, thus directing me towards a qualitative research paradigm.

Within all paradigms there are a number of assumptions that provide its framework. In order to provide a comparison of the qualitative paradigm (interpretivist theory of research) and the quantitative paradigm (positivist theory of research) I will explore the assumptions that underpin each paradigm.

Ontological, epistemological, axiological, rhetorical and methodological are the philosophical assumptions that have practice implications within the qualitative and quantitative paradigms (Cresswell, 1998, 75). The ontological assumption asks the question what is the nature of reality? Qualitative researchers or interpretivists, believe that multiple realities exist and that reality is subjective and socially constructed (Cresswell, 1998, Olson, 2001). My research concurs with this paradigm recognizing that the researcher, the participants and the audience reading my work constitute multiple realities. The quantitative researcher, or positivist, believes that there is one objective reality not dependent on the researcher (Brocco Murphy,1998, 37).

The relationship that exists between the researcher and that being researched is addressed by the epistemological assumption (Cresswell, 1998, 75). Qualitative research tries to lesson the distance between the researcher and that being researched. The researcher interacts with those being studied. This may take several forms including face to face interviews or collaboration with the participants. Guba and Lincoln (1988) describe the epistemology of the positivist as: "The investigator and the investigated object as assumed to be independent entities and the investigator to be able to study an object without influencing it or being influenced" (p110).

The third assumption focuses on the role of values in research and it is called the axiological assumption. Qualitative research recognizes that research is value laden and that bias exists. Researchers "... systematically acknowledge and document their biases rather than striving to rise above them" (Mellon, 1990,26). In quantitative research when bias is recognized or suspected strategies are implemented to eliminate or reduce it (Mellon,1990). "Values and bias are prevented from influencing outcomes so long as the prescribed procedures are rigorously followed" (Guba & Lincoln, 1988, 110).

The rhetorical assumption focuses on the language used to formulate the text of the research. The qualitative paradigm, writes "... in the voice of the participants in terms of the stories they presented and the voice of the researcher who is actively engaged in the reconstruction of meaning through interpretation" (Brocco Murphy, 1998, 40). The quantitative paradigm writes its text in a technical format from the voice of the researcher.

The conceptualization of the research process is the methodological assumption. The inductive approach is characteristic of the qualitative paradigm. Through this process "the researcher uses inductive logic, studies the topic within its context, and uses an emerging design" (Cresswell, 1994, 75). Within this assumption "...qualitative researchers endeavour to achieve what Lincoln and Guba define as credibility, transferability, dependability, and confirmability: the trustworthiness of qualitative research" (Bradley, 1943, cited in Olson, 2001, 6). Whereas, the quantitative paradigm is concerned with causal relationships and explanations that are grounded in reliable and valid findings through the process of deductive approaches (Cresswell, 1998, Van

Manen, 1990).

3.3 Research design and justification for this design

Denzin and Lincoln (1994) state that

> Qualitative research is multimethod in focus, involving an interpretive, naturalistic approach to its subject matter. This means that qualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of meanings people bring to them. Qualitative research involves the studied use and collection of a variety of empirical materials – case study, personal experience, introspective, life story, interview, observational, historical, interactional, and visual texts – that describe routine and problematic moments and meaning in individuals' lives (cited in Cresswell, 1998, 14).

A qualitative research design is the paradigm that best fits with my research question because it "... is an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyses words, reports detailed views of the informants, and conducts the study in a natural setting" (Cresswell, 1998, 15). By using a qualitative research design I explored the supervisory process of multi - disciplinary teams in adult mental health programs in Northwestern Ontario.

My research lent itself to the qualitative paradigm because of the exploratory nature of my research topic. By using qualitative methodology in the form of in depth interviews I interviewed front line staff of multi disciplinary teams and provide a detailed description and analysis of current supervisory practices. Qualitative methodology is the method of choice for description because it tends to be more exploratory in nature allowing for in depth description and analysis of specific situations (Pauch, 1996, Monette, Sullivan,& Dejong, 1998).

The method of data collection that was implemented in my qualitative design was face to face interviews which were augmented by an interview guide (see appendix 2) and interview probes. All interviews were audio recorded and transcribed. Qualitative research allows for flexibility with the interviewing process. Through the use of an interview guide, participants can describe their unique realities. Additional data can be obtained through the use of interview probes (Monette, Sullivan, & Dejong, 1998, 178:Polansky,1995,133; Schuerman, 1983,158). This form of data collection provided linguistic descriptors to describe and define the realities of the participants.

Qualitative research allows the researcher to isolate certain clusters and expressions that can be reviewed by the participants, thus acting as a method of data analysis and verification of the results (Miles & Huberman, 1994,6-7). It is essential that the themes be maintained in their original form during the course of the research. My research incorporated the use of themes and clusters as the main component of the data analysis. The original text from the interviews were presented in order to substantiate my findings.

Because limited research currently exists on the supervision of multi disciplinary teams, this exploratory study provides a detailed description of current practices thus making a valuable contribution to the literature (Acorn,1996, 26; Duffield et al.,1994, 30).Through description and narration, the subjective dimension of the human experience can be made visible. In other words, qualitative methods are concerned with subjectively understanding the deeper meaning of individual experiences and because of this was an appropriate means to explore my research topic (Tutty, 1996, 9&10).

3.4 Theory and the qualitative paradigm

Qualitative research can employ theories in different ways (Cresswell, 1998, 87). Firstly, social science theory may be absent from the study with the focus being on the description of the phenomenon and its issues (Cresswell,1998, 87). Secondly, qualitative research may define itself using a theoretical base for the study. Thirdly, the theory after perspective can occur once the data and analysis has been completed. Using this approach, theoretical perspectives are introduced as they relate to a specific topic from a psycho social and organizational perspective to compare and contrast with other theoretical models (Cresswell, 1998, 87). This research uses management and supervision theory as the theoretical base for my inquiry and as a frame of reference for the development of my research questions. This does not dismiss the fact that "...different theories may be simultaneously valid according to the researchers' and presumably the respondents', interpretations" (Mellon, 1990, cited in Olson,2001,6).

3.5 Phenomenology

Phenomenology is a method of inquiry within the qualitative paradigm (Cresswell, 1998; Miles & Huberman, 1994 Van Manen, 1990). "A phenomenological study describes the meaning of the lived experience for several individuals about a concept or a phenomenon (Cresswell, 1998, 51). It strives to gain a comprehensive understanding "... of the nature and meaning of our everyday experiences" (Van Manen, 1990, 9). Phenomenology is concerned with how a phenomenon is experienced. My research is influenced by the phenomenological orientation in that participants were asked to share their lived experiences of being supervised in the context of a multi disciplinary team. Because of my reliance on an interview guide and the literature to develop this guide my

research is not a pure phenomenological study.

Phenomenology is a method of inquiry that focuses on meaning through description and interpretation (Van Manen, 1990, 12). It allows for an in depth description of the phenomenon and it provides an opportunity for participants to share their unique realities retrospectively (Van Manen, 1994, 10). Phenomenological research is a method of inquiry used to study "... the problem that includes entering the field of perception of participants; seeing how they experience, live, and display a phenomenon; and looking for the meaning of the participants' experiences" (Cresswell, 1994,31). This requires the researcher "...to set aside her preconceptions to best understand the phenomenon as experienced by the participants" (Cresswell, 1994, 31).

Hermeneutic phenomenology is a study of 'essences' which "... may be understood as a linguistic construction, a description of a phenomenon" (Van Manen, 1990, 39). "The researcher writes research questions that explore the meaning of that experience for individuals and asks individuals to describe their everyday lived experiences" (Cresswell, 1994, 54). For example, describe for me your experiences of being supervised by someone of a different discipline. This question focuses on the essence or nature of the experience thus allowing the participant to respond with a description that "... shows us the lived quality and significance of the experience in a fuller and deeper manner (Van Manen, 1990, 11). "It is used to gain an understanding of what the issues and concerns are, and what significance the participants attribute to them" (Pauch, 1996, 65).

Van Manen (1994) suggests that ... hermeneutic phenomenological research may be seen as an interplay among six research activities:

> (1) turning us to a phenomenon which seriously interests us and commits us to the world;
> (2) investigating experience as we live it rather than as we conceptualize it;
> (3) reflecting on essential themes which characterize the phenomenon;
> (4) describing the phenomenon through the art of writing and rewriting;
> (5) maintaining a strong and oriented pedagogical relation to the phenomenon;
> (6) balancing the research context by considering the parts and whole (Van Manen, 1994, 30 - 31).

It is through the interplay of these six research activities that I have pursued my research topic. The phenomenon I have studied is of great interest to me for a multitude of reasons. As a social worker, I am very interested in how it it pertains to practice implications, including limited clinical instruction and limited professional mentoring (Baxter; Duffed, 1994; Read & Gehrs,1997; Levin & Herbert, 1990; Farley, 1994). This phenomenon may have implications in the loss of social work positions and the assimilation of professional roles (Levin & Herbert, 1990; Read & Gehrs, 1997). It also places greater emphasis on professional staff to become experts without supervisory instruction (Bueno, 1991b; Bradford & Cohen, 1994 cited in Asian, 1996).

The participants in my research lived the experiences they described and based on this information themes were developed to ensure the essence of these experiences. Through the art of writing and rewriting these experiences were documented. During this entire process I maintained a learning relationship towards the phenomenon, considering each participant's experience or 'essence' as a single entity as well as part of the whole.

3.6 The role of the researcher

Lincoln & Guba (1985) comment that the researcher is an instrument in the qualitative research process that interacts with the situation or the phenomenon being studied. The researcher in this context has an opportunity to respond to environmental clues, provide immediate feedback, and request verification of data. The researcher can also explore unexpected responses, collect information at multiple levels simultaneously and process data as soon as it is available. Cresswell summarizes these points when he states that "...the researcher is an instrument of data collection who gathers words or pictures, analyses them inductively, focuses on the meaning of participants', and describes a process that is expressive and persuasive in language" (p 14).

By becoming an instrument I entered the world of my participants. I obtained descriptions of their reality, and sought clarification and verification of the information sought. I had the opportunity to explore unexpected information and I did begin to process the data immediately. Through the process of instrumentation, I inductively analysed and focussed on the meaning of the participants' experiences of supervision and their supervision needs in the context of multi disciplinary teams.

3.7 The Study

(i.) Method of inquiry

My thesis committee was essential in providing feedback regarding qualitative research. I explored with my committee the possibility of pursuing my research by using a case study as my method of inquiry. After some deliberation, it was felt that each participant is a unit of analysis , thus eliminating a case study as my methodology. After this meeting, I once again reviewed the literature for purposes of determining the best 'methodological fit' for my research question. Upon consulting with my advisor, I made an argument for phenomenology as my method of inquiry. It is essential to note that my research is not a pure phenomenological study because I have used a semi structured interview guide. This I felt was necessary to allow me to stay focussed on the research topic and to assist with reducing my bias based on my experiences as a social worker being supervised in the context of a multi disciplinary team in an inpatient setting.

(ii.) Definitions

The front line staff in the adult mental health programs that participated in my research assumed a similar occupational role, despite professional diversity. "An occupational role may be defined as a set of activities or potential behaviours associated with an office or a position in an organization" (Egan & Kadushin, 1995 ,3). " Front line staff" refers to staff who provide direct patient/client care and is used interchangeably with the terms participant, subject, clinician, respondent, interviewee, supervisee, worker, individual, mental health worker, and therapist. Examples of front line staff may include nurses or social workers who provide direct practice. The

terms first line manager, boss, superior and supervisor refer to the person who provides direct management and supervision to the front line staff. "Multi disciplinary team" is used interchangeably with "interdisciplinary team" and "integrated system". For purposes of this research, it refers to front line staff of different disciplines being managed/supervised by the same person. It also refers to front line staff of the same discipline being supervised by an individual of the different discipline.

"Team based health care rests on the assumption that groups of care providers, representing multiple disciplines, can work together to fashion and implement care plans that are both comprehensive and integrated" (Alexander et al., 1996, 38). It assumes that professionals who once worked autonomously and independently can now work effectively with other occupational groups as members of an integrated team. This approach further assumes that all disciplines are committed to the group and its' goals (McHugh, West, Assatly, Duprat, Howard, Niloff, Waldo, Clifford, 1996, 24).

(iii.) The geographical context: Northwestern Ontario

Lake of the Woods District Hospital is the hub of adult psychiatric services for a significant portion of Northwestern Ontario. Situated on Lake of the Woods in Kenora, the hospital houses a Schedule One Program that consists of a 19 bed acute care inpatient psychiatric unit, a detox program, a day treatment program, addiction counselling services, and community counselling services. Two psychiatrists are affiliated with the Schedule One Program and they also provide outpatient services to four other communities in the Northwest region. These communities include Red Lake, Dryden, Sioux Lookout, and Fort Frances. Lakehead Psychiatric Hospital, in Thunder

Bay, Ontario, acts as a tertiary care centre for the acute inpatient psychiatric unit, which means that clients requiring long term treatment would be referred to that hospital.

The acute care psychiatric unit provides inpatient services to a number of communities in Northwestern Ontario. These communities are Kenora, Red Lake, Dryden, Sioux Lookout, Fort Frances, and all neighbouring First Nations communities including the fly in communities North of Sioux Lookout. All of these communities are geographically separated by approximately an hour and a half to a three hour commute.

Red Lake, Dryden, Sioux Lookout, and Fort Frances all have community mental health programs situated in their communities. A psychiatrist from the Schedule One Program visits these communities every six weeks for assessment and follow - up purposes. These psychiatrists also fulfill the role of expert in the mental health field, providing educational services to workers throughout the district and ongoing client consultation. The First Nations communities are all equipped with nursing stations that liaison with the acute care inpatient team when needed. As well, some of the First Nations communities have addictions counsellors and mental health workers that can access members of the acute care inpatient team.

The geography of Northwestern Ontario is rich in natural resources. Communities in Northwestern Ontario offer people many recreational activities that include: hunting, fishing, hiking trails, water sports, camping, snow machining to name a few. The main industries consist of working at community mills, mining, and tourism. The population density for individual

communities ranges from 5000 to 30,000 people and in some communities their population can triple at the peak of the tourist season. The population density for the First Nations communities ranges from 200 to 3000 people with very few employment prospects.

Northwestern Ontario is a region that is culturally diverse with approximately 19 % of the population being North American Indian (Statistics Canada, 1996). Political diversity also characterizes this region with the provincial government representative being a New Democrat and leader of the official opposition and our federal representative being a Liberal and Minister of Indian Affairs.

(iv) The employment context

The inpatient mental health team is one of the mental health teams that exists under the hospital umbrella. The second mental health team consists of three outpatient mental health programs. These include Community Counselling, Addictions Counselling, and the Challenge Club which all operate outside the physical plant of the hospital but on the same property. During the past year, many changes have occurred in these mental health programs as a result of attrition, retirement, and mental health reform. Within these programs I have witnessed the manager of the Challenge Club with a background in occupational therapy be replaced by a half time social worker, the retirement of the social work managers for Community Counselling and Addictions Counselling and the joining of three programs that were once managed by three individuals being managed by one individual, a nurse. These changes have all occurred within the past year and I am currently witnessing the amalgamation of a youth addictions program into this adult mental health system.

Community Counselling and Addictions Counselling both offer long and short term counselling. Community counselling provides counselling on mental health issues, while addictions counselling provides counselling on addictions issues including drugs, alcohol, solvents, gambling and eating disorders. They also complete addictions assessments for residential treatment programs. The disciplines represented in the composition of these two teams include, nursing, psychology, and the dominant discipline, social work. All participants have experience being part of a multi disciplinary team. The current supervisor of these teams is a nurse while the discipline of their previous supervisors was social work.

The Challenge Club is a day treatment program that provides a structured day program, supportive counselling and case management services to individuals with mental illness. This program has undergone significant staffing changes during the past six months. Three of the four staff employed have begun their positions since January and because of this were not asked to participate in my research.

New Directions Counselling Centre has been quite progressive with embracing mental health reform. In this vane, during the past two years, they have received sponsorship for three new mental health programs. These include the Assertive Community Treatment Team (ACT) which has been described as a "hospital without walls". It is comprised of a multi disciplinary team that provides community support to individuals with severe and persistent illnesses. A second program is the Court Diversion Program. This provides emotional support and advocacy to people with mental illness who are involved in the legal system. The third new program is in the infancy stage and is a

residential program for people with severe and persistent illness who are at risk of becoming homeless.

The counselling program that is sponsored by New Directions Counselling Centre is the outpatient adult mental health program and this also includes a case management position that was implemented approximately five and a half years ago. The staff on the mental health team provide short and long term mental health and addictions counselling. The case management position offers pragmatic day to day hands on supportive counselling. The educational backgrounds of the individuals working on this team consist of two social workers, a life skills coach, an individual with a Bachelor of Arts, and a manager with a social work background.

Red Lake Community Counselling and Addictions Counselling Services is located approximately three hours North of Kenora. It is a small rural community with a population of 5000 people. This community has one community counselling service which employs three social workers, one psychometrist, and one individual with a Bachelor of Arts degree. The current manager is a psychologist, who resigned from his position February 28, 2001. The services offered by this program include mental health and addictions counselling, as well as case management.

(v) Participants

Members from three multi disciplinary teams in Northwestern Ontario participated in this study. I interviewed 14 front line staff. The educational background of the front line staff was diverse, consisting of psychology, nursing, arts, and social work. The dominant discipline was social

work. Prior to the interviews, I had informally contacted the potential participants that I had planned to use as my purposeful sample. The purpose of the study was explained and a keen interest in the subject matter was communicated by the front line staff. I then followed up on this interest in the form of a letter (see appendix 1) in order to obtain a firm commitment from my research participants.

All of the participants in this study are currently employed by an outpatient adult mental health program and members of multi disciplinary teams. Two of the participants are case managers. These positions are new in the mental health arena within the past six years. Their job role is to assist people with mental illnesses with very pragmatic one on one assistance. Five of the participants have dual roles as mental health and addictions counsellors, while the other seven participants have areas of speciality, four in the addictions field and three in adult mental health.

There are several features that these three programs share. Each of these voluntary programs have a similar referral base. This includes self referrals, referrals from community hospitals, physicians, the District acute inpatient psychiatric unit, and other community agencies. These programs can also access Lake of the Woods District Hospital which provides acute psychiatric services to the District. The District incorporates Red Lake, Dryden, Fort Frances and Sioux Lookout. The services provided include hospitalization, assessment, outpatient treatment and follow - up, and referrals to community based mental health programs. Community mental health programs in the District assist the inpatient hospital team in providing continuity of patient care. The inpatient team provides community agencies with comprehensive psychiatric assessments and

recommendations for patient follow-up.

(vi.) Demographics

The participants in this study are all employed by the three mental health programs previously described. The services offered by these programs are short and long term mental health interventions and addictions counselling. All of these counsellors have experience working as part of a multi disciplinary team.

The respondents in my research ranged in age from 28 to 55 years with the mean age being 41.5 years. Eleven were female and three were male. Years of work experience in adult mental health programs ranged from one and half years to 22 years with 9.39 years being the mean. The number of years of work in current position ranged from six months to 22 years and the mean is 7.28 years.

The educational backgrounds of the participants varied. Two front line staff have a Bachelor of Arts Degree, one has a diploma as a registered nurse, two have a Masters in Psychology, three have a Masters Degree in Social Work, five have a Bachelor Degree in Social Work, and one has a Bachelor Degree in Social Work and a Masters Degree in Psychiatric Rehabilitation. The job titles are slightly varied with two case managers, four addictions counsellors, three mental and addictions therapists and five mental health therapists. The professional background of the participants' managers included social work and psychology with the social work manager in the process of being replaced by a nurse. Eight participants have a

supervisor of a different discipline while six share the same discipline as their supervisor.

(vii.)The interview process

I met individually with 12 participants in their offices at their place of employment and for purposes of convenience for the participants, I met one participant in my office and the other at her home. These interviews were scheduled from January 24, 2001 to April 17, 2001. Using the semi - structured interview guide (see appendix 2), participants were given the opportunity to describe their experiences in the supervisory process.

The interviews were audio recorded in their entirety and they were supplemented with observational notes. One of the interviews did not audio record on one side of the tape comprising approximately 20 minutes of the interview. After consulting with my advisor and reviewing my field notes from this interview, I contacted this participant by phone. Once I explained the situation with the audio recording, this participant willingly agreed to meet with me in her office to complete the interview. The interview was completed on April 17,2001.

The purpose of this research was reviewed with participants and their confidentiality assured (see appendix 1 & 3). I did advise participants that they may receive a copy of the written results if it is requested and that a final written thesis will be on file at the Defoe Library upon completion (see appendix 3).

Due to the small number of front line staff being interviewed, it was not possible to ensure participants' anonymity. Participants were advised of this fact. Participants were told that their participation in my research was voluntary and that they could withdraw from the research at any time.

(viii.) Data analysis

The audio recorded interviews were transcribed verbatim on a computer disk, printed and reviewed. I proceeded to read through the text of all of the interviews and made notes in the margins. The text from these interviews provided the descriptive analysis of the lived experiences of my participants. Through the process of reading and re reading these narratives I became familiar with my data and the themes that emerged. Van Manen (1992) proposes that theme captures the phenomenon being studied. Therefore as part of the thematic analysis, the researcher should use the highlight / selective approach whereby the text of the transcripts are read on several occasions and the researcher asks, "What statements or phrases seem particularly essential or revealing about the phenomenon or experience being described?" (Van Manen, 1992, 93). This is the approach that I used. As I read through the transcripts I asked myself; What are my participants telling me? What are the main themes? How are they experienced? How is supervision understood? How did participants develop this understanding of supervision? How do participants describe supervision? How does each individual experience relate to the group experience?

I then proceeded to re - read the transcripts and on this occasion I documented, using a computer, themes that emerged and direct quotes that described these themes. This process was essentially a

cut and paste method that assisted with building a story around each theme that captured the experiences of those in my research. Through an analytical process involving deduction from supervision theory, as well as an inductive process I found that I had initially developed 18 themes. These themes included: The Clinical Function; The Administrative Function; The Supportive Function; Peer Model; Same Discipline Supervision; Different Discipline Supervision; The Team; Supervisory Relationship; Supervisory Likes; Supervisory Dislikes; Changing Needs; Didactic Supervision; Supervisory Enhancement; Shared Experienced; Technology; Outside Resources; Other Disciplines; and Supervisory Process. Themes such as the clinical function, the supportive function, and the administrative function were developed based on my theoretical framework while other themes were developed more inductively.

The next step involved compiling statements from the narratives into meaning units or clusters that represented the themes in my research. The purpose of this process was to capture the collective experience of the participants and to determine how this experience shapes the phenomenon being studied. Throughout my analysis I coded my data using a coding scheme that I had devised. All of my interviews were coded using the initials of the program for which my participants were employed. I then sequenced the numbers with the initials to represent the order in which the interview occurred , for example CC2, would mean Community Counselling, interview number two. As a method of organizing my clusters of data I then proceeded to expand my coding system so that it would easily direct me to the data I required. For example, if I were looking for information from my interviews that dealt with the participant's experience with clinical supervision, I would have coded the information CC2 - 7 - blue, which meant Community

Counselling, page seven, highlighted in blue. This code was documented under the sub heading clinical function along with other codes from the interviews conducted. I did not use a consistent colour scheme per theme because I found this to be a cumbersome process as a result of having so much data. This coding scheme was beneficial in that it captured not only individual experience but it also referenced the collective experience around the same theme. Referencing the data in this manner quickly provided a visual picture of commonly shared experiences and those that were unique. Consistently throughout my analysis I would reference my data and its interpretation with the actual interviews, thereby ensuring that I was capturing the true meaning of my participants' experiences and their perceptions based on these experiences.

This process of thematic analysis provided more clarity and new insights into the lived experiences of the participants. This resulted in consolidating the18 themes that had emerged into three broad themes that include; The Supervisory Framework, The Multi Disciplinary Experience, and Supervision - The Big Picture. Several of the original themes were better placed as a sub heading under the broad theme and the name of a few of the original themes were changed in order to better represent my findings. For example, the original theme, clinical function seemed to best be represented by the theme, the supervisory framework with a sub heading of supervision defined.

Once these tasks were completed I then began to interpret the data. Interpretative analysis is concerned with integrating common and unique themes in the collective experience. Cresswell (1998) proposes using three guiding questions within the phenomenological tradition while interpreting the data. The first question asked, what happened in this experience? This assisted me

with developing a textual description. Secondly, I asked, how was the phenomenon experienced? This question enabled me to provide a structural description of the experience. Thirdly, I asked , what is the essence of the experience? This assisted me in developing an overall description of the phenomenon (148 - 149).

The final stage of my analysis involved comparing my findings to the literature. My findings also present recommendations that could potentially enhance the supervision of front line staff in the context of multi disciplinary teams in Northwestern Ontario.

(ix.) Strengths and limitations of this research

The exploratory nature of my method of inquiry coupled with the participants sharing their experiences from their point of view, provided an information rich sample. The interviewing process that consisted of an interview guide and face to face interviews enabled me to gather information from the participants and to seek clarification on points that were not clearly understood.

Using a purposeful sample may have produced an information rich sample, however the research findings are not representative of the general population. Instead this research, as in most qualitative work, has sought findings that have depth, description, and meaning and explore intensively the participants experiences.

A second limitation is that more strength could have been given to my findings if my design had accommodated more opportunity for observation in the field and follow up interviews (Pauch,

1996,70). This could have established a more descriptive contextual framework for my data and analysis (Pauch,1996, 70). However, due to limited time, energy, and financial resources this was not possible.

Phenomenological research is retrospective by nature (Cresswell, 1998). It relies on participants to recall their experiences which may be suspect to subjective bias and distortions. This is the final limitation of my research.

(x.) Reliability and validity

"Authenticity rather than reliability is often the issue in qualitative research. The aim is usually to gain an authentic understanding of peoples' experiences and it is believed that open ended questions are the most effective root towards this end" (Silverman, 1993,10). I have used open ended questions in my interviewing tool, and in the face to face interviewing format, thus enabling me to obtain an authentic description of the participants' experiences and their reality. Hamersley (1992) states that reliability "... refers to the degree consistency with which instances are assigned to the same category by different observers or the same observer on different occasions" (cited in Silverman, 1993, 146). The authenticity of my research was enhanced through the use of audio taping my interviews and having them transcribed (Silverman, 1993, 11). This allowed me to review my interviews on separate occasions to ensure the reliability of my findings and the themes and clusters that were developed.

"By validity I mean truth: interpreted as the extent to which an account accurately represents the social phenomena to which it refers"(Hamersley, cited in Silverman,1993,149). There are three paramount processes involved with ensuring validity in qualitative research. These three processes include:

> a) achieving a participant - observer role within the setting that allows the researcher access to everyday meaning, rationales, and actions employed by subjects ;(b)initiating and monitoring appropriately situated methodologies for data collection and quality control of data; and (c)documenting the methodological procedures involved in the collection, analysis, and interpretation of data (Kielhofner, 1982,73).

In order to ensure the validity of my research I strictly adhered to two of the processes discussed by Kielhofner (1982). I used appropriate situated methodologies to collect data. As indicated by Kielhofner (1982) the best form of data collection with professionals is an interview, conducted as a professional exchange. This was my primary form of data collection. Secondly, through the process of documentation, I clearly articulated the methodological procedures involved in my data collection, analysis, and interpretation.

In order to enhance the trustworthiness of my findings a third process was employed to ensure the validity of my research. Once I had completed the findings section of my thesis I selected three individuals, one from each of the three programs represented in my study and asked them to read my research results and provide me with direct feedback about the information that I had presented. I choose the three individuals based on my work experiences with them and their direct

and honest approaches. The feedback I received was quite positive and each felt that I had accurately reflected their views and the views of their colleagues. However, one of these individuals commented that she was surprised that some respondents described not having met with their supervisor when they first began their jobs for extended time periods. This I believe to be a significant comment because this participant nor her colleagues had described this sort of situation as part of their experiences. This respondent demonstrated that she was able to identify her reality and have a sense of the collective realities of her colleagues thus rendering the comment as insightful.

3.8 Summary

This study explored the supervision of multi disciplinary teams in adult mental health programs in Northwestern Ontario in the fall of 2000, and winter 2001. By using a qualitative research paradigm in the form of a phenomenological study I pursued this research topic by obtaining a purposeful sample and by conducting face to face interviews, using an open ended interview guide. The goal of my research was to determine the supervision needs of front line staff in the context of multi disciplinary teams in Northwestern Ontario. It was the intent of this research to provide valuable information that would enhance current supervisory practices. This study adds to the limited literature on this subject and it contributes to our understanding of theories of supervision in multi disciplinary setting.

CHAPTER IV.

FINDINGS

THE SUPERVISORY FRAMEWORK

4.1Supervision Defined

People's interpretation of supervision is dependent on a number of variables. An individual's experience of being supervised is an opportunity to learn first hand what supervision entails. Literature on models of supervision or supervision theory can set a framework for people's understanding. By providing supervision, people can also foster perceptions and beliefs about this process.

It is through the process of being supervised that people learn from their unique reality. In my research, the participants' individual experiences are shared, and based on these experiences they described their understanding of their supervisory needs, the processes in supervision that they liked and disliked, and the models of supervision that worked best for them. Experience in my research is the teacher. It is also the process of not being supervised that gives people perspective on the value of supervision. They learn in its absence the significant role it can play in their professional development as it pertains to clinical maturity and skill acquisition. By experiencing their reality, front line staff have developed insights into their supervisory needs and how these needs can best be met.

For those interviewed clinical supervision appears to be the hallmark of the supervisory process. It is critical to the field of mental health because it is the process whereby staff can obtain clinical direction, share ideas, enhance professional development and it also ensures worker accountability. Most participants referred to supervision as an "... opportunity to reflect on cases ..." and "...ensuring best clinical practices are being utilized". One person stated that;

> I don't think any of use operate in a perfect way. I think that supervision helps you reflect on what your doing and I think it helps you think about alternate ways, I said that quite a bit but I think that as a professional I find it really easy if you are not doing any kind of reflection about what you are doing. Just go back, I call it your professional rut. You go back to the skills that you know and you use those. But sometimes that is not good, you need new skills or alternate ways because the skills you know are going to be limited in those parameters. I guess I'm interested in expanding skills, that is what kind of therapist I am. That is what kind of professional I am. I want to develop skills, I don't want to be stuck in a profession. Supervision helps me with that sense.

Despite the significance given to clinical supervision, it was not readily obtained by all respondents. There appeared to be minimal formal mechanisms in place that promoted clinical instruction and guidance. Most supervisees expressed frustration with this lack of emphasis and expressed a need for clinical supervision to be deemed as important by their manager and as a process that should be accommodated. This finding is captured by these two individuals;

> Initially before that I was receiving what would be called collegial supervision, which means you go to another worker to get feedback on how you are doing. There was no supervisory process in place.

> Since I started working here I have been supervised primarily by my colleagues. I have not received formal supervision, I have received informal supervision only and that has been at my request to a colleague that I am working with. It is as informal as would think about certain things, bouncing ideas to actually reviewing cases with my colleagues. Like I said though this is informal, it has not been set up by my employer.

The experiences just described are reflective of the experiences of many of those interviewed. Factors which have been attributed to the absence of clinical instruction included workload demands of the manager, his/her limited clinical skills and frequent obligations out of the office. Front line staff would have liked their supervisor to have been more involved. They would have liked him/her to have provided them with strategies to improve their clinical skills and "... to listen to what my goals are professionally".

Participants placed great value on support from their supervisor. ''The fact that I feel heard, I feel supported, I feel validated, I feel valued. I feel a part of being needed by this agency...", this was the language used to describe some of their experiences with supportive supervision. Respondents wanted to feel appreciated by their supervisor, they did not want to feel like they were being taken for granted. They liked it when their manager made time to "give them a pat on the back", to validate their work. They also needed to know that their supervisor would support them publically. One counsellor stated that;

> I feel extremely supported. There is a lot of validation for what I do and there is also appreciation too and that is given in positive feedback, both verbally and in an annual evaluation.

Supervisory support comes in many forms. It is the acknowledgement and validation for work well done and it is an opportunity to share "issues and struggles". Support recognizes and acknowledges the need for debriefing and it also includes staff advocacy. The essence of supervisory support is captured in the following comments;

> I think that it is really key. I think for myself anyway that it is crucial that I feel that I have the support of a supervisor that I can go to if a difficult issue comes up to seek advice or support. Also, just in terms of the day to day challenges of the job, just knowing that your supervisor is someone, if things go wrong that they will support you, they will be an advocate for you.

In order for support from their supervisor to have any significant meaning, front line staff needed their manager to have an understanding of the work being done. They wanted support from someone they perceived as having an understanding of clinical work, in other words, someone they perceived as credible. Support in this context was valued because it was coming from someone who had clinical knowledge and skills. One participant had this to say:

> Yeah, okay, I'm getting a pat on the back but to get validation from my co workers because they know what I'm doing means more to me.

Support has to mean something to its recipient. Many felt that their manager was not always aware of their work nor had the clinical expertise that participants felt they needed in their supervisor. In these situations support from their peers had more value because "...my coworkers are more on par with what I'm doing and more knowledgeable ...".

Within their description of how they have experienced staff support, almost all participants discussed debriefing. For most this was not an active process that was incorporated into their work place. They recognized the importance of such a process and some commented about how they would like to see a debriefing process validated and implemented into their current practices. One respondent described her experiences;

> I have clients that I talk to that have really horrible jobs, that have to listen to other people's pain all the time. I talk to them about how important it is to have debriefing and how our system has that and we don't (I lie). I do it informally with my colleagues. We encourage each other to do that so we don't have to go home with it so it doesn't become part of our families..

Mental health workers liked the idea of having a formal debriefing process that would help them cope with their vicarious trauma, which had resulted from the traumatic life experiences of their clients. This therapist goes on to state that when the opportunity for debriefing occurred that;

> It was really nice. I think that kind of opportunity to be able to debrief, to have something set up so that it is there for you. Otherwise it seems the expectation is that you should be coping with all of this yourself, you should handle this. Because there is nothing put in place if you're not dealing with it there must be something wrong with you. I think the reality is that saying it is important and we need to acknowledge it, we need to process and deal with it and put it into our system is important.

Minimal importance was given to the administrative component of supervision. Interviewees acknowledged that it is a part of their manager's job but for most the tasks of administration consisted of the very pragmatic day to day running of the office. For the training of new staff, the administrative component appeared to play a greater role. There was recognition that there is merit and value with informing new staff of the policy and procedures as well as teaching them the paperwork requirements of the position. The administrative qualities of supervision was described by one individual as " ...the housekeeping business of paperwork". Staff commented on the activities that comprise administrative responsibilities as, file audits, approving vacation, and ensuring that staff are adhering to the policy and procedures of the agency. This social worker summed up the administrative component of supervision in the following statements.

> I guess a couple of things come to mind. One would be staff supervision involves the very pragmatic day to day things such as work schedules, covering the office, disciplinary action, approving holidays, supervising the day to day functions, defining how paper work is carried out, how overtime is handled, if it is how crisis are responded to. These are some of the very practical procedural things

The two primary areas of focus for my participants included the clinical and the supportive components of supervision. The desire to grow clinically appeared to be paramount. They wanted to ensure that they were using the best clinical practices in meeting the needs of their clients, they also wanted to ensure that they could enhance their skills by identifying areas of professional development, and they needed to get support from their supervisor throughout this process. Clinical and supportive supervision were deemed as essential components to working in adult

mental health. Their value is illustrated in the following statements;

> I am a really poor proof reader. I think that it is really hard to proof read your own stuff because you are caught up in the material and I think that therapy is the same thing. It is hard to reflect on your own case because you are caught up in the nuts and bolts and you're not seeing the bigger picture of the other things and the supervision helps with the validation of "yeah, that seems to work, maybe this one could go that way, you went in the right direction" and just giving some pointers on how to build on the direction you started.

4.2 The role of supervision

All those interviewed concurred that supervision played a significant role in their professional lives. They believed it offered opportunities for clinical input, debriefing, validation, feedback, and opportunities to learn the policy and procedures of the organization. Clinicians also saw supervision as an avenue to hold staff accountable for their work and as an avenue to deal with issues involving conflict. Unfortunately supervision for many of my respondents did not conform to these principles. Rather, a number of participants did not have any formal supervisory process in place. Consistently comments such as, "I would have liked to have had more structured supervision" or "I didn't receive supervision. It was void. It was absent." were made. This lack of supervision was perceived by these individuals as a deficit in their program.

A number of reasons were cited for this lack of a formal supervisory structure. The reasons included: the managers' lack of accessibility due to commitments out of the office; the managers' lack of clinical knowledge; managers not wanting to deal with internal issues of conflict; and the lack of time due to the managers' administrative responsibilities. Comments such as; "...buried his head in the sand ..."; "the director is not around a whole lot..." and "... or if I wanted to discuss a

case with anyone, it would be with a co worker." were frequently made.

When their supervisors did meet individually with them, supervisees stated that they did find this process helpful. They described these experiences as positive and saw it as an opportunity to enhance their clinical practice, receive feedback and validation, and as an opportunity for evaluation and review of professional development goals. These clinicians expressed a desire to have this type of interaction with their supervisor on a more consistent basis. For many, consistency in what their "boss" could offer was important because it provided opportunity to solicit input on professional matters with some degree of regularity. Unfortunately, this was often absent. For instance they described having to defer dealing with specific 'issues' until their manager was available. This did result in some issues being unresolved and some questions left unanswered. As one individual stated, if the supervisor were more accessible ...

> things would not get put on the back burner. I think that sometimes when I think "Aw, I want to ask my director this" I would like some feedback about this", I would like to say that nine times out of ten I do get the follow - up on that but there have been times where I hit another session with that same client and I have thought to myself "Oh, okay. Did not follow up on that, did not get that supervision" if we want to call it that ...

Participants wanted to have this one to one interaction with their manager. Many articulated that once a month or once every other month it would be beneficial to meet individually with their supervisor. If this were not a possibility they were willing to explore other options such as their manager having an open door policy at a specific time every week whereby he/she could be accessed by their staff in order to address pertinent issues. The benefits of having a

structured time or an open door policy was that it provided front line staff an opportunity to prepare for supervision and thus have their needs addressed. Structured supervision is beneficial because;

> It would be a lot less stressful. I guess it goes back to the isolation piece and the best work environment I have ever been in was one that where there was weekly supervision set aside and you didn't only have to bring cases, you could bring your personal goals. There was a lot more planning involved so I think that ultimately you became a better clinician because you were future oriented and setting goals. So without the regular supervision you have to be really highly motivated internally and this job can be tough in that it is easy to slide down and get complacent with your skills.

For those who had a formal supervisory process in place, they articulated the benefits of such a structure. They described their experiences as very positive with a work atmosphere that was quite supportive and open. The lack of covert behaviour and the open door policy of the supervisor lent itself to the sustained health of the team. These clinicians found their manager to be clinically knowledgeable, accessible, and supportive. They believed their supervisor was quite approachable and appreciated the use of the "open door policy".

> I think it makes a huge difference when people feel supported and heard and validated and there is a sharing of expertise. I think it is really critical. I think the morale in this particular agency is exceptionally good because of that, that people feel heard and there isn't any corporate stuff going around. I mean I think it is open. If there is an issue it is out in the open.

Front line staff in this field often work in isolation, by this I mean they work alone with the client in a therapeutic session for approximately one hour. In this context the only viewpoints they receive include that of the client and their own therapeutic interpretation of the client's reality.

Supervision does offer an opportunity to present cases, discuss therapeutic options, receive clinical direction and feedback. It also allows supervisees the opportunity to debrief, because as trauma helpers we need to have a formal mechanism in place to deal with vicarious trauma if the health of the staff is to be maintained. Whether supervision occurs in an individual or group context, it needs to happen and these therapists wanted it to happen. One individual shared this perception of supervision and it is one that I strongly agree with;

> On the other hand if you have someone who can inspire you , I think of Vivotski and using scaffolding, I think a good supervisor is able to use that concept and bring you up and to build you each time you meet.

Supervision was important to the respondents in my research. All clinicians wanted some form of supervision to occur in their work environment whether it was one to one or in the group context. Despite the many benefits of the one to one interaction, some did feel that it too had it's drawbacks. The lack of a more traditional supervisory structure provided some supervisees with latitude in their work. It enabled them to extend their work to community projects and other areas of interest. This professional autonomy also gave them opportunities to develop their own clinical style without the constant direction of their manager. One individual stated that;

> ...I have a lot of latitude to be able to work in the areas that I see as important. As long as it makes the agency look good and as long as we are professional about it my boss doesn't really care too much about how we do it.

Assisting with the resolution of conflict is another role that can be fulfilled by having a formal supervisory process. Those who described having no formal supervisory process were the

same individuals who described significant issues of conflict. For all of these people, conflict had arisen as a result of questionable clinical practices on the part of a colleague. These participants felt that these conflictual situations could have been averted if their supervisor had been providing supervision to staff combined with dealing with difficult situations as they arose. If the manager was unable to deal with these issues participants felt that a mechanism should have been put into place to deal with them.

> And then you get into the clinical side and you have the gaps I am really fearful. In an ideal world I would like to be able to go in and just sit down and say "This is what I am seeing, here are some strategies and solutions" and it would happen. But in this situation that person does not have to follow through on anything they say, I can only encourage the person to do it. That sounds even when I say it I think that's part of what the supervisor has is that authority and you do it or there might be some outcomes that are uncomfortable, but I don't have that piece. And then I guess given that it may not always happen ideally we really need a person who is at least designated to deal with the difficult issues and is also competent to deal with them.

4.3 The supervisory relationship

Supervision occurs in the context of a relationship. Participants, I believe, wanted to have positive relationships with their managers. They wanted to have "respectful relationships" that would enable mutual growth. Those interviewed identified the importance of trust and mutual respect in establishing a supervisory relationship. They had a desire to trust their supervisor and a need to feel that their supervisor was "on their side". Supervisees discussed the importance of manager - staff confidentially and the necessity of ensuring good boundaries in this relationship.

Being defined as important by their manager was perceived as validating the supervisor - staff relationship. Front line staff did not want to be "sloughed" off to other colleagues; they wanted their manager to invest time in their relationship. When one participant was asked "What aspects of the supervisory process in your place of employment do you find the most helpful?" the response was;

> I think it is just the very general, very positive tone that the supervisor sets, it really is sort of a trusting, accepting, accessible sort of relationship, and it happens to be the type of environment that I tend to thrive in. That would probably be the most, just the accessibility and the positive interactions.

Inherent in the supervisor - staff relationship is the issue of power. Respondents described their appreciation of power as the manager "having more power" because ultimately it is the manager who has the authority to set limits, impose disciplinary action, and hold staff accountable for their work. The aforementioned depicts a more hierarchical structure, however the structure preferred by clinicians was a more horizontal structure that is indicative of a collaborative professional relationship. Most therapists felt that their supervisor did not impose hierarchy but at times did need to utilize their power in order to bring resolution to challenging situations. One individual stated that;

> I think that both can lead to problems, horizontal and vertical. Sometimes in a vertical you need someone telling you what to do. You need some of that vertical. A good supervisor has the ability to shift between both actually. To know when to shift, but primarily the core is operating on a horizontal and then at times a good manager has to be able to do that shifting and have that awareness. Not all managers have that ability. Some managers get themselves into trouble because they are too vertical and they don't need to be vertical. I was in an experience like that and times when the manager was stressed they became too vertical and authoritarian and you are in a bind as a worker because they are your boss.

Power does factor into the manager - employee relationship. One person stated that "... I think supervisors can get in your way or be terribly empowering...". Similar thoughts were expressed by others. Some participants believed that individuals in a position of authority can achieve balance between the vertical and the horizontal but that this may be attributed to their personality or the style of the supervision. Others stated that they viewed their manager as a team member who was their equal when it came to clinical matters. One social worker articulated that I "... don't see there being a power differentiation ..." when it came to the clinical component of supervision.

Power in the supervisory relationship can be misused. Several clinicians described situations in which they felt their supervisor abused power. In these situations this misuse of power was imposed to force staff to comply with specific requests or "punish" staff for being too vocal or non compliant. The result of this abuse of power led one individual to mistrust and lose respect for her supervisor. These sentiments are captured in the following comments;

> I think it can be a balanced relationship, but if you have a person who does not want to be in a balanced relationship, then it can be a sense of a power and control relationship.

Power was recognized by participants as an important aspect of the supervisory relationship. They saw the value of supervisors using their power in the appropriate contexts. Respondents wanted their managers to hold staff accountable for their work. They also wanted their supervisors to acknowledge difficult situations and address them because inherent in the supervisory position is the power and authority to deal with these situations. One individual stated that;

> I think they (supervisors) should do their job. It is one thing to have a philosophy that you are a professional person in terms of your decision making and I respect that but if there are behaviours which are not addressed than it is a problem.

In describing their relationships with their supervisor, many mental health workers used terms including "style" "approach" "personality click" and "good fit". These factors were deemed as relevant because it influenced the type of relationship most front line workers had with their supervisor. If staff had respect for their manager's abilities in terms of their "... skills, background or expertise..." they were more inclined to have a positive relationship with their manager. Clinicians' perceptions of whether or not their supervisor was good at their job was also important. Several workers commented on the skills of a good manager and these points are best captured by the following;

> When you are giving someone direction, it can come across as really critical and one of the things I have found is that good supervisors are able to do is draw out of you what they need. They are more skilled and better trained for the most part in this area. So good supervisors that I have had have lead you down to where you find it yourself. Awful supervisors tend to strictly impose something on you that may not even be working. A good supervisor does validate, and even if it is a small piece in this large learning process they are doing it. They might do it frequently on these small pieces so when you walk out of there you are encouraged to go that direction and incorporate it or go and read a particular book or to build your skills.

4.4 The peer model

Peer supervision appeared to be a consistent form of supervision practised by mental health workers. Approximately half of these professionals described a formal context in which this occurred. The weekly "team meeting" or "staff meeting" was the forum for peer case reviews. It

offered the opportunity to bring forward new client profiles, as well as an opportunity to present the more difficult cases. In this context the advice, direction and feedback of peers was solicited. Front line staff described this process as one that provided them with validation, support, and new insights into the client situation. One individual stated that;

> ...we can do our case reviews like we are once a week where you would bring a hard case or an easier one and you just need some validation — whatever. You could still go to your peer when you needed to ...

Informal peer supervision is just that, "informal". It was an ad hoc approach to providing support validation, feedback, and treatment options to colleagues. It most often occurred in the context of a safe and trusting relationship and it involved the art of listening to what peers had to say. How this informal peer supervision was implemented ranged from informal gatherings of peers to visiting a colleague in their office. Participants elaborated that there were occasions when they needed to debrief, review treatment options, or receive validation. In these situations they would often choose a colleague they trusted, someone with whom they felt they had an equitable relationship. One clinician stated that;

> Yeah, Um, my job is a lot easier when I know I have people that I can go to if I need support, supervision, debriefing whatever. People that I trust, rely on, people that know where I am coming from, that kind of thing.

Despite the positive attributes of the peer model, it does have its deficits. Difficulty with the peer model became apparent when some staff members were not meeting the expectations of their job. Front line staff recognized that they had a responsibility to assist a struggling colleague but

situations had arisen where this assistance was not welcomed. The peer model described did not give them the power or authority to deal with the situation the way they would have liked. In fact what did occur was tension in peer relationships. This problem speaks to accountability in the peer model. Participants expressed a need to have built into the peer supervision model a mechanism that would hold staff accountable. These thoughts are articulated in the following statements;

> ... I don't want it to be so peer that there is no accountability because what happens if as peers there is conflict you still need some outside person to intervene.

A second concern of the peer model is the potential risk of a peer to elevate him/herself to the position of expert. When seeking the support and clinical input from their peers, Participants described wanting to be part of an equal relationship where all opinions are valued. In situations where a co - worker is perceived to be all knowing, equitable relationships do not exist. When colleagues

> ...go to a peer asking for assistance, they can either assist you as an equal and validate you and support you as an individual, or they can pull their own supervision role as they are the expert and you know nothing.

The latter is not indicative of the peer model. Peer supervision is about validating each other, dialoguing about struggles, building confidence in your peers, offering support, and exploring options. Ideally,

> ...there is not power dynamic there at all. You are talking to your peer, you're supporting each other, you're dialoguing and getting help from each other. It is sort of saying that everybody is equal but to do our job we need to dialogue and bounce things off of each other. Maybe we even need to share personal struggles with each

> other. If you have a really good relationship you can get out some of the really difficult struggles that we have. We all have them as a worker. We all have days when we are just not functioning as well and not doing as well and didn't handle this case as well as I would have liked to. You let down your guard and be a person rather than a so called tight professional the way we walk in a lot of the time.

Peer supervision played a significant role in meeting the supervision needs of front line staff. Most participants recognized the need to have a formal mechanism in place that would permit peer case reviews. One individual shared her recent experience;

> So I like this whole concept of meeting once a week to share some cases with the whole team. I also get a lot of my supervision needs met just from my colleagues. Very very peer.

The informal process of peer supervision is critical in providing avenues for clinicians to get their supervisory needs met. They recognized the value in this process as a way to share information and provide clinical and emotional support when it is needed. One person stated that;

> ...we do a lot of peer supervision, we do a lot of peer consulting, we do a lot of "Hey, here is what happened.". There is probably not a day that goes by that one of us is not in another person's office saying " What do you think about this or do you have anything on a..." a specific disorder.

If the peer model is important, supervisors need to validate and encourage the implementation of this model in the work environment. Some respondents expressed ambivalence about whether their manager supported this supervisory framework while others felt that this was the model of choice endorsed by their organization. Managers need to be clear what their expectations are and if they say

...that peer is important then you also have to make sure that peers are allowed to do that and not being looked at as "What are you doing talking again instead of at work?". The expectation needs to be clear then that is valued in the system and not just squeezing in time so that I end up phoning my colleague on the phone just so that people aren't saying that I'm saying " I have a really bummed out case here."

THE MULTI DISCIPLINARY EXPERIENCE

5.1 The team

The functioning of the team played a significant role in the lives of mental health workers. The openness of the team , the respectfulness of its members, the acknowledgement of diversity, and the willingness of team members to support and advocate for one another lent itself to healthy team functioning. Commitment to the team and a willingness to be an equal team member were also perceived as contributing factors. Several participants shared that they had a great team and what made it great was that team members made time for each other and that individuals on the team had established collaborative working relationships. One therapist shared this experience;

> You know we have a great team. It really depends on the personality of the people here. If we had people who were like "Well I'm too busy to talk to you !" and it happens. I mean you have people that you get along with and people that you don't get along with. We have a great team here. If personalities were different I think a person could be really lost.

The personality of team members affected team functioning. This experience was described by many interviewees. Clinicians wanted all team members to have equal status, they desired an equitable peer model that allowed them to work collaboratively with their colleagues. Equality among team members was perceived as imperative. Several staff members described situations that did not reflect this reality, rather they described situations whereby team members would assume the "expert role" in which a peer was elevated to a position of power. This was not what front line staff desired. What they desired was to have no "...type of power differentiation between new and

old staff." This power differentiation did lead to personality clashes among team members that resulted in the team not operating as effectively as it could. For a team to operate effectively, team members need to be committed to the team and make the necessary efforts to develop trusting, collaborative relationships with their colleagues. If this does not occur, "... it could be really awful. It could be I don't want to go to work tomorrow! I cannot stand the thought of walking in the door! I've been there. It's horrid".

Unfortunately, healthy team functioning was not the experience of all respondents. The polarization of team members led to a division among staff and negative behaviours. Front line staff recognized this as an area of concern and expressed a desire to be part of a well functioning team. In order for a healthy team to exist, they felt that there needed to be an acknowledgement that disagreements will occur but also that there is a process in place to deal with these conflicts as they arise. There also needed to be an acknowledgement that:

> ...people all bring different personality styles and preferences and somehow we have to live in this marriage that takes place eight hours a day. There are going to be disagreements and we need an avenue to work them out.

Healthy team functioning does enhance the effectiveness of the peer supervision model. Peer supervision is based on mutual trust, respect and sharing. It is about making time for your colleagues in an informal or formal situation. For a number of clinicians, the effectiveness of the team is what enabled their peer model to work successfully. The functioning of the team can either create a positive or negative work environment, and if the latter exists it can be

> ... demoralizing and if you don't have colleagues to rely on and you don't have formal structure in supervision, you've got people that are floundering, they are out of depths in the water and they're drowning.

Respondents wanted their supervisors to take a leadership role. They wanted their supervisor to provide direction, deal with issues of conflict and clearly articulate his / her expectations of their staff. Therapists did not want to flounder or feel out of their depths, they wanted their manager to be someone on whom they could rely. Consistently, supervisees shared that they could not depend on their supervisor for support, validation, clinical direction or conflict resolution. For those individuals who felt that their supervisor was accessible and willing to fulfill their job functions, they described a work situation that was characterized by job satisfaction and positive staff morale.

5.2 Composition of the team

Multi disciplinary teams in adult mental health programs are an evolving anomaly. For participants it created opportunities for professional development but it also threatened their professional identity. Most therapists enjoyed working with other disciplines. The manner in which problems were conceptualized and the methods used to deal with these problems were valued. They felt that there was merit in what these colleagues had to say and the different theoretical frameworks they would share. Front line staff "found room" for their ideas to be different from their colleagues and when required would seek out the opinions of those with other professional orientations. One individual summarized this experience:

> I like it because of the various perspectives that we get and different ways of viewing a case or situation that we get. Someone may see it

> this way and another person with the social work part may see it differently, someone else in say psychometry may have a different perspective also, some behavioural suggestions.

Despite the positive contribution that members of multi disciplinary teams provided to each other, concern was expressed that being part of a multi disciplinary team can threaten one's professional identity. As front line staff became more immersed in their roles as therapists they perceived themselves as having generic skills. One clinician stated; "... we are all generic, we all belong to the same union, here's what I do.". 'What I do' is essentially the same for all therapists regardless of their professional training. Another participant concurred with these comments, however, she felt that the opportunity was available to develop a clinical speciality; "... we all have generic skills, all of us have an expertise in a specific area ...".

Professional identity is important. Most professionals have colleges to whom they are accountable. Membership in their college was an employment requirement for most front line staff. This was one avenue by which they could maintain a connection to their discipline. However, this was not enough. Several participants indicated that they do not think in terms of discipline anymore but rather in terms of 'style' or 'approach' to therapy. They acknowledged that the mental health profession is comprised of many disciplines and that it is an eclectic combination. Some respondents discussed feeling detached from their discipline. One individual stated, "Actually discipline seems to become less important.". The loss of professional identity was a legitimate concern of the front line staff and it is acknowledged by this social worker:

> I know it has changed somewhat, there are new types of thinking going on. I don't think much as a social worker anymore in terms of

> my line of thinking. I might have similar sort of philosophical viewpoint about client self determination. To me it is working not in a specific field. Discipline is really not a big deal anymore. I still call myself a social worker but I don't really feel attached to the social work profession.

The erosion of one's professional identity was echoed by a number of participants. As a way to defer this erosion, front line staff would frequently consult with colleagues of the same discipline in order to get a "same discipline" response. Through dialogue with members of the same background, clinicians used the language of their profession and would quickly comprehend what the other was saying. Most of these therapists, I believe wanted to maintain their professional identity. They saw the value in maintaining this identity because;

> It creates some security in a very insecure government climate because if I maintain my professional identity and things don't work out here, then I can move on. If I have lost all my skills and credentials by being immersed into a multi disciplinary team, then I am vulnerable. With all the talks about cutbacks and mergers that are happening it motivates you to keep up your professional end for your own self protection.

Working in mental health does attract a number of disciplines. Despite the diversity in training the job functions of these disciplines are often the same or at least quite similar. Many respondents commented that there was an expectation for them to be proficient in their field. This diversity in the field coupled with the lack of discipline specific supervision contributed to the erosion of the professional identity of some of the therapists. Several reported having no separate distinction from their colleagues, only the letters they would place behind their name. Participants discussed their jobs and experiences as providing mental health and addictions counselling to their clients, as well as, some case management responsibilities. Their roles were the same, despite their

training. For many of these clinicians they were not actively receiving formal supervision. They were receiving ad hoc supervision from their peers. Some respondents felt (and I too believe) that this has eroded their professional identity. One individual shared this belief:

> I don't tend to think of it as discipline specific any more in terms of supervision. It is more or less the person's style which is important, especially in mental health because it is kind of generic profession where there are people of various disciplines.

5.3 The discipline of the manager

The discipline of the manager evoked much discussion. Participants who stated that they preferred to have a supervisor of the same discipline based their preference on their belief that their manager had a better theoretical understanding of their profession. They elaborated that this better theoretical understanding was evident when clinical issues were discussed in that the discussion was not a long drawn out process and they could get where they were going quickly. Issues concerning the language and the processes of the profession were believed to be better understood when the manager was of the same discipline. Professional validation was seen as an important contribution a supervisor of the same discipline could provide. Validation in this context appeared to hold significant weight because validation was being received from a person of the same profession who was in a position of power and who respected their work and their opinions. This individual shared her experiences of being supervised by someone of the same profession:

> I actually quite prefer it. Partly because I have been in a situation where I was supervised by someone who had a college diploma in Social Services and that was probably the hardest one. When my supervisor and I talk, we do know where the other is going quickly so it is not a long drawn out discussion trying to establish what we

> are talking about. So that is helpful. We agree that we have different areas of preference within the domain and I actually think that my supervisor has a lot of respect for my particular choice of areas that I prefer to work in. What I have noticed is that he often defers to me on those particular areas that I think is nice. Having someone that has the same background does I think work better because we can cut to the chase and we do talk a similar language.

Supervision in mental health programs was perceived by some mental health workers as no longer discipline specific but rather more dependent on a combination of the knowledge, style, and experiences of the manager. Front line staff felt that they had opportunities to learn from a supervisor who had a different clinical orientation and they welcomed these new strategies, frameworks, and approaches to providing service. Participants generally described their experiences as more of a

> ...different way of working and I find it quite refreshing because I am quite open to looking at alternative ways of working. I find that quite a useful thing, to be getting a different dynamic.

For respondents who shared this reality there was a recognition that one person could not meet all their supervisory needs. This resulted in therapists finding creative ways of getting their needs met. Having a manager of a different discipline, I believe, gently pushed clinicians to look outside the parameters of their program and access resources that could enhance their clinical knowledge. One social worker commented that:

> What I have said is that I would like a supervisor who had that knowledge but that is not what she is hired to do so I have to learn to live with that and create it so it is there. I think she has some appreciation for it and that is why she is really encouraging us to use the consult line and she seems to be open to purchasing some expertise when we need it so maybe a year from now I may have a different answer. I might say that this model is livable and you just

> have to do it very differently. It might be bringing us some change. Perhaps if they had just hired a social worker that person might have said "I am going to do all your supervision needs" so that we would not be getting some of the outside stuff formally. I think we have already had it from the psychiatrists coming, now maybe we are seeing some new things so sometimes change that you don't like can be helpful in the end.

Several participants stated that they felt that supervision was not discipline specific. They seemed to hold a common belief that;

> ... if a person has a good basic knowledge of how to do therapy it really doesn't matter much what the individual disciplines are. If a person is an occupational therapist doing psychotherapy they can get their supervision somewhere else as long as there is some accommodation for it,

Again the discipline of the manager does not appear to be as relevant. What was important to these individuals was that their supervisor have an appreciation for discipline specific knowledge. They wanted their manager to be aware and appreciate the approaches and processes involved in therapy. These respondents felt that is was important that their supervisor not just be concerned with the administrative component of the client paperwork, but actually ask questions as to why a specific technique was being used . For these front line staff clinical knowledge and an appreciation for the specific disciplines was imperative. They believed that a manager's lack of clinical knowledge presented opportunities to "accommodate" other forms of supervision. However they maintained a commonly shared belief that if:

> A good person with an MSW or a good psychologist or whoever happens to be in the supervisory position is capable of supervising the other disciplines if they are sensitive to some of the basic teachings of the other disciplines. Social work focuses on things like structural family therapy, strategic family therapy. A person has to be knowledgeable enough at least to know what somebody is talking

about when they are working in that way.

The discipline of the supervisor appeared less relevant when it is compared to the discussion concerning whether or not he / she had clinical expertise. Most therapists felt that there is a real belief on the part of their superiors that because they are professional they are proficient in their fields and as such, do not require supervision. However, front line staff want supervision; they want their managers to have clinical skills in order to augment and direct their learning. If the manager does not have clinical skills, participants want him/her to acknowledge the importance of supervision and build it into the program structure.

> I think it is very important they have some knowledge of what we are doing. How else do you get recognition of what you are doing? Support, validation, how else do you get adequately challenged? How else are your educational needs looked at and provided for if people have no appreciation of what you are doing and what that encompasses. If they don't have the expertise themselves how can they give it to you? How can they oversee or know when you have got it? If they don't know what you've got how are you valued? How are you recognized for the work you are doing and the energy you are putting in to get there?

The managers possession of clinical knowledge was more important than their discipline. If a he/she could offer clinical support and direction it was perceived as a real asset to the front line staff and the team. A commonly shared belief held by mental health workers was that if a manager does not have any clinical expertise, they could not offer their front line staff therapeutic treatment options, support in the context of clinical guidance and validation, or accurate staff evaluations because he/she would not know what to evaluate. Those interviewed felt that in a therapeutic work environment their supervisor needed to be capable of offering them some clinical input with both

individual cases and group work. In an ideal situation, several participants believed that it would be beneficial for their manager to be their mentor, however there was also the recognition that this is not always possible.

> In an ideal world, my manager would be somebody who could offer some clinical supervision. Somebody who could provide direction for where the program is going for program evaluation, to be able to sit down with us and say "okay, just because we have always been doing it this way, does not necessarily mean that we always have to do it this way", to sit down and give us some direction in terms of, most of the direction for us is in terms of running groups or making changes in our program as comfortable for the front line staff and has been motivated for the front line staff. So it has not even been at a meeting or anything it has been kind of off the cuff. " I went to this workshop, it looks like a good group". "Do you want to try running it?" type stuff as opposed to sitting down and saying " here's a gap in services." "What are we going to do?"

Most clinicians recognized the value of their manager having clinical knowledge. In those situations where frontline staff felt that they had more clinical insights and experience than their supervisor they wanted him/her to acknowledge that clinical support is still essential, and if their manager could not provide this or "... don't have it they should validate the fact that it is needed and do something to incorporate that.".

Some front line workers felt that the nonavailability of discipline specific supervision coupled with the supervisor's limited clinical knowledge had threatened traditional practices. Many therapists described not having been able to access same discipline supervision for many years, while others described having more clinical expertise than their supervisor. For these individuals this

resulted in them seeking out their colleagues for validation and clinical direction "...because my co workers are more on par with what we are doing and more knowledgeable...". The experiences of these front line staff are not reflective of traditional supervisory frameworks. One social worker shared the following insights;

> I think what happened is that when you have a manager that does not have clinical expertise that the supervision gets eroded and then you're lucky if you have front line workers that are ethical and accountable and know what they are doing, then that's great, but if you don't then that is where you are going to run into trouble.

Participants wanted their managers to have an appreciation and an understanding of their work and have clinical training that would enable them to recognize problem areas in their clinical practice. They also felt that a supervisor's clinical insight was beneficial because

> ...you need to have somebody who knows what is going on and how skilled your front line staff are, otherwise we are just going to go and continue what we are doing without any understanding that, I mean, unless you are a very self aware person, you don't think you are doing anything wrong and you don't have a manager who doesn't know what to do, then you are going to run into difficulties.

Therapists wanted their managers to be clinically and emotionally available to them. They wanted a formal process that would allow them to better get their needs met. Most respondents discussed wanting to have one to one supervision with their supervisor for purposes of case review, debriefing, and emotional support. Front line staff recognized that this can occur in other forums such as peer case reviews. There was certainly an emphasis on a formal supervisory structure and it was found in the comment of this participant. "We are lacking something in clinical supervision, a formal process but we are starting the process of looking at some ideas.".

Most therapists recognized that their supervisor could not meet all of their supervisory needs. They were using other resources to augment their supervisory needs. These other resources came in many forms including, consulting psychiatrists, community liaisons, staff training, the internet, and their peers. This point is illustrated by the following comments;

> And I guess like I said earlier, starting to use the consult line more often, starting to maybe use other people outside of the agency and even in the community. That is not formal that is very much an individual thing, you do as you need.

Changes in the supervisory process were inevitable because of the restructuring in the health care system and the diversity of the disciplines providing mental health counselling. These changes deviated from traditional frameworks and required that front line staff become creative in getting their supervisory needs met. Despite their experiences of the changing realities of supervision, most clinicians' perceptions of ideal supervision were consistent with the more traditional framework that they experienced while they were in university. Several clinicians described intense traditional supervision during their years in training. For one individual ideal supervision:

> ... is that you have a much wiser and clinically better person supervising you and someone who wishes you well. That should take you on as a protege and try to get the maximum they can get out of you. It makes you strive to be better, because you want to please your mentor and you want to be the best you can be. You are getting stroked when you are doing something good. So that has been historically absent from my experience.

5.4 The team meeting

All participants commented on their experiences in the weekly team meeting. For some this forum was called a staff meeting, others a team meeting or still others a case management meeting and it was in this context that a number of clinicians had there supervisory needs met . For those individuals who referred to these meetings as a team meeting their appeared to be a more congenial atmosphere that encouraged the sharing of not just administrative information but clinical consultation as well. They reported that their team meeting gave them the opportunity to share client information and solicit feedback. One mental health worker shared this experience:

> Okay. For example, I would bring forward a new client I am seeing, here is the basic presenting problem, here is the protective factors or the things that aren't right and getting worse, here is what is really feeding into the problem and here is my temporary plan right now. Here is what I think I am going to go. We get feedback from each other from the director around "Well that sounds really good, or have you thought about this or what about that."

These positive experiences were not shared by all participants. A number of respondents commented that case reviews did not work well for members of their team. What was interesting was that for these individuals their meetings were called staff meetings and not team meetings. The atmosphere of these meetings certainly appeared to differ from the situation just discussed. This is evidenced by the following:

> When the main purpose of a staff meeting is to finish as quickly as possible so that we can get on with our tasks, when you are bringing up a case and everyone is looking antsy to get out of the room you feel like you shouldn't be bringing it up.

Many therapists felt that the priority for staff meetings was the sharing of administrative information coupled with case assignment and that any additional time could be spent on case reviews. In this context peer case reviews were not the priority and in some situations if time did not allow these case reviews did not occur. For some mental health workers case reviews were usually the last agenda item for their meeting. This is illustrated by the following experience;

> ... so any management issues, administrative issues, whatever so that is when holidays, days off, who was out of the office, who is in the office, any new groups we were running, any workshops we might attend, things were brought, any kind of office management stuff. That usually took the first hour. The next little bit is going over new intakes that came in so depending on how many intakes we have, we could go through each one and discuss it, figure out who might be the best therapist so that can take anywhere from 15 minutes to an half hour and that leaves us about half an hour to discuss any cases we may want to discuss.

The assigning of new cases and the sharing of administrative information were similar meeting activities discussed by all front line staff. For those clinicians who described their meeting as a team meeting, they had built into their meetings peer case reviews. In these situations there appeared to be an emphasis on the team and a healthy work atmosphere based on mutual sharing and mutual respect among team members.

SUPERVISION — THE BIG PICTURE

6.1 The needs of the worker

(i.) The New Worker

As front line staff described their recollection of first starting their positions in adult mental health, they did articulate a number of needs. Supervisees shared that they would have liked their supervisor to have made time for them and to clarify the job expectations and the processes that were in place to fulfill those expectations. Participants, I believe, needed and desired guided direction that would have enabled them to develop confidence in their abilities to do their job. They wanted to develop a relationship with their supervisor in a traditional supervisory relationship because it was this person to whom they were accountable. One individual stated that:

> Supervision should be part of (even if it is once a month depending on the manager's role) a manager's role to have a supervisory relationship with their employees and that does not happen..

Many clinicians described situations in which they did not speak or even see their supervisor for many weeks when they began their positions. This resulted in new staff having to rely on their colleagues for their orientation and training. One individual shared this experience:

> I think it would have been nice if the supervisor would have given some clarity in direction of what the expectations were, of what the job was, if someone would have been clearly assigned so I wasn't constantly having to burden my colleagues although they were great about it. They were also fitting me in to their busy schedules as well. I was taking over a full time position of a person whom had been here several years already so everyone had their full caseloads. And to

> have to stop and find things for me, get things for me show me how to do things, definitely added a lot of extra work for them without acknowledgement or recognition for that.

This was not a unique experience. Many similar stories were shared. Participants described how their colleagues would provide them with peer support and supervision. This occurred in an ad hoc fashion with the exception that in some situations there was a weekly peer case review. I believe based on the information provided from respondents, that in most situations the front line staff were the individuals that provided supervision to new workers. This frequently occurred without a formal training mechanism in place and without the power and authority to do so. Many individuals described feeling that they had a responsibility to assist new colleagues because this was how they had been trained. One clinician recounted this experience:

> As a new staff coming in the door I don't believe that my supervisor actually spoke to me for the first month. So as far a finding my files, having cases it was completely coming from my colleagues. They definitely took a very active role in my training, in my learning. My supervisor provided me with a huge policy manual and sent me to my office with that. He came to me approximately a month after and said "I'm sorry I haven't had a chance to see you, how are you doing?" So peers automatically took on that responsibility.

Many respondents stated that they needed to have in place some supervisory process that would have offered consistency in their training. They indicated that they wanted:

> Just the chance to be with one person regularly, who is in a managerial role so that it gives me information that I have to pay attention to and helps me to develop consistently over time. There is structure where maybe we meet once a week initially and then every two weeks after that with one person. And the other thing is because that allows good boundaries. One of the essential qualities of supervision is that what you say is confidential.

When most therapists began their jobs in adult mental health they believed that they needed some form of a structured supervisory process. This was not the reality for most supervisees. For those workers who had a formal process, they felt that it provided them with an avenue to acquire clinical support and knowledge and it allowed them to be clear on issues concerning policy and procedures. It presented opportunities to ask questions and seek clarification, as well as receive feedback and validation. In this situation they reported that their supervisor was accessible to them and that he/she was someone they could seek out when the need arose. One individual described this experience about the role of supervision:

> ...the collegiality, the being supportive, the trust, the giving me the space and independence I need to operate creatively and in a creative way. It is really good with this particular supervisor. It's the mutual respect, accessibility, looking for my input and respecting and implementing sometimes what I have said

Difficulty did arise for those front line staff whose programs did not offer a supervisory structure for new staff. Some clinicians reported that some of the policies and procedures were not clearly articulated to them. Others described situations in which they were floundering because of limited clinical supervision. These individuals stated that they received feedback from a number of their peers on an informal basis and for some of these participants that was somewhat confusing. The lack of consistency in how feedback was attained and from whom it was obtained prohibited a healthy supervisory relationship to develop. Supervisees in this situation wanted to be accountable to their manager, not to a group of their peers with whom they wanted to secure equal status. They wanted their supervisor to define them as important by meeting with them on a regular basis (at least in the first months) rather than be away from the office where they could not be accessed.

They also reported wanting balance in the feedback they received both in the form of constructive feedback and validation. This reality is shared by this clinician in the following statements:

> Initially before that I was receiving what would be called collegial supervision, which means you go to another worker to get feedback on how you are doing. There was no supervisory process in place. That was confusing for me because I found that you need a one to one person over time especially as a new person to get supervision. If you start going to too many people you are going to get different responses and there is a different fit. You haven't got the chance to build a relationship with one person. And I noticed there were two people, but no one person was permanently defined as my supervisor so it was kind of confusing and I had to pick and choose who I would go to for different points and different reasons. My supervisor initially suggested that I go to certain people to get feedback. I think it puts myself and the other person in a bind because they are not seeing me ongoing and sometimes the fit is not always a good fit and if the person does not actually have responsibility for that position in the first place than it is a rather complicated process. Supervisory confusion I call it.

This lack of supervisory processes for new workers also created challenges for team members. Most front line workers described situations where they were responsible to orient and train new staff. One individual commented that, "We have typically been responsible for all the complete orientation of new colleagues.". These clinicians felt that they had a professional responsibility to assist their colleagues, particularly since their programs had no supervisory structure in place that could adequately address the needs of the new worker. Most respondents who provided new staff with peer supervision did so willingly, however they found themselves in a dilemma when they recognized that the new worker was struggling. This situation is illustrated by the following comments:

> Where the difficulty comes in is because we are on the same level as the other workers it is very difficult when there are glaring errors in maybe a skill or if someone is not following through with policy and procedure because I am not in a supervisory capacity. But I have to act as if I am. Then when it has been done it has had to be done in a very gentle way because it is easy to have resentment.

Participants wanted a supervisory process in place that could have better met their needs, the needs of new workers and the needs of their team members. The past experiences of most mental health workers placed much emphasis on team members to orient and train new staff. This process was not proven to be effective because team members did not have the supervisory authority that was warranted in some situations. Front line staff wanted to provide peer support and supervision to their colleague but not in an official supervisory capacity because it elevated team members to a position of power when all team members wanted to be on 'the same level'. What I believe respondents needed and wanted was for the supervisor to be more actively involved with their orientation and the orientation of new staff by providing more direct leadership and guidance. I believe, that clinicians would have also desired a more formal orientation and training process that would have provided them with a clear understanding of their job expectation, administrative process, and clinical direction. These points are articulated in the following comments:

> I guess ideally is to have a supervisory relationship right away, come into a work place and it is set up and defined for you. And it is not with your colleagues. I don't think it works with your colleagues. I think it works with your manager doing it myself, because the manager has the job and collegial puts you into a certain friction level. For me, I have always worked with someone kind of being my boss and being in that position.

(ii.) The Seasoned Pro

Supervision was seen by those respondents who had experience in mental health as a valuable process. They felt that they could still benefit from case reviews because learning is ongoing and it is important to stay aware of counselling techniques and strategies that are available. Supervision was perceived as a way to stay challenged and it allowed clinicians to avoid the "professional rut" that results from using "the same three tools". At any stage of one's professional development, mental health workers felt that there is a role for debriefing and validation that supervision provides, at least in part to sustain their own mental health.

There was a recognition by most therapists that life happens to all people including themselves and as a result they were not immune from issues of countertransference. Supervision was seen as an avenue to address these types of issues and as a way to prevent them from occurring. One woman shared these thoughts;

> I think that there should be a regular supervision set aside and enforced. It would not have to be as frequent of course with a seasoned worker as opposed to a new person but not forgetting that even a seasoned worker would benefit from being able to talk about cases or issues within themselves or whatever may be affecting their work. After a death perhaps for a while not working with death as a presenting issue because it could dredge up so much with oneself, or even after a divorce or major life experience for a while you may want to get some perspective because one's own experience may impact on the approach of the case. I think a supervisor also checks in to see how life is happening with the worker and how it could potentially cause a problem.

One challenge that was presented by a number of therapists was the tendency of more experienced workers to become dismissive and less willing to learn. In these situations front line staff indicated that there was a one upmanship whereby the experienced worker would assume the role of expert and dismiss input from their peers. In these situations several respondents felt that they could not consult with this colleague because "... if I meet with this individual too often then I don't have the confidence to go into the office and do what I need to be able to do" One individual stated that;

> I think that as you move through a profession, there maybe a tendency to become dismissive, to do the sort of one upmanship where you say "Well you think that is bad ..." now I have worked with and can rhyme off this whole litany of clients ...

In situations like this several front line staff felt that it was difficult to successfully implement a true peer supervisory model. They elaborated that these situations often led to tenuous peer relationships that affected the health of the team. It was in these situations that participants felt individual supervision would be beneficial.

Several 'seasoned' front line staff felt that one person could no longer meet all their supervisory needs. They believed that it was important to have a boss to whom they were accountable but that they did not have the expectation that their supervisor be all knowing. One person commented that; "... I don't think that the expectation be that they meet all our needs". These individuals had found creative ways to get their supervision needs met that went outside the scope of the traditional framework. Despite this, these participants believed that there continued to

be merit in meeting one to one with the manager on an infrequent basis and they saw value in peer case reviews.

> "What are you doing? How are you doing it? Where are you going with it?" so you know that you're not just going with the flow, you have a plan here and what is the plan. Even now I think that would be helpful to have somebody do that. Not necessarily once a week but it could be once a month and then have them say , "yeah, I think you're on the right track" or "have you thought about this" or" have you thought about that".

6.2 Mutual needs

(i.) Evaluation

There was recognition by mental health workers that their supervisory needs changed as they acquired more experience. Some similarities continued to exist between the new worker and the seasoned pro. Most respondents discussed the importance of evaluation. They believed it "...should be a useful and practical process" that would offer them opportunities to receive not only validation and feedback but it would also enable them to identify areas in their professional development that required enhancement. It was perceived to be a mechanism whereby they would identify learning goals in collaboration with their manager and then develop a plan of action to achieve these goals. Most of the front line staff in my research did not receive formal evaluations with any degree of regularity. Most reported having a desire to have this process in place and identified the absence of evaluation as something that should be changed. One individual stated that; "...evaluation, I think is one thing that is lacking.". The experiences that were recalled concerning evaluation spoke to it's absence at all stages of workers' professional development. Many front line staff recollected never having had a formal evaluation when they completed their probationary

period. What was remembered was just an informal comment in passing, such as; "Oh by the way I have written your letter and you have passed probation.". While another participant ..."assumed that he was not around and it got missed." . These were not unique experiences. As clinicians matured in their professional roles, the evaluation process became more elusive. Many reported not having an evaluation in years, while others could not remember when their last evaluation was completed. One supervisee commented that, "...I have not done it in years.". And another individual shared this experience:

> But also, I don't think that my supervisor has ever seen any of my written work, certainly my supervisor has never asked to sit in or hear a tape or video of any of my clients' sessions. My colleagues have seen my written work and they have commented on it. Similarly they have heard my perspective on a particular session but I have never had anyone sit in with me as a way of evaluating what I am doing and where I need to improve

Those participants who did receive a formal evaluation indicated that they found it to be a worthwhile process. They stated that their evaluation was based on feedback not only from their manager but also on input from their colleagues, community resources, and clients. The actual meeting to discuss the evaluation occurred one to one with their supervisor.

> It is based on observation through my files and recordings, through client feedback. I have to do client feedback every six months through this office, so that is taken into account. Also my peers as well as my collaterals in other agency feedback, from presentations and stuff that I get, we get copies of those and the two of us sit down together each year and put our goals for the year and then we have evaluations and see what goals have been achieved and identify new goals for the following year, so it is pretty inclusive I think.

Respondents wanted to have formal feedback by way of a staff evaluation. Several clinicians described this process as "lacking" in their programs. They believed that the evaluation process would have enabled them to review with their manager their professional development goals and the means to achieve them. It was also perceived as an opportunity to receive feedback, build confidence, and hold staff accountable. Evaluations at all levels of professional development were perceived as warranted.

However, the issue of an evaluation in the context of a multi disciplinary team raises an interesting dilemma. One individual shared the following:

> But I think if it isn't someone of your discipline, then what are they looking for? I have heard of another agency where the manager was not of the same discipline as the worker said "I am not signing this, I don't agree with it because you are not qualified to be evaluating the kind of work I do. You can decide if I came here on time and all of those kinds of things but as far as the quality ..."

The points raised by this participant, I believe, are indicative of the trends in health care. Many of the clinicians in my research have or had supervisors of a different discipline. For most of these individuals their job roles were similar, yet their disciplines different. The implications based on the aforementioned experience imply that if the evaluation process is to best meet the needs of the front line staff, then changes need to be made in order to accurately reflect the theoretical underpinnings of the respective disciplines. However, if evaluations are no longer discipline specific but rather focus on the job functions of the position, the manager needs to be qualified to accurately assess the work of their staff.

(ii.) Training

Ongoing training and staff development were identified as important. Workshops, teleconferences, and in house training provided opportunities for front line staff to learn new skills, refine old skills, acquire new information, network with other professionals, as well as generate new ideas. This clinician shared:

> ...I am very picky in terms of the ones I go to and I picked ones that my skills need to be enhanced so I find that they are helpful because I can then utilize them.

All front line staff indicated that they were permitted to attend one large conference a year, for example in Toronto, and a number of smaller conferences in their region including Winnipeg.

> Traditionally, there is one major trip a year so that we be for example to Toronto or, a major conference, one of the bigger tickets to it. Then there are the regional ones that occur, either in Kenora, Dryden, Thunder Bay, that kind of thing we attend . There are probably I would guess around three staff education opportunities out of office for people per year and then there is in office educational opportunities as well, teleconferences occur, we do staff education once a month when it is operating well wherein we bring to the table different topics and different issues and educate one another.

For those mental health workers who worked in the addictions field, their training was much more generous. They reported that the Ontario government, through specific initiatives paid for additional training that is required of addictions workers. All supervisees were satisfied with the amount of training they received and appreciated the benefits that it brought to their clinical practices.

For most front line workers the cost of accessing conferences and staff development opportunities was high. For those who lived in more remote communities the cost was that much greater. This cost was described by participants not just in terms of dollars, but also in terms of time and access. Several described situations in which the time allocated for a workshop was less than their driving time to attend. In situations like this, it was not feasible to attend such a learning opportunity because of the time and cost associated with attending. This reality is illustrated in the following comments:

> Okay. It's $100.00 to spend a night in a hotel and we're three hours from Kenora. You drive down there, you do a workshop, you're spending the night. So financially, it impacts us incredibly and we don't get a whole of a budget for travelling for overnight accommodations. So it is not easy for us I think, as it is you know, when we see these one day workshops in Kenora, or these lunch hour workshops, you know we are not going down to those. We just can't do it, it's not practical. Um, so financially the remoteness is one main issue. Time too. We are looking at days travel to get anywhere so it means that we are out of the office to get professional development if we choose to leave. The third issue, I think in Kenora, particularly there are a lot of groups that could do community education, for example New Directions put on a workshop that Lake of the Woods could go to, that the Youth Addictions Program could go to, that a whole bunch of other service providers could go to, we're essentially it in the community. There are no other health practitioners that work with adults. So what we do is among ourselves. We have a limited pool of resources. So, finances, limited resources, time constraints, I think that those are the main ways that living in a rural community negatively impacts development.

Despite these hurdles, one clinician did describe benefits to living in a remote area. There was a belief that because they were the only agency in the community to offer mental health services, they had opportunities to work with a diverse client population with unique problems.

These hands on learning opportunities provided direct learning experiences that might not be available in larger centres. As result of this, several therapists accessed creative ways to learn new skills and acquire new knowledge. They described frequent use of the internet, opportunities for in house presentations, and accessing colleagues in the district, as well as written resources. These thoughts were articulated by one respondent:

> However a couple of positive things. Because we are the only mental health agency we get everything that comes through the door, so there is a real opportunity for learning, there is a real opportunity for professional development. We don't have to worry about becoming stuck in a specialized rut here. We are all generalists and we are all getting a really great opportunity to look at some stuff that we might not see if we were in a larger centre or more urbanized centre. We have access to the internet, we have a professional library that is updated yearly. So I guess those are some of the ways we deal with being at the end of the road.

(iii.) Trusting Relationships

Trusting relationships were important to most mental health workers. This referred to both their relationship with their supervisor and their relationships with their peers. Within the manager - staff relationship, they needed to know that whatever information was discussed with their manager was confidential. Supervisees wanted the boundaries concerning confidentiality to be clear so that they could trust their manager not to breach the information shared. The context of a trusting relationship was perceived as a safe place where front line staff could share their vulnerabilities and professional struggles. It was a place where it was "okay not to know" information and it was a place where you could ask questions without any fear of being criticized for not knowing. This desire was expressed in the following comments:

> I guess I also need to know that, uh, how can I put it, that I can not know going in there. That I can ask the questions, Vulnerability I guess is what is coming to mind.

Another important feature of a trusting relationship with their supervisor was the acceptance of differences. This was described in two ways. For some it meant that differences of opinions could exist between them and their supervisor. In these situations participants wanted their supervisor to respect these differences and agree to disagree without their being any repercussions.

The second context in which the acceptance of difference was applicable pertained to discipline specific issues and activities. One individual described having a positive relationship with her supervisor and wanting there to be an acceptance of differences as it related to their disciplines. She stated that she wanted a "...positive working relationship with the person who is offering supervision and acceptance of differences if we were from different disciplines.".

Trust within the context of peer relationships was also believed to be important. Clinicians frequently commented that they would consult with "the peers they trust" on clinical matters, debriefing and for validation.

> I think that is the other piece is that to get real true support you have to feel safety and trust and one who I choose might not be one that my colleagues would choose.

It was in this context that front line staff shared their vulnerabilities, solicited clinical input and received support. These trusting relationships were built on equitable relationships, mutual respect, and mutual sharing. For some respondents the formal process of peer case reviews was hindered due to lack of trust between team members. In these situations clinicians did not feel that they could share what they were doing clinically. For these workers the formal context was not a

safe place because it was not a place where they felt they could show their vulnerability. This experience was described by one respondent;

> Once or twice we tried reviewing cases but it didn't work that well. I'm not quite sure why it didn't work that well, it just didn't. I suspect it had something to do with trust, suspicion.

Conflict among team members also affected the trust within their team. If conflict and other significant issues were not resolved, the formal peer process became threatened. Several team members described situations in which this did occur. They felt that the team was not a safe place because the lack of trust between colleagues "... became an us against them. It should not have happened but that is exactly what did happen because people became polarized on their positions."

Participants wanted to have trusting relationships with their managers. They wanted to know that their supervisor was "on their side" and looking out for their best interest. They also wanted to trust their colleagues and they needed and desired to have the formal peer process as a safe place where they could openly share information in a non threatening manner.

(iv.) Debriefing

The opportunity to debrief was a critical function of the supervisory process for front line staff. Many described this process as a way of offering checks and balances in their professional practices. They felt it would have given them an opportunity to release their feelings and it would also recognize and validate the effects that being a trauma helper can have on their professional functioning. Most participants wanted their managers to acknowledge that vicarious trauma does exist and validate the debriefing process in their work environment. The experiences of debriefing

for most therapists occurred in an informal context with peers they trusted. For many respondents there was no formal process in place that recognized nor validated debriefing or the effects that the impact of secondary trauma can have on front line staff. The essence of this non experience of debriefing is captured by the following experience;

> I remember seeing my supervisor on one occasion and being overwhelmed and feeling the heartache and the horrors of it and really if I was going to be working to further victimize this client or if I was going to be in a healing role with the client. I recall my supervisor saying "Oh, I don't deal with that ." and moving on to administrative issues. So at that point I realized very clearly that if I am going to process some of the horrors and develop some of the quirks I need, I was going to do that elsewhere. I sought my colleagues to do that and that certainly fit that bill very well.

This experience illustrated the role of the informal peer process in dealing with issues of debriefing. Consistently the role of peers in this process appeared to be critical in sustaining staff through difficult therapeutic processes. Debriefing was perceived as a way to prevent staff burnout but also as a way to ensure that the best therapeutic options were being offered to the client.

Front line staff described situations in which self protection techniques were imposed to protect them and their colleagues from counter transference and vicarious trauma. One respondent described that her team would safe guard against colleagues assuming cases that may be too closely parallel to their own personal reality. For example, if a colleague was newly separated they would not be given clients who were experiencing a similar reality. Another interviewee shared that her supervisor had implemented a policy that promoted the prevention of worker burnout by prohibiting the accumulation of too much overtime. In this situation the organization provided;

> encouragement for some self care and an acknowledgement that you're getting fried. Our policy here does not allow us to accumulate a whole pile of overtime and we are encouraged to use it because it is there. So it is that sort of thing. Knowing the signs when people are starting to get "burnt out" and pulling back and encouraging them to work on their self care.

Consistently clinicians recognized the importance of this process, yet for many it was not built into the supervisory functions. One individual stated that " Debriefing is big, we do debriefing ..." and when explored further discovered that;

> We don't have any formal structure for it ourselves. Now a lot of it we bounce off of each other and we have a great team for that.

Many of my participants wanted acknowledgement about the importance of the debriefing process. I contend that they saw merit in what this process had to offer and they would have appreciated having a process in place that would have validated their feelings and their issues in their therapeutic relationships with clients.

> I think that kind of opportunity to be able to debrief, to have something set up so that it is there for you. Otherwise it seems that the expectation is that you should be coping with all of this yourself, you should handle this. Because there is nothing put in place if you're not dealing with it their most be something wrong with you. I think the reality is that saying it is important and we need to acknowledge it, we need to process and deal with it and put it into our system is important.

(v.)Individualized Supervision

The supervision needs of front line staff are as individual as the experiences that they shared. All of the experiences had similarities as well as differences and all of these experiences were as

unique as those telling their story. This speaks to the need for managers to individually solicit from their front line staff what their supervisory needs are. The skill level, the needs articulated, the approaches used, the disciplines of the mental health workers, their personalities, their supervisory expectations and their resourcefulness in getting their needs met were not consistently the same. These individuals were diverse just like their needs are diverse, and because of this no one supervisory formula can meet all of their needs. These insights were recognized by this respondent:

> We are a diverse group. I think that is why she needs to listen very closely to all that we need. I think we need to be able to do our job and to be able to be really clear what we do need

What front line staff did articulate was a desire to get their supervision needs met, and there was a recognition by many that one person could not meet all of their supervisory needs. The one consistent finding was the desire by clinicians to have some form of supervision. For some the context was peer; for a few it was one to one with their supervisors; for others it was both; and for some it ranged from the use of technology to community resources. The bottom line was, the needs were diverse just as the means to getting those needs met were diverse. One interviewee recommended that one way a supervisor could address the supervision needs of front line staff would be have an opportunity to address "... professional development goals and I think that working in an individualized supervision plan would fit nicely with that.".

6.3 Creative Supervision

Front line staff were seldom supervised in accordance with traditional frameworks and many had turned to creative options in getting their supervisory needs met. The supervisory process for these individuals continued to be an evolving process. Several of these mental health workers were in a transitional phase exploring their supervisory options. One therapist had this to share:

> Well it is funny because we have just recently started talking about how we might be hiring people from outside with different specialities. Especially now with technology it does not have to be anyone local. Ideally if we could get our team healthy, we could do our case reviews once a week where you would bring a hard case or an easier one and you just need some validation — whatever. You could still go to you peer when you need to or call whoever you need to in the community, but maybe you know that you are getting some area of speciality coming up so it was not just case review but a lot of learning. So you would have the people like _____ who were coming with the psychiatric speciality or maybe we would have a clinical worker from CAMH who is also specializing in addictions who maybe we would network with every second month. There might be four that we find very helpful. I remember one time we had _____ come and do some stuff on eating disorders and it was really helpful. We watched him from behind the two way mirror. So I am thinking outside. I think it could be really unique. That is what I want.

(i.) The use of technology

The use of technology is augmenting traditional supervisory practices. Front line staff who described a "lack" of supervision in their workplaces tended to be the participants who accessed on - line sources more consistently. Most of the individuals who described regular access to the internet did so as a means of acquiring information on specific disorders, as a means of e - mailing experts in various fields to ask specific questions, as a way to access clinical chat lines to complete

peer case reviews , debrief, and receive support, and as a method of communication to colleagues in the community and throughout the country. Participants, used creative approaches to get their supervisory needs met. The use of technology changed the traditional framework of receiving supervision. The following comments captures these experiences:

> On - line supervision helps you to look at your case because you have to present your case and in doing so (even that just within the team here) you then have to look at your case more objectively. Frequently when you are getting involved with people and you are doing therapeutic work, beyond just counselling you are often dealing with issues of projection, transference, counter transference, those issues are very significant to deal with in supervision. That is when it becomes very clear what is going on and gets out of that role and moves you into a stronger therapeutic place again. By having to present and go through it, you have to process where you have gone and what you have done. You see things very differently. Having someone else ask questions about areas that they saw that maybe you've talked about but have not really moved on then you start looking at a whole different light of skill development. Rather than saying "same old, same old, status quo" you are constantly challenged. Without that you become stale very quickly, I think. You get caught up in a lot of the client's issues and you sometimes get caught up in your own issues that are similar to the client.

The aforementioned experience described the traditional purpose and process of supervision, however the context is different. Technology provided a venue for respondents to get their supervision needs met in the absence of a formal supervisory structure. This was not a unique experience. Many clinicians accessed similar internet resources to augment their supervision needs. For example:

> This week I was doing some new stuff and I e - mailed a colleague in Toronto to ask what they had. I think we are using technology a lot more. The computer web sites, looking up different things.

While another participant stated:

> I have two kinds of support that I use, one is a formal structured group that meets. We meet and present case information to each other . It is almost as if we do a bit of ad hoc reflecting team in that we try to work from a brief therapy perspective to give as much sometimes it is direction, sometimes it is just a different way of looking at the goals of the client, sometimes it is a way of reframing, sometimes it is just a way to provide support if someone is really frustrated, so we do that. Then the other one is an on - line bitch session about things that are frustrating.

Technology played a critical role for some front line staff in assisting them in meeting their supervisory needs. By accessing resources and peer consultation on line, therapists were able to obtain knowledge, clinical support, validation, and peer consultation at their convenience.

(ii.) Community Resources

Using community resources assisted participants with thinking outside the "box of your agency.". Almost all of those interviewed used community resources of one form or another to augment their supervision needs. The main resource utilized were the consulting psychiatrists. Mental health workers described their involvement with the psychiatrists as positive experiences that provided valuable clinical input, as well as information on medication therapy. They felt that they could access this resource by phone if the need arose or they could make arrangements for their client to meet the psychiatrist in their presence. All the therapists had access on a monthly basis to a visiting psychiatrist to their program. This experience articulated the benefits of this clinical resource:

> Well when the psychiatrist comes up that is definitely a time when we can get more of the medical psychiatric perspective. I have to say that

> he is very good about including me in his sessions and he is very good about the lunch time mini educational sessions. That is where it is not direct observing my skills; there is this conveying and teaching of skills. I would definitely count that as one of the most valuable pieces that I have in this particular work environment.

There appeared to be an emphasis on developing networks and partnership with community resources. Most respondents described accessing their colleagues in the region and consult lines as a method of obtaining clinical information and input. They seemed to appreciate the feedback and information they would obtain from using such resources. The sharing of ideas and experiences seemed to play a key role in these professional exchanges. Whether it was the sharing of community resource information to providing direct support, most front line staff did participate in the utilization of accessing colleagues in the district or consult lines. The benefits of networking and developing community linkages are discussed in the following comments:

> We can use the Addictions Research Foundation of CAMH clinical line, that kind of thing for clinical advice. There are those kind of resources and I also think that we use colleagues in the region. You know, I know that I have talked to other people in the region "Hey have you got anything about, for a female in her 30,s you know, it's very general but using people in the region.

Front line staff appeared to value the opportunities to use community resources and consult lines because they saw it as a way to provide quality service to their clients. It was a means to obtain information that would best meet their clients' needs. This process also recognized the distinct role that all professionals can have in the client's recovery process. This is best demonstrated by the following individual's experience:

> When you call that line and you say you are looking at withdrawal needs, you might get a physician, you might get a pharmacist. If your question is more of a clinical nature you might get a therapist. So it is really quite unique. This morning I had a call from the medical social worker for a client who was looking for community support. I think now we have really gone to partnership ...

What is interesting about the description of the information provided is that it is received from a number of disciplines coupled with the fact that clinical needs are obtained from a therapist and not a specific discipline. This is very much in keeping with the findings previously discussed and the concept of a generic manager.

Program partnerships did exist in other ways. A couple of participants described belonging to a specialized group of case managers that met every three months. The activities that surrounded these meetings included information sharing as it pertained to new legislation, new programs, job descriptions, and training opportunities. It was also an opportunity to review case load size and to receive validation for the type of work that was being done. On occasion, if someone is "stumped on a case" they may present non identifying case information as a way to solicit input from their colleagues. These quarterly meetings appeared to be a valuable resource to these workers, in part because these case manager positions are relatively new to the mental health field. Therefore these meetings provided an opportunity for these individuals to develop linkages with their regional counterparts.

> We look at current events in mental health, that would have an impact on how we deliver service. It could be new legislation or it could be a new mental health program that we would be receiving updates or updating each other on. Any training that is going on in the area that some of us might not be aware of, fill in the group and just general discussion of, I guess how we do our work. Like we

> shared our job descriptions and discussed how we differ and how we are similar.

Several respondents discussed their experience of their program hiring individuals with clinical expertise to meet with front line staff individually as a means of enabling staff to get their clinical needs met. The staff who described these experiences found them quite worthwhile. They perceived it as opportunity to enhance their clinical skills but also as a opportunity to practice clinical skills and to get "expert" direction.

> We used to have a visiting psychiatrist. He would come in and spend a few days with us as an inservice. We would each have time with him to go over cases and that person was available to review with you and would also be available to sit in with that person and get an assessment done at that time. That was quite ideal on a monthly basis.

As a way of learning, several supervisees shared that they would also make themselves available to any learning opportunities that they could access that involved someone whom they perceived as being an "expert" on clinical matters. They believed that there was merit in this form of clinical training because it allowed them to get objective clinical input from experts in the field and it created opportunities for " mentoring from other people.".

6.4 Front Line Workers Responsibility

Within the context of the supervisory relationship, front line staff took responsibility for getting their supervisory needs met. A number of individuals described situations and experiences in which they accessed community resources and technology. All participants described an ad hoc peer supervision model that augmented their supervisory needs. Several workers described situations in

which they would just make supervision happen with their manager. In the latter situation they felt that they needed to meet with their supervisor on a number of permanent issues. These issues ranged from debriefing to keeping their manager advised of significant policy or clinical issues. In these situations staff felt that they had a responsibility to keep their "boss" abreast of their cases as well as solicit their feedback. One individual shared; "If I need information or feedback on a case relevant situation, I just make it happen." while another participant stated, "... if I need supervision I need to initiate it. It is not the other way around.". Front line workers also described their role in taking responsibility for being prepared for the peer case review process. Several respondents discussed this process as being beneficial in meeting their supervisory needs. However, in order to reap the benefits it was essential to come to this forum with a prepared case.

> For the group supervision everyone is asked to come prepared to present a case that they may be having difficulty with or that they think they did a really good job with, that they want to share. It does not have to be problem focussed because every now and then a staff member will come in and say "I want to tell everyone what I did because it worked so well", and they will share that.

Within this framework there also appeared to be a responsibility for front line staff to share their triumphs as well as their struggles.

Front line staff have a responsibility to develop professionally and the organization via the manager has a professional and ethical responsibility with assisting them in attaining their professional development goals. Consistently, respondents discussed ways that they would enhance their own skill development. They shared their experiences with training opportunities, accessing experts in the field, reading the literature, as well as accessing technology and community resources.

It was through these mediums that front line staff broadened their knowledge base and fulfilled some of their professional development goals. Participants in this context frequently referred to themselves as "highly motivated" and wanting to enhance their skills. In these situations they often described having:

> ...to be very self motivated in order for this to work because , the other thing is that we don't really have anybody checking up to make sure we are doing things right or properly

Therefore, in these situations therapists were accountable to themselves for ensuring that they took ownership of their professional enhancement activities.

A final area in which interviewees described having had to take responsibility involved issues dealing with conflict. Several respondents described situations where "issues" between themselves and their supervisor developed. In these situations they felt that they had a responsibility to meet with their manager to discuss these issues. One therapist stated that when a situation arose, I would meet with my supervisor "...one to one with myself being there. You know when I have an issue I'll just say, may I talk to you about so and so ...". Most workers recognized that this was an appropriate course of action.

However, for a few of the front line staff discussing issues of conflict did not always lead to resolution. Several workers described situations in which there was conflict between team members. When these situations could not be resolved with their colleagues on an individual basis, members of the team would consult with their supervisor. If he/she failed to address the issue then respondents documented their concerns and forwarded them to their manager as a means of holding

their supervisor accountable. In these situations staff felt that they wanted to be part of a solution not part of a problem, but their managers failure to act intensified the conflict. In these situations some clinicians commented that they felt stuck and were uncertain as to their next course of action. For several individuals, conflict in these situations seldom got resolved to their satisfaction, if at all.

> So I know that two of the staff have gone and sat down and documented and shared this with the supervisor. We then pushed further and said "We need to be assured that there is a game plan happening here and we need you to share with us specifics of what you are going to do.

Participants took much initiative in getting their supervisory needs met. They took responsibility for the many facets of their professional development and they sought resolution to tenuous situations. Front line staff used creativity, ingenuity, and community networks as a means of getting their supervisory needs addressed.

6.5 Summary

Staff supervision is more than just a process that is comprised of a list of functions. It is more than one to one supervision with a supervisor and it is more than just interactions with other systems. It is a process that involves all of the above, combined with the creation of a work atmosphere that is conducive to professional growth, positive relationships, and innovation. Staff supervision is not confined to or exclusive to traditional frameworks. Its processes and functions are subject to the changing political and technological climate. Staff supervision is an evolving process and it will continue to evolve as long as traditional models are being challenged by government restructuring and advances in technology. Whether the framework that is being used is traditional or

new:

good supervision fosters professional development. Supervision is more that just discussing a case with somebody. Supervision should be creating a climate in which people use peer supervision, workshops, reading , experiences brought to the group and become part of the group knowledge base. Then people maintain an innovative attitude and they don't take the position that because they have been working for 10 or more years that they are as effective as they are going to be.

CHAPTER V

DISCUSSION

7.1 Discussion

The purpose of this chapter is to compare my findings to the literature. Most headings correlate to the headings in chapter two of this report with additional commentary on debriefing, peer supervision, and technology. The goal of this chapter is to illustrate the similarities and differences of my research to the literature, and in so doing, demonstrate that the supervision of multi disciplinary teams is a process in transition.

7.1 Comparison to the literature

(i.) Supervision Theory - A Social Work Perspective

Consistent with Kadushin's (1992) findings, most of my supervisees concurred with administrative, educational and supportive functions of the supervisory process. Minimal emphasis was given to the administrative function, however it was perceived as important in setting the context of the work environment through the sharing of policy and procedures as well as through the pragmatic day to day operations of the program.

The emphasis for most of my research subjects was on the clinical component of supervision which Kadushin (1992) refers to as the educational component. Participants perceived this function as a way to maximize their clinical knowledge and as a way to stay clinically challenged. Clinical supervision was also believed to be a way to share and improve on their capabilities thus creating confidence in the work they do. The educational function proposed in the literature refers to the sharing of clinical information as it pertains to social work theory (Kadushin, 1992, 19; & Middleman & Rhodes, 1985, 4). The clinical knowledge being sought by my respondents did not confine itself to one discipline but rather extended itself to the acquisition of skills and knowledge from multiple disciplines and approaches.

Kadushin (1992) states that the primary focus of supportive supervision is to enhance worker morale and job satisfaction. These areas of support are important and were indirectly discussed in my findings. For many of my subjects they defined support in the context of validation and appreciation for their work. Several elaborated that accessibility to their supervisor when difficult situations arose, positive feedback, unconditional support, and advocacy were also supportive features of their supervisors role. Through these activities the positive tone of the supervisor filtered through the team and that made:

> ... a huge difference when people feel supported and heard and validated and there is a sharing of expertise. I think that it is really critical. I think that the morale in this particular agency is exceptionally good because of that ...

The interactive process of supervision is defined in the context of a relationship between the supervisor and the worker (Kadushin 1992, 22; Shulman, 1993, 11).Within this context Kadushin

(1992) states that the supervisor is a middle manger reporting to the administrative directors. There was an absence of a middle management position for many of my participants and most of my them reported having supervisors who were considered senior management. Kadushin (1992) proposes that middle management is important and it is in the context of this supervisor supervisee relationship that the client benefits, because supervisors review client cases, and assess the skills of the worker to meet the client's needs. Most of the clinicians in my research communicated not having traditional supervision. In fact, many reported not seeing their manager for extended time periods. One individual stated that their supervisor had never seen their written work while several others commented that their supervisor had never seen them practice their clinical skills and several others indicated that they had more clinical knowledge and experience than their manager. A couple of front line staff even questioned whether or not their supervisor could even assess their skills to ensure that they were doing their job appropriately. This point became salient when discussing staff evaluations.

Inherent in Kadushin's (1992) supervisory model is the belief of same discipline supervision. This was a rare commodity in my findings. In most cases where it was possible, the one to one supervision was very sporadic and not a scheduled event. For those supervisees that did receive same discipline supervision more consistently, they described their supervisor as knowledgeable, open to discussion, and possessing good clinical skills.

Supervision occurs in the context of a relationship between supervisor and worker. Within the context of this relationship the supervisor should be fulfilling specific supervisory

responsibilities. Kadushin states;

> "... a social work supervisor is an agency administrative - staff member to whom authority is delegated to direct, coordinate, enhance, evaluate on the job performance of supervisees for whose work he is accountable. In implementing this responsibility, the supervisor performs administrative, educational, and supportive functions in interaction with the supervisees in the context of a positive relationship" (Kadushin, 1992,23).

Not all the managers in this research were social workers and according to my findings not all the supervisors adhered to the supervisory responsibilities outlined by Kadushin (1992). Several of my interviewees' experiences were somewhat consistent with this supervisory framework. However this was not the reality for most workers. My findings indicate that there was a lack of a formal supervisory structure, yet this is something that most staff would have welcomed. Consistently almost all respondents expressed a need to meet individually with their manager and consistently several indicated that supervision was "void" and/or "absent" from their experience in their current jobs.

Kaiser dicusses the importance of safety and trust as essential components of the supervisory relationship (Kaiser, 1997, 20). She defines safety as "...as the supervisees freedom to make mistakes and take risks without danger of an excessively judgmental response from the supervisor."(Kaiser, 1997, 21). Respect she proposes "... can be experienced both by the supervisors' expressing belief in supervisees' ability and in the value and relevance of their past professional life experience."(Kaiser, 1997,21). Many of my respondents concurred with Kaiser (1997) and the value placed on safety and respect in the supervisory relationship. They desired a positive relationship with their manager characterized by trust in which their manager defined them

as important. Again these findings are consistent with Kaiser who believes that trusting supervisory relationships are "growth promoting" (Kaiser, 1997, 21). Those who had experienced such a relationship described their supervisory experience quite positively. In these situations front line staff reported that their supervisor took a vested interest in their work, their professional development, and their professional well being. These findings are consistent with the teachings of Kadushin (1992) and Kaiser (1997). Unfortunately not all supervisor - supervisee relationships were positive. Several individuals described situations that hindered the development of such a relationship. They described situations where their manager was not accessible, did not consistently take an interest in their professional development, nor provide feedback or staff evaluations. Front line staff in this context seldom described their supervisory relationship in a positive framework.

Certainly, several of my findings do deviate from the traditional practices discussed by Kadushin. The context in which supervision occurs is different from the traditional one to one supervision with a manager of the same discipline. Instead my findings portrayed multiple professions being supervised by various disciplines with minimal accommodation for same discipline supervision. The emphasis was therefore not exclusive to social work theory and practices but focussed on a more comprehensive framework that acknowledged the theoretical underpinnings of other disciplines and approaches to therapy. The changing role of the supervisor is another noticeable difference that illustrates the discrepancy between the traditional role versus the existing reality. For many of my participants their supervisor was a member of senior management with the role of the middle manager disappearing. Several interviewees reported that because of administrative responsibilities and other management projects they could seldom access their

supervisor.

Both my findings and the literature are consistent on several points. The functions of supervision discussed by Kadushin (1992) and Shulman(1993) illustrate the relevance of the administrative, educational, and supportive function of supervision. My findings did not specifically refer to educational supervision but referred to this as clinical supervision, however the meaning of the two terms appear to be equivalent. This is simply an issue of semantics. There appears to be similarity in the activities of each supervisory function and there is also agreement that these functions are achieved in the context of a supervisory relationship.

The interactional supervision model conceptualizes workers as constantly interacting with a number of systems that are directly related to their job (Shulman, 1993,15). My findings are indicative of the interactional component of Shulman's (1993) teachings. Participants continually discussed their reciprocal interactions with other resources, including experts in the field, technology, community resources, and their peers. Through these interactions they augmented their supervisory needs by receiving clinical input, knowledge, support and validation. It also assisted them in identifying gaps in their professional development that required enhancement. This in turn assisted them in providing quality service to their clients.

Hughes and Pengelly (1997) present another social work perspective on supervision. These authors address the parameters around supervision which deal with the logistics of organizing and arranging ongoing supervision. This model implies several assumptions that were not consistent

with my findings. Firstly it assumes that supervision occurs individually between a supervisor and a worker with some degree of regularity. Secondly it assumes that staff do receive appraisals and individual performance reviews. The parameters of this model, that were consistent with my findings, were the expectation of confidentiality to exist in the supervisory relationship and that professional boundaries be maintained. One therapist in my research indicated that she documented her supervisory sessions which is also consistent with the teachings of this model. Confidentiality and boundaries were perceived by several respondents as critical if a trusting supervisory relationship were to exist. These front line staff needed to trust that information shared with their supervisor not be shared with their colleagues or other individuals. One person expressed these views:

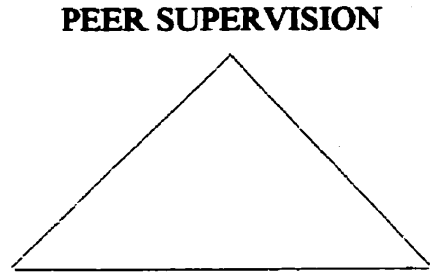
> Just the chance to be with one person regularly, who is in a managerial role so that gives me information that I have to pay attention to and helps me to develop consistently over time. There is structure where maybe we meet once a week initially and then every two weeks after that and with one person. And the other thing is because that allows good boundaries. One of the other essential qualities with supervision is that what you say in supervision is confidential. You have your strengths and weaknesses as an employee but it doesn't go to anyone else. It allows you a place of safety.

The parameters within supervision focus on what occurs in the face to face supervisory session with the supervisor. Again, there are inconsistencies in this model compared to that of my findings. For many of my supervisees, individual supervision was a rare commodity. Certainly when it did occur several commented that they prepared for their session and that it was an opportunity for both the staff and supervisor to address the supervisory functions cited by Kadushin (1992) and Shulman (1993). These practices are consistent with Hughes and Pengelly's (1997) teachings.

However for most participants this was not their reality. Hughes and Pengelly (1997) discuss in their supervisory model a number of activities that occur in the supervisor - staff relationship. These include working on concepts and skills, reviewing of case records, methods and tools, review and evaluation (Hughes and Pengelly, 1997, 38). Again, many of my respondents described most of these activities occurring without a degree of regularity within the context of a supervisory session with their manager. The expressed wish for several clinicians was consistency in getting many of these activities addressed within that context. For many the activities described by Hughes and Pengelly (1997) were fulfilled in the context of formal and informal peer supervision. One worker shared; "... I like what we did yesterday, a case meeting for peers but I still think it would be nice to have some one to one."

Hughes and Pengelly (1997) emphasize the interrelatedness of the supervisory process between the supervisor, the practitioner, and the service user which they refer to as the triangle of participants in supervision. They believe that the client receives service from the supervisor through the practitioner from the supervisory process.. The triangle of participants in the supervisory process for my research subjects would be more accurately reflected by including peers, the practitioner, and the service user, with peer not being exclusive to colleagues in the office but also those colleagues in the community and those accessed through technology. The triangle for my practitioners is best illustrated in the following manner.

TRIANGLE OF PARTICIPANTS IN SUPERVISION



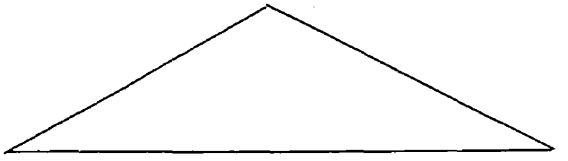
(Adapted from Hughes and Pengelly,1997, 41)

The second triangle proposed by these authors is the triangle of supervisory functions. This triangle consists of the managing of service delivery, facilitating practitioners' professional development , and focussing on practitioner work. The activities described in this triangle were compromised for many of my subjects. Front line staff in my research did describe professional development opportunities via use of conferences and workshops, however, most reported that they had not received staff evaluations on a consistent basis. A number of individuals described their experiences when they were new staff as receiving minimal guidance from their supervisor. In terms of focussing on the work of the practitioner, one therapist commented that her supervisor had never seen her written work, while many others reported not having seen their supervisor for extended time periods, while others reported that they had more clinical experience than their supervisor. Again the reality of many of my participants is not consistent with model presented by Hughes and

Pengelly (1997). This triangle for my practitioners is best represented by the following.

TRIANGLE OF SUPERVISORY FUNCTIONS

MANAGING SERVICE DELIVERY



THROUGH STAFF SELF INITIATION TO ENHANCE PROFESSIONAL DEVELOPMENT

PEERS FOCUSSING ON PRACTITIONER'S WORK

(Adapted from Hughes and Pengelly, 1997,41)

The underlying premise of these two triangles is that the participants in the first triangle are linked to the functions in the second triangle. Thus, a close relationship does exist between both triangles. My adaptation of these triangles, based on my research findings places more emphasis on the practitioner to enhance and identify the gaps in his/her knowledge and it also increases the responsibility of peers to provide feedback to colleagues on cases, resulting in service to the client through peer supervision and support.

(ii.) Role of the first line manager

During the past decade we have witnessed unprecedented changes to the Canadian health care system (Ferguson - Pare, 1998). These changes have created structural changes from a hierarchical framework to a delayered team based framework (Ferguson - Pare,1998, 11). Many of those interviewed discussed the emphasis of the team layered approach. For these respondents they preferred a more collaborative work environment that was not hierarchical.

My findings illustrate that three management positions that once existed have been consolidated into one senior management position. The new manager, who has a background in nursing, is now responsible to manage 15 professional staff plus an additional program. These findings are consistent with Pabst (1991) and Skelton - Green and Singh - Summer (1997) who found that managers in today's health care sector are managing increased staff ratios. These middle management positions now have increased role responsibilities including managing one or more units, staff supervision, standards for patient care, fiscal management and the management of the work environment (Acorn and Crawford, 1996,27, McGillis Hall and Donner 1997,16). For those interviewees who commented on those structural changes, there was a recognition that their manager has increased role responsibilities consistent with those cited by Acorn and Crawford (1996), McGillis Hall and Donner (1997) and Kerfoot (1993).

The literature on the role of the supervisor to teach practice skills presents opposing views. Authors such as Duffield (1994) Flarey (1996) and Drucker (1995) believe that clinical expertise on the part of the first line manager is no longer warranted. There appears to be a belief that front line

staff should be proficient in their fields, thus not requiring clinical supervision. These beliefs were evident in some of my findings. A number of participants commented that they felt that there was an expectation that because they were professional that they do not require supervision. There was also concern expressed by many therapists about the absence of clinical supervision that was provided in their current employment. For some this was because their supervisor did not have the clinical expertise to fulfill this function, thus rendering these findings consistent with authors such as Duffield (1994) Flarey (1996) and Drucker (1995).

Ferguson - Pare's (1998) role definition of the front line manager does not concur with these authors. Within this framework there is the expectation that managers need to demonstrate their competence by teaching practice skills, provide opportunities for staff development and growth, create a positive work environment, provide worker recognition through ongoing performance reviews and by maintaining relationships with individual workers (Ferguson Pare, 1998,11). These expectations were perceived by most participants as important in the supervisory role and in their supervisory experiences. Most supervisees would have liked these expectations to have been fulfilled, but unfortunately for many they were not. Consistently, they reported a lack of clinical supervision from their supervisor, the absence of ongoing staff evaluations, the absence of a trusting and emotionally safe work environment, and the absence of a supervisory relationship with their manager.

There were several respondents who did describe having had their supervisory expectations met. These clinicians described their supervisory experiences as very positive. In these supervisory

situations, the supervisor was perceived as having good clinical skills and was someone that they believed made time for individual relationships with their staff, provided them with staff development opportunities and created a positive work environment that offered support and recognition. Within this framework clinicians appreciated their supervisor 's ability to teach new skills, provide feedback on practice skills and job performance. It is these findings that are more consistent with those of Ferguson - Pare (1998) Kadushin (1992) Hughes and Pengelly (1997) and Shulman (1993) Pincus (1986,cited in Shulman, 1993, 22) and Heppner and Roehlke(1984, cited in Shulman, 1993, 22).

My findings indicate that the role of the first line manager is evolving and not bound by traditional frameworks. This is consistent with Acorn and Crawford (1996) Hall and Donner (1997) and Flarey (1996) who concur that there has been a transformation of the first line manager's role in terms of the responsibilities and the scope of their positions. These changes are evident in my research, however the statement that more accurately depicts my findings is that the role of the first line manager appears to be diminishing and the role of senior managers is expanding.

(iii.) The changing role of the first line manager

Skeleton - Green & Singh - Summer (1997) believe that role of the manager no longer consists of a narrow portfolio of discipline specific activities but now includes the managing of multi disciplinary teams. The multi disciplinary experience was described in my findings. Most front line staff commented about the diversity of their teams and the various theoretical approaches this diversity offered. Within the multi disciplinary team, participants needed their manager to

provide them with support, recognition, input and feedback, as well as involve them in decision making. These findings are consistent with Ferguson - Pare's (1998) work that presented five major themes identified by front line staff regarding their supervision needs with managers of various disciplines.

The managers in Ferguson - Pare's (1998) research indicated that front line staff are professionals and should be competent and independent team players. Several therapists in my research commented that they believed that the expectation is for them to be proficient in their field. Practice autonomy existed for most of my respondents because of the physical absence of the supervisor coupled with his / her lack of clinical knowledge. Bueno (1991b) and Bradford and Cohen (1994) who operate from a business perspective, believe that staff no longer require traditional supervision but need to maintain professional autonomy and take responsibility for their professional practices. My findings indicate that there is still merit to one to one supervision with a manager but that this supervision should be augmented with other supervisory practices. There was a recognition by several clinicians that their supervisor could not meet all their supervisory needs. This resulted in these individuals exercising their practice autonomy and finding other ways to get their supervisory needs met.

Ferguson Pare (1998) found that same discipline supervision had a significant positive influence on staff. Several therapists in my research shared that they preferred having a supervisor of the same discipline. They felt that their supervisor better understood their discipline and spoke the same professional language. One worker reported that there appeared to be respect between her

supervisor and herself about her abilities because they shared the same discipline. Validation in this context also held more meaning for some participants when it was received by a supervisor of the same discipline. For those participants where same discipline supervision did not exist, there appeared to be an appreciation for the other disciplines. However, several respondents felt that same discipline supervision should be accommodated. For one therapist this lack of same discipline supervision led to job stress and job dissatisfaction. These findings are consistent with Ferguson - Pare (1998) who argue that when same discipline supervision is absent it is connected to decreased job satisfaction, and increased job stress.

Baxter (1993) and Duffield (1994) place minimal emphasis on the supervisor's role to provide clinical instruction. Their emphasis is on the manager to assume specific roles such as a monitor, disturbance handler, resource allocator and leader to name a few. Some of my interviewees wanted their supervisor to fulfill some of these roles, particularly the role of disturbance handler, monitor, and leader. Most individuals wanted their "boss" to handle issues of conflict within the team and to address issues in the external environment by dealing with the "political flak". My findings also indicate that staff wanted their supervisor to be a leader; someone who would make job expectations clear and someone who would advocate for them. Most front line staff expressed a desire for their manager to monitor their work and the work of their colleagues in order to ensure that agency standards were being met but also to ensure accountability. Many workers felt that their supervisor was not fulfilling the roles and responsibilities of their position nor providing consistent leadership.

Consistent with the literature, my findings do indicate a shift from traditional management to new responsibilities and demands on the first line manager (McGillis Hall & Donner, 1997; Acorn & Crawford, 1996; Flarey, 1996). A number of respondents acknowledged changes in their supervisor's role in terms of the complexity of the tasks and the diversity of the disciplines that needed to be supervised. Because of this, one worker articulated that, "... I don't know what to expect from a manager right now...".

Many participants expressed feedback about the loss of professional identity and the assimilation of professional roles. This reality is shared in the literature. Read and Gehrs (1997) believe that mental health care delivery in today's political environment requires professionals to adapt to role changes that will expand beyond the parameters of their discipline by developing new professional competencies. Levin and Herbert (1999) discuss the changing role of social work, the lack of supervision and mentoring and the profound affect this has on social work practice. They believe that social work positions will be and have been lost to nurses and that social workers are often supervised by people of other disciplines with no access to same discipline supervision (Levin and Herbert, 1999, 31). The findings of these authors is consistent with the realities of those who were interviewed for my research.

Within this redesigned healthcare system, the main role of the first line manager is to manage people. Unfortunately, my findings indicate that some of the basic management responsibilities were not being met. Specifically, many supervisees reported the absence of staff evaluations, conflict resolution and leadership. This absence of specific management responsibilities is contrary to the

supervisory practices advocated by Kaiser (1997), Kadushin (1992) and Shulman (1993). Kaiser (1997) discusses the importance of staff evaluations and states that this is an important avenue for those in positions of authority over supervisees to monitor the work of his/ her staff (p 15). This she believes ensures worker accountability and it enables the identification of "... what the practitioner needs to learn in order to work more effectively." (P 15). Front line staff in my research wanted to receive feedback from those in positions of authority, unfortunately this was not the reality for most. This results in front line staff being expected to be clinical experts so that the manager can take care of managerial responsibilities (Bueno, 1991b,8). Several of the clinicians in my research commented about their perceived expectation that they needed to be proficient in their field. They attributed, this in part to the additional role responsibilities of their supervisor. From the information received in my research it appears that the model discussed by Bueno (1991b) is flooding into our local mental health delivery system.

(iv.) Group and Peer Supervision

All front line staff discussed some form of peer supervision in their professional experiences. Not all the peer supervision models were as pure as the model discussed in the literature review, yet most respondents described similar benefits and difficulties with their adaptation of these models. The nature of the adaptations discussed, varied among participants. Some shared that their supervisor was a part of the peer group while others described the absence of their manager and for some it was a combination of both models. One of the glaring differences in terms of the peer models discussed in my findings and in the literature is the role of the supervisor to present the cases in the group supervision process. Clinicians in my research described peer case reviews as

their responsibility to present their cases for consultation and feedback.

Benshoff's(1994) findings about the frequent nonexistence of counselling supervision by a supervisor is consistent with the findings of my research. For many of my supervisees, their limited didactic supervision with their supervisor resulted in them turning to their peers in a formal and informal capacity. The informal peer process I believe, was deemed as equally important as the formal peer supervision group. The informal process allowed for flexibility in getting needs met and dealing with questions or concerns that may have required immediate attention. Several therapists clearly indicated that the model of supervision developed and endorsed by their agency was peer supervision. Within these programs, the peer supervision model appeared to be firmly established and working well to meet the needs of the staff. Many individuals commented that because of the support and feedback that they had received from their peers, coupled with participants' perceptions about the limited clinical knowledge of their supervisors, they preferred to consult with their peers. Peer supervision for most of my respondents was based on mutual sharing of the supervisory functions discussed by Kadushin (1992, 482 - 483).

Consistent with the literature, my findings suggest that one of the main disadvantages of the peer model is the rivalry for leadership (Kadushin,1992, 483). A number of workers described situations where they felt other members on their team were trying to elevate themselves to the expert position. For some clinicians, this resulted in them not consulting with these colleagues on a consistent basis because of the lack of mutual sharing and the feeling that the expert colleague knew everything and the other staff knew nothing. It detracted from confidence building in the peer

relationship.

Another concern of the peer model discussed in my findings and in the literature involves the issue of supervisory power. My respondents agreed that there is value in the peer model, but that despite the egalitarian nature of this model, there are occasions where supervisors need to exercise the power that is inherent in their position. One of the situations in which they felt supervisors should use their supervisory power was with ensuring staff accountability. Front line staff felt that in this context supervisors should use their status in the agency hierarchy to ensure that the best clinical practices were being utilized as well as a means to provide staff direction. Staff in these situations wanted their supervisor to provide leadership and direction. Kadushin (1992) states that a supervisor "... is a leader in the explicit sense of having authority and the obligation to guide and direct ...".

For many supervisees in my research the peer model was used to replace most of the supervisor's functions. This was problematic for many respondents because of the lack of sanctioned authority by an individual in a position of power. It appeared that in some situations peer supervision was developed to fill a void created by the absence of the manager. This had inherent problems. It led to conflict among team members, resulted in poor team functioning, offered limited accountability and it resulted in the supervision of staff becoming compromised. Kadushin's (1992) peer and group supervision models differ in relation to the absence or presence of the supervisor and he offers specific recommendations for the implementation of both models. A true group model is directed and led by the supervisor while a peer model operates more autonomously

(p 483).

Many of my participants described reaping the benefits of peer supervision that are discussed in the literature. In particular the sharing and acquisition of clinical information through peer case reviews were described as the most significant contribution of this process, followed closely by peer emotional support. Kadushin, (1992), Fried Ellen (1999), and Benshoff (1994) all discuss similar benefits. These authors also address the effects that the peer model has on cohesion within the group. For those individuals who felt that they belonged to a healthy team, many perceived the peer process as a way to foster group cohesion.

(v.)Vicarious Trauma - Debriefing and The Role of Supervision

My findings concurred with the literature in its recognition of the effects of vicarious trauma on front line staff and the value of the debriefing process as a safe and respectful process used to normalize and validate the feelings and reactions of staff members. Many of my respondents felt that debriefing was a critical aspect of supervision. Through the process of supervision they believed that they could release their feelings and share their vulnerabilities. This supervision could come in the form of didactic supervision with a supervisor or peer supervision. Most clinicians described an informal process of debriefing with peers that occurred with some degree of consistency. Within these peer relationships most interviewees felt that they could share their issues because the colleagues with whom they chose to debrief were colleagues they trusted.

Recognition of the value of debriefing did not always translate into participants getting their needs met. Many workers felt that " debriefing is really big" however for many, no formal process was in place. This is certainly contrary to the recommendations of the literature.

The rotating presentation structure discussed by Pearlman and Saakvitne (1995) was one formal process described by a couple of respondents. The processed described was consistent with the teachings of these authors. These therapists felt that this rotating educational format was a valuable way to provide staff educational opportunities for themselves and their colleagues. Unfortunately my findings also indicated that when workloads increased the rotating presentation became compromised.

Those staff members who believed that their supervisor recognized and supported the debriefing process were the same individuals who had a mechanism in place to formally deal with vicarious trauma. This occurred primarily in the context of the peer case review and the opportunity to debrief individually with the supervisor. In both these situations clinicians believed that the debriefing process was critical to their best interest and the interests of the client. One participant shared these thoughts:

> ...I sort of specifically using peer supervision, I think without it, you're at risk for burnout and vicarious traumatization and all of those things. You can't do this kind of work and not have regular supervision. I think it is unhealthy if you do, and not only that you know that you need to bounce it off someone about what you are doing with your clients because I think you can do serious harm to the client if you don't know what you are doing or you may be going in the wrong way.

Coupled with these two forms of supervision several interviewees shared that their supervisor imposed self protection mechanisms in order to promote and sustain the health of the therapist. One such mechanism was that only a specific amount of overtime could be accumulated and then it had to be used in order to protect the therapist from becoming overworked. This finding is consistent with Pearlman and Saakvitnne (1995) in that these findings recognize and act on the need for therapists to receive ongoing staff supervision through the supervisor or in formalized peer relationships and through self protection techniques that are organizationally enforced.

(vi.)Technology and Supervision

The information highway has created numerous opportunities for access to information. As I browsed the net I was overwhelmed by the number of on line consultation and supervisory web sites that can be accessed. There were even bulletin board notices from health care professionals who would like to develop on line support groups with similar professionals. Examples of such notices and services can found in appendix four. Technology augmented the supervisory processes received by many of my participants. Consistently participants described accessing information via the net as well accessing chat lines with professionals in the field and more structured supervisory sessions.

Felix (1999) believes that technology is"... the hottest trend hitting the health communications field...". She believes that anyone can access a staggering array of health care information from journal articles to on line support groups (Felix, 1999,21). This trend appears to be consistent world wide. In a submission to the Australian government Crowe (1999) advocated

that the government provide additional funding to the Australian Psychological Society for computer technology. The reason for this request was to "...facilitate the spread and use of new technologies in rural and remote Australia. This proposal would fulfil his stated objective, using the opportunities provided by new technologies for professional education and training purposes in rural locations." (Crowe,1999, 5). By having these technologies Crowe (1999) believes that psychologists can gain access to "... existing teleconferencing networks and increase the number of psychologists who are on - line, thereby facilitating email supervision, establishment of peer supervision forums, and on line video supported face to face supervision." (p 5).

Reinforcing the emphasis on computer technology are many professional journals. These resources have extended themselves to include technology pages as regular feature articles. Journals such as The Canadian Healthcare Manager and Psychiatric Services, for example, provide on their technology pages changes technology offers in the delivery of specific services or lists of web sites that maybe clinically beneficial.

Technology is creating many exciting changes to traditional practices. Felix (1999) states that some computer companies can even offer customized health information web sites (p 23). She elaborates that , "... the site provides peer - re - viewed, evidence based health information, news and discussion groups ...". The information on these sites is constantly modified and updated resulting in access to the most current information on the subject matter, and is available 24 hours a day, 7 days a week at the users' convenience (Felix,1999, 23).

Certainly my findings concur with use and benefits of technology and the access it provides to information and support services. As technology continues to develop and technological processes become more refined it's long term effects on staff supervision will be interesting to determine.

(vii.)The Ethics of Supervision

I would be remiss if I did not include a discussion about the ethics of supervision. The professional practices of a supervisor greatly impact the people to whom they provide supervision.

> If practitioners are to treat their clients with the deepest possible integrity, they must have a place to go where they can carefully and honestly examine their own behaviour. That place ideally, is the supervisory relationship. Discussing the supervisory relationship without attending to the ethical dimension would ignore a crucial aspect of both the relationship itself and the function of supervision" (Kaiser,1997, 7 - 8).

In addressing ethical supervisory practices, Kadushin (1992) developed a comprehensive list of ethical behaviour and practices for supervisors. The following is such a list;

* Supervisors should act in an ethical and humane manner toward supervisees.
* Supervisors have an ethical obligation to meet the legitimate needs of the supervisee
* Superviors have an obligation to evaluate their staff objectively and fairly.
* Supervisors should refrain from taking advantage of differences in power.
* Supervisors should implement the functions of supervision conscientiously and responsibly.
* It is unethical for a supervisor to assign a case to a supervisee who is

without the necessary skills and knowledge to offer effective service.

* Supervisors are ethically liable if they a) fail to meet regularly with supervisee to review their work; b) fail to stop a negligent treatment plan.
* Supervisors are obligated to respect confidentiality of material shared with them in supervision. If this information needs to be shared the supervisee needs to be advised to whom and for what purpose.
* Supervisors have an ethical responsibility to make explicit their expectations of supervisees and the arrangements for working together
* Supervisors have to make themselves available during emergencies.
* Supervisors should avoid a dual relationship with employees particularly those related to sexual exploitation.
* Supervisors have has the gatekeeper function in the protection of clients.

These ethical responsibilities are guiding principles that should govern supervisory practices. I am very troubled that my findings are not more indicative of such practices. Certainly some individuals described the practices and the role responsibilities of their supervisor as meeting the criterion outlined by Kadushin (1992), but unfortunately this was not the norm. Many respondents described having supervision absent from their experience and no clear expectations regarding the functions of their job. Several shared their stories about concerns they had had about the clinical practices of colleagues, while others shared that they did not receive ongoing evaluations. As a mental health professional I am perplexed and dismayed by these findings, however they are somewhat consistent with authors like Benshoff (1994) who recognizes that supervision for professional counsellors is frequently non existent.

(viii.)Today's reality in the Canadian Health Care System

Consistently my findings portrayed deviations from a traditional supervisory framework. Many factors influenced these changes, including the increased responsibilities of the first line manager, the diversity of multi disciplinary teams, the lack of discipline specific supervision, and emphasis on peer supervision models. What has resulted for many participants was a loss of mentoring, supervision, and support. Levin and Herbert (1999) share similar findings. Consistent with my research these authors discuss the loss of discipline specific social work supervision and the loss of social work manager positions as a result of new management practices in the healthcare system. This was reflected in my findings that two social work management positions and one middle manager position were consolidated into one position that was filled by a nurse. Again this is a similar finding to that of Levin and Herbert (1999) who expressed concern about nurses usurping the role of social worker.

CHAPTER VI

CONCLUSION

8.1 Conclusions

This chapter outlines my expectations when I began this project and provides a synopsis of my research and a summary of the common needs of front line staff. It shares research highlights and an evaluation of the study including future research directives. Discussed in my findings are deviations from traditional supervisory practices in the context of multi disciplinary teams. I would be remiss if I did not include a discussion of the effects my findings could have on social work practices, policy, and education.

8.2 Expectations of the researcher

When I began this research project I did so with some thoughts and expectations of what I might discover. My perception of outpatient counselling in adult mental health was that it is more of a traditional social work environment, more so, than my current position. I expected that because of this, front line staff would have scheduled one to one supervision with their manager on a regular basis. This was not the collective experience of the clinicians in my research. In fact there appeared to be a greater reliance on peers to provide peer support and supervision.

My work experiences in more traditional social work environments adhered to the supervision model proposed by Kadushin (1992) who suggests that there are three key functions of supervision. My expectation was that the participants in my study would give equal importance to the supervisory functions discussed by this author. In fact that was not the situation. My research strongly indicated that respondents place the most emphasis on clinical supervision followed by supportive supervision. The administrative function was perceived as important but did not appear to be as valued as the other functions.

Front line staff in adult mental health programs are trauma helpers. By the nature of their work they become exposed to the trauma of their clients. I assumed that a formalized debriefing process would be a component their work environment specifically in the context of supervision. For the majority of the interviewees this was not their reality.

Being a member of a multi disciplinary team for me has been a positive experience. For the past five and a half years my supervisor has been a nurse. Being supervised by a person of a different discipline has provided me with new points of view from another profession; it has presented information from a different theoretical base and the language of the professions are different thus presenting opportunities for learning and educating. I thought that my subjects would share similar thoughts and perceptions as those just mentioned. In fact they did share similar sentiments augmented with additional benefits and detriments of being supervised by someone of a different profession.

My experience of having been supervised by an individual of the same profession was extremely positive. I anticipated the respondents in my research would have described their experiences of being supervised by an individual of the same discipline in a more positive manner than those being supervised by an individual of a different discipline. This was not always the situation and there appeared to be an appreciation for other disciplines' perspectives.

The word team implies a sense of working together, supporting one another, and the sharing of common goals. I believed that members of these teams would provide support to each other. I did not expect the degree to which this happens. It appears that peer supervision and peer support play an integral role in the lives of front line staff

My current social work position enables me to have access to a psychiatrist on a regular basis for purposes of clinical consultation or clinical supervision. The therapists in my research have access to this same service on a less frequent basis. I felt that they would access resources external to their programs to augment their supervisory needs. I did not have a true appreciation for the frequency at which this occurred or the 'type' of external resources that are used.

I approached this research project with much trepidation. I was concerned at the magnitude of such a feat and whether the topic I wanted to pursue had any true relevance to my profession. I expected this to be a tedious, cumbersome task that would be of minimal benefit. It has been anything but that. In fact it has been an incredible learning experience, not just from the vantage point of the information I have learned about supervision, but also from the perspective of learning

how to do research. It has also been extremely valuable having time in the field to learn of the experiences of my colleagues.

8.3 Synopsis

The front line staff that participated in my research were all members of multi disciplinary teams providing mental health services to clients in Northwestern Ontario. These therapists saw themselves as providing an important service and their priority was to provide service that was in the best interests of their clients. Most front line staff had more than five years of experience in adult mental health and during this time had had a variety of experiences in receiving supervision.

The work of Kadushin (1992) and Shulman (1993) provided the social work theoretical underpinnings for my study. I drew on other authors such as Ferguson - Pare (1998), Bueno (1991), McGillis Hall and Donner (1997), Duffield (1994), Kaiser (1997) and Read and Gehrs (1997) (to name a few) to augment my knowledge regarding supervision in multi disciplinary teams and the health care sector.

Supervision is a valuable process that needs to be accommodated in the field of mental health. New workers need to 'learn the ropes' when they begin a new job. This means not just the policies and procedures of the agency but also assistance with acquiring clinical knowledge and skills. Supervisors have an ethical responsibility to all their workers to ensure that workers receive supervision, and know what is expected of them in the context of their jobs. It is also the ethical responsibility of supervisors to ensure that staff are not endorsing client treatment plans that may

put the client at risk.

As front line staff matured in their role as therapist, their need for supervision persisted. The frequency of the didactic supervision with their supervisor decreased but their desire to have a trusting relationship with their supervisor continued. As well, the need for clinical supervision, debriefing, validation, support and some measure of professional autonomy continued to be perceived as important features of supervision.

Peer supervision was a commonly used supervision modality. Most participants described this process as their primary supervisory tool. Through this peer model many front line staff discovered the value of peer case reviews and the importance of receiving support and validation from peer members. The opportunity to debrief in this context was a final benefit of this process.

The multi disciplinary team added an additional dimension to the supervisory process. Several respondents discussed the absence of same discipline supervision and the potential erosion of supervision and one's professional identity as a result of the multi disciplinary experience. Others found merit in this experience citing the different theoretical perspectives of other disciplines as refreshing and good learning opportunities.

Change is characteristic of supervision in my findings. Traditional frameworks were being challenged by the composition of the mental health teams and by the supervisory practices used. The supervisory functions described by participants were consistent with the social work literature,

in particular Kadushin (1992) and Shulman (1993). Many of the clinicians used creativity as a means of getting their supervision needs met. Technology, community resources, professional development opportunities and peers are several examples of how people used their professional autonomy to receive the supervision they felt they needed.

During this research process it became clear that the supervision of multi disciplinary teams in outpatient adult mental health can be complicate.. The professional diversity, the size of the team, the personalities and styles of team members, and the changes in the political environment all impact on how supervision is provided. One thing is clear, front line staff in my study wanted supervision. Supervision, they felt, could come in many forms other than just one to one supervision with a supervisor. Informal and formal peer supervision were perceived as essential, as was the role of technology, community resources and experts in the field. Despite some core similarities in supervisory needs, diversity existed. It is important to acknowledge the individual supervisory needs of team members and not assume that one recipe can be used for all members. One way participants felt that their specific supervisory needs could get addressed was through the process of formal evaluations that would include specific staff development objectives as they pertained to the front line staffs' professional development goals.

8.4 Research Highlights

This has been an exercise about learning. The mental health workers in my study have extended themselves far beyond the parameters of a rigid supervision model. They were willing to explore creative options in getting their supervisory needs met. Their willingness to try new

supervisory technologies and to risk themselves in such a manner speaks highly of their desire to provide their clients with quality service.

The emphasis on the team and peer supervision were perceived by most interviewees as a valuable asset to their program. For many, this helped dissolve some of their feelings of working in isolation with their clients. The team was the venue used to conduct formal peer supervision. For many participants this was where they received clinical supervision, feedback, validation and support. The team for a number of therapists was a safe place where trusting relationships existed and where team members truly supported each other. This was an exciting finding.

The use of the internet and e - mail as a tool used to receive supervision, never entered my mind when I began this research project. Many clinicians described their experiences in accessing such resources. Some individuals shared that they have received on - line group supervision, while others commented that they e - mail their colleagues all over the country to receive clinical input and support. Clinicians who used technology said they did so on a daily basis and found it quite beneficial in meeting their needs. This I found truly fascinating.

8.4 Evaluation of the Study

My research was confined to a particular population of front line staff. The sample size was small and coupled with the narrow focus of my research does not lend itself to generalizing my finding to the general population.

As I began the process of interviewing participants, I found it challenging to juggle my interviewing style from clinician to researcher. The first couple of interviews, I approached with apprehension and I found that these interviews were completed within an hour. I also found that initially, I was more directive, in terms of interview probes. However, this did change early in the interviewing process when I became more comfortable with my new role. Despite my initial apprehension, the remaining interviews went relatively smoothly and respondents were candid and willing to share their experiences regarding supervision and their supervisory needs.

The candidness of the participants was an asset but also a deficit. The detail in some of the front line workers' stories was such that if I had used some of this data I would have breached the confidentiality of some of my respondents thus rendering the ethics of my research suspect. If I had been able to use some of this data I believe I could have given more strength to my findings.

My data collection process did use an interview guide to assist me in staying focussed on my research topic. Hence, my method of inquiry is not a pure phenomenological design. However, my research did allow me to know the supervisory experiences of my participants through their eyes and their reality. Through the process of face to face interviews I learned from my respondents' unique stories their supervisory experiences and needs. This I believe added depth to my data thus enhancing my thesis.

(i.) Future Research Directions

Throughout my research I have focussed on the research needs of frontline staff. I feel I have omitted a significant piece of the supervisory equation by not exploring the managers' experiences in providing supervision and the changes to their roles as a result of health care reform. Research in this area would certainly compliment my research.

Longitudinal research on the changes to the supervisory process will yield interesting results. Technology, and all it has to offer in terms of access to supervisory resources, I believe will have a significant effect on the supervisory process as they exist in the literature.
The emphasis on multi disciplinary teams and it's impact on the erosion of professional identity and discipline specific supervision is another research topic that warrants investigation. The professional implications of the erosion of discipline specific activities could potentially have profound effects on specific disciplines. Therefore, the effects of being a member of a multi disciplinary team on one's professional identity warrants further inquiry.

8.5 Recommendations and Implications

The findings of my research do have implications on social work policy, practice and education.

(i.) Policy

Professional colleges set out professional standards of practice for their members which address staff development, scopes of practice, competence and integrity, professional conduct, and supervision. The College of Psychologists for Ontario and The College of Nurses set out guidelines

pertaining to staff supervision while the Ontario Association of Social Workers in the heading under scope of practice simply states that there should be a "...provision of professional supervision to a social worker, social work student, or other supervisee;".

I believe that more stringent directives should be outlined that require front line staff to receive supervision after a specific number of hours of clinical practice. The British Association for Counselling and Psychotherapy (BACP) (1988) adhere to such a policy and it is one means by which front line staff get their supervisory needs met. It is also a means of ensuring clinical accountability and quality service to clients. BACP (1988) has very explicit guidelines that clinical supervisors must adhere to in providing supervision. Appendix 5 provides the BACP Code of Ethics and Practice for Supervision of Counsellors and their accreditation requirements. This code is a very detailed document that recognizes the necessity of supervision and it takes a firm position on supervisees receiving this form of monitoring and guidance. Compared to our provincial code, the British model offers much more explicit directives and guidelines regarding the supervisory process.

There is a need for mental health agencies to recognize the effects that secondary trauma can have on clinicians. Policy should exist that endorses and establishes protocol that enables front line staff to work through their vicarious trauma. This protocol can outline formal and informal mechanisms by which "working through" the vicarious trauma can occur. Developing such a policy would provide recognition that vicarious trauma does exist thus providing additional support to front line staff.

A third policy initiative that should be considered pertains to an orientation and training package for new staff. This package should outline the expectations of the job, policies and procedures of the agency, outline a supervision schedule as well as professional development opportunities that will enhance clinical skills.

A fourth policy initiative deals with membership in our respective colleges. As an employment requirement employers could require their employees be members of their college. This has several benefit; it promotes professional identification with a specific discipline; it is an avenue to ensure worker accountability; and it provides strength in numbers to professional colleges who should be advocating for our professional best interests.

(ii.) Practice

Supervisors need to aware of the supervision needs of their front line staff and staff have a responsibility to share these needs with their supervisor. This should occur in the context of a trusting relationship. Based on the stories of many of my respondents this has not been their experience.

Supervision in the context of multi disciplinary teams does have practice implications. Supervisors who have a different discipline than their staff should at minimum have some basic understanding of the underpinnings of the other disciplines. Supervisors need to be aware of the theoretical knowledge of these professions and the approaches these disciplines use in therapy. If a supervisor does not possess this knowledge or training nor have the time to acquire it, they should

acknowledge that supervision is important and make some accommodation for it.

Front line staff want supervision. The needs of front line staff, particularly in the context of multi disciplinary teams are diverse, and supervisors should recognize this diversity and develop with their staff individualized supervision plans. These plans should outline the supervisor's and the staff's responsibility with ensuring that front line staff supervision needs are met. This process would provide the opportunity to explore with staff their professional development goals and plans to assist them with achieving these goals. This supervisory format would allow for more concise feedback to be obtained for ongoing staff evaluations. It is also a mechanism that could ensure mutual accountability.

Managers and front line staff need to recognize that being part of a multi disciplinary team can threaten discipline autonomy. The assimilation of the therapeutic roles does not acknowledge specific disciplines, rather it combines a number of disciplines into similar job functions. Both supervisors and therapists need to utilize the mechanisms that exist, such as professional colleges, as a means of maintaining an identity with one's discipline. Supervisors have a responsibility in supporting their staff with this process by accommodating discipline specific activities and same discipline supervision if it is required by front line staff or their respective colleges.

Formal and informal peer supervision is a beneficial and essential supervisory process. There is a need however, to work towards changing the process if it causes disharmony and conflict among team members, for example, placing team members in the position of being in the primary

supervisory role of new staff or staff that are experiencing difficulties. In these situations staff who are of equal status as those struggling or new team members do not have the power or authority to enforce change. Managers need to acknowledge the power and authority given to them by their position in the organization and assume the responsibility of dealing with such issues.

The final practice implication of my research involves the use of technology. Technology presents many exciting and unique opportunities to both supervisors and staff. There needs to be a recognition, by staff and management of the merit technology can have in assuming a supervisory role, both in the access to information and in the professional services that are offered on - line. There needs to be a willingness to have an open mind about the future possibilities and directives that this supervisory modality can provide and a continued willingness to explore creative options.

(iii.) Education

The educational implications of my findings concur with the findings of Levin and Herbert (1999). Supervision in mental health services is not consistent with the curriculum taught in schools of social work (Kadushin & Egan, cited in Levin and Herbert,1999, 27). Educators in schools of social work need their teachings to more accurately reflect the changes in supervision that currently exist in the health care field. Traditional social work models are being challenged, and the mentoring, the didactic supervision and discipline specific supervision that historically was available has become eroded. Schools of social work now have a responsibility to provide students with the tools they need to get their supervisory needs met as well as maintain their professional identity.

Appendix 1

Letter to front line staff.

Address

Data

Dear Participant,

I am a graduate student at the University of Manitoba Faculty of Social Work. My advisor is Dr. Lyn Ferguson (204-474-8273). I am doing qualitative research in the form of face to face interviews using a semi structured interview schedule. The focus of my research is; what are the supervisory needs of front line staff from the perspective of members of multi disciplinary teams in outpatient adult mental health programs in Northwestern Ontario. This information will be helpful in understanding the effects of restructuring of the Health Care System on the supervisory process in Adult Mental Health programs.

Your name was obtained from your office directory. It is my hope that you might be willing to take part in an interview process to assist in understanding your experiences as a front line mental health worker. An interview lasting approximately one and one half to two hours would be conducted with you. The interview would be tape recorded. The interview would remain confidential and the tape would be erased as soon as my study is completed. Due to the small number of front line staff participating in this research, participants' anonymity can not be assured however, front line staffs' confidentiality will be maintained.

It is my desire to study the supervisory process of multi disciplinary teams from the perspective of front line staff. I will then provide feedback that hopefully will be beneficial..

If you are willing to participate, please call me at 807 - 468 - 9861, ext.413 and sign the enclosed consent form and send it back to me. I will be in touch with you in the near future to arrange a time to meet. Thank you for your help and I look forward to discussing this research with you more fully.

Sincerely,

Denise Cronin - Forsyth, BSW

Appendix 2

Interview Guide for Front Line Staff

DEMOGRAPHIC INFORMATION

1. Age: _____

2. Gender: _____

3. Educational Qualifications: _____

4. Job Title: _____

5. Years of Work Experience in Adult Mental Health: ____

6. Years of Work Experience in Current Position: _____

7. Professional Discipline: _____

8. Professional Discipline of your Manager: _____

INTERVIEW GUIDE

1. Please tell me what staff supervision means to you.

2. Please describe your experiences of being supervised by someone of the same discipline/ someone of a different discipline.

3.Please tell me what you needs are in staff supervision.

Use probes if the following areas are not addressed.
Clinical Supervision
Administrative Supervision
Supportive Supervision

4. Are there other forms of supervision that you receive other than what you have spoken of. If so please tell me about these experiences.

5. Are there aspects of the current supervisory process that you find helpful? What are these aspects?

6. Are there aspects of the supervisory process that you do not find helpful? What are these aspects?

7. Are there changes that you would like to see implemented in the way the supervisory role is fulfilled? What are these changes?

8. What recommendations would you make to enhance current supervisory practices?

9. Would you like to make any additional comments?

Appendix 3

Consent Form for Front Line Staff

Consent Form

January 20,2001

Researcher: Denise Cronin- Forsyth
(807) 468 - 4181

Advisor: Dr. Lyn Ferguson
Faculty of Social Work
University of Manitoba, Wpg.
(204) 474 - 8273

I have been invited to participate in a qualitative study that will describe the supervisory needs of front line staff from the perspective of members of multi disciplinary teams in adult mental health programs in Northwestern Ontario. The title of this thesis research is: "Supervision Needs of Multi Disciplinary Teams in Outpatient Adult Mental Health Programs in Northwestern Ontario". I understand that I have been asked to share my experiences as a front line worker as they relate to my employment in my current position. It is hoped that this research will assist front line staff and their first line manager with enhancing the supervisory process in adult mental health programs.

I understand that Denise Cronin - Forsyth will be interviewing me once for about an hour and a half to two hours and recording our conversations through the use of a tape recorder. I understand that I have the freedom to not answer any of these questions.

I also understand that I may terminate the interview or withdraw from this research project any time without penalty.

I agree to participate in this study knowing that the taped conversations will be kept strictly confidential and that all the tapes will be kept under lock and key until they are destroyed once the research project has been completed. I understand that the data from the interview will be used for research purposes only, including a thesis document and publication. I further understand that all identifiable information will be excluded from all disks and written material. I also understand that the anonymity of the front line staff can not be assured, however, confidentiality will be maintained.

I understand that I may receive a copy of the results if I request it and that a final written thesis will be available at the University of Manitoba.

If I require any additional information I can contact Denise Cronin - Forsyth at 807 - 468 - 9861, ext.413. If I have questions concerning the ethical aspects of this study I can communicate with the Ethics Committee through Wayne Taylor, Joint - Faculty Research Ethics Board (JFREB) at 204 - 474 - 8877.

I have received two copies of the consent form, one of which I can keep.

SIGNATURE OF PARTICIPANT DATE

SIGNATURE OF INVESTIGATOR DATE

APPENDIX IV

Examples of internet supervision options

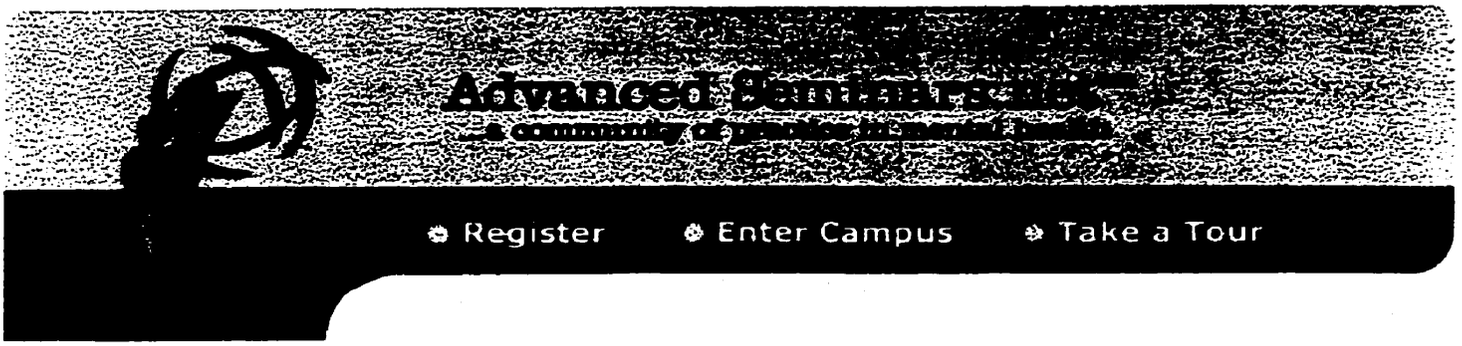
Self Psychology Bulletin Board

Self Psychology study/peer supervision group

From: Tmagnik@yahoo.com
Date: 18 Jan 2000

Comments

I am a clinical social worker in downtown Chicago. I am interested in getting together a small group of practicing clinicians with strong self-psychological orientations to form a study/peer supervision group. If you are interested please respond and share your ideas for the formation of such a group. Thanks!



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Peer Supervision Groups

Advanced Seminars.net is the first eLearning portal to recognize the need for mental health clinicians to create their own peer supervision groups. We offer you the opportunity to gather a group of your peers with similar interests and create you own peer supervision group. For example, if you gather a minimum of 5 of your colleagues (for a total of 6 groups members) you can create your own private, password protected forum that meets in real time to discuss case material. We even offer you a private message board for your group in addition that allows you to communicate with each other 24 hours a day, 7 days a week. This means you have access to your peer group anytime you need it. You also get two communication channels for the price of one!

The subscription cost of this arrangement, including hosting and all technical support is $99.00 per month per group member. If you wish to be able to access our Virtual Campus and have 24/7 access to fellow practitioners from around the globe as well as all of our Campus collaboration features such as the Campus Cafe and Virtual Library with its hundreds of online mental health resources, the subscription cost is $125.00 per month per group member.

Register Now!

World Association For Online Education

ACHE

JOIN THE PEER RESOURCES NETWORK

WHAT IS THE PEER RESOURCES NETWORK?

The Peer Resources Network (PRN) is a membership-based service provided by Peer Resources, a non-profit, educational corporation, specializing in the development of peer, coach and mentor programs. Membership includes:

- A subscription to our print publication: Compass: The Magazine for Peer Assistance, Mentoring, and Coaching;
- A subscription to our monthly Internet publication: The Peer Bulletin;
- Access to our password protected website documents;
- On-line expert consultation through e-mail and toll-free telephone;
- Discounts on workshops and training events;
- Other benefits (see below).

For a comparison between membership and non-member services, see our Comparison Chart.

We hope you will join with us in this effort to support the services and materials that we provide to strengthen peer, coach and mentor programs.

HOW DO I JOIN THE PEER RESOURCES NETWORK?

STEP 1: Choose Annual Fee Category

- Use the **Student Rate** ($21.40) if you are registered as a full-time student in any post-secondary institution.
- Use the **Individual Rate** ($53.50) if you want to continue to receive publications and gain additional services.
- Use the **Institutional Rate** ($107.00) if two to five persons

from the same address would like to receive all services.

STEP 2: Choose Payment Option
You can pay by cheque, money order or VISA. Cheques should be made payable to the "Peer Resources Network."

STEP 3: Select Registration Option

- Print and mail the information requested on the Membership Form to: The Peer Resources Network, 1052 Davie Street, Victoria, British Columbia, V8S 4E3, Canada
- Print and fax the information requested on the Membership Form to: 1-250-595-3504; or
- Complete the On-Line Membership Form and submit by secure e-mail.

As a Result of Becoming a Member of the Peer Resources Network

You Will Receive:

- Access to the largest and most comprehensive peer, coach and mentor database in the world;
- Publications which provide up-to-date information about trends, practices, and issues in the coaching, peer and mentor fields;
- Instant consultation services with experts in coach, peer and mentor work via e-mail and toll-free telephone;
- Research documents to support coach, peer and mentor program proposals;
- Analysis and feedback from coach, peer and mentor experts about program proposals, plans, or ideas;
- Free feedback from expert writing coaches about your proposals, documents, or research dissertations;
- Free use of our coaching school placement service coaches;
- Support from coaches, peer and mentor program leaders throughout the world;
- Field-tested forms, surveys, and instruments used to recruit, select, supervise, and evaluate coaching, peer and mentor programs;

- Opportunities to participate in pilot projects, trying out new materials, techniques, and resources; and
- An individualized, unique password giving access to all our internet services.

You Will Be Able To:

- Retrieve with the click of a button the latest coach, peer and mentor training curriculum modules from the internet;
- Suggest topics that our training experts can turn into customized training modules for use in your program;
- Consult with experts in how to recruit, select, train, supervise, and evaluate in peer and mentor programs;
- Learn from peer and mentor program leaders and coaches around the world how they resolved difficulties and issues;
- Contact coaches, peer and mentor leaders in your geographic region or in regions you want to visit for professional development;
- Receive state-of-the-art information on trends, techniques, and practices in coaching and the peer and mentor fields;
- Improve the quality of written materials used in coaching, mentorship or peer work;
- Decide which coaching school or service best meets your needs;
- Receive reviews of up-to-date books, articles, and other relevant resources associated with coaching, peer and mentor work;
- Obtain summaries and annotated bibliographic information of all the latest published coach, peer and mentor research; and.

You Will Gain:

- Extra time while we do the search for the right materials for your peer or mentor program or coaching interests;
- Knowledge on how to establish a successful peer or mentor program or find an appropriate coach;
- Confidence in peer and mentor program delivery through discussion with the world¹s leading authorities;
- Skill as a peer and mentor program leader by participating in on-line discussions or in-person workshops;
- Reduced fee access to train-the-trainer workshops and discounts

on professional training and support resources;

- Abilities to help students, employees, clients, or colleagues benefit from relationships with coaches, mentors and peers;
- Support to assist in resolving coach, peer and mentor program concerns through collaboration with experts;
- Expert, confidential advice at minimal cost and in many cases without taking time off from your job; and
- Productivity in your work by involving coaches, peers and mentors in areas such as dispute resolution, career development, health and safety education, goal-setting, problem-solving, decision-making, cultural understanding, and performance appraisal.

Special Note to Libraries and Resource Centres	If you are associated with a library or resource centre, you can obtain all these services for your library or resource centre patrons. You will be provided with a site-specific password that will allow your clients access to our on-line or toll-free services at your site. You will also receive printed copies of all our publications and discounts on the purchase of all our other resources as part of your membership.
Special Note if Requesting Student Status	A student status rate is available to anyone who is a full-time student at a university or college or a full-time student in a distance learning program that emphasizes peer assistance, coaching, or mentoring.

On-Line Membership Form

If you are concerned about sending personal or financial information over the internet, read our privacy statement.

Name
Title
Organization
Street
City
Province/State
Country (If outside North America)
Postal/Zip Code

Is this address:
- Work
- Home
- Work and Home

E-mail address (Required)
Phone (Work) (Required)
Phone (Home) (Optional)
Fax (Optional)
Cell (Optional)

Primary Interest Area (select all that apply):
- Peer Assistance
- Coaching
- Mentoring

Annual Fee Category
- Individual Rate ($53.50)
- Institutional Rate ($107.00)
- Student Rate ($21.40) (Must be a full-time student)

University/School (If requesting student rate)

Payment Method:
- Credit Card (VISA Only)
- I will send a money order or check
- I will send a purchase order
- Please invoice me by E-mail (Not available for student rate.)
- Please invoice me by fax (Make sure your fax number is included above.)

○ Please invoice me by postal mail (Not available for student rate.)

Credit Card Information:
We do not store credit card information. All processing is handled by a real person. Your VISA receipt will be mailed to the address you provided above. Our computer system and data collection procedures are completely hacker-proofed, and cannot be accessed by unauthorized personnel.

VISA VISA

[ ] VISA Number
[ ] VISA Expiry Date
[ ] Name on card

[redacted]

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APPENDIX V

British Association for Counselling and Psychotherapy

Code of Ethics and Accreditation Standards

www.bac.co.uk

Code of Ethics and Practice for the Supervision of Counsellors

1. Status of the Code

1.1 In response to the experience of members of BACP, this Code is a revision of the 1988 Code of Ethics & Practice for the Supervision of Counsellors.

2. Introduction

2.1 The purpose of the Code is to establish and maintain standards for supervisors who are members of BACP and to inform and protect counsellors seeking supervision. Throughout this Code the terms Counsellor and Counselling are used in accordance with the definition of counselling in the Code of Ethics & Practice for Counsellors.

2.2 All members of this Association are required to abide by existing Codes appropriate to them. They thereby accept a common frame of reference within which to manage their responsibilities to supervisees and their clients, colleagues, members of this Association and the wider community. Whilst this Code cannot resolve all ethical and practice related issues, it aims to provide a framework for addressing ethical issues and to encourage optimum levels of practice. Supervisors and supervisees (counsellors) will need to judge which parts of this Code apply to particular situations. They may have to decide between conflicting responsibilities.

2.3 Counselling Supervision is a formal and mutually agreed arrangement for counsellors to discuss their work regularly with someone who is normally an

experienced and competent counsellor and familiar with the process of counselling supervision. The task is to work together to ensure and develop the efficancy of the supervisee's counselling practice.

Counselling Supervision is the term that will be used throughout this Code. It is also known as supervision, consultative support, clinical supervision or non-managerial supervision. It is an essential part of good practice for counselling. It is different from training, personal development and line management accountability.

2.4 The Association has a Complaints Procedure which can lead to the expulsion of members for breaches of its Codes of Ethics & Practice.

3. Nature of Counselling Supervision

3.1 Counselling supervision provides supervisees with the opportunity on a regular basis to discuss and monitor their work with clients. It should take account of the setting in which supervisees practise. Counselling supervision is intended to ensure that the needs of the clients are being addressed and to monitor the effectiveness of the therapeutic interventions.

3.2 Counselling supervision may contain some elements of training, personal development or line-management, but counselling supervision is not primarily intended for these purposes and appropriate management of these issues should be observed.

3.3 Counselling supervision is a formal collaborative process intended to help

supervisees maintain ethical and professional standards of practice and to enhance creativity.

3.4 It is essential that counsellor and supervisor are able to work together constructively as counselling supervision includes supportive and challenging elements.

3.5 There are several modes of counselling supervision (see 5), which vary in appropriateness according to the needs of supervisees. More than one mode of counselling supervision may be used concurrently. This code applies to all counselling supervision arrangements.

3.6 The frequency of counselling supervision will vary according to the volume of cousnelling, the experience of supervisees and their work setting.

4. Anti-discriminatory Practice in Counselling Supervision

4.1 Anti-discriminatory practice underpins the basic values of counselling and counselling supervision as stated in this document and in the Code of Ethics & Practice for Counsellors. It also addresses the issue of the client's social context, B.2.7.3 of that Code (1996).

4.2 Supervisors have a responsibility to be aware of their own issues of prejudice and stereotyping, and particularly to consider ways in which this may be affecting the supervisory relationship. Discussion of this is part of the counselling supervision process.

4.3 Supervisors need to be alert to any

prejudices and assumptions that counsellors reveal in their work with clients and to raise awareness of these so that the needs of clients may be met with more sensitivity. One purpose of counselling supervision is to enable supervisees to recognise and value difference. Supervisors have a responsibility to challenge the appropriateness of the work of a supervisee whose own belief system interferes with the acceptance of clients.

4.4 Attitudes, assumptions and prejudices can be identified by the language used, and by paying attention to the selectivity of material brought to counselling supervision.

5. Modes of Counselling Supervision

There are different modes of counselling supervision. The particular features of some of these modes are outlined below. Some counsellors use combinations of these for their counselling supervision.

5.1 One to One, Supervisor-Supervisee. This involves a supervisor providing counselling supervision on an individual basis for an individual ocunsellor who is usually less experienced that the supervisor. This is the most widely used mode of counselling supervision.

5.2 Group Counselling Supervision with Identified Counselling Supervisor(s). There are several ways of providing this form of counselling supervision. In one approach the supervisor acts as the leader, takes responsibility for organising the time equally between the supervisees, and concentrates on the work of each individual in turn. Using another approach the supervisees allocate counselling supervision time

between themselves with the supervisor as a technical resource.

5.3 One to One Peer Counselling Supervision. This involves two participants providing counselling supervision for each other by alternating the roles of supervisor and supervisee. Typically, the time available for counselling supervision is divided equally between them. This mode on its own is not suitable for all practitioners.

5.4 Peer Group Counselling Supervision. This takes place when three or more counsellors share the responsibility for providing each other's counselling supervision within the group. Typically, they will consider themselves to be of broadly equal status, training and/or experience. This mode on its own is unsuitable for inexperienced practitioners.

5.5 Particular issues of competence for each mode are detailed in the Code of Practice B.2.6.

6. The Structure of this Code

6.1 This code has two sections. Section A, the Code of Ethics, outlines the fundamental values of counselling supervision and a number of general principles arising from these. Section B, the Code of Practice, applies these principles to counselling supervision.

A. CODE OF ETHICS

A.1 Counselling supervision is a non-exploitative activity. Its basic values are integrity, responsibility, impartiality and respect. Supervisors must take the same

degree of care to work ethically whether they are paid or work voluntarily and irrespective of the mode of counselling supervision used.

A.2 **Confidentiality**
The content of counselling supervision is highly confidential. Supervisors must clarify their limits of confidentialty.

A.3 **Safety**
All reasonable steps must be taken to ensure the safety of supervisees and their clients during their work together.

A.4 **Effectiveness**
All reasonable steps must be taken by supervisors to encourage optimum levels of practice by supervisees.

A.5 **Contracts**
The terms and conditions on which counselling supervision is offered must be made clear to supervisees at the outset. Subsequent revisions of these terms must be agreed in advance of any change.

A.6 **Competence**
Supervisors must take all reasonable steps to monitor and develop their own competence and to work within the limits of that competence. This includes having supervision of their supervision work.

B. CODE OF PRACTICE

B.1 **Issues of Responsibility**

B.1.1. Supervisors are responsible for ensuring that an individual contract is worked out with their supervisees which will allow them to present and explore their work as honestly as possible.

B.1.2 Within this contract supervisors are responsible for helping supervisees to reflect critically upon their work, while at the same time acknowledging that clinical responsibility remains with the counsellor.

B.1.3 Supervisors are responsible, together with their supervisees, for ensuring that the best use is made of counselling supervision time, in order to address the needs of clients.

B.1.4 Supervisors are responsible for setting and maintaining the boundaries between the counselling supervision relationship and other professional relationships, e.g. training and management.

B.1.5 Supervisors and supervisees should take all reasonable steps to ensure that any personal or social contact between them does not adversely influence the effectiveness of the counselling supervision.

B.1.6 A supervisor must not have a counselling supervision and a personal counselling contract with the same supervisee over the same period of time.

B.1.7 Supervisors must not exploit their supervisees financially, sexually, emotionally or in any other way. It is unethical for supervisors to engage in sexual activity with their supervisee.

B.1.8 Supervisors have a responsibility to enquire about any other relationships which may exist between supervisees and their clients as these may impair the objectivity and professional judgement of supervisees.

B.1.9 Supervisors must recognise, and work in ways that respects the value and dignity of supervisees and their clients with due regard to issues such as origin, status, race, gender, age, beliefs, sexual orientation and disability. This must include raising awareness of any discriminatory practices that may exist between supervisees and their clients, or between supervisor and supervisee.

B.1.10 Supervisors must ensure that together with their supervisees they could consider their respective legal liabilities to each other, to the employing or training organisation, if any, and to clients.

B.1.11 Supervisors are responsible for taking action if they are aware that their supervisees' practice is not in accordance with BACP's Codes of Ethics & Practice for Counsellors.

B.1.12 Supervisors are responsible for helping their supervisees recognise when their functioning as counsellors is impaired due to personal or emotional difficulties, any condition that affects judgement, illness, the influence of alcohol or drugs, or for any other reason, and for ensuring that appropriate action is taken.

B.1.13 Supervisors must conduct themselves in their supervision-related activities in ways which do not undermine public confidence in either their role as supervisor or in the work of other supervisors.

B.1.14 If a supervisor is aware of possible misconduct by another supervisor which cannot be resolved or remedied after

discussion with the supervisor concerned, they should implement the Complaints Procedure, doing so within the boundaries of confidentiality required by the Complaints Procedure.

B.1.15 Supervisors are responsible for ensuring that their emotional needs are met outside the counselling supervision work and are not solely dependent on their relationship with supervisees.

B.1.16 Supervisors are responsible for consulting with their own supervisor before former clients are taken on as supervisees or former supervisees are taken on as clients.

B.2 **Issues of Competence**

B.2.1 Under all of the modes of counselling supervision listed above, supervisors should normally be practicing and experienced counsellors.

B.2.2 Supervisors are responsible for seeking ways to further their own professional development.

B.2.3 Supervisors are responsible for making arrangements for their own supervision in order to support their counselling supervision work and to help them to evaluate their competence.

B.2.4 Supervisors are responsible for monitoring and working within the limits of their competence.

B.2.5 Supervisors are responsible for withdrawing from counselling supervision work either temporarily or permanently when their functioning is impaired due to personal or emotional difficulites, illness,

the influence of alcohol or drugs, or for any other reason.

B.2.6 Some modes require extra consideration and these are detailed in this section.

One to one supervisor - supervisee A
Group counselling supervision with identified and more experienced supervisor A,B,D,E
One to one peer counselling supervision A,B,C,D,G,H

Peer group counselling supervision A,B,C,D,F,G,H

A. All points contained elsewhere within the Code of Practice should be considered.
B. Sufficient time must be allocated to each counsellor to ensure adequate supervision of their counselling work.
C. This method on its own is particularly unsuitable for trainees, recently trained or inexperienced counsellors.
D. Care needs to be taken to develop an atmosphere conducive to sharing, questioning and challenging each others' practice in a constructive and supportive way.
E. As well as having a background in counselling work, supervisors should have appropriate groupwork experience in order to facilitate this kind of group.
F. All participants should have sufficient groupwork experience to be able to engage the group process in ways which facilitate effective counselling supervision.
G. Explicit consideration should be given to deciding who is responsible for providing the counselling supervision, and how the task of counselling supervision will be carried out.
H . It is good practice to have an

independent consultant to visit regularly to observe and monitor the process and quality of the counselling supervision.

B.3 Management of Work

B.3.1 The Counselling Supervision Contract

3.1.1 Where supervisors and supervisees work for the same agency or organisation the supervisor is responsible for clarifying all contractual obligation.

3.1.2 Supervisors must inform their supervisee, as appropriate, about their own training, philosophy and theoretical position, qualifications, approach to anti-discriminatory practice and the methods of counselling supervision they use.

3.1.3 Supervisors must be explicit regarding practical arrangements for counselling supervision, paying particular regard to the length of contact time, the frequency of contact, policy and practice regarding record keeping, and the privacy of the venue.

3.1.4 Fees and fee increases must be arranged and agreed in advance.

3.1.5 Supervisors and supervisees must make explicit the expectations and requirements they have of each other. This should include the manner in which any formal assessment of the supervisee's work will be conducted. Each party should assess the value of working with the other, and review this regularly.

3.1.6 Supervisors must discuss their policy regarding giving references and any fees that may be charged for this or for any other

work done outside counselling supervision time.

3.1.7 Before formalising a counselling supervision contract supervisors must ascertain what personal counselling the supervisee has or has had. This is in order to take into account any effect this may have on the supervisee's counselling work.

3.1.8 Supervisors working with trainee counsellors must clarify the boundaries of their responsibility and their accountability to their supervisee and to the training course and any agency/placement involved. This should include any formal assessment required.

B.3.2 **Confidentiality**

3.2.1 As a general principle, supervisors must not reveal confidential material concerning the supervisee or their clients to any other person without the express consent of all parties concerned. Exceptions to this general principle are contained within this Code.

3.2.2 When initial contracts are being made, agreements about the people to whom supervisors may speak about their supervisees work must include those on whom the supervisors rely for support, supervision or consultancy. There must also be clarity at this stage about the boundaries of confidentiality having regard for the supervisor's own framework of accountability. This is particularly relevant when providing counselling supervision to a trainee counsellor.

3.2.3 Supervisors should take all reasonable steps to encourage supervisees

to present their work in ways which protect the personal identity of clients, or to get their client's informated consent to present information which could lead to personal identification.

3.2.4 Supervisors must not reveal confidential information concerning supervisees or their clients to any person or through any public medium except:

a) When it is clearly stated in the counselling supervision contract and it is in accordance with all BACP Codes of Ethics & Practice.

b) When the supervisor considers it necessary to prevent serious emotional or physical damage to the client, the supervisee or a third party. In such circumstances the supervisee's consent to a change in the agreement about confidentiality should be sought, unless there are good grounds for believing that the supervisee is no longer able to take responsibility for his/her own actions. Whenever possible, the decision to break confidentiality in any circumstances should be made after consultation with another experienced supervisor.

3.2.5 The disclosure of confidential information relating to supervisees is permissible when relevant to the following situation:

a) Recommendations concerning supervisees for professional purposes e.g. references and assessments.

b) Pursuit of disciplinary action involving supervisees in matters pertaining to standards of ethics and practice.

In the latter instance, any breaking of confidentiality should be minimised by conveying only information pertinent to the immediate situation on a need-to-know basis. The ethical considerations needing to be taken into account are:

i Maintaining the best interest of the supervisee
ii Enabling the supervisee to take responsibility for their actions
iii Taking full account of the supervisor's responsibility to the client and to the wider community

3.2.6 Information about work with a supervisee may be used for publication or in meetings only with the supervisee's permission and with anonymity preserved.
3.2.7 On occasions when it is necessary to consult with professional colleagues, supervisors ensure that their discussion is purposeful and not trivialising.

B.3.3 **The Management of Counselling Supervision**

3.3.1 Supervisors must encourage the supervisee to belong to an association or organisation with a Code of Ethics & Practice and a Complaints Procedure. This provides additional safeguards for the supervisor, supervisee and client in the event of a complaint.

3.3.2 If, in the course of counselling supervision, it appears that personal counselling may be necessary for the supervisee to be able to continue working effectively, the supervisor should raise the issue with the supervisee.

3.3.3 Supervisors must monitor regularly how their supervisees engage in self-evaluation of their work.

3.3.4 Supervisors must ensure that their supervisees acknowledge their individual responsibility for ongoing professional development and for participating in further training programmes.

3.3.5 Supervisors must ensure that their supervisees are aware of the distinction between counselling, accountability to management, counselling supervision and training.

3.3.6 Supervisors must ensure with a supervisee who works in an organisation or agency that the lines of accountability and responsibility are clearly defined: supervisee/client; supervisor/supervisee; supervisor/client; organisation/supervisor; organisation/supervisee; organisation/client. There is a distinction between line management supervision and counselling supervision.

3.3.7 Best practice is that the same person should not act as both line manager and counselling supervisor to the same supervisee. However, where the counselling supervisor is also the line manager, the supervisee should have access to independent counselling supervision.

3.3.8 Supervisors who become aware of a conflict between an obligation to a supervisee and an obligation to an employing agency must make explicit to the supervisee the nature of the loyalties and responsibilities involved.

3.3.9 Supervisors who have concerns about a supervisee's work with clients must be clear how they will pursue this if discussion in counselling supervision fails to resolve the situation.

3.3.10 Where disagreements cannot be resolved by discussions between supervisor and supervisee, the supervisor should consult with a fellow professional and, if appropriate, recommend that the supervisee be referred to another supervisor.

3.3.11 Supervisors must discuss with supervisees the need to have arrangements in place to take care of the immediate needs of clients in the event of a sudden and unplanned ending to the counselling relationship. It is good practice for the supervisor to be informed about these arrangements.

Equal Opportunities Policy Statement

The 'British Association for Counselling' (BACP) is committed to promoting Equality of Opportunity of access and participation for all its members in all of its structures and their workings. BACP has due regard for those groups of people with identifiable characteristics which can lead to visible and invisible barriers thus inhibiting their joining and full participation in BACP. Barriers can include age, colour, creed, culture, disability, education, 'ethnicity', gender, information, knowledge, mobility, money, nationality, race, religion, sexual orientation, social class and status.

The work of BACP aims to reflect this commitment in all areas including services to members, employer responsibilities, the recruitment of and working with volunteers, setting, assessing, monitoring and

evaluating standards and the implementation of the complaints procedures. This is particularly important as BACP is the 'Voice of Counselling' in the wider world.

BACP will promote and encourage commitment to Equality of Opportunity by its members.

Accreditation

The British Association for Counselling and Psychotherapy welcomes applications from qualified and experienced counsellors who wish to become BACP Accredited.
BACP Accreditation as a counsellor offers a direct route to Registration as an independent practitioner with the United Kingdom Register of Counsellors.
Many employers require BACP accreditation for employment as a counsellor.
The criteria for individual counsellor accreditation follow and details of how to order the application pack are given after the criteria.
If you are in doubt as to whether or not you meet the criteria, please contact the Accreditation office.

Counsellor Accreditation

These criteria apply only to counsellors working with individuals or couples. They do not apply to group counselling.

There are **four** routes to Accreditation. The successful applicant will be one who prior to application:

1. i. **Has completed a** BACP Accredited Counsellor Training Course
and has had at least 450 hours of counselling practice supervised in accordance with paragraph 2, over not less than three and not more than five years.
OR

Has undertaken a total of 450 hours of successfully completed counselling training comprising two elements:
a) 200 hours of skills development
b) 250 hours of theory

and has had at least 450 hours of counselling practice supervised in accordance with paragraph 2, over not less than three and not more than five years.

OR

ii. Is claiming little formal (course based) counselling training, but can provide evidence of ten years experience in counselling as understood by BACP with a minimum of 150 practice hours per year under formal supervision. The last three submitted years must have been supervised in accordance with paragraph 2. [NB: This route will no longer be available to applicants after 31 December 2002.]

OR

iii. Can provide evidence of a combination of:
(a) some formal counselling training **and**
(b) several years of practice (of 150 hours minimum per year, under formal supervision). This includes a requirement for at least 450 hours of counselling practice supervised in accordance with paragraph 2, over three years.
75 hours of completed counsellor training = 1 unit
1 year of supervised practice = 1 unit
Together, the total must add up to 10 units.

Applicants claiming two or more training units must show a balance of theory and skills approximately in line with that stated in 1.i.

1. iv. Can provide evidence of:
   a. Having obtained S/NVQ Level III in Counselling
   [This will be seen as equal to 4 units.]
   b. Four or five years of supervised practice (of 150 hours minimum per year under formal supervision. This includes a requirement for at least 450 hours of counselling practice supervised in accordance with paragraph 2, over three years).
   At least two years must be subsequent to obtaining the S/NVQ Level III qualification.
   c. One or **two units of Continuing Professional Development [CPD]** (of 75 hours each unit), which must be subsequent to obtaining the S/NVQ Level III qualification.

Together the total must add up to 10 units.

One year of supervised practice = 1 unit

75 hours of CPD = 1 unit.

In addition to the above, the applicant is required to meet the following criteria:

2. Has an agreed formal arrangement for counselling supervision, as understood by BACP, of a minimum of one and a half hours monthly on the applicant's work, and a commitment to continue this for the period of the accreditation.
3. Gives evidence of serious commitment to ongoing professional and personal development such as regular participation in further training courses, study, personal therapy, etc.
4. Is a current individual member of BACP and undertakes to remain so for the accreditation period.
5. Has a philosophy of counselling which integrates training, experience, further development and practice. Evidence of at least one core theoretical model should be demonstrated.
6. Demonstrates practice which adheres to the BACP Code of Ethics & Practice for Counsellors and undertakes to continue working within this Code.
7. Can show evidence of having completed a minimum of 40 hours of personal counselling or has engaged in an equivalent activity consistent with the applicant's core theoretical model.
8. Can show evidence of serious commitment to working with issues of difference and equality in counselling practice.

Applicants are asked to give evidence of the above in the form of a written application including two case studies. Assessors will be looking for congruence between all parts of the application as well as checking that the above criteria have been and are being met.

If you think you meet the criteria the next step to take is to purchase the application pack. To order the pack by cheque please print this page. complete the details and

forward the form with your payment to our address.

The forms are now available on floppy disk. The disk is in Word 6.0/95 format so can be used in Word 6.0, Word 7.0, or Word 97.
The cost of the application pack without a disk is **£11.75**.
The cost of the application pack with a disk is **£15.00.**

Counsellor Accreditation Application Pack Order Form

I request an application pack for BACP Counsellor Accreditation.

I enclose a cheque for £11.75/£15.00 made payable to **British Association for Counselling and Psychotherapy**

Counsellor

Membership No:
Forname:
Surname:
Address:
Post Code:
E-mail:

I would like the pack to contain the application forms on disk:

If you wish to pay by Credit Card please complete the details below.
This is a secure site for Credit Card Payments
Minimum amount £10.

My Card Number is:

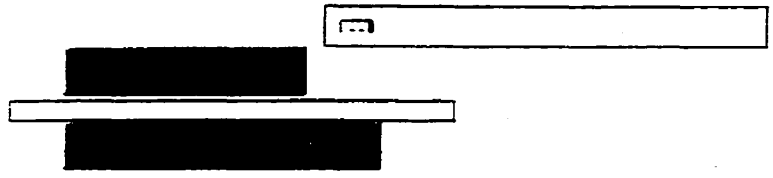
Expiry Date:

Name (as on the card):

Issue Number:

I would like to order the Counsellor Accreditation pack ☐

I would like to order the Counsellor Accreditation pack plus a disk ☐



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