Clinical Supervision in the Victorian Alcohol and Other Drugs Sector

Final Report

Prepared for

Primary Health Branch, Rural & Regional Health & Aged Care Services Division, The Department of Health

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THE BOUVERIE CENTRE, VICTORIA'S FAMILY INSTITUTE – LA TROBE UNIVERSITY

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1. Executive Summary

1.1 Background

The Bouverie Centre has provided Clinical Supervision training to the Victorian Alcohol and Other Drugs (AOD) field since 2004. This training has been funded by The Department of Health (The Department), Victoria, in order to build workforce capacity to provide high quality client services and to recruit and retain specialised staff.

This report describes a project undertaken by The Bouverie Centre commencing in 2008 which aimed to document, understand and support the provision of clinical supervision to workers in the AOD sector. Firstly, an appraisal was conducted of the clinical supervision practices in the sector. This included an examination of the supervision currently being provided together with an enquiry into what people in the field thought supported and constrained best practice in this area. Secondly, the effects of The Bouverie Centre Clinical Supervision Training were investigated. Finally, four peer supervision groups for graduates of the clinical supervision training were established.

1.2 Project Aims

The six major aims of the project were:

Aim One
To conduct an audit into the clinical supervision that is currently being accessed by workers in the AOD sector.

Aim Two
To understand and document the factors that may support the best practice of clinical supervision in the AOD sector.

Aim Three
To understand and document the factors that may constrain the best practice of clinical supervision in the AOD sector.

Aim Four
To understand the impact of The Bouverie Centre Clinical Supervision Training and the process of implementing ideas learned in the training.

Aim Five
To understand what people in the AOD sector consider the future direction for clinical supervision and how this could be supported by The Bouverie Centre.

Aim Six
To establish four peer supervision groups for graduates of The Bouverie Centre clinical supervision training.

1.3 Key Findings from the completion of aims 1 through 6

The Victorian AOD sector has largely embraced the concept of clinical supervision for its workers. However, there is great variability across organisations in what is being offered. Workers seem to have a good understanding of the purpose of supervision and as a group strongly endorse the practice. Their managers may share this understanding and have good intentions to provide this, however face barriers of inadequate funding, consistent support and divergent attitudes to the tasks and processes of supervision.

The following is a summary of the results of the six specific areas of enquiry covered in the current report.

1.3.1 Aim One: An audit into AOD clinical supervision practice, with findings from data gathered from workers who completed the web survey

Majority of workers report receiving clinical supervision

i. Of the 241 workers surveyed, 77% were currently accessing some type of clinical supervision.

ii. For most workers this was on at least a six weekly basis.

iii. The most common way to receive clinical supervision was through individual supervision.

Workers receiving no clinical supervision

i. Twenty-three per cent of workers who completed the survey reported receiving no clinical supervision at all or only on an informal basis.

Worker's expectations and understanding of clinical supervision

i. Collectively, workers' expectations and understanding of the purpose of clinical supervision seem congruent with The Department's strategic directions and also the functions of supervision as documented in the literature on clinical supervision. For instance, the workers expectations included using supervision as an accountability mechanism to review their work with clients and its impact on them personally and professionally.

ii. The majority of workers seemed to have a good grasp of what constitutes good - or at least adequate - supervision. Most workers reported being satisfied that their current supervision arrangements were, for the most part, meeting their professional needs.

Worker's suggestions for how to improve clinical supervision

The workers who reported being less than "very satisfied" with the *individual clinical supervision* they received made the following suggestions for improvement:

i. That it be provided by someone who is not a line manager
ii. That it be held more regularly and for longer sessions

iii. That clinical supervisors increase their training and expertise in clinical supervision and AOD clinical knowledge
iv. An increased focus on reflective practice, constructive feedback and professional development
v. A greater need to prioritise clinical supervision by both supervisor and supervisee.
vi. clinical supervision by both supervisor and supervisee.

Those less than 100% satisfied with their *facilitated group supervision* suggested the following improvements:

i. That it be provided by someone who is not a line manager
ii. That it be held more frequently
iii. That it be more structured
iv. That it be replaced by individual supervision
v. That supervisors increase their supervisory skills and knowledge of AOD sector work.

Finally, workers who gave *peer group supervision* satisfaction ratings lower than 5 out of 5 made the following suggestions for improvement*:*

i. That it be better organised and focused
ii. That it be held more frequently
iii. That it be more focused on clinical issues as opposed to group dynamics
iv. That it have a strengths-based focus.

The importance of clinical supervision within the AOD sector

Eighty five percent of workers surveyed suggested that clinical supervision should be mandated for all staff involved in the provision of direct AOD services to clients and/or their families. This is a strong support for clinical supervision from workers, which could form a foundation for more consistent sector wide guidelines and practices.

Ninety percent of the workers surveyed strongly endorse clinical supervision. However, they perceive the AOD sector, and their organisation within it, as placing less importance on it. This suggests that the AOD workforce is ready to embrace further implementation, standardising and formalising of clinical supervision. The AOD sector and organisations within it have an opportunity to capitalise on the readiness of workers to embrace supervision.

The strong support of the surveyed workers for clinical supervision contrasts with some of the perceptions held by managers and supervisors of workers' attitudes to supervision. Further, it is surprising that more than 20% of the workers surveyed report receiving no clinical supervision despite it being highly valued by both workers and managers.

1.3.2 Aim Two: The factors that support good clinical supervision practice – data from focus groups and telephone interviews.

Of the factors seen to support clinical supervision practice that were highlighted by managers and supervisors, the following were the most common:

- A strong positive management attitude to clinical supervision
- Clear definition, focus and education for all staff about clinical supervision
- Open organisational discussions of the tensions relating to clinical supervision
- A recognition that the functions of clinical supervision are multifaceted and aim to meet the needs of clients, staff and organisations
- A recognition that workers have a right to clinical supervision but that responsibility for the content and delivery of supervision is shared between management and staff.

1.3.3 Aim Three: The identified barriers to accessing and delivering clinical supervision

The following barriers were considered by managers and supervisors to be the most common and important to accessing and delivering clinical supervision:

- Poor consistency in the delivery of supervision
- Inadequate supervision and support for supervisors
- Time, resourcing and funding constraints, including poor availability of supervisors and inadequate remuneration for supervisors
- Divergent attitudes regarding the tasks and process of supervision

1.3.4 Aim Four: The implementation of The Bouverie Centre Clinical Supervision Training

There was a range of reported outcomes as a result of supervisors and managers attending The Bouverie Centre Clinical Supervision Training. Clinical supervisors reported many individual benefits including an increase in confidence in their abilities as a supervisor, the acquisition of formalised frameworks for thinking about and delivering supervision and an increase in job satisfaction.

The training seems to have impacted on organisations in several ways. For instance, some reported an overall increase in systemic thinking, a greater consistency with which supervision is delivered and several agencies had developed supervision models.

The training was also seen as part of a sector-wide change that has been occurring over recent years. This change is perceived as a greater focus on professionalism within the AOD sector.

The training has been well attended and enthusiastically welcomed by the sector. The current challenge is how to sustain changes to supervision practice from managers and supervisors and to capitalise on the readiness of workers for an increased focus on the consistent practice of supervision.

1.3.5 Aim Five: Future directions for the clinical supervision in the AOD sector as reported by members of the AOD sector

- There is a need to address the resourcing issues associated with clinical supervision.
- Further training, education and support for clinical supervision with various stakeholders.
- The development of a set of sector wide guidelines for the provision of clinical supervision, including consideration of whether to mandate clinical supervision for all workers.
- The provision of SOS Groups for clinical supervisors.
- The provision of organisational consultations regarding the implementation and practice of clinical supervision.
- Continued clinical supervision training.
- The development of clinical supervision resources.

1.3.6 Aim Six: Summary of the establishment of Supervision of Supervisors Groups (SOS Groups)

Four SOS Groups were established across metropolitan and regional Victoria. Two of the groups consisted of supervisors who were from various organisations, gathered together according to region. These regionally based groups met monthly following an initial facilitated session to negotiate the boundaries and purpose of the group. The focus of these SOS Groups was on the challenges faced by supervisors in the everyday practice of clinical supervision in AOD services. The participants gained support and shared ideas and resources through a group process of discussion, reflection and feedback with peers and the facilitator.

The other two groups were based in specific organisations. These had similar tasks to the regionally based groups with an additional dimension to provide an avenue for these organisations to discuss and develop their own particular supervisory model.

Feedback, both formally and informally, from all the SOS Groups was overwhelmingly positive. The participants valued both the facilitation from

the Bouverie Centre consultant and the support and knowledge of peers in the group.

The two regionally based SOS groups are continuing to meet beyond the life of this project with group members taking on responsibility for co-ordination. They now have a peer facilitation model. The organisation based groups are currently negotiating with The Bouverie Centre about continuing to provide some group facilitation.

1.4 Future Directions

The Department of Health has supported an effective strategy to train a significant number of AOD clinical supervisors over four years. While the clinical supervision training strategy has contributed to continuing clinical and service improvement, an ongoing strategy of clinical supervision training, further development and support for the sector will be required if clinical supervision is to become a sustainable and useful practice.

1.4.1 Clinical Supervision Guidelines

Assist the sector to clearly articulate values about clinical supervision to help workers, supervisors and senior managers understand what it is and what role supervision can play in relation to staff support, development and client outcomes. Our recent consultation and survey has highlighted the need for clear and consistent guidelines across the sector.

The Bouverie Centre will establish a clinical supervision working group comprised of representatives from The Department, senior managers, clinical supervisors and direct service workers from the sector. The working group will develop minimum standards and guidelines, as well as a strategy for dissemination to the sector.

A working group to develop uniform guidelines that capture the complexity of the AOD sector service delivery components.

1.4.2 Workforce Development and Implementation Strategies

Continue to provide clinical supervision training in order to build supervisory expertise and capacity in the sector. To maintain sustainability in supervision across the sector and continue to develop good practice, a suite of training and consultation initiatives will meet the needs of different audiences. These initiatives include Supervision of Supervisors Groups and tailored organisational consultations. There is currently a waiting list for further supervision training and some organisations have already requested consultations or further professional development for staff.

Clinical supervision training and ongoing consultation, supervision and support to organisations and clinical supervisors.

1.4.3 Resource Package

Facilitate the acquisition and transfer of a resource package for the sector. Managers, supervisors and supervisees have all identified the need for access to a range of resources that will assist in the implementation of supervision within specific agencies. A web page will be created for clinical supervision with a variety of downloadable resources and links.

Development of an AOD sector clinical supervision resource package

1.4.4 Knowledge Transfer

Continue to build on the current momentum for change in relation to clinical supervision by raising the profile of supervision across the sector. Clinical supervision will be show-cased to maintain and encourage continued sector development.

Utilise regular AOD Network forums and/or create forums for the sector to discuss and share their practice wisdom.

2. Introduction

This report will describe a project that was undertaken by The Bouverie Centre. It aimed to detail the current practice of clinical supervision across the AOD sector. Further, it sought to establish and trial a model of support to AOD clinical supervisors who were graduates of The Bouverie Centre's Clinical Supervision Training Course.

This report is written in several sections. It begins by providing a background to the current The Department funded investigation. It then explains the methods of data collection that were used for the audit of clinical supervision practice and the establishment of the Supervision of Supervisors Groups. The next section presents quantitative data about the profile of clinical supervision as reported by AOD workers. This is followed by a description of common themes about the practice of clinical supervision gathered through a qualitative investigation with senior managers, managers and clinical supervisors. Data gathered by the survey from workers were used to supplement what was learned from the focus groups and interviews. The establishment of four Supervision of Supervisors Groups is further described. This is followed by a discussion and recommendations about future directions for developing best practice clinical supervision in AOD agencies in Victoria.

2.1 Background

The Bouverie Centre has been providing training to the Victorian AOD field in the area of clinical supervision since 2004. At the commencement of this project, 186 people from 71 different AOD agencies across Victoria had graduated from the six day training course.

The Bouverie Centre's clinical supervision training program commenced as one project within the Victorian Alcohol and Other Drugs Workforce Development Strategy 2004-2006. The project overlapped several of the strategic directions for the workforce. These were in the areas of:

- Specialist AOD workforce skill development – building the capacity of the AOD workforce to provide high quality responsive client services
- AOD workforce recruitment and retention – increasing the capacity of the AOD workforce to attract and retain highly specialised staff
- Quality AOD treatment services – to support attainment of quality standards for funded AOD services and workers.

In order to assist the implementation of the training, in June 2008 The Department of Health funded the current project through The Bouverie Centre with the following aims:

- To establish a support network for supervisors by organising Supervision of Supervisors Groups for graduates of the course
- To understand and document current clinical supervision arrangements as practiced in AOD organisations
- To investigate the impact of The Bouverie Centre's six day clinical supervision training

- To make recommendations about the supports required for good clinical supervision practice in AOD services based on the above findings.

2.2 What is clinical supervision?

There is a range of definitions of supervision that reflect the complexity of the task. A central idea is that clinical supervision is based on a working alliance between supervisee and supervisor, in which supervisees offer an account of their work, reflect on it and receive support, feedback and guidance where appropriate from the supervisor (Carroll, 2007).

Supervision aims to increase the competence, confidence and creativity of the supervisee in order to enhance the service delivered to clients and meet the clinical governance goals of the employing organisation (Inskipp and Proctor, 1993). Clinical supervision may be individual or group based. In the context of this report, clinical supervision is considered as distinct from line management meetings that focus more on administrative tasks. However, it is recognised that in practice it is often difficult to separate the two responsibilities.

Carroll (2007) summarises the functions of supervision as follows:

- To offer a mechanism to review work with clients and offer protection to clients.
- To offer a reflective space for supervisees to gain insights into their work which can lead to improvements in service delivery to clients.
- To assist supervisees to identify their strengths and weaknesses.
- To offer peer learning.
- To provide an opportunity to keep up to date with professional learning.
- To consider ethical and professional issues.
- To provide a forum to consider the issues that may arise from balancing the needs of the various different stakeholders in the supervisees work.
- To allow supervisees to measure and reflect on the impact of their work on themselves and to identify personal reactions to it.
- To offer a third perspective on the work, from someone who is not part of the client's system.
- To ultimately enhance the welfare and service delivery to the client.
- To create a forum for accountability to the organisation, clients and to relevant professional bodies.
- To provide a pathway for supervisees to be up to date in research and innovation in their area.

Kavanagh, Spense and Wilson (2002) reviewed the effectiveness of supervision in Australian alcohol and drug services and found that it aides the acquisition of complex clinical skills in workers. They also cite that satisfaction with supervision or perceived high quality supervision is associated with higher levels of job satisfaction and morale. They found that it is the quality of the supervision that is important, not merely its presence, in effecting change with both client outcomes and job satisfaction.

Kavanagh et al (2002) also highlight three specific challenges for the AOD sector in providing supervision. The first involves the unique dynamics that have

resulted from the workforce comprising recovering and non-recovering workers and are thought to require particular attention to the supervisory relationship and process. The second is that alcohol and drug specific professional courses are not common and hence clinical supervision could have a particularly critical role to play in workers professional development. The last specific challenge is that the supervisory process for the AOD workforce takes place in a client context of drug and alcohol problems, which are particularly prone to relapse, self harm and high levels of complexity.

Hence, it is important to consider this report in the context of viewing clinical supervision as a complex task, taking place within a sector that is implementing a new process, amidst some significant AOD sector specific challenges.

2.3 Variables that influence the implementation of service innovation

In a study of the implementation of single session work in the Victorian community health sector, Weir (2008), it was found that there were ten overarching variables that affected the uptake of service innovation. This was informed by the work of Rogers (1995) and Greenhalgh, Robert, MacFarlane, Bate and Kyriakidou (2004) who identified common factors that influence whether a new practice will be taken up in service organisations. The ten major factors were:

1. *Relative advantage:* the perception by all stakeholders that the new practice is better than the current one or that the practice can help to solve a current problem.
2. *Compatibility:* the extent to which the new practice fits with the values, beliefs and needs of the service that is implementing it.
3. *Complexity:* whether the new practice is perceived as simple to understand and adopt.
4. *Trialability:* whether the new practice can be easily evaluated.
5. *Observability:* the visible adopting of the new practice by respected colleagues and a perceived disadvantage in not adopting the practice.
6. *Re-invention:* whether the new practice can be modified to suit individual contexts.
7. *Organisation adaptability:* whether an organisation can adopt their procedures to incorporate the new practice.
8. *Risk:* whether the benefits of adopting the new practice outweigh the potential risks.
9. *Training and Support:* whether there is effective training and ongoing support available.
10. *Incentive and Regulation:* whether the new practice is specified by a governing authority or comes with inducements.

The implementation of clinical supervision in the AOD sector will be considered in the following report in light of these factors.

2.4 Audit of AOD clinical supervision practices

The audit attempted to understand the system and organisational factors that may be of influence in the uptake of clinical supervision in the AOD sector. As outlined above, there are many factors, in addition to training, that influence whether new ideas will be successfully implemented. The audit sought to obtain a clear representation of the clinical supervision that is currently being offered within AOD organisations and to understand what the sector thinks is supportive or may be acting as a barrier to accessing and delivering clinical supervision. The field was invited to describe what they thought the impact of The Bouverie Centre's clinical supervision training was and what they thought would be required from organisations and the systems that support them for supervision training ideas to be implemented in the future.

2.5 The establishment of a pilot Supervision of Supervisors Group (SOS Group) network

The establishment of multiple peer groups was proposed to provide an opportunity for graduates of The Bouverie Centre's clinical supervision training course to continue to develop their supervisory skills and gain professional support. This was based on a group model where some sessions were facilitated by an external facilitator, from The Bouverie Centre, while others were peer led. The group was intended to provide an opportunity for participants to reflect on and discuss their work as supervisors.

2.6 Sample and Terminology

The following report and the findings outlined above must be considered in light of an understanding of the sample involved in this study. Approximately twenty five percent of workers employed in the AOD sector responded to the survey and twenty five managers and supervisors attended focus groups or interviews. It cannot be said whether this group represents a valid representation of the views of the entire sector. For instance, it may be that those individuals who are particularly interested in and supportive of clinical supervision responded to a voluntary survey on this topic.

The term 'workers' as used in this report, refers to people who completed the web based survey. These people are employed in direct service roles to AOD clients and their families in regional and rural Victoria.

The terms AOD field and AOD sector are used interchangeably in this report to refer collectively to employees of AOD organisations, the AOD peak bodies and The Department.

3. Project Work Plan

3.1 Aims One to Five: Audit and exploration of AOD Clinical Supervision Practices

Several different data collection methods were used to gather information about organisational practices of clinical supervision in the AOD sector. The following table illustrates the types of methods used to collect data, who the intended target group was and the timeframe within which each study was conducted.

Type of Data Collection Method	**Target Group**	**Timeframe**
Focus Groups	Clinical Supervision Training Course Graduates	Group 1 North Western Metropolitan Region 1st September, 2008 Group 2 Barwon South Western Region 29th September, 2008 Group 3 Eastern and Southern Metropolitan Regions 30th September, 2008
Telephone Interviews	Senior Managers and CEO's	From September 2008 – May 2009
Web based survey	Workers involved in direct service delivery	March – April 2009

3.1.1 Focus Groups

Group Recruitment

The project officer endeavoured to contact all 186 participants who had graduated from The Bouverie Centre's Clinical Supervision Training course by July 2008. They were invited by phone and email to express an interest in attending a focus group to discuss clinical supervision in the AOD sector. The four regions that expressed the most interest were targeted to host a focus group.

Focus Group Questions

Each focus group lasted 90 minutes and the questions were grouped into two areas with three main questions in each. The two areas were:

- the organisational context for clinical supervision
- the impact of the Bouverie Centre six day training.

- Questions eliciting information about the organisational context for clinical supervision were:
- What are some of the beliefs held in your organisation about supervision?
- What are the key elements in your organisation that support good clinical supervision practices?
- What are the barriers in your organisation to delivering high quality supervision?

Questions examining the impact of The Bouverie Centre's training were:

- How has doing the six day training influenced supervision practices in your organisation?
- What have been the challenges for you in implementing ideas learned in the training, in your organisation?
- What could The Bouverie Centre do differently in the future to support these ideas being implemented in your workplace?

3.1.2 Telephone Interviews

Semi-structured telephone interviews were conducted with CEOs and senior managers from across the nine Department regions. CEOs and managers were selected to reflect a representation of various service types, sizes and Department regions. The interviews were approximately one hour in duration.

Telephone Interview Questions – see Appendix B

The interview questions were grouped into several topics:

- Background/demographic information
- The organisation's policy
- An audit of the current supervision model including strengths, gaps and future directions
- Impact of The Bouverie Centre training.

3.1.3 Web Survey

A web based survey for workers involved in direct service provision to AOD clients – see Appendix C

A 105 item web based survey was specifically constructed for the purpose of the project. The survey was designed to:

- Profile the demographic characteristics of workers

- Investigate the clinical supervision currently being received by workers involved in direct service provision to AOD clients and/or their families/friends (e.g., perceptions of type, quantity, content, satisfaction)
- Audit workers' perceptions of the organisational/sector practices known to promote or constrain access to and uptake of workforce developments such as clinical supervision
- Build a description of individual workers' expectations of clinical supervision and of their clinical supervisors
- Explore the impact of The Bouverie Centre's clinical supervision training

To our knowledge, no other instrument suitable for eliciting the type of information we required was in existence/published at the time of conducting the survey. Hence, a number of quantitative (scaled using 5-point Likert-type scales) and qualitative items were generated based on information gleaned from the literature on clinical supervision. A hard copy version of the survey was initially piloted with a small group of people in the field. Based on feedback received from the initial trial, some modification was made to the wording.

Advertising the Questionnaire

All workers employed by an agency/organisation receiving funding from The Department for the provision of AOD related services and who worked directly with AOD clients and/or their families/friends, were invited to complete the online questionnaire. Workers were able to complete the survey during March and April 2009.

Participation in the survey was solicited using a variety of means including:

- Advertising in the VAADA newsletter.
- A letter sent to service managers by The Department of Health endorsing the survey and encouraging managers to allow staff the time to complete it.
- Service managers notified by The Bouverie Centre via email as soon as the survey went "live".
- During the March AOD Service Providers Conference, Paul Smith (Director: MHD Operations), reinforced the importance of participation in the survey during official announcements.
- Four lap top computers set up at the March AOD Service Providers Conference for workers to complete the survey during conference breaks.
- Periodical posting of reminders and brief updates on preliminary findings in the VAADA e-news daily communication from March 6th until April 24th when the survey closed. Similar details were also sent directly to service managers on two occasions in the weeks leading up to the survey's closure.

3.2 Pilot of Supervision of Supervisors Groups

During August and September 2008, the research team endeavoured to contact all graduates of The Bouverie Centre's clinical supervision training course, at that time 186 people, by telephone and email. They were invited to express an interest in joining a Supervision of Supervisors Group (SOS Group). Advertisements were circulated through The Department of Health Regional Advisors Groups, explaining that groups would be established in the four regions that exhibited the most interest and demand for supervision of supervision.

Training graduates were invited to attend monthly, two hour group sessions, with facilitation provided by a staff member from The Bouverie Centre for 3-4 sessions, the purpose of which was for supervisors to:

- Gain professional support;
- Build on knowledge gained in the clinical supervision training course;
- Contribute to their ongoing development as a supervisor;
- Share practice wisdom with other graduates through case presentations and discussion.

See Appendix D for a sample Expression of Interest. Those who expressed an interest in joining a group were required to gain written consent from their manager to attend.

4. Presentation and Discussion of Findings

4.1 Aim One: Audit of Clinical Supervision Practice

4.1.1 Sample Description

Focus Groups

Three focus groups were held with representatives from four different Department regions. A total of twelve people attended. Two from the North/West Metropolitan Region, six from the Barwon/ Southwest Region and four from the Southern and Eastern Metropolitan Regions. Participants from the Southern and Eastern Metropolitan regions were invited to join a combined focus group, as group members were located in similar geographic areas. The attendance rate was lower than expected with several graduates who indicated that they would attend, not attending on the day. Many cancelled on the day of the focus group stating that situations had arisen at their work places which meant that they were no longer able to attend.

Focus group participants were graduates of The Bouverie Centre Clinical Supervision Training, from 2004 – 2008. All were providing clinical supervision to between three and twenty four people at the time in which the focus group was held.

Table 1 Focus group participants: Demographics, frequencies

Professional Role:	
Manager	6
Senior Clinician / Counsellor	4
Team Leader / Coordinator	2
Types of Clinical Supervision Provided:	
Individual and Group Supervision	7
Individual Supervision Only	3
Group Supervision Only	2
Clinical Supervision Held in a Separate Meeting:	
Yes - separate meeting	7
No - combined with administrative tasks	5

Eleven of the clinical supervisors reported receiving clinical supervision themselves. Some had a formalised arrangement and some were on an as needs basis. It was not clear in all cases if this covered their work as a supervisor or just work with clients. One reported receiving no supervision at all.

The focus group participants were from a variety of professional backgrounds and held qualifications in the following areas:

- Nursing (x2)
- Psychiatric nursing (x2)

- Diploma in AOD (x2)
- Social work (x1)
- Psychology (x2)
- Welfare Work (x1)
- Business Administration Management (x2)
- Bachelor Social Sciences (x1)
- Teaching (x2)

Telephone Interviews

Thirteen CEO's and Senior Managers were interviewed by telephone. They were from a variety of professional backgrounds and held qualifications in the following areas:

- Psychology (x3)
- Diploma of Youth Studies/ Diploma of Alcohol and Drugs
- Diploma of Alcohol and Drugs/ Diploma of Community Services Management
- Graduate Certificate in Addictions/Counselling/Masters in Health Administration
- Education/Community Development
- Nursing/ Certificate IV Alcohol and Drugs
- Psychotherapist Training
- Health Services Management
- Social Welfare
- Psychology and Family Therapy
- Geneticist/Graduate Diploma of Alcohol and Drugs/ Masters in Management

Of the thirteen people interviewed by phone, seven provided clinical supervision in their roles, six did not.

Ten of those interviewed had completed The Bouverie Centre's Clinical Supervision Training, three had not.

Web Based Questionnaire

Two hundred and sixty-three people in total completed the survey. Twenty-two workers indicated that they were not involved in the provision of direct service to AOD clients and/or their families/friends. Thus data collected from this subset were excluded from analysis.

Proportionally, the remaining 241 workers represent approximately 25% of the current workforce.

Figures 1 through 5 and Tables 2 and 3 in Appendix E display the demographic characteristics of the sample.

Approximately 60% of the workers surveyed work in metropolitan regions, while approximately 30% are employed in direct service provision to AOD clients and/or their families/friends in regional and rural Victoria (Figure 1).The majority of workers were between the ages of 30 and 59 years (see Figure 2). Sixty four percent of workers identified as female, 31% as male, and 5% did not give a response to this question (Figure 3). Around 30% of workers indicated that they are involved in the provision of clinical supervision and/or line management in addition to direct client contact (Figure 5).

There was a broad range of experience amongst workers, including a number who had been employed in the AOD field for significant periods of time, 14% had been employed for 11 – 14 years with an additional 10% employed for 16 or more years (Figure 4). The sample comprised workers from a myriad of different educational / professional backgrounds – perhaps illustrative of the sector as a whole. Likewise, there were representatives from a broad range of different services being offered by the sector (see Tables 2 & 3).

4.1.2 Stock take of supervision practice, from workers

The following section describes and summarises the basic features of the data that were collected from workers involved in the direct provision of AOD related services, including typical scores, as well as the variation of responses. As previously discussed, the survey instrument was specifically constructed for the purpose of the study. Survey items were not statistically validated. Therefore findings of this research need to be further replicated to validate the findings obtained. Nonetheless, the implications of the preliminary findings are important and need to be disseminated for further discussion.

What type of clinical supervision are workers currently receiving in their role?

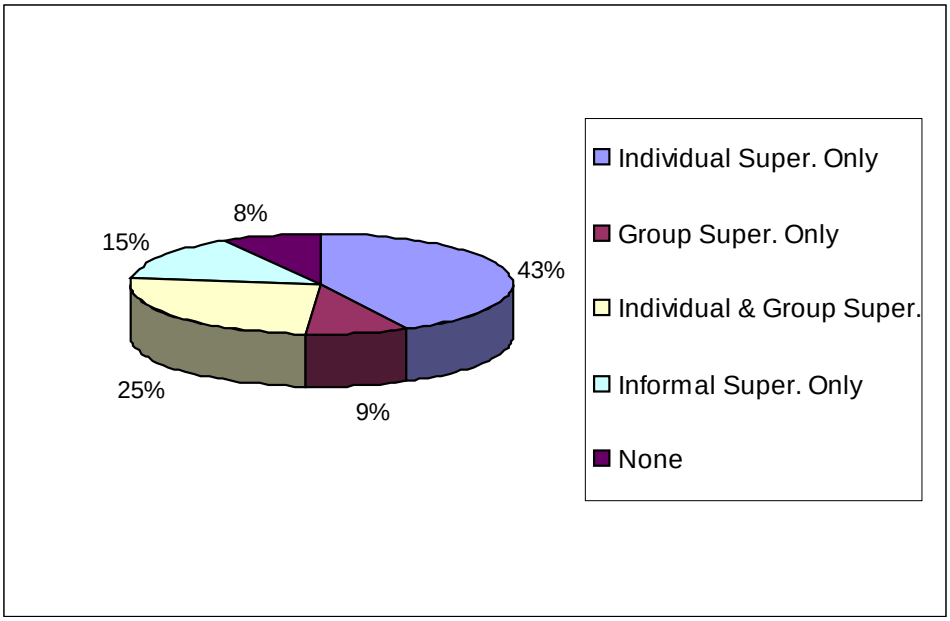

Figure 6: Types of clinical supervision currently received by workers, percentages

Inspection of Figure 6 reveals that 185 workers who responded to the survey (77%) access some type of formal clinical supervision in their role. 23% are not currently receiving any clinical supervision that is of a formalised nature.

Workers were most likely to indicate that they receive individual clinical supervision only (*n*=103 or 43% of the sample). Twenty-five percent of the sample reported accessing both individual and group supervision. Less than 10% of those surveyed indicated that they take part in group supervision only, rather it is an adjunct to individual supervision.

Profiling workers' experience of individual supervision (n=163)

The majority of workers accessing individual clinical supervision do so on a fortnightly (30%) to monthly (48%) basis. 90% of workers receive clinical supervision for a duration of 50 minutes to one hour (See Tables 4 & 5 in Appendix F).

A small cohort (*n*=12) indicated that they only meet with their individual clinical supervisor one to four times a year or on an as needs basis (Note: five of these people also receive group supervision). Furthermore, there were two workers who reported receiving two hour supervision sessions on a fortnightly basis.

Over half of those receiving individual clinical supervision reported that this is provided by their line manager (n=98). Almost 30% of recipients of individual clinical supervision specified that their agency either commissions an external supervisor, or allows them to see someone external to their organisation during work hours for the purposes of clinical supervision. Almost 80% of this group indicated that there is no formal reporting arrangement between the external clinical supervisor and the organisation despite this being either paid for being conducted during work time. (See Tables 6 & 7 in Appendix F)

These findings reflect that individual clinical supervision is provided with some consistency across the sample. It is most often delivered on a monthly basis for 60 minutes by the person's line manager.

Profiling workers' experience of facilitated group supervision (n=69)

Most recipients of facilitated group supervision (78%) meet at least once a month for this purpose (See Table 8 in Appendix G) For the majority (96%), sessions are generally one to two hours in duration (See Table 9 in Appendix G). Of the two workers indicating that their facilitated group sessions last from four hours to one business day, one attends the process only once a year, while the other does so every other month. Furthermore, three of the four workers who report that they only receive facilitated group supervision one to four times a year also attend individual clinical supervision.

Just over half of the workers (*n*=39) indicated that someone external to their organisation facilitates group supervision (See Table 10 in Appendix G). According to 62% of this group, there is no formal reporting

arrangement in place between their organisation and the external supervisor with regards to clinical supervision.

Profiling workers' experience of peer group supervision (n=38)

Of the thirty eight workers participating in peer group supervision, over 70%, have the opportunity to do so on a weekly to monthly basis. For the majority (82%), peer group supervision is held over a one to two hour period. Five of the six workers who indicated only receiving peer group supervision one to four times a year or an ad hoc basis also attend individual clinical supervision. (See Tables 12 & 13 in Appendix H).

What happens in clinical supervision?

Table 14: What happens in individual, facilitated group and peer group supervision, frequencies and percentages

	Individual Supervision (n=163)	*Facilitated Group Supervision (n=69)*	*Peer Group Supervision (n=38)*
Case discussion and case planning, including discussion about intervention with clients	123 (75.46%)	51 (73.91%)	31 (81.58%)
Reflection about the emotional impact of cases on you	121 (74.23%)	51 (73.91%)	26 (68.42%)
Reflection/discussion about the client–worker relationship	114 (69.94%)	51 (73.91%)	26 (68.42%)
Reflection about the supervisory relationship	62 (38.04%)	22 (31.88%)	10 (26.32%)
Planning for professional development	109 (66.87%)	25 (36.23%)	17 (44.74%)
Discussion about your role in your organisation/team	104 (63.8%)	27 (39.13%)	21 (55.26%)
Discussion of professional/ethical issues	108 (66.26%)	54 (78.26%)	30 (78.95%)
Receiving feedback about your work	109 (66.87%)	31 (44.93%)	22 (57.89%)
Giving feedback to your supervisor	71 (43.56%)	25 (36.23%)	*N/A*
Giving feedback to your peers	*N/A*	*N/A*	28 (73.68%)
Discussion of group dynamics (i.e. the supervision group)	*N/A*	38 (55.07%)	15 (39.47%)

Table 14 gives an overview of the general tasks involved in clinical supervision. The values within parentheses symbolise the proportion of workers receiving a particular type of supervision who endorsed a given

response. For instance, 75% of the workers receiving individual supervision indicated that such sessions involve case discussion and case planning.

Inspection of Table 14 suggests reflection about the supervisory relationship features less heavily in the clinical supervision received by the sample than the other tasks listed. By contrast, most workers indicated case discussion and case planning, reflection about the emotional impact of cases on a worker and reflection on the worker-client relationship, as well as the discussion of professional/ethical issues are addressed in this space. These tasks correspond to the general functions of clinical supervision as reflected in the literature.

Table 14 further reveals that planning for professional development, discussion about one's role in the organisation and giving feedback to one's supervisor happen far less in facilitated group supervision than in individual clinical supervision, and to a lesser extent, than in peer group supervision. This reflects that group and individual supervision attend with differing emphases to the tasks of supervision.

How satisfied are workers with the clinical supervision that they currently receive?

Participants were asked to rate how satisfied they are with the individual, facilitated group or peer supervision they are currently receiving using a one to five Likert-type scale, where 1 equals very dissatisfied and 5 equals very satisfied.

Irrespective of the form it took, workers were on average largely satisfied with their experience of clinical supervision. (Average scores: individual = supervision 3.96; facilitated group supervision = 3.80; and peer group supervision = 3.81).

Suggested improvements to clinical supervision

Those who rated their satisfaction as less than 5 were asked to comment on what changes were needed in their individual, facilitated group and peer supervision to better meet their needs. The themes that emerged from the qualitative responses to this request are presented below.

Individual clinical supervision

Thirty-four of the 163 workers receiving individual clinical supervision gave satisfaction ratings lower than 5.Themes that developed out of their open ended responses are as follows:

- **External supervision** – clinical supervision to be provided by someone external to the organisation, or by someone without links to the operational running of the organisation (i.e. not a line manager).
- **Frequency** – individual supervision to be held more regularly; greater frequency; sessions to be longer.
- **Supervisor's knowledge and skills** – supervisor to learn more about clinical supervision and how to deliver it; expand his/her AOD and clinical knowledge; use knowledge of

supervision to educate supervisees about the value of supervision.

- **Reflective** – sessions to assist workers to review their own work.
- **Feedback and professional development** – supervisor to provide useful/relevant feedback and direction; challenge and inspire supervisees to improve; monitor adherence to best practice standards.
- **Professionalism** – supervisor to maintain confidentiality; avoid excessive familiarity; follow up.
- **Resources** – more time in clinician and supervisor's schedules; priority given to clinical issues in supervision; employer to cover the added expenses involved in accessing external supervisor.
- **Focus** – greater structure; purposeful.

Facilitated group supervision

Forty-two percent of the workers participating in facilitated group clinical supervision (*n*=29) were less than "very satisfied" with such sessions. Themes that developed from their open ended responses are as follows:

- **Mutual trust** – greater openness and transparency from participants.
- **Frequency** – facilitated group supervision to be held on a more regular and frequent basis.
- **Management presence** – group to be facilitated by someone external to the agency; nil management personnel in sessions.
- **Facilitation** – facilitator to balance the needs of each group member; sessions to be more structured and focussed.
- **Group supervision to be replaced with individual supervision**.
- **Supervisor's knowledge and skills** – supervisor to learn more about clinical supervision and how to deliver it; expand his/her AOD and clinical knowledge.

Peer group supervision

Of the 38 survey workers who take part in peer group supervision, 12 gave satisfaction ratings lower than 5. Two of these did not think that improvement was required. Themes developed from the remaining 10 participants' open ended responses are as follows:

- **Facilitation** – better organisation; structure; focus.
- **Frequency** – peer group supervision to be held on a more regular and frequent basis.
- **Team dynamics** – to be addressed openly and improved.
- **Greater focus on the client and clinician** – prevent the discussion of group dynamics overshadowing this.
- **Strengths based** – less punitive in nature.

Workers' expectations of clinical supervision

Workers responding to the questionnaire were asked the open ended question: What do you expect from clinical supervision? They were encouraged to consider individual and group supervision in their answers. Themes that emerged from the data collected are listed below, ordered from the most to the least frequently endorsed category. These responses represent a composite of views and do not reflect that each individual holds all of these expectations or understanding about clinical supervision.

- **Support for issues related to work and help to process/address the impact of the work on them personally.** Most workers clearly expect this and their responses ranged from:
  - Emotional support; to be listened to and understood; acknowledgement of the emotional impacts of the work on the supervisee.
  - Space to express one's feelings and explore personal reactions to the work / client; debriefing.
  - Monitoring of caseloads; burnout prevention efforts.

These worker expectations relate to the supervisory function of providing an opportunity for supervisees to reflect on the impact of the work on themselves. This seems to address some of the issues underlying the The Department strategic direction of improving AOD workforce recruitment and retention.

- **Professional development -** another common expectation of clinical supervision that appeared in the responses - that is:
  - a forum for workers to learn and grow professionally; improved skills and knowledge; increased competence
  - a mechanism for workers to keep up to date with developments in the field and contemporary research findings; to access relevant resources / information
  - identifying training needs; formatting strategies to target professional development/career path needs
  - to be challenged and stretched.

These worker expectations relate to the supervisory functions of focusing on the supervisee's professional development and formulation of strategies and interventions to work with clients. This corresponds with The Department strategic direction of building a specialist, high quality AOD workforce.

- **Assistance reflecting on one's way of working, on clients and the organisation.** This was listed amongst workers' expectations and included:
  - A forum to reflect on the way one practices; appreciation of how the self or one's own issues influence responses to clients.
  - Case discussion and planning; chance to explore/discuss different ways of working/interventions and try out different ideas; reflection on one's working relationship with a client.

- Space to focus on the workplace; discuss tensions and issues with other staff; discussion of workplace policies, procedures and infrastructure and how they might be constraining or supporting one's work.

This corresponds well with the functions of supervision in relation to reflecting on, reviewing and enhancing service delivery to clients. It also addresses the supervisory function of providing a forum for addressing the needs and tensions of various stakeholders within the supervisees workplace. This area relates to the Department's strategic directions of building a specialist skilled workforce and to supporting the attainment of quality standards for AOD services.

- **The opportunity to receive feedback about work practice**, including constructive criticism, guidance and suggestions for improvement also featured often in comments. This area also included wanting assistance negotiating organisational protocols and procedures.

These expectations relate to the functions of supervision in identifying supervisee strengths and weaknesses and the offering of a third perspective on the work with clients. It addresses The Department strategic direction in the areas of building specialist skills development, retention of specialist staff and the provision of quality services to clients.

- **Type of environment/context**. The central ideas were:
  - Safety; freedom from criticism and judgement; respect.
  - Confidentiality.
  - With regard to group supervision - active participation from a range of colleagues; exposure to different ideas and perspectives.
  - Honesty / transparency from supervisor or colleagues.
  - Reliability and consistency.

- **Accountability**, that is – assurance that one is acting in accordance with ethical, organisational and professional standards; for ethical and professional issues to be kept on the agenda.

This is clearly in line with the accountability functions of supervision and The Department directions in the area of attaining quality standards for AOD service provision.

- **Qualities that workers ideally want in a clinical supervisor.** The responses also pointed to some of these, including:
  - Someone who is suitably experienced and competent.
  - Someone external to the organisation or someone who is not the supervisee's line manager.

- **What workers expect to gain personally from clinical supervision.** Some made mention of outcomes other than those already listed, including:
  - Increased confidence and self efficacy.
  - To grow and develop as a person.

- Increased creativity and energy.

- **Increased connectedness within one's team and across the organisation.** Some wrote about the benefits they expected the organisation and its staff to reap from clinical supervision.

Workers' expectations of clinical supervisors

Workers were asked to describe what they thought made a good clinical supervisor. A few examples were given to illustrate including: experience working with AOD clients, previous experience in one's role and group facilitation skills. The themes that emerged from their responses are presented below, ordered from the most to the least frequently endorsed category.

- **Experience and knowledge**. Perhaps not surprisingly, this featured very heavily in workers' ideas about what makes a good clinical supervisor. This encompassed:
  - Clinical expertise particularly working with the AOD and mental health client group;
  - Supervisory and management experience;
  - Understanding of the tasks associated with the supervisee's role;
  - Life experience.

- **Good interpersonal skills** were also often included on workers' wish lists. The responses ranged from:
  - Good listener, makes an effort to understand a supervisees' internal frame of reference;
  - Responds to supervisee with warmth, empathy and compassion;
  - Has the capacity to build a rapport/connection with a supervisee.

- **Demonstrates support and respect for the work that a supervisee does - someone who creates a safe space for learning.** Workers indicated that they want a supervisor who:
  - Is collaborative, consultative, focuses on a supervisee's strengths, and someone who is open-minded;
  - Is non judgemental, approachable, someone who shows "unconditional positive regard";
  - Acknowledges and validates the emotional impact of the work on supervisees;
  - Maintains confidentiality.

- **Displays the necessary knowledge and skills to identify a supervisee's learning needs and facilitate his/her professional growth**.
  - Responsible for monitoring the quality of service delivered by supervisees.
  - Provides honest feedback; offers well informed advice/recommendations; supplies relevant resources.

- Assists with the acquisition / refinement of clinical skills; identifies/targets career path needs.
- Not afraid to challenge and stretch supervisees.
- Holds supervisee accountable to professional and ethical standards.
- Caters to the different learning styles and needs of supervisees; able to utilise different supervisory interventions/models.

- **Someone with independence from their organisation or from management** – e.g. someone external from the organisation; not a line manager.
  - Only ten out of two hundred and forty one workers felt it was important that a supervisor be external to the organisation.
  - Some did not think it was necessary that the supervisor be external to the organisation but rather that he/she have the capacity to assume different hats.
  - Others thought that having a supervisor with some insight into an organisation's workings would be advantageous, that is someone with: knowledge of an organisation's culture, processes, and expectations of staff; familiarity with potential constraints posed by the workplace.

- **Group facilitation skills** were also identified by some as a characteristic of good supervisor, including:
  - Able to address group dynamics.
  - Balances the different needs of individual group members.

- **Other personal qualities:**
  - Someone who is passionate about supervision and committed to staff and client welfare.
  - Someone who is organised and reliable; can stay to task; follows up on previous sessions.
  - Someone who is self aware; knows their limitations; doesn't transfer his/her own issues onto supervisees; encourages supervisees to consider how the self influences one's action and knowledge; seeks good clinical supervision for himself/herself.
  - Someone with the capacity to be objective; assists the supervisee to take analysis and logic into account as well as feeling; someone with proven problem solving skills.
  - Someone who is trustworthy, patient and flexible.

To what extent does clinical supervision meet workers' expectations?

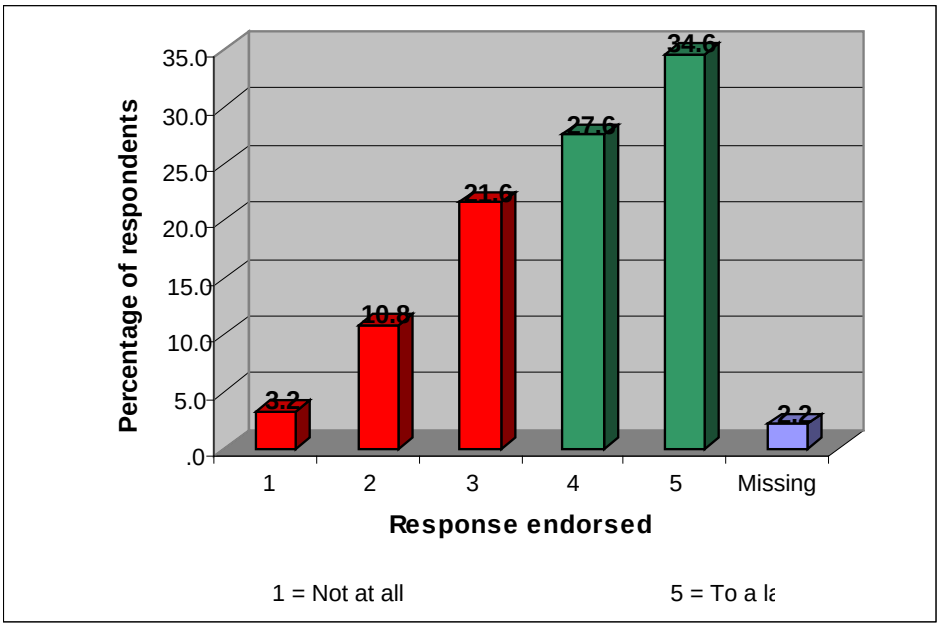

Figure 7: The extent to which the clinical supervision currently being received by workers met their expectations, frequencies

In addition to being asked what they expected from clinical supervision, workers were further required to rate how closely their current supervision met their expectations using a 1 to 5 scale (where 1 equals not at all and 5 equals to a large extent). Sixty-two percent of workers receiving formal supervision reported that, to a large extent (rating of 4 or above), these expectations were being met by their current clinical supervision arrangements. For 14%, this was not at all the case (rating of 2 or below).

To what extent do clinical supervisors meet workers' expectations?

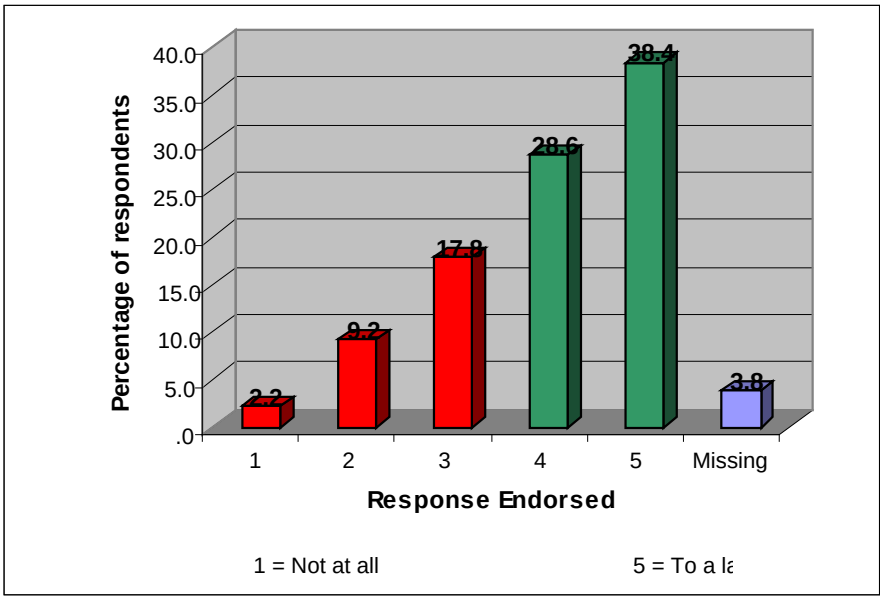

Figure 8: Workers' current clinical supervisors: extent to which they match workers' idea of someone who is a good supervisor, percentages

Workers were also asked to indicate the extent to which their current supervisor embodied their ideas of someone who is a good supervisor. Sixty-seven percent of survey workers receiving formal clinical supervision evaluated their current supervisor favourably – assigning a score of 4 and above. A small cohort (11%) indicated that their current supervisor did not live up to their ideal much at all (rating him/her a 2 or below).

Workers' ratings of the importance of clinical supervision

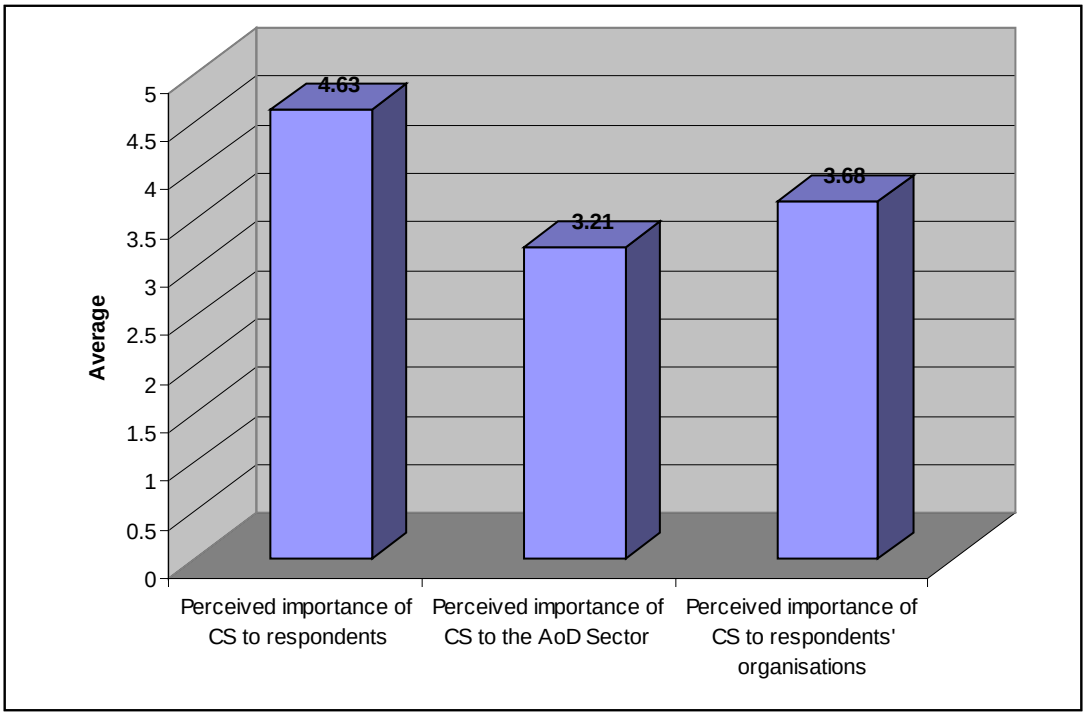

Figure 9: Workers' ratings of the level of importance attached to clinical supervision by themselves, the AOD Sector and their organisation, frequencies

The above graph shows that workers perceive themselves as prizing clinical supervision more highly (m=4.63) than the AOD Sector (m=3.21) or than their organisation (m=3.68). There was a weak, statistically significant, positive, relationship between workers' ratings of how important they consider clinical supervision is to the AOD Sector and how important they believe their organisation considers clinical supervision to be (r=.32, p<.001). Workers were inclined to rate their organisation as in step with the field in terms of the significance it attaches to clinical supervision.

This is of relevance when considering future directions for the AOD sector as workers appear ready for further development of the practice of clinical supervision. At present the workers perception of the importance that the sector and organisations within it attach to clinical supervision does not meet the level held by the workers themselves.

Workers reporting that they receive no formal clinical supervision

Clinical supervision is not currently being offered to 14 of the 20 workers who indicated that they receive no clinical supervision at all – not even informally.

The remaining six cited the following as rationales for why they have not been accessing clinical supervision (*despite it being on offer*):

- A belief that the allocated clinical supervisor lacks the skills or knowledge to cater to their specific needs as AOD clinicians.
- Lack of time and availability.
- Cannot see the value in the process.

Organisational context

Clinical supervision policy

Table 15: Clinical supervision policy, frequencies

	Yes	*No*	*Missing Response*
Respondent's agency has a written policy relating to clinical supervision? (*N*=241)	143 (59.34%)	82 (34.02%)	16 (6.64%)
Respondent read organisation's clinical supervision policy? (*n*=143)	82 (57.34%)	59 (41.26%)	2 (1.4%)
Written policy followed in respondent's case? (*n*=82)	70 (85.37%)	10 (12.2%)	2 (2.44%)
Clinical supervision discussed when respondent commenced employment / or when clinical supervision was introduced into the workplace? (*N*=241)	147 (61%)	91 (37.76%)	3 (1.24%)
Clinical supervision arrangements that were discussed initially were followed in respondent's case? (n=147)	107 (72.79%)	38 (25.85%)	2 (1.36%)

Inspection of Table 15 reveals that just over a half of the workers who responded to the questionnaire (59%) agreed with the statement “My agency has a written supervision policy”. The majority of those reporting having read this policy document (70 out of 82), indicated that for them personally, the policy had been adhered to. A similar trend was observed with regards to the discussion of supervision at induction or when clinical supervision was introduced into the workplace. Only 61% of the sample claimed that they had participated in such discussions, with the majority of this subset specifying that arrangements made at this time were followed through for them personally (73%).

The mandating of clinical supervision

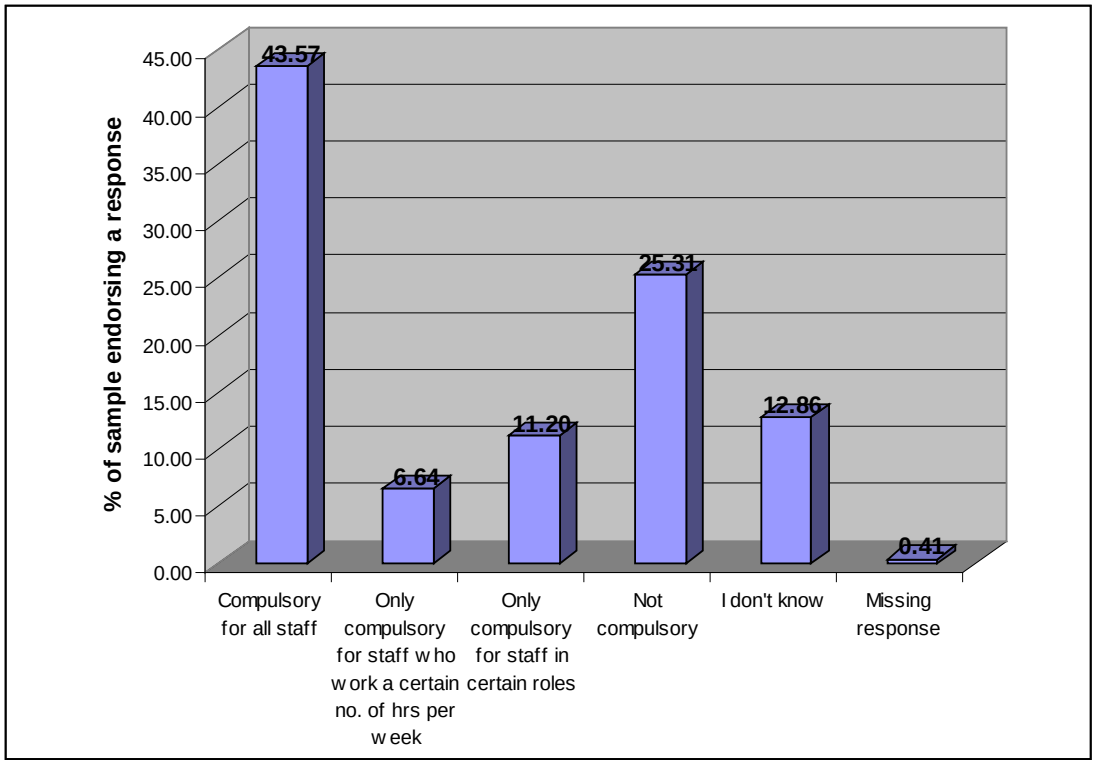

Figure 10: Clinical supervision: Compulsory for staff involved in the provision of AOD related services in workers' agencies? Percentages

Figure 10 shows that 44% of workers work in organisations where it is compulsory for all staff involved in the direct provision of AOD related services to attend clinical supervision. A further 18% indicated that clinical supervision is mandatory, but only under certain conditions (staff who work over a certain number of hours per week or staff who are in certain roles). Approximately one quarter of the sample indicated that participating in clinical supervision is not mandated by their organisation. A further 13% were unclear about the voluntary/involuntary status of clinical supervision in their organisation.

Two hundred and four workers (85% of the sample) maintain that clinical supervision should be mandated for all staff involved in the provision of direct AOD related services to clients and/or their families (with 6 missing responses). Workers were asked to give a rationale for their response. Few specifically discussed why clinical supervision should be mandatory as opposed to voluntary. Those who did so mentioned the following:

- Unless compulsory, workers may not seek clinical supervision, unaware that they need it or unable to see its value – clinical supervision is the kind of activity that one only sees the benefits from after participating in it; "she'll be right" attitude prevails in the sector.
- Must be compulsory in order to guarantee that organisations make clinical supervision available to workers, ensure it is a priority and that financial resources are devoted to it, rather than putting it on the "backburner".

- Must be compulsory to guarantee that workers make clinical supervision a priority – multiple competing demands mean that clinical supervision can be "bumped" off a worker's agenda.
- Clinical supervision is important.

Rather than directly commenting on why clinical supervision should be compulsory vs. voluntary, most workers appeared to comment on why it was important. The themes that emerged from their responses are presented below, ordered from the most to the least frequently endorsed category.

- Accountability – for quality assurance purposes; to ensure workers meet ethical, professional and best practice standards.
- Monitor impact of the work on workers and safeguard against burn out and vicarious traumatisation of the workforce – to encourage workers to self care; to ensure workers maintain their psychological wellbeing.
- Professional development – forum for workers to learn and grow professionally; importance attached to continuous improvement and maintaining one's skills; mechanism for workers to keep up to date with developments in the field and contemporary research findings.
- Debriefing about clients and the workplace – important space to offload and to receive support about one's work.
- Reflective practice – avenue for workers to reflect on their work including personal reactions emerging from contact with a client; belief that this assists the supervisee in being a better worker; clinical supervision in and of itself promotes self reflection.
- Promotes a healthy organisational culture – increases workplace morale and job satisfaction; helps in staff retention; improves connection between workers and between workers and their organisation; decreases staff members "offloading" with one another.
- Feedback and guidance – important space to receive feedback and direction from an experienced other; opportunity to seek alternative perspectives from someone "more removed" from a situation.
- Improved client outcomes – to ensure client welfare; for the benefit of consumers.
- Nature of the work – complex clientele; high intensity work; stressful and emotionally taxing; subset of the workforce not highly educated.
- Occupational health and safety issue – organisation owes a duty of care to its workers.
- Professional duty to one's clients.
- Consistency in service delivery across the organisation.

These responses reflect a good understanding of the diversity of functions and benefits of supervision which is consistent with the literature on the subject.

Workers perceptions of agency based factors that support the provision of clinical supervision

Table 16 in Appendix I lists a number of agency practices / factors which have the potential to support and maintain the provision of clinical supervision.

Approximately half of the workers rated their organisations favourably (assigning scores 4 and above) with regards to:

- the regularity of the clinical supervision that is on offer;
- Management's commitment to and understanding of the process.

By contrast, workers were less inclined to agree that:

- Clinical supervision is well documented and formalised in their organisation (corresponding with findings outlined previously in this report).
- Different formats are made available to them (eg. the choice of individual or group supervision).

Workers' perceptions of agency based factors that constrain the accessing of clinical supervision

According to the workers surveyed, of the factors listed as potentially constraining access to clinical supervision (See Table 17 in Appendix J), the following prove the most challenging for workers in their organisations:

- Direct clinical work being prioritised over clinical supervision by supervisees;
- Poor availability of supervisors;
- Excessive workload for the supervisee.

By comparison, workers considered the following points less of a barrier to access, in their agency, than the others listed:

- Clinical supervision not being offered at all, or not offered to those workers under a certain time fraction;
- A poor relationship with one's supervisor;
- The nature of shift work.

When considering the above points, it is important to remember that the workers who responded to the survey may not be representative of all the AOD workers. For instance, shift workers may have been underrepresented in the survey.

4.1.3 Audit of supervision practice: reports from managers and supervisors

The themes and quotes selected for discussion in this section of the report are drawn from extensive analysis of the focus group transcripts and phone interviews interlaced with data that emerged from the worker questionnaire. The following five areas were of most relevance to the aims of this report:

1. The perceived organisational factors that support good clinical supervision practice in AOD agencies
2. Barriers to providing and receiving clinical supervision in AOD agencies
3. Exploring the impact and implementation of The Bouverie Centre Clinical Supervision Training

4. Areas for development for the AOD sector in implementing and delivering clinical supervision
5. Possible roles for The Bouverie Centre in the implementation and development of clinical supervision in the AOD sector

4.2 Aim Two: Understanding the organisational factors that support good clinical supervision practice in AOD Agencies

There were many organisational beliefs, values and practices that were seen to support the provision of good clinical supervision. The most common as described by managers and supervisors were:

- Management attitude to clinical supervision
- The benefits of clearly defining and educating all staff about clinical supervision
- Open discussion of the tensions relating to clinical supervision
- A recognition that the functions of clinical supervision are multifaceted and aim to meet the needs of clients, staff and organisations
- A recognition that workers have a right to clinical supervision but that responsibility for the content and delivery of supervision is shared between management and staff.

These will be described and related to the organisational factors that have been found to support the implementation of new practices, as outlined earlier in the Introduction to this report.

A positive management attitude to clinical supervision

Managers and supervisors repeatedly stated that they believe a critical element in supporting the practice of clinical supervision is the attitude of management. An organisational culture where senior managers, managers and team leaders endorsed clinical supervision was seen as highly supportive of the practice. This was reflected and operationalised in the following ways:

- An attitude of management that reflects “a rounded assumption about supervision, seeing it as professional development and a method of accountability” (Manager, Telephone Interview). One manager described an organisation that valued supervision as one where “Management have a belief in the importance of supervision, it’s fundamental to good practice” (Manager, Telephone Interview).
- Clinical supervision being embedded in personnel recruitment and induction, in particular, being asked to discuss their attitude to clinical supervision during the selection process, clinical supervision being defined in position descriptions and workers being briefed about any supervision policies during induction.
- Resources being dedicated to supervision, for instance, allowing time and resources for training of supervisors, budgeting and planning for provision of supervision to staff in after hours programs.

Some managers see that they also have a responsibility to develop a culture that supports the acceptance of clinical supervision, as one manager said “if staff are suspicious of supervision, it is a management problem”.

Is a management attitude of commitment to supervision perceived by workers in the field? Of the workers who responded to the questionnaire, approximately half rated their organisation favourably in relation to their management's commitment to and understanding of the supervision process. However, workers were less inclined to agree that clinical supervision is well documented and formalised in their organisation. Workers also rated the level of importance that they personally attach to supervision as higher than that attached by their organisation or the sector generally. (See figure 9 on page 30).

This suggests that although in many agencies a clear, positive management attitude to supervision is conveyed, it is often an area that could be improved. An area for even greater development by organisations is the formalising of supervision processes, this in turn would reflect greater management endorsement.

A clear definition of clinical supervision

A clear definition of clinical supervision, in policy and practice, was seen by managers and supervisors as supporting good supervision, creating a feeling of safety for the supervisee and supervisor. Some points that were identified as being important to define were:

- The purpose of clinical supervision;
- Clarity about the distinction between line and performance management and clinical supervision;
- Roles and responsibilities in the supervisory relationship;
- Confidentiality (both client and the staff member's).

In addition, clearly articulated processes, agreements and contracts with both internal and external supervisors were valued by supervisors and managers.

When asked about their organisation's supervision policy, almost 60% of workers said that their agency had one. For those who had read this document, the majority felt it had been followed in their case. However, for approximately 40% of the sample of workers, they were unaware of their agency policy and a similar number reported that supervision was not discussed with them during their induction or when it had been introduced to their agency.

Despite this process not being formalised for almost 40% of workers, their expectations and understanding of the purpose of clinical supervision are consistent with The Department strategic directions and also the purposes of supervision as documented in the literature.

In terms of the factors that are likely to influence whether clinical supervision is successfully implemented, it is important that the concept is simple to understand and that procedures associated with it are well understood. For some organisations this seems an area for improvement, although there is a strong foundation to build on with workers having a good understanding of the overall functions of supervision.

Tensions relating to clinical supervision are openly discussed within the organisation

Clinical supervisors from several organisations spoke of valuing a culture where tensions related to clinical supervision can be openly discussed and worked through over time. Some of the tensions identified by managers and supervisors included:

- managing the dual roles of being a line manager and clinical supervisor;
- where there is a difference in professional backgrounds of supervisor and supervisee;
- gender issues;
- perception of a mismatch between skill and experience of the supervisor and supervisee;
- where accessing clinical supervision is viewed as being a sign of weakness or burnout.

Some supervisors discussed using a "strengths-based, reflective model" of clinical supervision to encourage supervisees to overcome fears of exposure during supervision. Workers also valued this approach, as reported in the questionnaire.

One supervisor spoke of the negative attitudes and beliefs held by some supervisees about supervision, such as fears about being "told off" and tensions relating to age and professional background of supervisors. This supervisor spoke of working with such attitudes and said that there is an "expectation that this could be an issue, we expect it and work with it in an ongoing way, as opposed to 'you've got to fix it' ".

Clinical supervision is supported in organisations where it is viewed to be of value in responding to the needs of clients, supervisees and organisations

Some managers and supervisors identified that the uptake of clinical supervision is supported in organisations when it is seen as multifaceted: where the functions of supervision are seen as balanced between meeting the needs of clients, staff and the organisation as a whole.

Clinical supervision was identified as both a mechanism for reflecting on service delivery and also an aid to staff welfare. "We see supervision as a system to review and do as good a job as possible" (Manager, Telephone Interview). Clinical supervision is "a window of opportunity to get to know supervisees" (Manager, Telephone Interview).

Several managers and supervisors identified that it was important for clinical supervision to be driven by meeting the needs of the supervisee. Negotiation with the supervisor and, in some cases, in contract with the supervisor, was a way in which this could be achieved.

Although difficulties with meeting targets was often stated as a barrier to providing clinical supervision, one manager stated: "Well serviced staff mean that targets are more attainable" (Manager, Telephone Interview).

This point seems to relate to two of the factors that influence whether a new initiative will be successfully implemented: compatibility and relative advantage.

As described earlier in this report, the compatibility of a new practice with the needs and values of an organisation is important. In addition, it is critical that the new practice be seen to provide an advantage to the various stakeholders. Thus, when clinical supervision is viewed as a valuable, multifaceted response to various needs it is both compatible and relatively advantageous.

When Clinical Supervision is viewed as both a worker's right and a shared responsibility

Managers and supervisors discussed the importance of seeing clinical supervision as a worker's right. If organisations hold the belief that it is an automatic right to receive supervision, it can help to moderate possible stigma associated with accessing it. Seeing clinical supervision as a worker's right assists all levels of an organisation to view it as part of the culture for which they all hold a responsibility. This also has implications for funding bodies when considering funding to fulfil a reasonable duty of care to their workforce who are exposed to layers of complexity and trauma in the provision of service delivery to clients.

Sharing responsibility for supervision was also seen as important. Several levels and types of responsibility for clinical supervision were identified by managers and supervisors. For instance, it is important that supervisees are well educated about the role and definition of clinical supervision. Managers identified it as their responsibility to educate workers about supervision and it is then important for workers to be instrumental in driving the content of supervision sessions.

4.3 Aim Three: Understanding the barriers to providing and receiving clinical supervision

Managers and supervisors were able to identify a range of barriers that they considered constrained the provision and accessing of supervision. The most frequently discussed barriers were:

- Lack of consistent organisational standards;
- Poor supervision and support for supervisors;
- Time and funding constraints;
- Lack of physical space;
- Poor attitudes to supervision;
- The impact of external clinical supervision.

These barriers will be explored below.

Poor consistency in delivery of supervision (sector wide)

The most common reason stated by managers and supervisors as being a barrier to achieving good supervision practice was if it was being delivered in an ad hoc manner. This includes situations where there is a lack of clear and consistent expectations about the parameters of supervision, no definition of supervision and where it is carried out on an 'as needs' basis. Having site based policies as opposed to organisation wide policies, was seen as contributing to a lack of consistency.

One manager spoke of the difficulties of an organisational culture in which supervision was very individually based, with little organisational openness, transparency and consistency about clinical supervision.

This lack of consistency was also reflected in the range of different models that are currently being used across the sector. For instance, organisations with similar service delivery models using different models of supervision delivery.

Poor supervision and support for supervisors

Several managers spoke of clinical supervisors having limited or no access to supervision about their supervision and discussed there being little quality assurance in relation to clinical supervision in the AOD Sector.

Other concerns raised included: few opportunities for ongoing skill development; poor support and learning for supervisors; and the risk of isolation for supervisors, particularly if only one person from on organisation was holding this role.

One supervisor spoke of the need for clinical supervisors to be supported to manage complex roles that combine direct service delivery to clients and management responsibilities.

From the research that has been conducted on implementation of new practices, as outlined earlier in this report, it is clear that adequate training and support will be key elements if clinical supervision is to be successfully implemented and sustained throughout the sector. At present, this is an area for improvement in the AOD sector.

Time and funding constraints

Many supervisors and managers spoke of the constraints of having inadequate funding to support management infrastructure. In addition they highlighted the difficulty of The Department Funding and Service Agreement targets not being adjusted to reflect the time and resources required to deliver clinical supervision. As a result, clinical supervision may be offered on an ‘as needs’ basis or ad hoc manner. For workers, the prioritising of direct clinical work over supervision was constraint to accessing supervision. Workers also rated the lack of availability of clinical supervisors and their own excessive workload as significant barriers to accessing supervision.

The logistical difficulties associated with supervising outreach, part time and overnight staff was seen as a barrier by managers and supervisors. Supervising staff who work outside of traditional hours required some flexibility from both the supervisee and supervisor. For instance, it may require staff or managers to work additional, overtime hours for which there was little funding. Interestingly, workers did not cite being a shift worker as a barrier to accessing clinical supervision, although it is possible that shift workers were underrepresented in the sample.

There was an identified lack of adequate remuneration for supervisors. There may be little difference in pay between senior clinicians who are conducting clinical supervision and the staff that they are supervising. This was viewed by supervisors and managers as inaccurately reflecting the skills required to fulfil the role. It was seen by some managers as contributing to supervisees questioning the expertise of the supervisor.

Physical space

Not having appropriate, private space in which to conduct supervision was viewed by several managers as a barrier. For instance, some organisations were conducting supervision in a group office or a café as no private rooms were available.

Attitudes to clinical supervision

There were several attitudes and beliefs towards supervision that were seen as creating some tensions to providing and accessing it. Managers and supervisors suggested the following:

- A perceived mismatch between supervisee and supervisor professional backgrounds can lead to questioning the usefulness or appropriateness of the supervision.
- Fear by supervisees about how the content of supervision may be used by supervisors and managers. (Interestingly, this was considered an issue by managers, but was not identified as such by workers.)
- Workers who have been in the field for some time may feel devalued by the idea and concept of supervision. As one supervisor from a Focus Group said "there is a perception that the more years you have been on the ground the better you can handle it" (Supervisor, Focus Group).
- Lack of understanding about the purpose and nature of supervision can lead to fears of being judged.

In addition to the attitudes discussed by managers and supervisors, workers suggested the following beliefs as barriers to accessing available supervision:

- Belief that their allocated supervisor lacked the skills or knowledge to cater to their specific needs as an AOD clinician.
- Not being able to see value in the process.

Impact of external clinical supervision

There were several stated difficulties associated with the provision of external clinical supervision, where a supervisor from outside the organisation or outside the team but within the organisation is engaged to provide either individual or group supervision. Although some agencies had clear reporting and contractual arrangements, this was not always the case.

Some managers were concerned about poor clinical accountability in cases where there were few or no reporting arrangements in place. There was a desire to have clear communication and protocols to ensure clinical accountability and clarity of process but some managers did not think that this was occurring.

Eighty percent of the workers who responded to the survey who were receiving external individual clinical supervision indicated that they were unaware of any formal reporting arrangements between their supervisor and their employing organisation. For those workers receiving group supervision that was run by an external facilitator, almost 62% were unaware of any formalised reporting arrangements. So, although managers were concerned about the possibility of poor clinical accountability where external supervisors were used, few organisations seem to have established protocols. It is possible that these protocols may exist with supervisees being unaware of them. However, this

scenario raises concerns about the supervisees confidentiality, as external supervisors may be feeding back information to managers that supervisees are unaware of.

There were also concerns from managers about how to ensure that external clinical supervision, where provided by an external consultant, reflected consistency with the organisational service delivery model.

4.4 Aim Four: Exploring the impact and implementation of The Bouverie Centre Clinical Supervision Training

Managers, supervisors and workers described their perceptions of the impact of The Bouverie Centre Clinical Supervision Training on supervisory practice. The most commonly discussed effects can be grouped into three main areas:

- The impact on individual supervisors;
- The impact on organisational practice of supervision;
- The impact on the AOD sector.

An exploration of these areas will follow.

Impact on individual clinical supervisors

There were many reported individual benefits of The Bouverie Centre's training to supervisors who had completed the course. Some of these were:

- An increased confidence as a supervisor;
- Formalised thinking regarding supervision;
- Increased awareness and commitment to supervision;
- Changed view of self as a supervisor, a clearer identity of self in role as a supervisor;
- Increase in job satisfaction;
- Feeling more informed and encouraged;
- Provided a framework and language for talking and thinking about supervision;
- Greater understanding of the importance of giving feedback and how to do this with supervisees;
- The provision of creative strategies for policy and session development.

"I have more considered conversations" (Supervision Training Course Graduate, Focus Group).

"It was excellent training, it confirmed some things, was great at assisting reflection, giving new ideas and building on existing ideas" (Supervision Training Graduate, Telephone Interview).

Impact on organisational practice of clinical supervision

Clinical supervision graduates in the focus groups and managers interviewed pointed to the different ways training had benefited organisations. It was reported that the training:

- Informed the supervision model of several organisations;
- Had effected change in organisational processes relating to supervision;
- Had led to broader conversations about supervision within organisations;
- Increased the extent to which managers and staff think systemically;
- Led to an organisation wide approach to supervision as opposed to team by team;
- Led to a peer supervision group being established in one organisation;
- Helped to set up a culture of concern with regard to exploring and addressing ethical issues.

"As a manager, I feel increased confidence in the supervisor's abilities" (Manager, Telephone Interview).

"The reported views about the team leader's supervision have improved" (Manager, Telephone Interview).

A small number of workers receiving clinical supervision who responded to the questionnaire indicated that their supervisor had received training at The Bouverie Centre and some offered feedback regarding the impact of the training on their organisation and on the way in which supervision was delivered. The themes emerging from the ten responses are presented below. However, as this is such a small number of responses, it is unclear whether this reflects a generalised outcome of the training:

- Enhanced service delivery – more purpose and direction; greater passion and expertise to draw from; sessions are more client focussed and supervisee led.
- Positive influence on the workplace – addressed issues and relationships within the workplace; changed the culture of the work site.
- No observable impact.
- Source of support for supervisors.
- Promoted further interest in the training.

Impact on the AOD sector

The supervision training was viewed by some managers and supervisors as part of a change that has been occurring in the AOD sector over recent years. This change reflects a perceived professionalization of the sector.

"Supervision is now seen as compulsory and an ongoing process. This is a change, part of a change that has been happening over the last few years" (Supervisor, Focus Group).

The fact that consistent training was offered across the sector was valued by managers and supervisors. This was seen to endorse the notion of clinical

supervision in the sector and to professionalise it. Managers also appreciated that the training was free of cost.

"It's not just tacked on, it's a specialist area now, there is more professionalism" (Supervisor, Focus Group).

What has assisted graduates in implementing the ideas from the training in their organisation?

It was seen as highly beneficial if agencies were able to send more than one person at a time to the training. This created a sense of team for some people. It allowed for a stronger voice to advocate for and implement changes and to continuously keep developing ideas learned in the training.

Several people also discussed the impact of managers doing the training, even if they were not providing supervision. It was seen as useful to have 'organisational authority' when trying to influence change and implementation of new ideas.

"It's good for managers to do the training, even if they are not doing clinical supervision, this helps to embed the model and legitimise it" (Manager, Telephone Interview).

"Senior staff did the training, they were initially reluctant but then came back championing the cause" (Manager, Telephone Interview).

Developing clarity about the purpose of clinical supervision was seen as helpful in implementing the training ideas. For instance, separating management and support of staff involved in critical incidents (which may require formal debriefing and review of operations) from the tasks relating to clinical supervision. This is consistent with the implementation factor of 'complexity' which relates to the importance of practice innovations being simple to understand and adopt.

The training manual was described as a useful resource aiding reflection and planning. In addition, some supervisors and managers identified benefits in holding regionally based training, such as good networking and the possibility for future peer support.

Barriers to implementing the ideas learned in The Bouverie Training

Many of the barriers identified by managers and supervisors to implementing the ideas learned in the training were similar to those encountered in delivering clinical supervision best practice. For instance:

- Perceived negative attitudes towards supervision held by supervisees;
- Lack of understanding about supervision by supervisees;
- Poor support for supervisors after completion of the training course, including no opportunity for follow up by the trainers and minimal supervision of supervision;
- Isolation of supervisors following the training, particularly if only one person was trained in an organisation;
- The informality of supervision arrangements and lack of consistent protocols within organisations;

- Structural issues, i.e. no physical space in which to conduct supervision;
- Poor funding for supervision, i.e. The Department Funding and Service Agreements were not seen to adequately account for the provision of supervision;
- Difficulties in supporting and supervising shift and part time workers.

In addition, managers and supervisors discussed an overall lack of numbers of clinical supervisors and a need for more training for newer supervisors.

4.5 Aim Five: Areas for development for the AOD sector in implementing and delivering clinical supervision

Resourcing issues

Managers and supervisors repeatedly stressed the difficulty of trying to adequately resource clinical supervision. A change in funding arrangements was the most commonly suggested approach to progressing the implementation and development of clinical supervision in the AOD sector.

This need was described in various ways across different organisations but had the following central tenets:

- There is a desire to have supervision time funded, i.e. for staff and supervisors.
- The need for an adaptation of Funding and Service Delivery Agreements to reflect a reduction in service delivery targets and an inclusion of supervision time.
- Clinical supervision would be legitimised if funding arrangements better reflected its occurrence.
- Additional funding is required to resource staff in 24 hour programs to attend clinical supervision.
- Brokerage funding is desired to fund external supervision in some cases.
- A desire to have smaller AOD teams, approximately five staff, so that managers could deliver supervision to their total team in a consistent manner.

Education, training and support issues

Workers suggested various areas of education that could assist the practice of clinical supervision in their agency. They were:

- An education campaign encompassing how to best utilise supervision, research on the efficacy and benefits of supervision and documentation to outline the nature and purpose of supervision.
- Training and support for supervisors including formal supervision skills training and supervision of supervision.

These areas were also highlighted by managers and supervisors.

Accessibility and voluntariness

Eighty five percent of the workers surveyed maintain that clinical supervision should be mandated for all staff involved in the provision of direct AOD related services to clients and/or their families. Although it is possible this view may not accurately represent the views of the general AOD workforce, as the worker sample was based on a voluntary response to the web survey and thus the sample may be biased towards those with a particular interest in clinical supervision, this is a very high proportion of the workers. This high level of support for the mandating of clinical supervision may reflect a view held by workers that it is their right to consistently receive supervision and it places responsibility on funding bodies and organisations to provide it.

The implementation and development of clinical supervision in the AOD sector: future roles for The Bouverie Centre.

Supervision of Supervisors Groups (SOS Groups)

More than half the managers interviewed suggested that co-ordinating and facilitating Supervision of Supervisors Groups would be a useful way for The Bouverie Centre to contribute to the development of clinical supervision in the AOD sector. They wanted a facilitated forum for clinical supervisors to meet and discuss issues involved in implementing clinical supervision in organisations as well as ongoing professional development and peer support.

The role they envisioned The Bouverie Centre playing in this process was:

- Administrative co-ordination by email and telephone;
- Group facilitation;
- Provision and dissemination of relevant resources.

There were several models of SOS Groups suggested by managers and supervisors. They were:

- Peer groups comprised of clinical supervisors from various organisations and grouped regionally;
- Peer groups comprised of clinical supervisors from the same organisation.

Organisational consultations

Some supervisors and managers thought that their organisation could benefit from an individualised organisational consultation regarding implementing clinical supervision. This would meet specific, individual organisational needs but could also provide consistency across the AOD sector if provided by one consulting service.

Clinical supervision training

Many managers and supervisors spoke of the value of continuing to provide the clinical supervision training. They desired that the training be regularly offered free of charge to organisations. Regional organisations expressed a strong interest in the training being held locally.

Several managers and supervisors suggested that a refresher course could be offered to graduates of The Bouverie Centre's Clinical Supervision Training. This could be held several months after completion of the training and could be held in conjunction with a SOS Group.

Clinical supervision resources and guidelines

Some managers and supervisors discussed types of resources that they would find useful in helping to develop and sustain clinical supervision in the AOD sector. A web based forum for sharing resources such as templates and contracts as well as journal articles and other literature was identified by some as a potentially valuable way to support supervisors in their role. This web based system could also operate a 'helpline' or chat room type of support structure for clinical supervisors. Also, there was a desire expressed by some to see the development of a consistent set of guidelines for the practice of clinical supervision across the AOD sector.

4.6 Aim Six: Pilot of Supervision of Supervisors Groups

4.6.1 Establishment of the Pilot SOS Groups

Of the 186 Clinical Supervision Training Course graduates that we sought to invite to join a SOS Group, approximately 25% had either changed roles within the AOD sector and were no longer doing supervision or had left the AOD sector altogether. Approximately another 25% did not respond to either the email or telephone call.

The most interest in joining a SOS Group came from supervisors in the Barwon Southwest, the Grampians, the Southern Metropolitan, the Eastern Metropolitan and the North/Western regions.

The first SOS Group to commence in September 2008 in Geelong comprised of supervisors from The Barwon Southwest and Grampians Regions. Eastern and Southern Metropolitan supervisors were clustered together to meet in Box Hill, with this group also forming in September 2008. The supervisors in these groups were from organisations that provide a range of client services from in-patient hospital settings, counselling and Community Health settings to group programs.

The initial two sessions of the North/West Metropolitan SOS Group were poorly attended and a decision was made to offer organisation based SOS Groups to several large North/West Region organisations that had numerous trained supervisors. The agency based SOS Groups were established at Moreland Hall in December 2008 and YSAS North in March 2009.

The group based at Moreland Hall was comprised of supervisors who all did The Bouverie Centre clinical supervision training together. The SOS Group was timely as at the time of commencing, this organisation was in the process of developing their model of clinical supervision provision. The SOS Group was able to build on the learning environment that had already been established through the training program and was also used to feed into other larger organisational discussions that were taking place about clinical governance and supervision.

The YSAS SOS Group, in the northern metropolitan region, was made up of senior workers, team leaders and managers who were also clinical supervisors. This group is still developing its membership and terms of reference.

Table 18: Number and types of Supervision of Supervisors Group sessions.

Region	Number of Facilitated Sessions	Number of Unfacilitated Sessions	Total Number of Sessions
Barwon Southwest SOS Group	6	3	9
Eastern/Southern Metropolitan SOS Group	7	2	9
Moreland Hall	2	2	4
YSAS	3	1	4

4.6.2 Summary of SOS Group Content and Process

In the first session of each group, time was spent discussing and negotiating the parameters of group content and process. The main areas that were covered were:

- Group membership (should the group be open or closed?);
- Confidentiality;
- Dates, times, venue;
- Culture of the group, including how to address any concerns;
- Style or model of the group, including session structure;
- Role of the facilitator;
- Group administration;
- Topics for discussion.

The notes from these initial discussions were distributed amongst the group and provided to new members as they joined to familiarise them with the culture and agreements of the group.

Some of the common topics for discussion were:

- What is clinical supervision?;
- Difficult sessions;
- Boundaries and clinical supervision;
- Team dynamics and clinical supervision;
- Self care for clinical supervisors.

The sessions were structured with some initial time for participants to check in with each other about how they were and any follow up from previous sessions. The sessions were mainly dedicated to open conversation about a particular topic or a case discussion which was used to facilitate discussion of a topic or theme. Group members volunteered to take responsibility for either presenting a case for reflection or generating discussion about a topic.

Facilitator Observations

Several important issues emerged from the experience of establishing and facilitating the SOS Groups. For instance, in establishing the groups it was important to openly discuss the situation where more than one representative from an agency was attending the SOS Group. This was of even greater relevance where there were people attending who reported to each other and this was a situation that occurred in both the organisation based and regional groups. This had implications for confidentiality, boundaries and openness. It was a task of the facilitator to manage discussions and to offer suggestions about this.

It was important that roles and responsibilities for the group were clearly articulated, particularly as the groups moved towards being peer led as opposed to externally facilitated.

Despite each of the groups having a membership of eight to ten participants, often only three to five people would attend a given session. This small number did not inhibit a useful discussion. However, it does highlight the need to establish groups that have more members than may attend on any given day, as the demands of the job often meant that participants were unable to attend at the last minute.

It was clear from the SOS Group discussions that AOD clinical supervisors are in very complex roles which often demand that they belong to several different hierarchical groups within organisations. They often juggle the demands of complicated and chronic clinical cases as well as being part of management teams and decision making processes related to staff performance. This can place a unique responsibility and pressure on supervisors for which they require a variety of professional support.

4.6.3 Evaluation of SOS Groups

Table 19: Supervisors ratings of SOS sessions, average responses.

	Overall Average (*N*=11)	*m* Group 1 (*n*=5)	*m* Group 2 (*n*=5)
1.1 The facilitated sessions were more useful than unfacilitated sessions	**4.18**	4.60	3.80
1.2 The facilitator knew the subject matter well	**4.73**	4.80	4.60
1.3 The facilitator ensured that everyone could contribute	**4.91**	5.00	5.00
1.4 The facilitator was comfortable working with multiple and divergent perspectives at the same time	**4.91**	4.80	5.00
2.1 The correspondence I received in relation to the SoS group was clear, eg. Emails, phone calls relating to dates, times and topics for groups.	**5.00**	5.00	5.00
2.2 The correspondence I received in relation to the SoS group was timely.	**4.73**	4.60	5.00
3.1 The frequency of the SOS Group sessions met my needs.	**4.64**	4.60	4.80
3.2 The length of the SOS Group sessions met my needs.	**4.45**	4.40	4.80
4.1 To what extent was the content of the sessions useful and applicable to your work as a Clinical Supervisor?	**4.36**	4.80	4.00

**Only one respondent from Group 3 filled in the questionnaire. This person's results are incorporated in the overall average ratings.*

Evaluation forms were completed by 11 SOS participants at the conclusion of our formal engagement with the groups. (*See Appendix K*). Workers were required to use a 1 to 5 scale (where 1 represents strongly disagree / not useful and 5 represents strongly agree / very useful) to rate a series of statements designed to assess different aspects of their experience of the SOS Group.

Overall, Table 19 reveals that on average, workers rated their experience of Supervision of Supervision very positively. The Bouverie Centre's trainer's facilitation and administration skills were regarded highly, with many considering facilitated sessions superior/more useful than those led by peers alone. Session content was also evaluated as being very useful and applicable to workers' work as clinical supervisors.

4.6.4 Future of the SOS Groups

The Barwon Southwest SOS Group and the Eastern/Southern Metropolitan SOS Group have continued to meet beyond the life of this project. These groups have allocated responsibility for co-ordinating the administrative tasks previously held by The Bouverie Centre's Project Officer to group members. They continue to operate as peer supervision groups. The

Barwon Southwest group is meeting on a bi-monthly basis and the Eastern/Southern Metropolitan group is meeting monthly. They have a regular attendance of five to eight members.

The SOS Group that was based at Moreland Hall continues to meet within the structure of another organisational meeting with clinical supervision as an agenda item.

The group based at YSAS is currently developing its terms of reference and is negotiating with The Bouverie Centre regarding facilitation.

5. Conclusion

The Victorian AOD sector has been in the process of cultural change over recent years, moving towards greater professionalism and an increased recognition of the complexity of the work undertaken by those supporting clients with alcohol and drug addictions. It is commendable that The Department has invested well in the provision of high quality training for clinical supervisors and that the field has embraced the training with such enthusiasm. Two hundred and three people have graduated from The Bouverie Centre Clinical Supervision Training course with over seventy agencies represented and it is clear that there is much support for the delivery of clinical supervision, from workers, supervisors, managers and The Department

What is less certain is whether the practice of supervision will be reliably and consistently taken up by all agencies in a way that is sustainable and of most benefit to staff and ultimately, to clients and organisations. From the current research, it seems that there are some organisations where there is good practice that meets the needs of the workforce and that covers the recognised functions of supervision. Conversely, there are some organisations where very little is being provided or taken up and it may be delivered in an ad hoc or reactive manner. Many organisations have a good understanding of supervision and there is support from managers and interest from workers. However, poor processes have inhibited good practice.

To ensure further development of clinical supervision and to promote its best practice in the AOD sector, there is a strongly stated need for supervisors to receive ongoing support about supervision. This objective is consistent with the research regarding successful implementation of new practices. Simply training people in a new skill is not enough to guarantee that practice will change. Ongoing support and consultation with peers and external agents is crucial. This support may take several forms depending on organisational type and size. For instance, the provision of Supervision of Supervisors Groups, organisational consultations and forums addressing the specific issues faced by clinical supervisors in the AOD sector.

There is a strong endorsement of the practice of clinical supervision from workers in the AOD workforce. The sample surveyed overwhelmingly supported the mandating of clinical supervision for AOD workers. The workforce saw themselves as viewing clinical supervision very highly but did not necessarily consider that their organisations and sector shared their view. For leaders in this sector, this suggests that there is currently an opportunity for a more considered and consistent development of the practice of clinical supervision. This may involve the formalising of current practice, development of minimum standards and advocacy for recognition of the complexity of the role of supervisors.

The efforts and endorsement of clinical supervision by managers is also crucial. In organisations where senior managers are strongly supportive of clinical supervision, this was reported as having positive effects on promoting clear expectations and responsibilities.

There are a range of models of clinical supervision currently being provided in AOD organisations, from individual to facilitated and peer led group supervision. At best this reflects that the various forms of supervision can meet different needs of supervisees and organisations and that supervision structures have been selected and developed to best suit the needs of specific organisations.

Alternatively, it may suggest that at times supervision is currently being delivered in an inconsistent manner based on affordability and reactivity. The diversity of service delivery models and organisation types across the AOD sector demand that clinical supervision be provided by organisations in a flexible, consistent, reliable and thoughtfully tailored manner.

There is some debate in the AOD sector about the place of externally provided clinical supervision. Where external clinical supervision is provided there are often unclear, minimal or no reporting requirements between the supervision provider and funding agency. This is of concern when considering the accountability function of supervision, both clinical accountability to clients and also an organisational accountability to staff welfare.

The effects of The Bouverie Centre Clinical Supervision Training appear to be evidenced at a number of levels: the individual supervisor level, the organisational level and a sector-wide level, effecting professionalization. Interest and attendance at the course has been high. Feedback reflects that the course is meeting the needs of the trainees; however, like any new initiative, support is needed to ensure this is sustained and built upon once training has been completed. In part this could be achieved through measures such as the show casing of sector wide best practice of clinical supervision and the development of minimum standards for clinical supervision provision.

The pilot Supervision of Supervisors Groups have been valued and well attended in the regions where they were established. They appear to contribute to a system of support and ongoing learning for supervisors, as well as acting as a valuable meeting space for reflecting on and discussing the business of clinical supervision across the sector. The coordination function performed by The Bouverie Centre was critical to the establishment the groups and in the absence of continued funding, this role will be the shared responsibility of the group members.

The work of the AOD sector in attempting to implement more widespread and improved clinical supervision practices in recent years is notable and worthy. This is an effort to not only attract, support and retain well qualified staff but also to contribute to improvements in service delivery to clients and improve quality assurance processes for organisations.

The provision of best practice clinical supervision has significant ramifications for funding bodies when considering Funding and Service Agreements and when negotiating targets for service delivery; whilst it is evident that clinical supervision is of value to clients, staff and organisation, it is not a clearly quantifiable component of service delivery. Therefore, such continuing efforts are a long term endeavour and require from all parties a commitment to reflect and build on new practices.

The research team wish to particularly acknowledge the time given by those involved in this project in telephone interviews, focus groups, the web survey and SOS Groups in reflecting on their own practice and experience. From their shared experience, it seems the current practices in the AOD sector provide a strong foundation for greater consistency in providing clinical supervision that is responsive to multiple needs.

6. Future Directions

The Department of Health has supported an effective strategy to train a significant number of AOD clinical supervisors over four years. While the clinical supervision training strategy has contributed to continuing clinical and service improvement, an ongoing strategy of clinical supervision training, further development and support for the sector will be required if clinical supervision is to become a sustainable and useful practice.

6.1 Clinical Supervision Guidelines

Assist the sector to clearly articulate values about clinical supervision to help workers, supervisors and senior managers understand what it is and what role supervision can play in relation to staff support, development and client outcomes. Our recent consultation and survey has highlighted the need for clear and consistent guidelines across the sector.

The Bouverie Centre will establish a clinical supervision working group comprised of representatives from The Department, senior managers, clinical supervisors and direct service workers from the sector. The working group will develop minimum standards and guidelines, as well as a strategy for dissemination to the sector.

A working group to develop uniform guidelines that capture the complexity of the AOD sector service delivery components.

6.2 Workforce Development and Implementation Strategies

Continue to provide clinical supervision training in order to build supervisory expertise and capacity in the sector. To maintain sustainability in supervision across the sector and continue to develop good practice, a suite of training and consultation initiatives will meet the needs of different audiences. These initiatives include Supervision of Supervisors Groups and tailored organisational consultations. There is currently a waiting list for further supervision training and some organisations have already requested consultations or further professional development for staff.

Clinical supervision training and ongoing consultation, supervision and support to organisations and clinical supervisors.

6.3 Resource Package

Facilitate the acquisition and transfer of a resource package for the sector. Managers, supervisors and supervisees have all identified the need for access to a range of resources that will assist in the implementation of supervision within specific agencies. A web page will be created for clinical supervision with a variety of downloadable resources and links.

Development of an AOD sector clinical supervision resource package

6.4 Knowledge Transfer

Continue to build on the current momentum for change in relation to clinical supervision by raising the profile of supervision across the sector. Clinical supervision will be show-cased to maintain and encourage continued sector development.

Utilise regular AOD Network forums and/or create forums for the sector to discuss and share their practice wisdom.

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8. Appendices

A. Project Work Plan

AOD Clinical Supervision Training and Implementation

Stage 3: Action Plan for Evaluation of Impact of Supervision Training and Delivery of Peer Supervision Group Pilot

Overall Objective: To run 2 simultaneous projects which add to the body of knowledge available on how to best provide and support clinical supervision in AOD services in Victoria.

One project seeks to audit current supervision practices and review the impact and effectiveness of recently delivered Clinical Supervision Training. The other project will establish Pilot Peer Supervision Groups for Clinical Supervisors and will examine and document learnings from this pilot so that a model of supporting supervisors can be recommended to the field. Information from each project will be used to inform the planning and delivery of the other.

Month/timeframe	Evaluation of Training	Supervision of Supervisors Groups (SOS Groups)	Outcomes
July	Develop Action Plan	Develop Action Plan	
	Write 1 page summary of project to distribute at AOD Service Providers Conference	Write 1 page summary of project to distribute at AOD Service Providers Conference	Promotion of projects
August	Book focus groups • Venues • Dates • Staffing • Catering?		
	Develop research methodology for project	Collate list of course graduates contact details	
	Collate list of managers (Ange to provide), services, past course graduates	Request expression of interest to join SOS Group via: • Email to graduates and letters to managers	
	The Department to write letter to promote project to managers (Bouverie to write)		
	Develop questions for managers		

	Develop questions for focus groups		
	Promotion of project via: • Brief presentation and flier distribution at Service Providers Conference • Letter/ Phone Call to managers • Email to Clinical Supervision course graduates • Email to Regional Advisors • Advertise via VADA		Engagement with services established
	Conduct a stocktake/audit of current supervision practices in AOD services via: • Telephone interviews with service managers • Focus groups with clinical supervisors • Web based survey with staff		
September	Begin contacting managers	Determine criteria for inclusion in Pilot for SOS following: • Focus groups • EOI • Manager feedback	
	Begin running focus groups (9/1 per Department Region) • 1 hour duration • What are current supervision practices? • Discuss impact of organisations policies, procedures and context relating to supervision • Impact of the training course • What else could the course have done?	Choose 4 Pilot sites • At least 1 regional group • Groups to be run monthly • Alternatively facilitated by Bouverie staff, model to be decided in consultation with groups	9 Focus Groups run
October	Develop web based survey with *British Demographic*	Week 1: Facilitate 1st and 2nd SOS Pilot Group Week 2: Facilitate 2nd and 3rd SOS Pilot Group Week 4: 1st SOS Debrief (SOSD)	Bouverie Staff to • facilitate groups • provide information • act as conveyer of information from training research to SOS groups • provide resources that are developed

			as a result of action research
	Commence analysing data from initial focus groups and manager interviews	Purpose of SOSD to: • Reflect on key themes from SOS groups • Develop and record information and knowledge about what makes supervision groups work • Analysis of benefits of SOS groups to supervisors and in turn their supervisees/staff	Pilot SOS groups evaluated and wisdom documented ongoingly. Development of resources to assist in effective, sustainable peer supervision network
	Continue running focus groups and conducting interviews informed by collected/analysed data		
November	Advertise and promote web survey	Run SOS and SOSD Groups	
	Complete development of web survey		
December	Publish web survey on line (contingency plan: for Feb if not complete by Dec)	Run SOS and SOSD Groups	
	Intense promotion of on line survey		
January	Final managers interviewed	Run SOS and SOSD Groups	
February	Final collation and analysis of manager surveys		Managers interviewed Staff surveyed
March	Collation of web survey and analysis of data		
April	Disseminate results of interviews, focus groups and surveys to field via: • VADA Newsletter • Service Provider Conference	Disseminate results of interviews, focus groups and web surveys to SOS Groups	Body of knowledge developed, collated, analysed and disseminated
		Completion of Pilot SOS Groups	Pilot SOS Groups delivered
May			Evaluation of SOS pilot groups completed
June	Write and submit Stage 3 Report	Develop recommendations for the future of SOS Groups	Stage 3 Report including Recommendations • for effective future implementation of supervision in workplaces • for how to best support supervisors
July	Plan resources to be developed in Stage 4, for		

	organisations based on recommendations of report and learnings from SOS Groups		
Stage 4 Recommendations/Future Directions	Policy recommendations	How to implement across other regions 1 Day Best Practice Seminar	Action Plan for Stage 4
	Resources and structures developed to support supervision organisationally in AOD services	Development of Web based supports for services for supervisors and services wanting to promote supervision	
	Resources for managers wanting to establish effective supervisory structures	Additional "Catch Up 6 Day Clinical Supervision" training for new employees and staff new to supervision role	

B. Focus Group and Telephone Interview Documents

Focus Group Questions to Supervisors

Organisational Context

1. What are some of the beliefs that are held in your organisation about supervision?

Probes
- Look for both positive and negative around usefulness
- On staff retention
- Staff enjoyment/satisfaction in job/position

2. What are the key elements in your organisation that support good clinical supervision practices?

Probes
- Policies? (Clinical supervision specific or embedded in other policies?)
- Staff recruitment policies ie. Targeting of supervision skills
- Organisational valuing of supervision (as evidenced in various ways…)

3. What are the barriers in your organisation to delivering high quality supervision?

Probes
- Resourcing (eg. Time pressures)
- Staff skills (eg. Supervisor training, supervisees understanding of supervision)
- Role clashes
- Lack of understanding of role of clinical supervision, mismatch of models

Impact of 6 Day Training

4. How has doing the 6 Day training influenced supervision practices in your organisation?

Probes
- Impact on organisational understanding of supervision
- Impact on frequency/duration
- Impact on model – establishment or development
- Impact on informal debriefing
- Impact on professional development plans
- Impact on performance planning
- Personal impacts eg.
- Development of policies and procedures

5. What have been the challenges for you in implementing ideas learned in the training, in your organisation?

Probes

- Personal/individual/self
- Organisational level
- Time
- Numbers of people trained from your organisation

6. What could the 6 Day Training Course and The Bouverie Centre, in the future, do differently to support these ideas being implemented in your workplace?

Probes

- Course specific feedback/ideas
- Resource development
- Tools
- Advocacy

Telephone Interview Questions for Managers

Demographics

What is your role?
What is your professional background?

Do you provide clinical supervision in your role?

- How many staff? Their backgrounds?
- If not, is it provided?

- If not, why?

- If someone else provides it, what is that person's role?

Have you completed the 6 Day Bouverie Training?

What is the frequency and duration of clinical supervision?

Structure/Model

Organisational Policy

Are their any organisational policies relating to clinical supervision?

- Is there a clinical supervision specific policy?

- Is it embedded in other staff supervision policy?

What is the usefulness of these policies?

- Do people read it?

- Do people follow it?

Is your organisation's supervision practice based on any particular beliefs or values? For instance

- informed by clinical practice, such as CBT?
- Influenced by the clinical supervision training
- Other?

Current Practice/Model

What do you see as the strengths of your current clinical supervision arrangements and model?

How is this achieved?

What is the impact of clinical supervision in your organisation in the following areas?

- Informal debriefing

- Clear PD pathways
- Contributions for performance appraisals
- Resourcing/staffing issues

What would your ideal model for clinical supervision in your organisation look like? What elements/structures/procedures are already in place? What still needs to happen?

What do you consider to be the gaps in your organisation's supervision practice or model?

What are the barriers to overcoming these? What would assist you in this?

Impact of 6 Day Training

How has doing the Clinical Supervision Training influenced supervision practices and policies in your organisation?

What has assisted implementing ideas learned in the training?

Have there been any barriers to implementing ideas from the training in your organisation?

What could the course/Bouverie do differently to support these ideas being implemented in your workplace? Eg. Resources? Tools? Advocacy?

Participant Information and Consent Form for Focus Group

The Bouverie Centre has received funding from The Department of Health to determine what current clinical supervision practices exist in organisations in the Alcohol and Other Drugs Sector, and to understand what contributes to sustainable and high standard supervision . The Bouverie Centre has also received funding to review the impact of the recently delivered Clinical Supervision Training Program.

Study Aim

To investigate what supervision practices currently exist, what contributes to high quality supervision and what barriers exist in agencies to provide this.

To investigate the impact of the Clinical Supervision Training Program.

Confidentiality

Every effort will be made to protect the anonymity and confidentiality of participants. All information collected during this research will be kept confidential and only the researchers will have access to the information and know the identity of participating organisations. Individuals will not be named in the reporting of the research and all identifying information about you will be removed. Participating organisations will only be named with the approval of the CEO and only in connection to any collaborative presentations at conferences etc. All transcripts and audiotapes will be kept in a locked cabinet with any computer files being password protected. After the final research report the original data will be kept in a special secure facility at La Trobe University and destroyed after a period of 5 years.

Declaration of informed consent and individual agreement to participate.

I…….. have read the participant information details and any questions I have asked have been answered to my satisfaction. I ....., agree to participate in the study above knowing that I may withdraw this consent at anytime. I agree that information collected from the study may be presented at conferences or published in journals on condition that I am not identified in the material without my consent.

Signature of staff participant:

Date:

I will adhere to all conditions set out in this document.

Signature of researcher:

Date:

C. Web survey for workers involved in AOD direct service

Request for Worker Feedback on Clinical Supervision

The Bouverie Centre has received funding from The Department of Health to document clinical supervision practices within Alcohol and Other Drug (AoD) agencies across Victoria.

As part of the research, we have prepared a questionnaire canvassing the experiences of workers involved in the provision of Alcohol and Other Drugs related services. It asks you to reflect on factors that promote and contribute to the sustainability of good supervision practice.

Consent to participate in the research will be implied from completion of the survey. Participation is entirely **voluntary** and **anonymous**. All responses will be treated with the strictest of confidence.

The survey should take around 15 to 20 minutes to complete and **must be finished in one sitting**. Please respond to each question with the first answer that comes to mind (do not deliberate for too long). There are **no** right or wrong answers. Just give the answer that is most accurate for you.

On behalf of the research team, thank you in advance for taking the time to complete this questionnaire. Your contributions will play a valuable role in building a rich profile of clinical supervisory practices in AoD state-wide.

If you have any queries or concerns please do not hesitate to contact us at any time – Sally Ryan, phone 9385 5100 or email s.ryan@latrobe.edu.au or Michelle Wills, m.wills@latrobe.edu.au.

Section One

Please answer the following questions by selecting the appropriate response. Your answers will help provide us with information about your specific service context. Remember, your responses will remain completely confidential.

1. Please enter your age:

- ☐ 18 to 29
- ☐ 30 to 39
- ☐ 40 to 49
- ☐ 50 to 59
- ☐ 60 or older

2. Please enter your gender:

- ☐ Male
- ☐ Female

3. What is your professional/educational background (Please select any that apply)?

- ☐ Education/Teaching
- ☐ Social Work
- ☐ Aboriginal/Torres Strait Islander Health Work
- ☐ Diploma in Counselling
- ☐ Family Therapy
- ☐ Nursing
- ☐ Certificate IV in Alcohol and Other Drugs Work
- ☐ Psychology
    i. **If "Psychology" is selected**, "Are you a registered psychologist?"
        - □ Yes
        - □ No
- ☐ Psychiatric Nursing

☐ Diploma of Welfare Work

☐ Diploma of Youth Work

☐ Other, please describe:

_____
_____
_____

4. How long have you worked in the AOD sector?

☐ Less than 1 year

☐ 1 to 2 years

☐ 3 to 5 years

☐ 6 to 10 years

☐ 11 to 15 years

☐ 16 to 20 years

☐ More than 20 years

5. Which area does your agency operate in?

☐ Barwon South West

☐ Eastern Metropolitan

☐ Gippsland

☐ Grampians

☐ Hume

☐ Loddon Mallee

☐ North Western Metropolitan

☐ Southern Metropolitan

6. Which AoD specific program do you work in (Please select any that apply)?

☐ Counselling, Consultancy and Continuing Care

☐ Youth Outreach

☐ Drug Diversion

☐ Supported Accommodation

☐ Community Based Pharmacotherapy

☐ Outreach (Adults)

☐ Intensive Case Management Service

☐ Koori/Aboriginal Community Alcohol and Drug Work

☐ Adult Residential Withdrawal Service

☐ Youth Residential Withdrawal Service

☐ Home Based Withdrawal

☐ Mobile Needle Syringe Program

☐ Family Counselling

☐ Residential Rehabilitation

☐ Acquired Brain Injury

☐ Dual Diagnosis

☐ Other, please describe:

_____

_____

_____

7. Please mark any tasks that make up your role

☐ Direct services to clients

☐ Clinical supervision to staff in your organisation

☐ Line management

8. What type of organisation do you work for?

☐ Community Health Centre

☐ Hospital/Health Care Network

☐ Non-government Organisation – AOD specific

☐ Non-government Organisation – General Health

☐ Non- government Organisation - Welfare

☐ Mental Health

☐ Other, please describe:

_____

_____

_____

In this survey we refer to 'clinical supervision'. By this we mean individual or group supervision, where the focus of this space is on work practice with clients. The tasks can include education, reflective processes about the client-worker relationship, giving and receiving feedback, and the planning of professional development. For the purpose of this survey, 'clinical supervision' <u>does not</u> refer to 'line management' meetings that may involve more administrative tasks.

9. What type of clinical supervision do you personally currently receive in your role? (Check any that apply) ***MANDATED QUESTION***

- ☐ Individual

<u>If Individual selected:</u>

i. Who provides you with your individual clinical supervision" (Check any that apply)
   - ☐ Line manager (e.g., team leader or manager)
   - ☐ Senior worker
   - ☐ Clinical supervisor (special role within the organisation)
   - ☐ Someone from outside my team but within the organisation
   - ☐ Someone from outside my organisation
     a. **If "Someone from outside my organisation" selected**, "Is it paid for by the organisation?"
        - ☐ Yes
        - ☐ No
     b. **If "Someone from outside my organisation" selected**, "Is it conducted outside of work hours?
        - ☐ Yes
        - ☐ No
     c. **If "Someone from outside my organisation" selected**, "Is there a formalised reporting arrangement?"
        - ☐ Yes
        - ☐ No
        - ☐ I don't know

        If yes selected, "What is the arrangement?" (Select any responses which apply)
        - ☐ Quarterly written report

- Feedback to the organisation if issues arise
- Other, please describe ……

ii. How often do you receive individual supervision?
- Weekly
- Fortnightly
- Monthly
- Other, please describe ……

iii. On average, how long are these individual supervision sessions?
- 50 minutes
- 1 hour
- 1.5 hours
- Other, please describe ……..

iv. Is there a separate meeting for individual clinical supervision as opposed to it being part of another meeting?
- Yes
- No
    a. **If no selected**, “What other meeting is it combined with?”.....

v. Thinking of the individual supervision you currently receive, which of the following is/are likely to happen in a session? (Check any that apply)
- □ Case discussion and case planning, including discussion about intervention with clients
- □ Reflection about emotional impact of cases on you
- □ Reflection/discussion about the client – worker relationship
- □ Reflection about the supervisory relationship
- □ Planning for professional development
- □ Discussion about your role in your organisation/team
- □ Discussion of professional/ethical issues
- □ Receiving feedback about your work
- □ Giving feedback to your supervisor
- □ Other, please list ……
- □ None of the above

□ Group

If Group selected:

i. Do you have group supervision with a supervisor?
   □ Yes
   □ No

If yes selected:

1. Who facilitates your group supervision?
   - □ Line manager (e.g., team leader or manager)
   - □ Senior worker
   - □ Clinical supervisor (special role within the organisation)
   - □ Someone from outside my team but within the organisation
   - □ Someone from outside my organisation
     i. **If "Someone from outside my organisation" selected**, "Is there a formalised reporting arrangement?"
        - □ Yes
        - □ No
        - □ I don't know

     If yes selected, "What is this arrangement?" (Please select any that apply)
        - □ Quarterly written report
        - □ Feedback to the organisation if issues arise
        - □ Other, please describe ……
2. How often is facilitated group supervision held?
   - □ Weekly
   - □ Fortnightly
   - □ Monthly
   - □ Other, please describe
3. How often do you attend facilitated group supervision?
   - □ Weekly
   - □ Fortnightly
   - □ Monthly
   - □ Other, please describe
4. On average, how long are these facilitated group supervision sessions?
   - □ 1 hour

- 1.5 hour
- 2 hours
- Other, please describe ……

5. Thinking of the group supervision you currently receive, which of the following is/are likely to happen in a session? (Check any that apply)
   □ Case discussion and case planning, including discussion about intervention with clients
   □ Reflection about emotional impact of cases on you
   □ Reflection/discussion about the client–worker relationship
   □ Reflection about the supervisory relationship
   □ Planning for professional development
   □ Discussion about your role in your organisation/team
   □ Discussion of professional/ethical issues
   □ Receiving feedback about your work
   □ Giving feedback to your supervisor
   □ Discussion of group dynamics (ie. The supervision group)
   □ Other, please list
   ……
   □ None of the above

ii. Do you have peer supervision (i.e., supervision that is not facilitated)?
   □ Yes
   □ No

   If yes selected:

   1. How often is peer supervision held?
      - Weekly
      - Fortnightly
      - Monthly
      - Other, please describe
   2. How often do you attend peer supervision?
      - Weekly
      - Fortnightly
      - Monthly
      - Other, please describe
   3. On average, how long are these peer supervision sessions?
      - 1 hour
      - 1.5 hour

- 2 hours
- Other, please describe

4. Thinking of the peer supervision you currently receive, which of the following is/are likely to happen? (Check any that apply)
   - □ Case discussion and case planning, including discussion about intervention with clients
   - □ Reflection about emotional impact of cases on you
   - □ Reflection/discussion about the client – worker relationship
   - □ Reflection about the supervisory relationship
   - □ Planning for professional development
   - □ Discussion about your role in your organisation/team
   - □ Discussion of professional/ethical issues
   - □ Receiving feedback about your work
   - □ Giving feedback to your p
   - □ Discussion of group dynamics (ie. The supervision group)
   - □ Other, please list

…….

- □ None of the above

□ Informal debriefing conversations (By this we mean conversations that are not formally structured but may be important, powerful and responsive to immediate needs.)

<u>If "informal debriefing conversations" selected:</u>

i. Who do you have informal debriefing conversations with? (Check any that apply)
   - Allocated supervisor?
   - Colleagues
   - Other (e.g., manager; admin person)

<u>If "Informal debriefing conversations" response is selected along with "Group" or "Individual" responses:</u>

i. Are informal debriefing conversations ***routinely*** fed back into formal supervision?
   - Yes
   - No

If only "Informal debriefing conversations" response is selected:

i. Is individual / group clinical supervision offered by your agency?
   □ Yes
   □ No
      1. **If yes selected**, "Please briefly explain the circumstances which currently prevent you from receiving clinical supervision"

_____
_____

      2. **If no selected,** NOTE: please **do not prompt** workers to answer:
         - Section 1, Questions 10, 11
         - Section 3, Question 5, 6
         - Section 4, Question 3, 4, 6, 7, 8

□ None of the above

If "None of the above is" selected:

i. Is individual / group clinical supervision offered by your agency?
   □ Yes
   □ No
      3. **If yes selected**, "Please briefly explain the circumstances which currently prevent you from receiving clinical supervision"

_____
_____

      4. **If no selected,** NOTE: please **do not prompt** workers to answer:
         - Section 1, Questions 10, 11
         - Section 3, Question 5, 6
         - Section 4, Question 3, 4, 6, 7, 8

10. Are supervisees in your organisation able to select their internal clinical supervisor?
   □ Yes
   □ No
   □ N/A, workers at my organisation do not receive individual supervision or workers receive individual supervision from someone external to our organisation, etc.

11. If supervisees in your organisation receive external supervision that is paid for by the organisation and conducted on work time, are they able to choose who they see?

- □ Yes
- □ No

12. Does your agency have a private space in which supervision can be held?

- □ Yes
- □ No

i. **If yes selected**, “Do you think this is important?”

- □ Yes
- □ No

Section Two

The following questions focus on the policy and procedures relating to supervision in your organisation. Please select the appropriate response.

1. Does your agency have a written policy relating to clinical supervision?
   - Yes
   - No
   - I don't know

   i. **If yes selected**, "Have you read the policy?"
      - Yes
      - No

      1. **If yes selected**, "Is the policy followed in your case?"
         - Yes
         - No

2. Was clinical supervision discussed with you when you commenced employment/started clinical supervision?
   - Yes
   - No

   i. **If yes selected**, "Were the supervision arrangements you discussed at that time followed in your case?"
      - Yes
      - No

3. Is it compulsory for all staff involved in the provision of AoD related services in your agency to attend supervision? (Please select the appropriate response)
   - Yes
   - Yes, but only for staff in particular who work over a certain amount of hours per week
   - Yes, but only for staff in certain roles
   - No
   - I don't know

4. Do you think that clinical supervision should be mandated (Please explain your answer)?
   - Yes

_____
_____
_____

□ No

_____
_____
_____
_____

Section Three

The following section concentrates on attitudes and beliefs about supervision in your organisation and in the sector. Please select the response that best represents your answer.

1. Using the scale below, please indicate how important you think **the AoD sector, including funding and peak bodies,** considers clinical supervision is for its workforce:

Not at all important				**Very Important**
1	2	3	4	5

2. Using the scale below, please indicate how important you think **your organisation** considers clinical supervision is for its AoD workers:

Not at all important				**Very Important**
1	2	3	4	5

3. Please indicate which of the following you consider are strengths of your organisation's supervision practices, using the scale below:

	Not at all				**To a large extent**
Clinical supervision is well understood by ***people providing clinical supervision*** to AoD workers in this agency	1	2	3	4	5
Different formats of clinical supervision (eg. individual, group) are offered by this organisation	1	2	3	4	5
There is space in this agency to reflect on practice in relation to workplace culture, as well as case focused	1	2	3	4	5
Clinical supervision is held regularly in this agency	1	2	3	4	5
Clinical supervision is valued by this agency's management	1	2	3	4	5
Management in this agency is committed to making clinical supervision happen	1	2	3	4	5
Clinical supervision is well understood by this agency's ***management***	1	2	3	4	5
There is a clear policy on clinical supervision in this agency	1	2	3	4	5
People providing clinical supervision to AoD workers in this agency have some formal training in supervision	1	2	3	4	5
Clinical supervision is documented and formalised in this agency	1	2	3	4	5
Sufficient organisational resources and time are devoted to clinical supervision by this agency	1	2	3	4	5
Clinical supervision is well understood by staff in this agency	1	2	3	4	5

4. Please comment on/ clarify any of the above responses and add any other areas that you consider to be strengths.

_____
_____
_____

5. Thinking about the clinical supervision provided by your agency, to what extent does it:

	Not at all				**To a large extent**
Increase supervisees' competence	1	2	3	4	5
Increase supervisees' confidence	1	2	3	4	5
Increase supervisees' creativity	1	2	3	4	5
Help promote better service to clients	1	2	3	4	5
Provide a learning space or is educational for supervisees	1	2	3	4	5
Provide support	1	2	3	4	5
Provide an avenue to keep up to date with current best practice	1	2	3	4	5
Offer an opportunity to plan for professional development	1	2	3	4	5
Assist personal development as it relates to work	1	2	3	4	5
Increase supervis***ees***' job satisfaction and morale	1	2	3	4	5
Create a professional/career pathway for supervi***sors***	1	2	3	4	5
Decrease burnout	1	2	3	4	5
Provide an avenue for providing and receiving feedback	1	2	3	4	5

Increase clinical accountability	1	2	3	4	5

6. Are there any other benefits from the clinical supervision provided by your agency? If so, what are they?

_____
_____
_____

7. Thinking about ***your agency***, to what extent do the following factors constrain ***workers involved in Alcohol and Other Drugs Services*** from accessing clinical supervision:

	Not at all				**To a large extent**
Clinical supervision is not offered to Alcohol and Other Drugs workers	1	2	3	4	5
Excessive workload of supervis***ees***	1	2	3	4	5
Limited availability of supervisors	1	2	3	4	5
Direct clinical work is prioritised over clinical supervision by supervis***ees***	1	2	3	4	5
Supervisors' inexperience	1	2	3	4	5
Doesn't meet workers' needs	1	2	3	4	5
Poor relationship with supervisors	1	2	3	4	5
Fear that the content of sessions will be "used against" the workers	1	2	3	4	5
Direct clinical work is prioritised over clinical supervision by supervis***ors***	1	2	3	4	5
Supervisees feel intimidated by supervisors	1	2	3	4	5
The nature of shift work	1	2	3	4	5

Lack of understanding about clinical supervision by supervis***ees***	1	2	3	4	5
Clinical supervision is not considered valuable/worthwhile by the **organisation**	1	2	3	4	5
Supervision is not offered to workers employed under a certain time fraction	1	2	3	4	5
The organisation does not ensure that staff understand what is involved in supervision (e.g. Supervision is not explained at induction, there is a poor or unclear supervision policy)	1	2	3	4	5
Clinical supervision is not considered valuable/worthwhile by the **sector**	1	2	3	4	5

8. What else do you think might assist the practice of clinical supervision in your agency? (e.g., resources; tools; advocacy)

_____
_____
_____

Section Four

This section refers to your attitudes/beliefs about your own supervision. Please select the response that best represents your answer.

1. Using the scale below, please indicate how important clinical supervision is to you as a worker:

Not at all important				**Very Important**
1	2	3	4	5

2. What do you expect from clinical supervision? (Please consider individual and group supervision in your answer.)

_____
_____
_____
_____
_____
_____

3. Using the scale below, please indicate how closely the clinical supervision you currently receive meets your expectations:

Not at all				**To a large Extent**
1	2	3	4	5

4. Thinking of the clinical supervision you currently receive:

i. Using the scale below, please indicate how satisfied you are with your Individual Supervision:

Very Unsatisfied				**Very Satisfied**
1	2	3	4	5

- **If <5 selected**, "What needs to change for individual supervision to better meet your needs and increase your satisfaction?"

_____
_____
_____
_____
_____
_____

ii. Using the scale below, please indicate how satisfied you are with your Facilitated Group Supervision:

Very Unsatisfied				**Very Satisfied**
1	2	3	4	5

- **If <5 selected**, "What needs to change for Facilitated Group Supervision to better meet your needs and increase your satisfaction?"

_____
_____
_____
_____
_____
_____

iii. Using the scale below, please indicate how satisfied you are with your Peer Group Supervision:

Very Unsatisfied				Very Satisfied
1	2	3	4	5

- **If <5 selected**, "What needs to change for Peer Group Supervision to better meet your needs and increase your satisfaction?"

_____
_____
_____
_____
_____
_____

5. What do you think makes a good clinical supervisor? (e.g., experience in working with AOD clients; previous experience in your role; group facilitation skills, etc)

_____
_____
_____
_____
_____
_____

*****ONLY PROMPT WORKERS TO ANSWER QUESTION 7, 8, 9 IF THEY INDICATE THAT THEY RECEIVE INDIVIDUAL SUPERVISION (SECTION 1, QUESTION 9) OR GROUP SUPERVISION WITH A SUPERVISOR (SECTION 1, QUESTION 9) *****

6. Using the scale below, please indicate how closely your current clinical supervisor matches your idea of someone who is a good supervisor

Not at all				**Very closely**
1	2	3	4	5

7. Does your clinical supervisor receive supervision about their role as a supervisor?

☐ Yes

☐ No

☐ I don't know

8. Has your clinical supervisor completed any training in the area of clinical supervision?

☐ Yes

☐ No

☐ I don't know

i. **If yes selected**, "Was his/her Clinical Supervision Training at The Bouverie Centre?"
   - ☐ Yes
   - ☐ No
   - ☐ I don't know

   1. **If yes selected**, "What impact has your clinical supervisor's training had on":

      a. Your organisation

      _____
      _____

      b. Your supervisor's delivery of supervision

      _____
      _____

Is there anything we have missed which you think is important in helping us understand your experience of clinical supervision? If so, please use the comments box below to tell us what it is.

Thank you for taking the time to complete this questionnaire

D. Sample correspondence re SOS Group

Sample letter sent to supervisors re SOS Group

12th august, 2008

Dear Colleagues,

Re: Focus Groups and Proposed Group Supervision for Clinical Supervision Training Graduates

As a graduate of the Bouverie Centre's AoD Clinical Supervision Training, we are excited to write to you about further developments in this area. We have been engaged by The Department of Health to try to understand what factors promote and contribute to the sustainability of good supervision practice. We are also organising four pilot peer Supervision of Supervisors Groups (SOS Groups) for the supervision training graduates.

Invitation to a One Hour Focus Group

The Bouverie Centre's Community Services Team is holding a focus group in your region to reflect on supervision practices. We are keen to hear your ideas in relation to supervision in your workplace in the following areas:

- What is currently working well in your supervisory practice?
- Which areas need more development?
- What may have changed as a result of the supervision training?
- How does your organisation support clinical supervision?

How will this help you?

The learning from this exploration will:

- be communicated to the sector to help inform your practice
- contribute to the development of organisational resources,
- assist in planning future policy, training and organisational supports.

Clinical Supervisors Peer Supervision Groups (SOS Groups)

As a graduate of The Bouverie Centre's AOD Clinical Supervision Training, we are offering you an opportunity to participate in a Pilot Peer Supervision Group for Clinical Supervisors.

This is an opportunity to:

- gain professional support
- build on knowledge gained in the course
- contribute to your ongoing development as a supervisor
- share practice wisdom with other graduate supervisors through the processes of case presentations and discussions.

What will the Bouverie Centre Staff do?

- Co-ordinate and establish four pilot SOS Groups, ie. Organise times, dates and venues
- These will be in Departmental regions according to interest received and run for 2 hours, monthly

- Facilitate some of the group sessions. This facilitation role can be flexible and determined in consultation with each group.
- Provide information and feedback from the focus groups and interviews with agency staff.
- Begin developing resources for organisations.

Please register your interest by 12th September, 2008 by returning the attached form by fax to Sally Ryan on fax no: 9381 0336

If you have any questions please call Sally Ryan or Michelle Wills on ph: 9385 5100 or email us on s.ryan@latrobe.edu.au or m.wills@latobe.edu.au

Please Return by September 12th, 2008 to Sally Ryan on fax no: 9381 0336

AOD SUPERVISION PROJECT REGISTRATION FORM

Name: _____

Organisation & THE DEPARTMENT Region: _____

Work phone / Mobile phone: _____

E-mail: _____

Current position: _____

I am interested in participating in a Supervision of Supervisors Group (SOS Group) to be held monthly from late September/ Early October 2008 □ Yes □ No

To be completed by Manager

Approval given to attend?

Monthly Supervision of supervisors Group □ Yes □ No

Name and position: _____

Signature: _____ Date: _____

Sample letter to managers regarding the project

Dear Manager

We are writing to advise you of a project that is being run by The Bouverie Centre for clinical supervisors in the AOD field. Since 2005, The Bouverie Centre has been providing clinical supervision training to supervisors in the AOD field. In order to further promote useful and sustainable supervision practices we have been engaged by the AOD field to pilot four peer Supervision of Supervisors Groups (SOS Groups).

We will be coordinating and facilitating pilot SOS Groups for supervisors who are graduates of the Bouverie Centre's Clinical Supervision Training Course. Upon completion of the project, learnings about the peer supervision group model will be documented and examined and recommendations provided to the field.

Peer supervision groups provide an opportunity for colleagues to share practice wisdom, learn from other participants and to receive and provide feedback about their work practices. It is hoped that group members will provide a professional support base for each other and will continue to build on knowledge gained in the course. This in turn has benefits for organisations and staff and ultimately clients using services.

It is envisaged that the SOS Groups will run for a 2 hour period each month between October 2008 and April 2009 and will be based in four Department regions, exact regions to be determined by interest. As the manager of someone who provides clinical supervision to staff members, we seek your support in allowing your clinical supervisor to attend the group. Our previous experience in establishing peer supervision groups has found that they are most successful if formerly endorsed by managers. To this end we attach a statement, to be signed by you, of consent for supervisors to attend the SOS Groups.

You may also be contacted shortly to take part in a review of supervision practices in the AOD field. Managers of services will be interviewed by telephone, supervisors will be invited to attend a one hour focus group held in their region and supervisees will be asked to fill in a web based survey. The learning from this exploration will be fedback to the sector to help inform your practice. It will contribute to the development of organisational resources and assist in planning future policy, training and organisational supports in the area of supervision.

If you have any questions please feel free to contact Sally Ryan or Michelle Wills on 9385 5100 Please return the consent statement via email to Sally Ryan sryan@latrobe.edu.au or fax to 9381 0336.

Yours sincerely,

E. Demographics of web survey sample

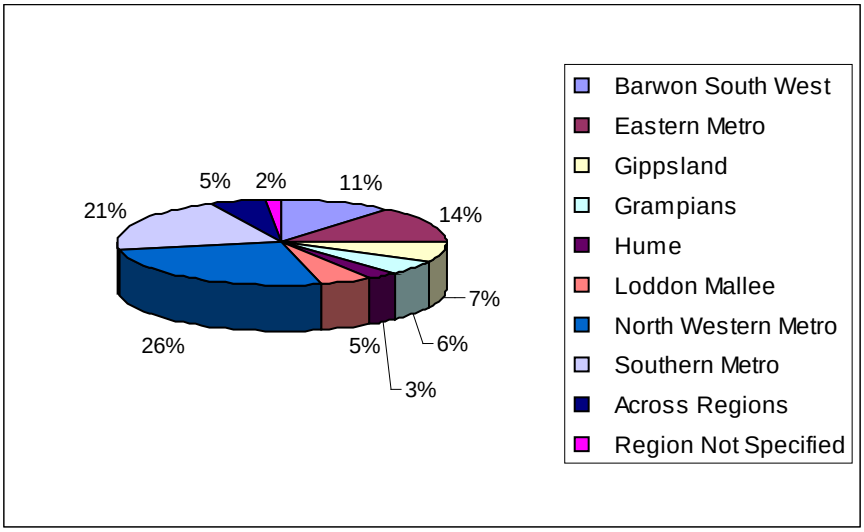

Figure 1: Region in which workers' agency operate, percentages

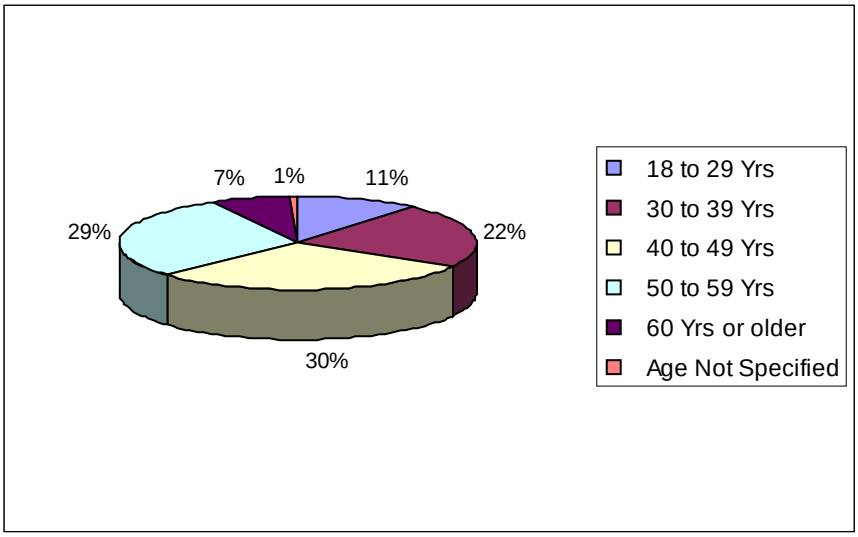

Figure 2: Age group of workers, percentages

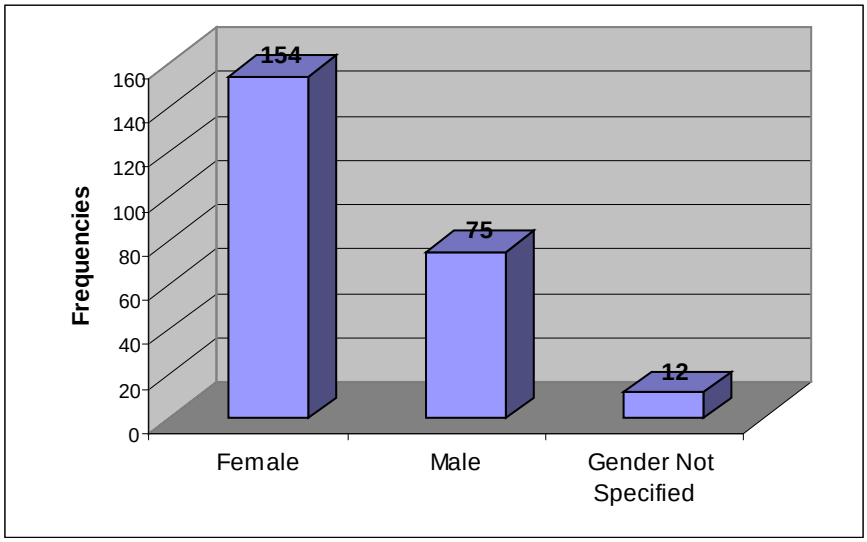

Figure 3: Gender of workers, frequencies

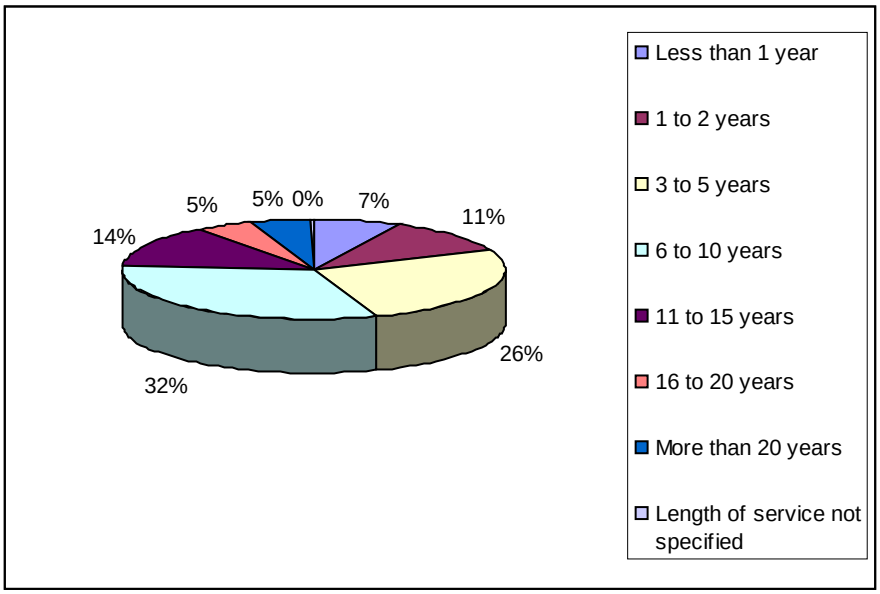

Figure 4: Length of service in AOD field, frequencies

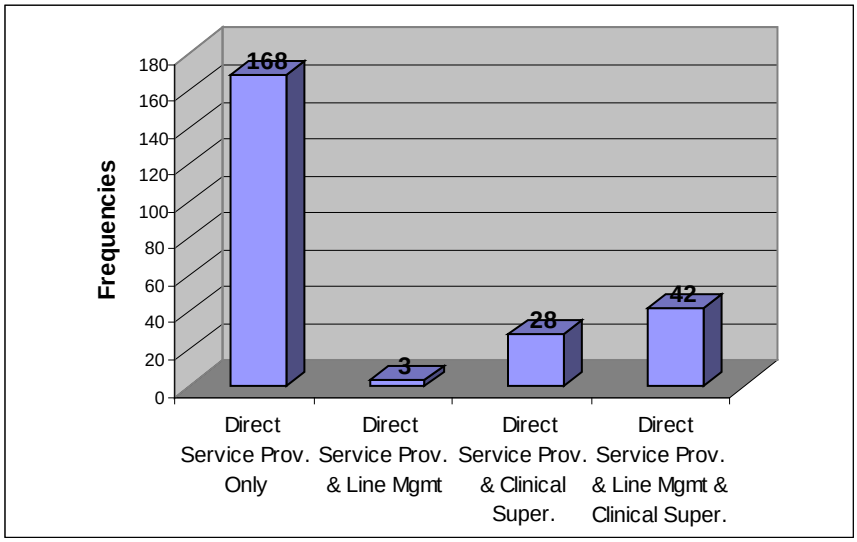

Figure 5: Involvement in higher management duties, frequencies

Table 2: Professional / educational background of workers, frequencies

Education/Teaching	20
Social Work	42
Aboriginal/Torres Strait Islander Health work	1
Counselling Diploma	41
Masters or Graduate Diploma in Counselling & Human Services	7
Family Therapy	10
Nursing	46
Certificate IV AOD	92
Diploma of AOD	25
Graduate Diploma or Graduate Certificate in AOD / Substance Abuse / Addiction Studies	16
Psychology	39
Registered Psychologist	20
Psychiatric Nursing	14
Welfare Work Diploma	32
BA Welfare Studies	2
Youth Work Diploma	13
BA or Certificate IV in Youth Work	9
Health Promotion or Health Science or Community Development	7
Certificate IV in Mental Health	3
Women's Health	3
Criminology or Justice	4
Other	20

Note: Values represent number of workers endorsing a response

Table 3: AOD Specific Program in which workers work, frequencies

Counselling, Consultancy and Continuing Care (CCC)	116
Youth Outreach	39
Drug Diversion	37
Supported Accommodation	16
Community based pharmacotherapy	12
Outreach Adults	17
Intensive Case Management	13
Koori/Aboriginal Community AOD Work	16
Adult Residential Withdrawal	39
Youth Residential Withdrawal	18
Home based Withdrawal	17
Outpatient Withdrawal	3
Post Withdrawal Linkages	3
Mobile Needle Syringe Program	5
Family Therapy	25
AOD Family Support	4
Residential Rehabilitation	21
ABI	12
Dual Diagnosis	52
Other	18

Note: Values represent number of workers endorsing a response

F. Profiling workers' experience of individual supervision

Table 4: Individual clinical supervision - How often held, frequencies and percentages

	Weekly	*Fortnightly*	*Monthly*	*3 weekly*	*6 weekly to 2 monthly*	*1 to 4 times yearly*	*Ad hoc / As needs basis*	*Other / Not Specified*
Workers receiving individual clinical supervision (*n*=163)	11 (6.75%)	48 (29.45%)	79 (48.47%)	5 (3.07%)	6 (3.68%)	6 (3.68%)	6 (3.68%)	2 (1.23%)

Table 5: Individual clinical supervision - Average length of sessions, frequencies and percentages

	50 mins to 1 hr	*90 mins*	*2 hrs*	*Other*
Workers receiving individual clinical supervision (*n*=163)	147 (90.18%)	11 (6.75%)	3 (1.84%)	2 (1.23%)

Table 6: Individual clinical supervision - Facilitated by whom, frequencies

	Line Manager	*Senior Worker*	*Clinical Supervisor (special role within the org.)*	*Outside team (within org.)*	*External Facilitator (Paid for by org. & or conducted during work hours)*	*External Facilitator (Not paid for by org. / conducted outside working hours)*
Workers receiving individual clinical supervision (*n*=163)	98	20	17	16	47	8

Note: Categories are <u>not</u> mutually exclusive (i.e., respondent's clinical supervisor might be both a line manager and a senior worker)

Table 7: Workers receiving individual clinical supervision from an external facilitator - Details

	Outside Work Hours?		*Paid for by Agency?*		*Formal. Report Arrangement?*		
	Yes	*No*	*Yes*	*No*	*Yes*	*No*	*Missing Response*
Workers receiving individual clinical supervision from an external facilitator (either paid for by organisation or conducted during work hours) (*n*=47)	9 (19.15%)	38 (80.85%)	32 (68.09%)	15 (31.91%)	9 (19.15%)	37 (78.72%)	1 (2.13%)

G. Profiling workers' experience of facilitated group supervision

Table 8: Facilitated group supervision - How often held, frequencies and percentages

	Weekly	*Fortnightly*	*Monthly*	*5 to 6 Weekly*	*2 Monthly*	*1 to 4 times Yearly*
Workers receiving facilitated group supervision (*n*=69)	4 (5.80%)	8 (11.59%)	42 (60.87%)	3 (4.35%)	8 (11.59%)	4 (5.80%)

Table 9: Facilitated group supervision - Average length of sessions, frequencies and percentages

	Less than 1hr	*1hr*	*90mins*	*2hrs*	*Greater than 2hrs*
Workers receiving facilitated group supervision (*n*=69)	1 (1.45%)	20 (28.99%)	25 (36.23%)	21 (30.43%)	2 (2.90%)

Table 10: Facilitated group clinical supervision - Facilitated by whom, frequencies

	Facilitated Group Supervision Session: Facilitator Type				
	Line Manager	*Senior Worker*	*Clinical Supervisor (special role within the organisation)*	*Outside team (within organisation)*	*External Facilitator*
Workers receiving facilitated group supervision (*n*=69)	15	7	8	8	39

Note: Categories are <u>not</u> mutually exclusive (i.e., respondent's clinical supervisor might be both a line manager and a senior worker)

Table 11: Workers receiving facilitated group supervision from an external facilitator - Details

	Formalised Reporting Arrangement in Place?		
	Yes	*No*	*Missing Response*
Workers receiving facilitated group supervision from someone external to the organisation (n=39)	14 (35.90%)	24 (61.54%)	1 (2.56%)

H. Profiling workers' experience of peer group supervision

Table 12: Peer group supervision - Frequency held, frequencies

	Weekly	*Fortnightly*	*Monthly*	*6 Weekly*	*2 Monthly*	*Twice Yearly*	*Ad hoc / As needs basis*
Workers receiving peer group supervision (*n*=38)	7 (18.42%)	7 (18.42%)	14 (36.84%)	1 (2.63%)	3 (7.89%)	1 (2.63%)	5 (13.16%)

Table 13: Peer group supervision - Average length of sessions, frequencies

	Less than 1hr	*1hr*	*90mins*	*2hrs*	*Greater than 2hrs*	*Other (not specified)*
Workers receiving peer group supervision (*n*=38)	3 (7.89%)	12 (31.58%)	11 (28.95%)	8 (21.05%)	2 (5.26%)	2 (5.26%)

I. Workers audit of organisational factors supporting good clinical supervision

Table 16: Workers' audit of the organisational factors supporting good clinical supervision practice in their agency, frequencies and means

	Ratings Assigned						
	Not at all				*To a large extent*		
	1	*2*	*3*	*4*	*5*	Missing	*M*
Supervision is well understood by people providing supervision to AOD workers in this agency	19 (7.88%)	37 (15.35%)	56 (23.24%)	45 (18.67%)	82 (34.02%)	2 (0.83%)	3.56
Different formats of clinical supervision (eg. individual, group) are offered by this agency	59 (24.48%)	53 (21.99%)	29 (12.03%)	36 (14.94%)	62 (25.73%)	2 (0.83%)	2.95
There is space to reflect on practice in relation to workplace culture, as well as case focused	29 (12.03%)	51 (21.16%)	54 (22.41%)	48 (19.92%)	57 (23.65%)	2 (0.83%)	3.22
Clinical supervision is held regularly in this agency	27 (11.20%)	34 (14.11%)	39 (16.18%)	60 (24.90%)	79 (32.78%)	2 (0.83%)	3.54
Clinical supervision is valued by this agency's management	19 (7.88%)	26 (10.79%)	49 (20.33%)	48 (19.92%)	94 (39%)	5 (2.07%)	3.73
Management in this agency is committed to making supervision happen	22 (9.13%)	36 (14.94%)	51 (21.16%)	45 (18.67%)	84 (34.85%)	3 (1.24%)	3.56
Supervision is well understood by this agency's ***management***	21 (8.71%)	33 (13.69%)	52 (21.58%)	56 (23.24%)	75 (31.12%)	4 (1.66%)	3.55
There is a clear policy on supervision in this agency	39 (16.18%)	46 (19.09%)	52 (21.58%)	43 (17.84%)	53 (21.99%)	8 (3.32%)	3.11
People providing clinical supervision to AOD workers have some formal training in clinical supervision	21 (8.71%)	39 (16.18%)	56 (23.24%)	45 (18.67%)	75 (31.12%)	5 (2.07%)	3.48
Clinical Supervision is documented and formalised	45 (18.67%)	49 (20.33%)	57 (23.65%)	42 (17.43%)	44 (18.26%)	4 (1.66%)	2.96
Sufficient organisational resources and time are devoted to clinical supervision in this agency	36 (14.94%)	58 (24.07%)	47 (19.50%)	37 (15.35%)	57 (23.65%)	6 (2.49%)	3.09
Clinical supervision is well understood by staff in this agency	24 (9.96%)	44 (18.26%)	71 (29.46%)	52 (21.58%)	46 (19.09%)	4 (1.66%)	3.22

J. Workers' audit of organisational factors constraining good clinical supervision

Table 17: Workers' ratings of the extent to which factors in their organisation constrain workers from accessing clinical supervision, frequencies and means.

	Ratings Assigned						
	Not at all				*To a large extent*		
	1	*2*	*3*	*4*	*5*	Missing Response	*M*
Clinical supervision is not offered to Alcohol and Other Drugs workers	134 (55.60%)	33 (13.69%)	38 (15.77%)	6 (2.49%)	20 (8.30%)	10 (4.15%)	1.90
Excessive workload of supervis***ees***	53 (21.99%)	48 (19.92%)	58 (24.07%)	33 (13.69%)	35 (14.52%)	14 (5.81%)	2.78
Limited availability of supervisors	60 (24.90%)	39 (16.18%)	41 (17.01%)	27 (11.20%)	49 (20.33%)	25 (10.37%)	2.84
Direct clinical work is prioritised over clinical supervision by supervis***ees***	47 (19.50%)	31 (12.86%)	62 (25.73%)	45 (18.67%)	40 (16.60%)	16 (6.64%)	3.00
Supervisors' inexperience	75 (31.12%)	38 (15.77%)	61 (25.31%)	29 (12.03%)	23 (9.54%)	15 (6.22%)	2.50
Doesn't meet workers' needs	73 (30.29%)	42 (17.43%)	65 (26.97%)	18 (7.47%)	26 (10.79%)	17 (7.05%)	2.47
Poor relationship with supervisors	101 (41.91%)	48 (19.92%)	52 (21.58%)	10 (4.15%)	16 (6.64%)	14 (5.81%)	2.08
Fear that the content of sessions will be "used against" the workers	97 (40.25%)	42 (17.43%)	40 (16.60%)	13 (5.39%)	32 (13.28%)	17 (7.05%)	2.29
Direct clinical work is prioritised over clinical supervision by supervis***ors***	78 (32.37%)	49 (20.33%)	50 (20.75%)	20 (8.30%)	24 (9.96%)	20 (8.30%)	2.38
Supervisees feel intimidated by supervisors	119 (49.38%)	43 (17.84%)	31 (12.86%)	14 (5.81%)	15 (6.22%)	19 (7.88%)	1.93
The nature of shift work	133 (55.19%)	24 (9.96%)	33 (13.69%)	11 (4.56%)	18 (7.47%)	22 (9.13%)	1.89
Lack of understanding about clinical supervision by supervis***ees***	77 (31.95%)	47 (19.50%)	55 (22.82%)	22 (9.13%)	23 (9.54%)	17 (7.05%)	2.41
Clinical supervision is not considered valuable/worthwhile by the **organisation**	106 (43.98%)	37 (15.35%)	46 (19.09%)	15 (6.22%)	17 (7.05%)	20 (8.30%)	2.10
Supervision is not offered to workers employed under a certain time fraction	133 (55.19%)	30 (12.45%)	30 (12.45%)	6 (2.49%)	22 (9.13%)	20 (8.30%)	1.89
The organisation does not ensure that staff understand what is involved in supervision (e.g. Supervision is not explained at induction, there is a poor or unclear supervision policy)	80 (33.20%)	35 (14.52%)	53 (21.99%)	15 (6.22%)	40 (16.60%)	18 (7.47%)	2.55
Clinical supervision is not considered valuable/worthwhile by the **sector**	88 (36.51%)	29 (12.03%)	64 (26.56%)	15 (6.22%)	24 (9.96%)	21 (8.71%)	2.35

K. Supervision of Supervisors Group Evaluation Form

Supervision of Supervisors (SoS) Group – Evaluation

***Please indicate which SoS group you attended*:**

☐ Barwon Southwest SoS Group

☐ Eastern/Southern Metro SoS Group

☐ Moreland Hall SoS Group

☐ Eastern/Southern Metro SoS Group

Please answer the following questions by circling the number that best represents your experience of the SoS Group. There is space to add suggestions on how to improve the quality of the SoS Group at the end of each section.

1. Facilitation Component	**Strongly Disagree**				**Strongly Agree**
1.1 The facilitated sessions were more useful than unfacilitated sessions	1	2	3	4	5
1.2 The facilitator knew the subject matter well	1	2	3	4	5
1.3 The facilitator ensured that everyone could contribute	1	2	3	4	5
1.4 The facilitator was comfortable working with multiple and divergent perspectives at the same time	1	2	3	4	5

1.5 What needs to change for the facilitation of the SOS Group to better meet your needs?

2. Co-ordination / Group Administration	**Strongly Disagree**				**Strongly Agree**
2.1 The correspondence I received in relation to the SoS group was clear, eg. Emails, phone calls relating to dates, times and topics for groups.	1	2	3	4	5
2.2 The correspondence I received in relation to the SoS group was timely.	1	2	3	4	5

2.3 What needs to change for the co-ordination of the SOS Group to better meet your needs?

3. Frequency / Length of Sessions

	Strongly Disagree				Strongly Agree
3.1 The frequency of the SOS Group sessions met my needs.	1	2	3	4	5
3.2 The length of the SOS Group sessions met my needs.	1	2	3	4	5

3.3 With regards to SoS Group sessions, what frequency or length of time would better meet your needs?

4. Content of Sessions

	Not Useful				Very Useful
4.1 To what extent was the content of the sessions useful and applicable to your work as a Clinical Supervisor?	1	2	3	4	5

4.2 What content needed to change or be covered for the SOS Group to better meet your needs?

5. In Conclusion

5.1 Are you interested in continuing to attend a SOS Group in the future?

5.2 Any further comments or feedback?