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Boundaries and responsibilities in clinical supervision

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INTRODUCTION

Anyone who has ever asked a good friend to listen while they divulge a pressing problem will have some idea of the benefits of being a clinical supervisee. Hopefully, their friend will have been attentive, concerned and, possibly, even constructively helpful. The person with the problem may have been given ‘food-for-thought’ and now see their difficulty from a changed, more positive perspective.

They may be encouraged, enlightened and enriched with new insights!

We would, surely, all want a friend like that! A friend who knew how to listen without missing the important bits, how to offer advice only when it was asked for — and then only if it was considered totally necessary; how to keep the conversation on the right track, without veering off on irrelevant tangents; how to avoid dominating the discussion with their own issues; how to bring the conversation to a controlled close; how to prevent being interrupted by the mobile phone playing The Entertainer; and especially, a friend who didn’t have to leave right in the middle of the most important part of what you had to say, because the children were due to be collected from school.

Our friends want to do their very best for us. Often, though, there are limits to what they can do, paradoxically, because there are often no limits on the way that they do it. Friends rarely say: ‘I’ve got exactly 20 minutes to talk to you’ or ‘I’ll turn off the phone’ or ‘let’s go for a coffee, but only if there is no one else in the café’ or ‘come and see me every other Tuesday at 4 o’clock’. The free-and-easy approach that our friends may adopt could very well result in us getting exactly the help we want, or it might leave us feeling pleased with our friend for offering — and trying — to do something for us, but also somewhat frustrated and with a sense that our business is still ‘unfinished’.

Meeting with your clinical supervisor is not the same as talking to a friend. While it could well be a friendly encounter, there are good reasons why clinical
supervisors should aim to do the very things that friends would never dream of doing. They should limit what they can do, and when they can do it. If clinical supervisors want to be more than a friend to their supervisees, they need to do what friends will never do to us — impose limits on their interactions with supervisees. However, in clinical supervision, limits are important and, when used carefully, will serve to enhance the quality of the experience.

A useful adage for clinical supervision might therefore be:

Less is more and more-or-less is not good enough!

Just like a house, any clinical supervision arrangement is likely to collapse very quickly without a strong foundation to support it. Without a carefully considered infrastructure — which includes agreed roles, responsibilities, boundaries and a contract that confirms all of those factors — clinical supervision runs the risk of becoming a friendly chat that can leave the supervisee feeling un-heard, un-helped and even more confused and frustrated than ever before. It is essential that the clinical supervisor gives a great deal of attention to designing and building the infrastructure to his work with a new supervisee, before the supervision work begins in earnest.

- How many of you reading this are currently engaged in clinical supervision without having negotiated any agreement or set boundaries beforehand with your clinical supervisor?
- What might be the consequences of you continuing in clinical supervision without having negotiated any agreement or set boundaries beforehand with your clinical supervisor?

Boundaries bring an element of consistency to the clinical supervision process. In my view, this leads to another very important reason for applying boundaries to a clinical supervision arrangement, and it is this:


Unless the clinical supervision arrangements are maintained consistently, it will be very difficult for both parties, and for the supervisee in particular, to begin to feel safe and ‘trust’ within the professional relationship. As with most relationships, personal or professional, a degree of trust is required in order to allow rapport to develop. It is the rapport — a connection or bond — between the participants that allows for the development of a sense of security and safety, and an open and honest exchange of views and ideas. It is only when both parties in the supervisory arrangement feel that the situation is safe enough for them to be as open, honest and as frank as possible that they will really begin to work at their best, together.

For any clinical supervision arrangement to be sustained in practice, boundaries and responsibilities will need to be discussed and agreed before the supervision begins in earnest, and outlined in a way that is meaningful and easily understandable. The main elements of any supervisory agreement will then form the basis of what is called The Clinical Supervision Contract. Most clinical supervision contracts are written down and signed, although some supervisors may prefer to use a verbal contract.

This rest of this chapter will contain a discussion of the basic components of a clinical supervision infrastructure, including the necessary boundaries that might be set in place and the roles and responsibilities of both the supervisee and the clinical supervisor. I will finish by outlining some of the ways in which clinical supervisors might prepare and use a clinical supervision contract.

THE BOUNDARIES OF CLINICAL SUPERVISION

Boundaries are everywhere in everyday life. We are aware of them every time we fly to another country for a holiday or when our child’s ball flies across the fence into next door’s garden. In sport, the boundary lines mark out the area into which the play must be confined. Cross those lines and the game stops. It is worth considering that even the most fervent soccer fan will accept that a goal does not count if a player in his team was ‘offside’ at the time. In clinical supervision boundaries are used to indicate where we are (metaphorically), how and where the work will be carried out and what is considered to be ‘fair play’ and what is ‘offside’.

Herd (2004) state that the boundaries of the supervisory relationship are important concerns and that the maintenance of good boundaries between trainees and supervisors is crucial to the integrity of the supervisory relationship. I have described, below, four main boundaries that can be used to build an infrastructure for clinical supervision. I refer to these as the boundaries of: Relationship; Content; Time; Space and Confidentiality. Each of these boundaries has, within it, a sub-set of parameters that are used by the clinical supervisor and supervisee to determine the limits within which they can operate.

The first meeting

During their first meeting, before any proper supervision work has begun, both parties need to establish enough information to enable them to be sure that they wish to at least begin working together in clinical supervision. My suggestion would be to set such a meeting up with the sole intention of gathering this information, and establishing the other boundaries to be discussed below, perhaps calling it a ‘pre-contractual meeting’ or similar name to imply that supervision will only start once the basic ground rules have been discussed and agreed.

For each boundary, below, I have raised a series of questions that can be used to set these pre-determined limits, and I have, in some cases, made suggestions as to how they might be applied. Final decisions on what are applicable boundaries should be made in agreement by individual supervisors and supervisees, as individual circumstances may have a bearing on the decisions made. It should be remembered, however, that clinical supervision is a professional relationship with the ultimate aim of enhancing the supervisee’s clinical work. If that principle is borne in mind it will also soon become apparent that, in this model at least, the roles and responsibilities of both the clinical supervisor and supervisee are closely intertwined with the various boundaries. By answering the questions below, both parties will not only be setting the limits of their input, but also be defining why they are participating, what they can offer and what they cannot offer.
The boundary of relationship (1)

Before clinical supervisors can feel comfortable enough to work with their supervisors, they need to have some sense of who they are speaking to. And, before going any further, I feel that it is important to state the obvious — supervisors are allowed to ask questions. Unfortunately, while it may be a perfectly reasonable statement, it is not uncommon for both participants to assume that only the clinical supervisor should be asking questions. In many supervision arrangements it is often an implicit assumption that the clinical supervisor is automatically in a ‘one-up position’ in relation to the supervisee — perhaps due to a more senior professional standing — and is the only one allowed to ask questions about professional experience and expertise.

I totally disagree with this premise; I would go further and state that not only are supervisees allowed to ask pertinent questions of the clinical supervisor, but also that they should be encouraged to use those questions as the basis for a decision on whether they wish to continue working with that particular clinical supervisor, in the future.

What sorts of important information might the supervisee need to obtain from their clinical supervisor before agreeing the supervisory relationship?

- Who is the clinical supervisor?
- What is the clinical supervisor’s experience of clinical supervision for healthcare workers?
- What is the clinical supervisor’s specialist area(s) of clinical experience and expertise?
- What does the clinical supervisor expect from the supervisee in relation to the clinical supervision?

I have listed some typical questions that the supervisee might ask, together with an outline of the information that can be gleaned from asking them, in Box 3.1.

BOX 3.1

**Information for the supervisee to gather: Who is the clinical supervisor?**

- What is your name (what would you like me to call you)?
- Where do you work and what do you do there?
- How long have you been in your current post and where else have you worked recently that might have given you experience relevant to your supervision of me?
- What do you think that clinical supervision is about?
- How much experience do you have of supervising people in my clinical field?
- Do you prefer any particular model or style of clinical supervision?
- Do you have any specific training in clinical supervision?
- What would be the minimum length of time that you could reasonably commit to supervising me?

The answers given to such questions will be very useful in allowing the supervisee to gain a greater understanding of the clinical supervisor. The clinical supervisor’s experience and knowledge (both clinical and supervisory) and their particular way of working might be apparent not only in the answers themselves, but in the way they are given. Similarly, the observant supervisee may be able to glean a sense of whether the clinical supervisor is someone who is seriously interested in the process of clinical supervision and committed to supervising them.

Before the end of the first meeting, the clinical supervisor should also have gathered enough information to feel reasonably certain that they understand at least something of the following:

- Who is the supervisee?
- What does the supervisee expect to gain from being supervised?
- Why does the supervisee want supervision now?

If they are to answer these key questions fully, the clinical supervisor will need to seek answers to a range of equally pertinent questions. I have listed some typical questions that the clinical supervisor might ask in Box 3.2.

BOX 3.2

**Information for the clinical supervisor to gather: Who is the clinical supervisee?**

- What is your name (what would you like me to call you)?
- Where do you work and what do you do there?
- What other clinical experience do you have?
- Have you been supervised previously?
- Why have you chosen me for your clinical supervisor?

The answers that the supervisee gives to the questions will be very helpful in allowing the clinical supervisor to understand a number of things about the supervisee, including their current level of clinical experience and — consequently — whether they are appropriately qualified and experienced enough to supervise them. The clinical supervisor may also find it helpful — and possibly enlightening — to have a sense of what the supervisee expects to get out of the process of clinical supervision, both specifically and generally, and why the supervisee has chosen them. Answers to this question might range from an unrealistic, idealized view of the clinical supervisor, at one extreme, to an apathetic, ‘stuck-for-choice’ response, at the other extreme. The clinical supervisor is likely to be encouraged by a more balanced and well-considered answer than either of those.

The boundary of content

The boundary of content, to use a sporting analogy, is used to determine when the supervisee ‘balls’ it in — and out — of ‘play’. Within this boundary are contained all the issues that will be considered ‘fair game’ for the supervisory process. Once the clinical supervisor and supervisee discuss and agree what can be brought to supervision, they will know, by omission, those areas that cannot be considered. And it should be remembered that this boundary applies to both parties.
It would be very tempting to see clinical supervision as your own personal space, in which you can talk about whatever you like: holidays; relationship problems; changing physical appearance; application for another healthcare post, all spring to mind as potential ‘grist for the mill’.

The short answer is: any topic that has a direct connection to my being a healthcare professional. Some topics may be more obvious than others and present themselves more readily to the clinical supervisor. Talking about a television drama to my clinical supervisor might seem like a pointless and time-wasting exercise, but what if it featured a character that reminded me of a client that I am working with, and had triggered off several new ideas about my work with that person? It might suddenly become relevant and a new source of information to assist the supervisory process.

Jones (2001) feels that clinical supervision involves establishing professional relationships that are concerned with safe and effective (clinical) practice. He states that it is important that clinical supervisors and supervisees are able to work together constructively and he goes on to say that clinical supervisors and supervisees should consider their roles and responsibilities outside of supervision and how these might influence the supervision relationship.

Hawkins and Shohet (1989:53) have described four main elements involved in clinical supervision (see Box 3.3). Although most clients never attend supervision with the supervisee, these four elements will always be present, either in a real and tangible way, or in some other way — usually through talking, thinking and feeling something about them. That said, I have, in the past, been involved in ‘live’ client-present clinical supervision where the client has listened to the clinical supervisor and supervisee discuss the clinical assessment. The clinical supervisor has a responsibility for guiding the supervisee toward thinking about the client and helping to maintain a connection between the supervisee, the client, the working environment and the clinical situation.

**BOX 3.3**

**The key elements in clinical supervision**

- The clinical supervisor
- The supervisee
- The client (or the work, generally, being undertaken)
- A work context

An essential responsibility, within the boundary of content, is for the clinical supervisor to decide if they are up to the task of offering the supervisee what they are expecting to get from supervision. The clinical supervisor needs to consider if they have the appropriate clinical experience and professional background to match with the supervisee's own background, professional orientation and level of experience. They also need to consider if their personal style of supervision — the models they use, and their theoretical orientation — fits the needs of that particular supervisee. Relevant questions that the clinical supervisor might ask the supervisee are outlined in Box 3.4. Some psychological frameworks are discussed in Chapter 5.

It is not enough for supervisors to assume that they will be able to offer their own particular brand of supervision to every supervisee they meet.

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**The boundary of relationship (2)**

In an ideal healthcare world, the clinical supervisor and supervisee would not meet outside of the carefully pre-arranged time of the supervision session itself. They would not debate the best course of action for a new client at a case conference, overhear each other's conversations in the dining room or even bump into each other at the local pub. In an ideal world, both parties would not know each other outside the confines of the clinical supervision room, and the supervision process itself would occur in a pure form, free from the intrusive clutter of the real world and unencumbered by embarrassment, pride and concerns about being seen to be 'good enough'.

But, things are different in the real world. Not only do clinical supervisors and supervisees often have professional (and possibly personal) contact with each other outside supervision, one may even be working closely with the other — and even have managerial responsibility for them. If supervision is to be practised in a way that allows both parties — and in this case, especially the supervisee — to feel relaxed and safe about the process, I suggest that close attention should be given to applying the ‘boundary of relationship’.

One way of thinking about this boundary is to see it as a guide to what each person can expect from the other, and also what they cannot expect. A good starting point for deciding this is to refer back to the boundary of content, above. By applying the boundary of content, it is impossible for the clinical supervisor and supervisee to discuss anything that is not, in some way, related to the supervisee's clinical practice. So, with this parameter in place, it becomes easier for the clinical supervisor to decide what can (and cannot) be offered to the supervisee.

The clinical supervisor's responsibility here is to ensure that only clinical supervision is offered in the clinical supervision session. Idle chat is not appropriate; neither is gossip, managerial supervision or therapy.

If the supervisee wants to talk about going on holiday, for example, the clinical supervisor might ask questions like: How long will you be away? What affects will this have on your clients? Will you need to ask someone to cover your caseload? What do you feel about leaving your work behind you? All of these questions are designed to assist the supervisee in thinking about the specific relationship between the holiday and the clinical work. However, the clinical supervisor should be discouraged from asking: Did you get a good deal on the flights? Are you going with your partner? Have you been there before? Do you like Italian food? Those questions have nothing to do with the clinical work of
the supervisee and take the conversation down a particularly 'chatty' and an un-supervisory road. While supervision might be carried out in a friendly manner, the clinical supervisor has a responsibility to ensure that the supervision process does not become simply a 'chat' between 'friends'. Supervisors should be constantly alert to when the conversation is drifting away from the central focus, of the supervisee's work, and do all they can to bring it back.

If the supervisee begins to talk about a personal relationship difficulty or other domestic problems — perhaps issues about bringing up their children — the clinical supervisor's responsibility is, once again, to make the connection between the material presented and its bearing on the supervisee's clinical work. If it has no bearing on the clinical work, the supervisee should be, gently, encouraged to find another forum for working on those issues. There may be other decisions to make regarding issues that are obviously very important to the supervisee, but which have no direct relation to their clinical work. As tempting as it might be, especially for practitioners working within the mental health field, supervisors should not allow themselves to be drawn into becoming the supervisee's therapist, counsellor or 'agony aunt'.

However, there may be a pressing issue for the supervisee that is hard to ignore because it keeps reoccurring, but which does not have a 'work context', and therefore clearly sits outside this boundary. In that case, the clinical supervisor has a responsibility to bring attention to it and, as carefully as possible, suggest that the supervisee might consider seeking professional counselling or some other appropriate form of help with the difficulty.

In the previous edition of this book, a number of other erroneous models of supervision, arising out of the clinical supervisor's lack of understanding of — and preparation for — the role, were described (Driscoll 2000:67, Box 3.3). These include:

- The Road Works Model, where the clinical supervisor tells the supervisee which direction to take in their practice;
- The Firefighter Model, which has the clinical supervisor attempting to dampen down the metaphorical 'smouldering fires' that occasionally flare up in practice; and
- The Great Pretender Model, in which the clinical supervisor avoids confrontational issues with the supervisee, and gives the impression that everything in the supervisory garden is rosy — all of the time.

These practices, and other equally unhelpful ones outlined by Driscoll, are not conducive to the facilitation of successful clinical supervision and should be avoided at all costs.

In some healthcare settings, the organizational situation may demand that the clinical supervisor is also managerially responsible for the supervisee. As a clinical supervision purist I am not in favour of this arrangement, and would strongly discourage it, as it has the potential to cause confusion and consternation for both parties. I am aware of more than one supervisee who has become disenchanted with the process, very quickly, due to the clinical supervisor's insistence on talking about duty rosters, overtime, holiday cover and even raising professional conduct and disciplinary issues in what should be a space for thinking solely about the supervisee's clinical work.

The confusion between clinical supervision and managerial supervision is, in my view, probably the single most important reason why clinical supervision fails to become fully implemented within some healthcare organizations and a key reason, frequently cited by supervisees, for personal dissatisfaction with the process. Some healthcare line managers who provide clinical supervision for their teams are — or at least, believe they are — able to 'switch' from one role to the other — and back again — with consummate ease. I know of one line manager who talks to supervisees about 'taking my manager's hat off and opening my clinical supervisor's ears'. Such an approach is to be commended, but it does have potential pitfalls:

- Even when the clinical supervisor can genuinely resist the urge to speak like the supervisee's line manager, they may still think like a line manager — and this will not be lost on the supervisee.
- Many supervisees will be extremely uncomfortable about bringing anything to supervision that might cause their clinical supervisor/manager to see them in 'a bad light'.
- The supervisee has to think to the future and their career development. There are promotions, references and annual performance reviews to consider.
- The anxiety surrounding giving a good impression — or, at least, not giving a bad one — to the 'boss' can be so stifling as to render supervisees virtually speechless when faced with their clinical supervisor/manager.

For me, the notion of a solid structure — or framework — within which to practise clinical supervision is of paramount importance. Without such a structure, supervision would be chaotic and confusing, to say the least. When we consider the key elements that go to make up this structure, the boundary of relationship has to be seen as one of the most vital. An understanding of it ensures that both parties are clear about their individual roles and responsibilities within the supervisory process, and — as importantly — what they are not expected to do. In Box 3.5, 1 have outlined what the clinical supervisor might do — and not do — with the supervisee to help reinforce the boundary of relationship.

**BOX 3.5 Some ways to maintain the boundary of relationship**

Clinical supervisors should encourage supervisees to only discuss:
- Anything that is directly related, or connected to, the supervisee's clinical work with clients, patients or colleagues or the clinical work in general.

The clinical supervision process should not contain elements of:
- A friendly chat
- Gossip

During a clinical supervision session it is not appropriate for supervisors to act out the role(s) of:
- Therapist
- Counsellor
- Agony aunt
- Line manager
In the next section, I will look at another fundamental boundary of clinical supervision, that of time, and how it might be used most effectively.

The boundary of time

Many sporting events start — and stop — when the referee blows his whistle and last precisely as long as is stipulated by the rules. The venue is always fixed well in advance and there are a pre-determined number of matches in a ‘season’ or cup competition. While it might be disadvantageous to see clinical supervision as a competitive ‘sport’, some of the same principles apply to arranging a meeting between clinical supervisor and supervisee.

Applying the boundary of time to a clinical supervision contract allows both the supervisee and supervisee to make, in agreement between themselves, important decisions about the venue, frequency and duration for the supervision work. Without this important ‘boundary’, any supervision arrangement runs the risk of becoming disorganized, disjointed and very disagreeable.

In order to apply the boundary of time appropriately, I suggest that the clinical supervisor and the supervisee discuss and then answer the questions below, in a way that is — as far as possible — appropriate to, and manageable by, both of them. It would be unwise to propose that only the clinical supervisor’s needs are to be taken into consideration when setting the boundary of time. If the supervisee feels pressured into agreeing to an arrangement that is unsuitable for them, the supervision arrangement is likely to break down quickly and, possibly, irreparably. Some key questions to consider regarding the boundary of time can be summarized as:

- When (and where) will each clinical supervision session take place?
- How often and for how long?
- How many sessions?
- How long will each session last?

When (and where) will each clinical supervision session take place?

The clinical supervisor and supervisee should try, as far as possible, to arrange a regular time to meet. If the time for each session can be agreed in advance, even for only a few sessions at a time, it will serve the purpose of allowing the supervisee to feel more supported and secure in their supervision.

Similarly, the place for each session should be agreed in advance and adhered to as far as possible, for as long as possible. If either party wants to change the time of the meeting, it should be done as far in advance as possible.

How often and for how long?

The questions of how frequently clinical supervision session should occur, and how long each session should last, are crucial to the overall success of the experience. The answers will often depend on a number of factors including: organizational constraints; the amount of clinical work each supervisee is bringing; and whether the supervisee will be seen alone or in a group. Generally, consideration of the following points may be useful when planning the length and frequency of supervision sessions with a supervisee:

- The amount and intensity of the supervisee’s clinical work.
- The availability of the clinical supervisor.
- The constraints and existing policies of the organization.

- How will you find the time for regular and formalized clinical supervision in busy practice?
- What might be the consequences of:
  a) doing so, and
  b) not doing so?

How many sessions?

There are few standard ‘bench-marks’ in terms of clinical supervision session frequency. One model that exists, from the practice of psychoanalysis, is to halve the number of hours spent seeing clients (or patients) and to spend that time in supervision. This usually requires a weekly attendance at clinical supervision. For many practitioners, however, especially those in NHS settings, this is a totally impractical suggestion.

As a starting point, I would suggest holding clinical supervision sessions every four weeks. Some healthcare workers may prefer a shorter frequency (perhaps meeting fortnightly) and some, either by necessity or through choice, may desire even longer gaps between sessions.

Winstanley and White (2003) conducted a validation study of the Manchester Clinical Supervision Scale and recommended that supervision sessions should be monthly or bi-monthly in frequency.

How long will each session last?

As with the frequency of sessions, the length of each clinical supervision session must be agreed at the first meeting between clinical supervisor and supervisee and before the work ‘proper’ begins. Once these times have been agreed, it is the responsibility of both parties to ensure that it is applied to each and every subsequent clinical supervision session.

A popular time, per individual clinical supervision session for healthcare workers, seems to be forty-five minutes. Some healthcare workers trained or training in psychotherapy prefer the so-called psychoanalytic hour, which lasts, somewhat confusingly, for fifty minutes. It is so-called because some therapists with large caseloads, and a requirement to schedule several patients ‘back-to-back’ in any one day, find it beneficial to leave ten minutes or so between appointments for ‘thinking time’ and for recording the session. Winstanley and White (2003) suggest that clinical supervision sessions should last for one hour, and that they could be extended by a further thirty minutes for community practitioners. Sloan (2003) recommends that perhaps the nursing profession needs to consider establishing a minimum amount of supervision for its practitioners. This would
appear to be a suggestion that would be appropriate for all healthcare professionals to consider. Sloan also recommends negotiating a protocol for cancellations and a procedure for contacting the clinical supervisor in an emergency situation.

Both the clinical supervisor and supervisee should try not to let clinical supervision sessions overrun and do what they can to avoid starting late. An important responsibility for the clinical supervisor is to ensure that the session is gently, but firmly, ended as close to the agreed time as possible.

A useful strategy for good time-keeping in clinical supervision sessions is to keep a clock or watch in sight during the session, perhaps by taking off a wrist-watch and putting it on the desk. The clinical supervisor may wish to announce the amount of time left, as the end of the session approaches, by saying something like, 'we have got ten minutes left, is there anything else you would like to say that you haven't already mentioned?' This can have the effect of helping the supervisee to consolidate their thoughts, which will assist in bringing the session to an orderly and satisfying conclusion.

The boundary of space

When thinking about the boundary of time, it is important to consider the associated concept of the boundary of space. I use this term to refer to the environment within which the time will be spent. This is about not only the physical space (the room itself, and its location) but also the quality of that space, and the potential of it to promote a high standard of clinical supervision work. It is a responsibility of the supervisor to consider the location of the room itself, and its suitability to the task of supervision.

The questions below are raised with the intention of assisting clinical supervisors in their selection of a suitable venue. Issues concerning the location of the room, whose room it is, its size and furniture and the potential for disturbance when in the room can be crucial to the perceived quality of the supervision process and should not be considered as insignificant to the planning process. Some key questions to consider regarding the boundary of space can be summarized as:

- Where will clinical supervision happen?
- Finding a room.
- Can you eliminate or reduce the prospect of interruption?

Where will clinical supervision happen?

The question of where the supervision will take place can be addressed from two perspectives. Firstly, is the room on the clinical supervisor's 'patch' or will the clinical supervisor travel to meet the supervisee? Answering this question automatically determines who has responsibility for 'managing' the room; ensuring that it is available at the required times and suitably prepared for each session.

Secondly, the clinical supervisor needs to know whether or not there is enough available space in their office or usual place of work. Also, is where the clinical supervisor regularly works too busy or too noisy to consider making it the venue for supervision? If they usually work in an open-plan office environment, for example, can they find a big enough room to use on a regular basis?

Finding a room

Can you have the same room at the same time on a regular basis or will you need to book different ones? Having to book rooms for each separate session can lead to confusion and disruption of the sessions, if it is not properly managed. Supervisors need to feel that they are being attended to by the clinical supervisor and that their needs are paramount, at least for the time set aside for their clinical supervision.

If it is necessary to book different rooms for each supervision session, try to do it for the whole year, or another considerable 'block' of time, and not from one session to another. Giving this block of dates to your supervisee, in order that she knows where she will be several weeks in advance, can go a long way to establishing a sense of containment and assurance in the supervisee.

Can you eliminate or reduce the prospect of interruption?

It is important that you do everything possible to ensure that you will not be inappropriately disturbed during the supervision session. Interruptions can come from so many different places, often all at once, that it will be difficult to prepare for all of them, but it is important that, as a clinical supervisor, you consider that for the period of the supervision session it is your number-one priority other, perhaps, than for certain very specific and predetermined events for which you are prepared to be contacted. If there are issues that you consider important enough to be contacted about during supervision sessions, make sure you have a clear idea what these are and tell whoever is likely to contact you well in advance.

The boundary of confidentiality

Another important responsibility that both the clinical supervisor and the supervisee will need to acknowledge is one that I call the boundary of confidentiality. This is potentially the most confusing and misunderstood of all the boundaries of clinical supervision. Although the interest in clinical supervision appears to be flourishing, there has been a concern among some theorists that the potential minefield of legal, accountability and ethical issues may be making the road from passive interest to practice one that is too difficult for many healthcare professionals (Cutcliffe et al 1999).

Supervisees will, no doubt, be concerned that their privacy and rights to confidentiality will be protected during the supervision process. For many supervisees, the supervisory relationship is unlikely to be successful if trust cannot be established early and maintained throughout the duration of the process. However, there is more than just the supervisees' rights to confidentiality to be considered.

There are at least three people involved in the process of clinical supervision: the clinical supervisor; the supervisee; and the client. In some cases, the word 'client' might represent a single person, a couple, a family, a small group of people, or even a large caseload of clients. Everyone that a particular clinical supervision session refers or relates to is entitled to expect that their rights to confidentiality are recognized and, where appropriate, are upheld. For this reason,
many supervisees are encouraged to seek the permission of their client(s) before bringing their work to a clinical supervisor. Some models of clinical supervision (and some clinical supervision contracts) require explicit, often written, permission from clients that their material can be presented to clinical supervisors before the process can begin. Some clinical supervisors, who receive clinical supervision themselves, may also make a similar request of their supervisees. Naturally enough, this stringent requirement can make the whole process so much like a metaphorical minefield that many practitioners don’t even consider it as an option at all. Similarly, the clinical supervisor has a right to expect that any material of a professional or personal nature disclosed to the supervisee may also be treated with respect and held in confidence.

It is also necessary for both the clinical supervisor and the supervisee to understand that it may be appropriate, under certain, previously agreed circumstances, for the confidentiality rule to be broken. At the contracting stage (see below), and before formal clinical supervision begins, a frank discussion should take place about the use of confidentiality within supervision and its inherent limitations. An important responsibility here is for both the clinical supervisor and supervisee to agree on the circumstances under which confidentiality must be broken and how this should be done. Any proposed breach of confidentiality deemed necessary by the supervisor should be discussed in full with the supervisee. What I am referring to, specifically, is the question:

**To what extent will confidentiality be applied and maintained during the clinical supervision process?**

If clinical supervisors say to supervisees ‘everything you tell me will be held in the strictest confidence’, they are likely to be demonstrating a serious lack of understanding of the nature of confidentiality as it applies to their employing organization and possibly also giving the supervisee a false sense of indemnity from professional misconduct. It follows, therefore, that while all supervisees might consider that they are entitled to have any issues raised during clinical supervision protected from being disclosed to anyone outside the process, it is important to consider under what circumstances the clinical supervisor might feel compelled to discuss the supervisee’s work (or behaviour) with a third party. Local healthcare organization policies will, in the first instance, probably be the best guide to making decisions about how far the boundary of confidentiality can extend within any particular clinical supervision arrangement.

As a starting point, clinical supervisors might agree with their supervisees that the boundary of confidentiality could be broken when a matter raised is deemed (by either one of them) to be illegal, in breach of either party’s professional code of conduct or infringes on the employing organization’s disciplinary and/or complaints policies and procedures. In addition, the clinical supervisor and supervisee may wish to agree at the outset of the clinical supervision sessions that the clinical supervisor will advise the supervisee to report the misconduct to the relevant authority himself. It could be agreed, and even included in the supervision contract, that the clinical supervisor will report the matter if she is satisfied that the supervisee has failed to do so themselves, at the earliest opportunity.

The recording of information in a professional healthcare context is another sensitive and often contentious issue that is an integral part of the boundary of confidentiality. The possible legal and ethical implications of making and keeping notes about clinical supervision sessions also need to be given much careful consideration.

Important questions for the clinical supervisor and supervisee to consider include:

- Will the clinical supervision session records be made available to anyone other than the clinical supervisor and supervisee?
- Are there circumstances under which it might be appropriate to show the written record of the clinical supervision sessions to a third party?
- Who else might be entitled to demand to see a written record of the clinical supervision sessions?

Once again, these considerations may appear so off-putting as to scupper the clinical supervision process before it begins. But, if a reliable evaluation system of the process of clinical supervision is to be established, then some sort of record will need be kept. Dimond (1998a) has suggested that the employer resourcing the provision of the clinical supervision should have the right to receive ‘The minimum necessary information for effective monitoring to take place.’ Dimond further cautions nurses considering setting up clinical supervision systems that: ‘If disciplinary proceedings were to be brought against either the clinical supervisor or supervisee then the complete supervision record might have to be made accessible to the employer if it is relevant to an issue arising in the proceedings’ (Dimond 1998a). She adds that if the clinical supervision sessions take place during working hours — which is the most desirable option — then the ownership of the records themselves will reside with the employer. Dimond also states that courts may be in the position of subpoenaing clinical supervision notes, other than when information is exempt from disclosure on grounds of legal professional privilege.

My suggestion for record keeping in clinical supervision (Power 1999) is that the supervisor should keep a very brief record of each supervision session, perhaps detailing the following information:

- The date of the clinical supervision session.
- The time it began.
- The time it ended.
- The names of those attending the clinical supervision session.
- A brief, general, note of the issues raised and discussed.
- The agreed date of the next clinical supervision session.

This record would not contain specific personal information on patients or any other information that could identify individuals. It is rarely necessary, in my experience, for supervisees to use more than a person’s first name, whether that person was a patient, colleague or other associate. I have also managed to retain enough information about the details of the sessions by using code words or letters of the alphabet, in any records that I have kept.

Some clinical supervisors advise their supervisees to keep a diary of reflective practice to which they can refer during clinical supervision sessions. In addition, supervisees may wish to keep reflective diaries specifically referring to the
supervision sessions, as an adjunct to, and a reminder of, the clinical supervision itself. Again, Dimond (1998b) warns that such notes may, in certain circumstances, be required to be made available to the courts. It would be unfortunate though, in my view, if concerns of a legal nature prevented clinical supervisors or supervisees from keeping reasonable records of clinical supervision sessions, as many will value the benefit of a written reminder or aide-mémoire. If supervisors and supervisees take care over what, how and where they record the process of their clinical supervision sessions, it will lead to increased input, and output, and informed evaluation of the whole process.

Similarly, when the boundary of confidentiality is recognized as a tool to enhance the safety and security of the clinical supervision process, rapport is likely to increase and the supervisory process will be enhanced. Once it is fully explored, understood, defined and agreed at the beginning of the clinical supervision process, the boundary of confidentiality will no longer be seen as a threat or a reason to abandon clinical supervision. On the contrary, an awareness of the need for this boundary and an acceptance of it should lead to a more open supervisory relationship in which both participants treat each other as responsible adults.

THE CLINICAL SUPERVISION CONTRACT

Once they have been agreed to by both parties in the clinical supervision process, the ground-rules that I have discussed above will form the basis of the Clinical Supervision Contract. The intention of the contract is to help bind both parties to the arrangements and agreements that have made during the preliminary clinical supervision meeting. The contract is a two-way agreement, which should contain a strong element of joint ownership within it. If the contract is not made with the whole-hearted and equal input of both the clinical supervisor and supervisee any agreements reached are likely to be quickly breached. The process of drawing up the contract will help make the process more defined and explicit for both the clinical supervisor and clinical supervisee, and drawing it up together will strengthen the ownership of it. Wilkin (1998) states that the supervision contract: ‘basically ... encourages a reciprocal relationship-orientated approach, whilst outlining the boundaries and individual responsibilities of both clinical supervisor and supervisee’.

While the clinical supervision contract can be made verbally, many clinical supervisors and their supervisees prefer to have written versions of the contract which is signed by both parties at the first session and copies of which are held by both parties as aide-mémoire. Taking the time to do this can lead to a consolidation of the professional relationship between the clinical supervisor and the supervisee. It also helps to avoid any later confusion around just what was agreed. However, Sloan (2005) states that the drawing up and keeping of documentation is an aspect of clinical supervision that can instil a great deal of anxiety in the supervisee. He feels that this concern often relates to who will keep (and, presumably, view) the documentation, what information will be recorded and for what purpose it will be used.

A typical method of drawing up the clinical supervision contract would be for the clinical supervisor and supervisee to talk about the boundaries in turn and then agree on the extent and limitations of each of them. It might then be a

simple matter of stating in the contract that both parties have agreed to ‘Work within the boundary of relationship as previously discussed’, and so on for each boundary. Other clinical supervisors might prefer to clearly state each element of each boundary on a separate sheet of paper, which both parties would sign. This method, while very thorough, might be considered too time-consuming and unnecessarily faddistic for many participants.

Whatever method of making the contract is chosen, it is vital that both the clinical supervisor and supervisee have discussed, fully understood and agreed on all of the important components. Howard (1997) suggested a twelve-item clinical supervision agreement checklist. This includes the following points:

- Purpose
- Professional disclosure statement
- Practical issues
- Goals
- Methods and evaluation
- Accountability and responsibility
- Confidentiality and documentation
- Dual relationships
- Problem resolution
- Statement of agreement

In Box 3.6, I have offered a template for a clinical supervision contract, which is reasonably typical of those used by a number of healthcare organizations. This contract includes many of the essential components necessary and can be used, at the very least, as a starting point for developing more specific ones. Healthcare professionals should consider what fundamental information they would need to include in contracts for use in their own organizations, and alter the template accordingly. Ultimately this decision needs be made by those healthcare professionals who are leading the development of clinical supervision in the relevant organizations, with very specific reference to the organization and its personnel.

**A template for contracting in clinical supervision**

**ANYTOWN HEALTHCARE N.H.S.TRUST**

**CLINICAL SUPERVISION CONTRACT** (page 1)

**THIS CONTRACT WILL COMPLEMENT THE TRUST POLICY AND GUIDELINES ON CLINICAL SUPERVISION**

**DESIGNATION: Clinical supervisor**

**DESIGNATION: Clinical supervisor**
BOX 3.6 (Cont'd)

VENUE: Interview Room, Health Centre.
TIME/FREQUENCY: Every two weeks, for one hour.
REVIEW OF SUPERVISION:
Every six months, between clinical supervisor and supervisee. New contract to be
signed after the review.

CLINICAL SUPERVISION CONTRACT (page 2)

JOINT RESPONSIBILITIES:
1. To honour the contract.
2. To maintain the boundaries of Relationship; Content; Time; Space and
   Confidentiality, as discussed and agreed to in the preliminary supervision meeting.

CLINICAL SUPERVISOR’S RESPONSIBILITIES:
1. To provide supervision as per policy and guidelines.
2. To record each client discussed in supervision on a recording sheet after each
   session.
3. To record the time and date of each supervision session on a recording sheet
   after the session.

SUPERVISEE’S RESPONSIBILITIES:
1. To accept supervision as per policy and guidelines.
2. To prepare material to be discussed, in advance of the supervision session.
3. To pre-select suitable clients for presentation at the supervision session.

NOTE:
a) Supervision sessions will only be cancelled due to sickness, or if making the
   session becomes impossible for either party.
b) If the need for supervision arises outside contracted sessions, a clinical
   supervisor will accommodate the supervisee as soon as possible for an extra
   session.

NB: The boundaries of confidentiality within supervision are anything that is
illegal, that breaks the individual’s professional code of conduct or infringes
the Anytown Healthcare N.H.S. Trust Disciplinary Policies.

SIGNED:
Clinical Supervisee: __________________________ Date: __________________________
Clinical Supervisor: __________________________ Date: __________________________

On reflection ... chapter summary

- Limits are important in clinical supervision, and serve to enhance the quality of
  the supervisory experience.
- The structure of the clinical supervision process is defined by its various
  boundaries and the limitations of those boundaries.
- The boundaries of clinical supervision include the boundaries of relationship:
  content; time; space; and confidentiality.
- A clinical supervision contract can make the process more explicit.
- Drawing up a contract together can help consolidate the ownership of it.

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