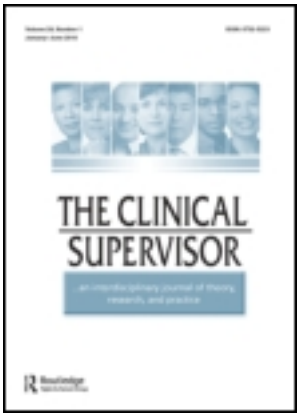

The Clinical Supervisor
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/wcsu20

Interprofessional Clinical Supervision in Mental Health and Addiction: Toward Identifying Common Elements

Marion Bogo [a], Jane Paterson [b], Lea Tufford [a] & Regine King [a]
[a] University of Toronto, Toronto, Ontario, Canada
[b] Centre for Addiction and Mental Health, Toronto, Ontario, Canada

Available online: 09 May 2011

To cite this article: Marion Bogo, Jane Paterson, Lea Tufford & Regine King (2011): Interprofessional Clinical Supervision in Mental Health and Addiction: Toward Identifying Common Elements, The Clinical Supervisor, 30:1, 124-140

To link to this article: http://dx.doi.org/10.1080/07325223.2011.564961

The Clinical Supervisor, 30:124–140, 2011

ISSN: 0732-5223 print/1545-231X online
DOI: 10.1080/07325223.2011.564961

Routledge
Taylor & Francis Group

Interprofessional Clinical Supervision in Mental Health and Addiction: Toward Identifying Common Elements

MARION BOGO
University of Toronto, Toronto, Ontario, Canada

JANE PATERSON
Centre for Addiction and Mental Health, Toronto, Ontario, Canada

LEA TUFFORD and REGINE KING
University of Toronto, Toronto, Ontario, Canada

This study explores the experiences and perceptions of clinicians from a range of professions to articulate general principles for clinical supervision in mental health. Seventy-seven volunteer clinicians participated in 14 focus groups in 2008–2009. They discussed their perceptions about clinical supervision, facilitators, and barriers. Discussions were digitally recorded and transcribed verbatim, and qualitative analytic methods were used to identify themes and exceptions. The study found frontline clinicians identified interacting factors they associated with quality clinical supervision. Themes related to the structure, content, and process of supervision and contained common elements across professions and those that were specific to nursing. Considerable agreement exists regarding principles for interprofessional supervision in mental health; that it is available on a regular and crisis-responsive basis, and that supervisors are expert in clinical interventions for specific populations and have the skills for teaching

This study was funded by The Office of Nursing Practice and Professional Services, Centre for Addiction and Mental Health, and The Social Sciences and Humanities Research Council of Canada Institutional Grant, Factor-Inwentash Faculty of Social Work, University of Toronto. The authors wish to acknowledge The Advanced Practice Nurses/Clinicians Steering Committee, Centre for Addiction and Mental Health, and Ms. Sarah Manson for their assistance with this project.

Address correspondence to Marion Bogo, Factor-Inwentash Faculty of Social Work, University of Toronto, 246 Bloor Street West, Toronto, ON M5S 1A4, Canada. E-mail: marion.bogo@utoronto.ca

and supporting staff. Some nurse participants expressed unique perceptions about clinical supervision based on their professional traditions and approaches, which requires further study before advancing a common model of supervision across professions.

KEYWORDS clinical supervision, interprofessional, organizational change

INTRODUCTION

Clinical supervision is recognized in the mental health literature as contributing to clinicians' professional development and achieving organizations' accountability for ethical and effective practice (Gaitskill & Morley, 2008; Kadushin & Harkness, 2002; Proctor, 1986). When health organizations adopt program management structures, traditional profession-based supervision is no longer available and supervision may be offered by professionals from disciplines other than that of the clinician. While studies of supervision in general have identified its benefits, research has not specifically examined the experiences of frontline clinicians in interprofessional supervision. This article reports on a study that explored clinicians' perceptions of their interprofessional supervision in a program management model in a center for addiction and mental health that is currently implementing a recovery model of clinical practice (Brown, 2001; Drake, Merrens, & Lynde, 2005). Implications for common elements for an approach to clinical supervision across professions are provided.

OUTCOMES OF CLINICAL SUPERVISION

Powell (1991) noted two decades ago that effective supervision affects job retention and turnover, increases job satisfaction, and indirectly promotes a higher quality of patient care. More recent studies continue to propose supervision as important for organizations to achieve best outcomes for clients, improved staff competence, and increased job satisfaction (Arvidsson, Lofgren, & Fridlund, 2001; Kadushin & Harkness, 2002). A substantial amount of theoretical and practice literature in clinical supervision across a number of professions, such as nursing (Butterworth & Faugier, 1992; Cutcliffe, Butterworth, & Proctor, 2001), occupational therapy (Gaitskill & Morley, 2008; Hunter & Blair, 1999), psychology (Bernard & Goodyear, 2009), and social work (Munson, 2002; Shulman, 1993), and the empirical base is also developing.

A recent meta-analysis of 27 studies of supervision in child welfare, social work, and mental health found that supervision contributed to positive worker outcomes through providing task assistance, social and emotional

support, and supervisory interpersonal interaction (MorBarak, Travis, Pyun, & Xie, 2009). Task assistance involved educational activities, providing tangible advice, knowledge, coaching, skills, and solutions for clinicians' practice. Support was related to workers' emotional needs and job-related stress. Interaction referred to clinicians' perceptions of the supervisory relationship and satisfaction. Supervision was found to have beneficial outcomes in increased job satisfaction, organizational commitment, retention, job performance, and psychological well-being. Detrimental outcomes were also found related to intention to leave, turnover, job stress, burnout, and negative psychological well-being such as depression and anxiety. The task-assistance dimension had the strongest link to beneficial work outcomes.

Similar findings emerge from studies specifically in mental health (King, Lloyd, & Holewa, 2008; Strong et al., 2003) and addiction (Eby, McCleese, Owen, Baranik, & Lance, 2006; Knudsen, Ducharme, & Roman, 2008; Powell & Brodsky, 2004). For example, frontline clinicians from various professions in a mental health service in Australia valued supervision for providing professional development and maintaining competence, for providing support, increasing satisfaction and job retention, and decreasing burnout (Strong et al., 2003). Importantly, clinicians found clinical supervision helped preserve profession-specific skills and identity in an interprofessional workplace, especially for new workers. However, supervision practices and availability was highly variable with no organization model or policy, and little time for supervision and training supervisors.

Studies in the United Kingdom found high workload, time management, and lack of resources reported as stressors by nurses, social workers, and occupational therapists (King et al., 2008). After the introduction of a case management model, social workers and occupational therapists related stress to role ambiguity, as they no longer had their specialized roles. Supervision was perceived as protective against burnout. Similarly, researchers found positive benefits of supervision, such as assisting clinicians with the dissonance they experienced between their professional values and the tasks they performed (Taylor & Bentley, 2005).

Regarding addictions, Eby, Burke, and Birkelbach (2006) studied, over five years, the relationship between clinical supervisory experiences and work attitudes and burnout among counselors and, in turn, how burnout relates to employee turnover. These researchers found that the quality of the clinical supervisory relationship is clearly important to counselors. Counselors who have a more favorable view of their clinical supervisor report more job satisfaction, organizational commitment, perceived organizational support, and less perceived role overload and burnout. Similarly, Knudsen, Ducharme, and Roman (2008) found when substance abuse counselors in the United States rated clinical supervision highly this was associated with less intention to leave their jobs, less emotional exhaustion, greater feelings

of autonomy, and higher perception of fairness in decision making in the organization, and in job demands and rewards.

Studies within the addictions field have also surveyed counselors' views of their current and preferred supervisory experiences. In a national survey of 134 substance abuse counselors in the United States, respondents reported that their current supervision experiences included a high level of support and encouragement, and the provision of information by their supervisors (Culbreth, 1999). Primary topics in supervision included selecting treatment strategies, discussing client progress, and the formation of a diagnosis. It is interesting to note that the former experiences of support, encouragement, and provision of information also formed the preferred model of supervision counselors desired. Counselor preferences diverged in the area of supervisory approaches and included a preference for either co-therapy with the supervisor or live observation with the supervisor in session as opposed to the review of audio-video tapes and use of one-way mirrors. Overall, counselors indicated a high level of satisfaction with their supervisory experiences.

DIMENSIONS OF CLINICAL SUPERVISION

Supervision from members of one's own profession varies in mental health and addictions, and in various regions. For example, in Canada when restructuring in health organizations includes adoption of program management and elimination of profession-based departments, frontline clinicians no longer receive profession-specific supervision (Globerman, White, & McDonald, 2002). However, clinical supervision within the addictions field is mandatory in some states in the United States, given that state-certified, recovering, substance abuse counselors with high school diplomas may work in tandem with non-recovering substance abuse counselors holding graduate degrees (Culbreth & Borders, 1999).

A review of studies of supervision in nursing and social work (the two largest disciplines in the center where this research was undertaken) found numerous similarly valued characteristics, such as availability, positive relationships, mutual communication, support, and delegating responsibility (Bogo & McKnight, 2005; Jones, 2005). Also valued are clinical supervisors who have expertise, knowledge about tasks, are skillful, and are able to provide instrumental support (Begat, Severinsson, & Bergen, 1997; Himle, Jayaratne, & Thyness, 1989; Hykras, 2006).

Differences in the social work and nursing literature, however, were also found, based on traditions and practices of clinical supervision in each profession. In social work, supervision is a valued tradition perceived as ensuring agencies' accountability for effective service through providing professional development for social workers (Kadushin & Harkness, 2002).

Perspectives on supervision vary in the nursing literature; in North America supervision has an administrative flavor (Cutcliffe, 2005) at times viewed as hierarchical and punitive, whereas in some European countries the emphasis is on professional development through reflective practice and support (Gilmore, 2001; Jones, 2005).

In conclusion, profession-specific theoretical and supervisory approaches exist and evidence that supervision is an important factor in achieving positive worker outcomes is increasing. There is less clarity, however, regarding perceptions of various mental health professions when supervision is offered in an interprofessional context. The term *interprofessional* reflects an assumption in the literature that collaboration among professions leads to improved client care. Collaboration is based on an understanding of one another's contributions and an integration of their respective perspectives (D'Amour, Ferrada-Videla, Rodriguez, & Beaulieu, 2005). In the interest of developing effective supervision, it is important to examine the experiences and perceptions of clinicians from a range of professions to determine whether common elements for a generic mental health supervisory model can be articulated and offered among professions.

METHODOLOGY

This study was conducted in a center for addictions and mental health which had been created through the amalgamation of two addiction services and two mental health facilities in Toronto, a large urban city. The new organization is Canada's largest teaching hospital, as well as one of the world's leading research centers in addiction and mental health (Centre for Addiction and Mental Health [CAMH] Strategic Plan, 2006–2009). The organization's clients include individuals with serious and persistent mental illness and substance use, as well as a large forensic population. Service is offered in both inpatient units and outpatient clinics. With amalgamation, profession-based departments were replaced with a program management structure. Clinical supervision was now offered by the program manager or by specially designated advanced practice nurses and clinicians from various professions.

Clinical supervision for all frontline clinicians was seen by senior administration as a practice to improve patient outcomes. What was not known was the way in which this supervision was being enacted and received and implications of receiving supervision from a professional in a field different from one's own profession. The aim was to elicit insights for an approach to interprofessional supervision. Therefore, an exploratory qualitative study was conducted using a form of general qualitative data analysis that draws on some elements of grounded theory methods (Charmaz, 2006; Strauss & Corbin, 1990, 1998). Focus groups were chosen to collect qualitative data about the specific topic of concern to the study. Qualitative researchers view

focus groups as an efficient way to obtain data from individuals with similar interests and concerns. Group discussion can stimulate reflection, in this case about clinical supervision (Cresswell, 1998; Krueger & Casey, 2000).

Participants

Since most clinicians in the center were expected to now be involved in supervision, perhaps interprofessional supervision, the researchers initially sought to enroll clinicians from all professions, especially those with greatest representation at the center (nursing and social work), and clinicians of different ages, gender, and work experience. Psychiatrists were the only profession not recruited, as they do not participate in supervision through the progam management structure. Clinicians spontaneously expressed interest in the topic and were eager to contribute their opinions to the researchers. Hence, rather than limit the number of participants at the outset of the project, the researchers sent a general announcement in 2008–2009 about the study through e-mail and also through presentations at team and discipline meetings. Focus groups were scheduled periodically and participants self-selected when they would attend.

Approval was obtained from the Research Ethics Board at the center and written informed consent was given by all participants at the beginning of each focus group. From a population of approximately 611 frontline clinicians, 77 clinicians from a range of professions participated in 14 focus groups of approximately 2 hours. (See Table 1.) Fifteen clinicians worked in addictions programs and 62 in mental health programs.

Attendance at the groups ranged from 1 to 13 participants. Fourteen participants (18%) were male and 63 (82%) were female. Four focus groups included clinicians from the same profession in different programs throughout the center, seven groups included clinicians in the same program from different professions, and two groups included clinicians in both the same program and profession.

Supervision received varied for the 77 participating clinicians, with 74% ($N = 57$) receiving supervision. Of the 57 participants reporting receiving

TABLE 1 Professional Affiliation of Participants in the Focus Groups

Profession	Professional population frontline staff	Focus group attendance
Nursing	400	23
Social Work	123	29
Occupational Therapy	30	5
Recreation Therapy	25	10
Case Worker/Child and Youth Worker	31	9
Stress Management Therapy	2	1
Total	611	77

supervision, 63% ($N = 33$) stated that it is scheduled. Formats for supervision include individual, received by 40% ($N = 23$), and group, received by 53% ($N = 30$) (4 participants did not respond). Thirty-eight percent ($N = 21$) reported receiving supervision from a staff member of a profession different from their own.

Data Collection and Analysis

Two members of the research team, doctoral students with experience in mental health and supervision, collected demographic data and information about supervision at the beginning of the focus group. A semi-structured interview guide was used to guide discussion of participants' experiences and perceptions about clinical supervision, facilitating factors, and barriers. Discussions were recorded, transcribed verbatim, and entered into QSR NUD*IST Vivo (1999) software program for data management. Transcripts were anonymized to protect participants' confidentiality.

The researchers conducted seven focus groups consisting of a range of clinicians. In this first stage of coding three of the researchers independently read the same transcripts and developed initial codes for segments of the text (Charmaz, 2006). The researchers then met together and compared these initial codes and began to categorize the data, working iteratively with the transcripts to achieve consistency and resolve discrepancies. Through this process they built conceptual categories for a coding framework. This framework was then used by two researchers to analyze the subsequent transcripts.

During this stage of data analysis, it became apparent that the perceptions of some nurses differed from those of their colleagues, both colleagues from other professions and from nursing. Accordingly, we sought out more nurse participants to enrich the data and elaborate on the emerging category regarding profession-specific alternate views. Despite repeated efforts to increase nurses' participation, the final sample remained small.

Once the remaining transcripts were coded using the conceptual categories, the researchers examined and regrouped some categories to identify and describe themes. Preliminary findings were presented and discussed with a group of advanced practice nurses and clinicians on two occasions.

RESULTS AND ANALYSIS

The data analysis resulted in the emergence of a consistent theme of common elements of quality clinical supervision along with two other themes, one about interprofessional supervision and one about nursing-specific issues.

Quality Clinical Supervision

Interacting factors associated with quality clinical supervision emerged across participants that were related to the structure, content, and process of supervision.

Structure

Some professionals, such as occupational therapists and social workers, received regularly scheduled profession-based supervision prior to organizational restructuring. Drawing on those experiences, they expressed the desire for available, regularly scheduled sessions for systematic case and clinical discussions, and reflection on both positive and negative aspects of their practice. Workload demands and a crisis-oriented attitude were identified as barriers to scheduled supervision.

Participants also noted the importance of having supervision available "when I need it." Ad hoc supervision, referred to as spontaneous, crisis-driven, informal, and "on the fly" occurs when "you are having a lot of struggles" with something that has just occurred. Participants wanted to "just grab [supervisors] and say, look at this, what's happening?"

Content

Participants from a range of professions acknowledged the value of learning new knowledge directly related to increasing their ability to practice more effectively with the specific client population. Committed to improving patient care, they respected knowledgeable and resourceful supervisors who encourage clinicians to "pick up themes and continue to work on them," and offer supervision on treatment models the staff is not expert in but may be useful for patients. Supervision on topics such as safety or self-care was seen as preventive, preparing staff and strengthening their skills.

Also important are opportunities to reflect on their practice, identify "blind spots" and develop their identity as clinicians. As one nurse commented positively, "the supervision approach is more about your feelings, and your style, and what you are doing rather than the focus on planning care for the patient. It's very, very different now." A nurse described working intensively with a "very difficult patient for a matter of months" who asked for a different primary nurse when she was on vacation.

> It was just automatically changed. And I thought, well this is a good experience as far as if there's a relationship difficulty, let's work on it because outside you're working on changing relationships. [The supervisor] asked me how I felt and I thought, somebody asked me how I felt and it wasn't always how the patient was feeling and I thought, this is

> really important because I have a lot of feelings and nobody ever said, how do you feel? And I was able to communicate it and it was a really good experience.

Similarly, social workers and occupational therapists view supervision as an opportunity "to talk about our own struggles as clinicians . . . the counter-transference issues" and "processing of our practice." It has "more to do with me and my capability of providing care for the patient."

Process

Clinicians value an approach that creates a sense of safety in which sensitive matters can be introduced. A focus group of social workers and nurses agreed that in clinical supervision you "allow yourself to be vulnerable about your work, [and] it is really important that a dynamic of trust is present." Safety and trust were perceived as more important than whether the supervisor was from the same profession. A further example of safety was provided by a nurse who discussed her own behavior with a patient as follows: "If I saw somebody else responding that way [I would think that] would be unacceptable." Feeling safe in supervision meant she felt "more free to say anything . . . . A lot of times we base what our feelings are as far as gender, ethnic, diversity . . . and are there any of my beliefs that are more or less affecting the way I'm reacting? So it [safe supervision] really helps me acknowledge what I'm doing."

Feeling accepted and validated was identified as important across professions. Practice in mental health and addiction in this setting is seen as complex with challenging client and environmental problems. Clinicians spoke about feeling overwhelmed, and their uncertainty and "bad feelings" when confronted with a client they feel is challenging. An accepting supervisor helps clinicians reflect on "what you're doing is really great but you could also look at it from this angle."

Participants acknowledged the importance of a reciprocal process; that supervisors ask for feedback about their supervision and encourage clinicians to suggest changes for improvement. When feedback is taken seriously it is evident, as it is used. Reciprocal respectful relationships model a parallel process that clinicians then use with clients.

Participants recommended adapting supervision based on identified needs at different stages in clinicians' careers. New clinicians are fearful of "making a mistake or seeming like you do not know what you are doing or you do not have the right answer." Clinical supervisors can offer support and "walk with you along your journey." This may be a time for profession-specific supervision. Experienced clinicians, new to the organization, need supervision responsive to their expressed needs for assistance. Experienced nurses, social workers, and occupational therapists all identified

that they could benefit from clinical supervision throughout their career, stating "there is always more to learn," and "I can get locked in my perspective and it's always good to have new feedback or new information or new perspectives on things because then it can improve the care that I am providing to clients." Nurses pointed out that their regulatory body standards state that nurses should not perform a task or a skill if they are not comfortable with it and hence as job expectations change and new knowledge is available, clinical supervision is a means for further professional development.

Interprofessional Supervision

Participants had mixed feelings about receiving supervision from professionals in a field different from their own profession. From all professions some participants reflected wistfully on positive experiences of supervision and mentoring prior to program management. Others, however, recalled negatively too much focus on administrative matters and not enough focus on the clinician. Almost universally participants agreed that the key elements of valued supervisors are their clinical expertise and ability to provide new and relevant practice knowledge in a respectful and safe process. These dimensions appeared to override the supervisor's professional affiliation.

Participants identified teams as a central support for practice and when group supervision was provided in teams valued supervisors were those skilled at promoting cohesion, which in turn leads to engaged discussion and problem solving. As a nurse commented, "When we first started a lot of people were silent or they would avoid coming in and now the participation, usually there's a full room for supervision and you get, all the disciplines are involved. And once in a while one of the doctors comes in as well."

While clinicians value supervision from professions other than their own, they also expressed a need to discuss profession-specific issues and learn about new trends. Much of their profession-specific work does not get discussed in interprofessional supervision, as the language and philosophies are different; to understand profession-specific issues lengthy explanations of professional content would be required. Especially where one is the lone member of the profession on the team, professional meetings are important. An occupational therapist commented about a profession-based retreat: "It was the first time on a large scale that I had seen other OTs [with the] same concerns and the same worries and the same problems as I did . . . there are people that I could go to for advice and for guidance." Social workers wanted to "connect [to] social work values and ethics" about client-centered work, especially when they perceived some tension with their program's goals to protect the public. Nurses wanted to be "in touch with nursing-related issues and changes in the profession." Some observed, however, that profession-specific meetings dealt with general issues whereas

supervision in the program dealt with their specific concerns related to daily practice.

Perceptions of Nurses about Clinical Supervision

While nurse participants valued elements in common with other professions, they did express alternate views about autonomy and the place of correction in supervision.

Common elements

Similar to participants from other professions, nurses in general appreciated available, process-oriented supervision offered both regularly and "when I need it." They found interdisciplinary teams "more supportive because you have them around all the time" and teams do not make nurses feel negatively judged. One nurse commented, "I would like other nurses to really know that supervision is a good thing. Because some people really, they think supervision and they feel that they're gonna stand out, they're gonna be criticized for what they say; it's safe to disclose how you're feeling."

Autonomy

Some nurses held quite different perceptions than other nurse participants and those from other professions related to autonomy. The theme expressed was that as professional nurses and members of a regulatory college a nurse is expected to be autonomous and self-reliant. Work is viewed as independently organized and accomplished. As one nurse participant stated, "[I expect to] supervise my own self by following up based on the care plan to see what things are corrected, improved on [based on] what the client's needs are. And if it's something which I think is beyond my scope or not my scope I would bring it forward to other team members [for their help]." This participant explained that the nursing team "are doing the work . . . and know when we need to change . . . we should, we don't always do that, but we should go to each other first . . . and then, when I have to go outside the team then I have to, but . . . first, the immediate [nursing] team that's working with the patients . . . ." The nursing rotational team leader system was noted as a way for the charge nurse to facilitate discussions about the primary care plan. This was seen as supportive, not as supervision.

Correction

A second theme unique to nurses was their fear of correctional supervision. Framed within a hierarchical view of supervision, the request by a supervisor for a meeting with a nurse was seen as likely about punishment, a negative,

a discipline, such as "Okay, what did I do wrong?" Some nurse participants reported receiving more supervision when something has gone wrong, resulting in fear and apprehension when called to meet with a supervisor and surprise when the meeting turns out to be about something positive and receiving praise. These participants recommended supervisors who are available in daily practice to regularly address both positive and negative issues and who build strong interdisciplinary teams that are experienced as more supportive.

Nurses reported similar fears when referring to colleagues who, instead of supporting other nurses on the team, look for errors to report to the regulatory nursing body. One said, "This is the only profession where I really see it ever done where we kind of eat our own rather than being supportive of each other if something has happened . . . if we can get cohesiveness in the [nursing] team-where it's not blaming. It's supporting and building up if somebody needs a little bit of help, whether it's taking them aside or getting an in-service where we all can learn."

Connected to this theme was the negative perception about receiving supervision from the person one reports to, with the sentiment that one is not as free to be open with clinical issues one is struggling with because of the fear of negative performance evaluation.

DISCUSSION

Program management in mental health organizations and community settings has resulted in clinicians receiving supervision from supervisors whose professional discipline may differ from the clinician's. Concerns have been raised about the impact of interprofessional supervision on maintenance of professional standards and identity as well as quality of care for clients (Berger & Mizrahi, 2001). This study found, however, that supportive, clinician-focused, content-oriented supervision offered by knowledgeable and skilled clinical experts was perceived as beneficial, regardless of the supervisor's profession. Supervisors' expertise regarding the client population and effective interventions, as well as their ability to promote learning and a sense of competence for clinicians, emerged as highly valued.

This finding is of importance in the context of promoting the use of evidence-based practice. Clinical research in mental health and addictions has produced numerous studies demonstrating effective models for a range of problems. For example, the Addiction Technology Transfer Centers (ATTC) located throughout the United States have been at the forefront of knowledge production for professionals in the addictions field. Resources focusing on the implementation of evidence-based interventions in substance treatment settings (Jones & Williams, 2009), Motivational Interviewing strategies (Miller & Rollnick, 2002), and treatment for co-occurring

psychiatric and substance abuse disorders (Pacific Southwest ATTC, 2008) are but a sampling of the rich reservoir of knowledge for frontline professionals and clinical supervisors. Informing the production of evidence-based practice of the ATTCs is the Clinical Trials Network of the National Institute on Drug Abuse, which focuses on improving the quality of drug abuse treatment through the study of behavioral and pharmacological treatment interventions in multisite clinical trials and the dissemination of research results to physicians, clinicians, and patients (see http://www.drugabuse.gov/CTN/home.html).

Organizations offer a variety of educational activities to transfer this new knowledge into practice. Ongoing supervision of new models of care is likely a crucial mechanism to ensure that these new practices will be implemented in an effective manner. For example, the literature outlines the common features of evidence-based recovery-oriented practices in mental health (Brown, 2001; Drake et al., 2005). It appears from this study that these mental health professionals give priority to supervisors who are able to provide leadership in teaching and mentoring about expert and new approaches that yield positive outcomes for clients. This supervisor capability may override the professional affiliation of the supervisor.

Clinicians described a range of qualities and competencies of supervisors and processes for valued supervision. In this respect this study provides additional data to support empirical findings about the importance and dimensions of supervision from the perspective of frontline clinicians in a variety of health professions (Bogo & McKnight, 2005; Cutcliffe et al., 2001; Cutcliffe & Hyrkas, 2006; Gaitskill & Morley, 2008; MorBarak et al.,2009) as well as confirms "practice wisdom" articulated by experienced clinical supervisors (Bindseil et al., 2008). One can conclude that in general, a core set of common elements for supervision exists.

However, some concerns must be taken into account before one can recommend a common model of supervision for all professions in mental health and addictions. The first concern relates to new graduates. Students in their respective professional educational programs receive supervision in clinical practice from senior clinicians in their profession. As new employees in interprofessional teams, these recent graduates must learn to garner support and supervision from professionals whose discipline is different from their own. Recently an increased focus on interprofessional care and education has emerged. This new development may prepare clinicians who are open and receptive to interprofessional supervision. Nevertheless, recent graduates expressed the wish and need for connection to their primary profession. This sentiment is consistent with developmental models of supervision which recognize that individuals progress through beginner, intermediate, and expert stages in their professional education and development and require different supervision strategies in different stages (Stoltenberg &McNeill, 2009). Professional practice leaders in

clinicians' specific profession can also provide orientation, socialization, mentorship, and career guidance, especially in the first few years of a new professional's career. Future research endeavors can develop and compare approaches to clinical supervision that balance uni-professional identification as well as developing competence in new interprofessional approaches specific to populations served.

The second concern identified in this study that presents some challenges for an organizational policy and model of clinical supervision relates to traditions in nursing, including identification as self-regulating professionals. Future research can yield a more complex understanding of the relationship between supervision and professional autonomy so that a truly generic clinical supervision approach for all professions can result.

This study is limited by the self-selected sample and the fact that all participants worked in the same organization. Despite numerous attempts at recruitment of nurses and efforts to schedule meetings at convenient times given work schedules, we had low participation of nurses. Had other participants attended, additional themes may have emerged. Although one limitation of using focus groups can be participants' reluctance to disagree with dominant perspectives, this was not the case, as alternative opinions were expressed. Surprisingly, almost no comment was made about the role of psychiatrists in this mental health setting. In this center in the program management model physicians were rarely the designated team leader. Given their advanced clinical training and experience, and involvement in cutting-edge evidence-based interventions, however, it appears timely to examine whether psychiatrists are exercising clinical leadership in teams, a role that has been an important contribution in the past.

Mental health and addiction services are increasingly held to the standard of the provision of evidence-based treatments. For people with mental health problems, there is often a gap in the services they receive between the practices that have demonstrated effectiveness and everyday clinical practice. Clinicians must endeavor to ensure that the models of treatment they use are grounded in a solid base of evidence. To achieve this standard it is essential for organizations to intentionally support staff with models of clinical supervision that will ensure that practitioners are fully informed, and develop and maintain professional competence.

REFERENCES

Arvidsson, B., Lofgren, H., & Fridlund, B. (2001). Psychiatric nurses' conceptions of how group supervision programme in nursing care influences their professional competence: A 4-year follow-up study. *Journal of Nursing Management*, *9*, 161–171.

Begat, I. B. E., Severinsson, E. I., & Bergen, I. A. (1997). Implementation of clinical supervision in a medical department: Nurses' views of the effects. *Journal of Clinical Nursing*, *6*, 389–394.

Berger, C., & Mizrahi, T. (2001). An evolving paradigm of supervision within the changing health care environment. *Social Work in Health Care*, *32*(4), 1–18.

Bernard, J. M., & Goodyear, R. K. (2009). *Fundamentals of clinical supervision* (4th ed.). Columbus, OH: Pearson.

Bindseil, K., Bogo, M., Godden, T., Herie, M., Ingber, E., King, R., Kitchen, K., Paterson, J., Reyes, M., Rolin-Gilman, C., Ryan, K., Srivasta, R., & Tufford, L. (2008). *Clinical supervision handbook*. Toronto, Ontario, Canada: Centre for Addiction and Mental Health.

Bogo, M., & McKnight, K. (2005). Clinical supervision in social work: A review of the research literature. *The Clinical Supervisor*, *24*(1/2), 49–67.

Brown, C. (Ed.). (2001). *Recovery and wellness: Models of hope and empowerment for people with mental illness*. Binghamton, NY: Haworth Press.

Butterworth, T., & Faugier, J. (Eds.) (1992). *Clinical supervision and mentorship in nursing*. London: Chapman and Hall.

Centre for Addiction and Mental Health (CAMH). (2006). Centre for Addiction and Mental Health Strategic Plan 2006–2009. Toronto, Ontario, Canada: CAMH.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Thousand Oaks, CA: Sage.

Cresswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage.

Culbreth, J. R. (1999). Clinical supervision of substance abuse counselors: Current and preferred practices. *Journal of Addictions and Offender Counseling*, *20*, 15–25.

Culbreth, J. R., & Borders, L. D. (1999). Perceptions of the supervisory relationship: Recovering and nonrecovering substance abuse counselors. *Journal of Counseling & Development*, *77*, 330–338.

Cutcliffe, J. R. (2005). A comparison of North American and European conceptualizations of clinical supervision. *Issues in Mental Health Nursing*, *26*, 475–488.

Cutcliffe, J. R., Butterworth, T., & Proctor, B. (Eds.) (2001). *Fundamental themes in clinical supervision*. London, UK: Routledge.

Cutcliffe, J. R., & Hyrkas, K. (2006). Multidisciplinary attitudinal positions regarding clinical supervision: A cross-sectional study. *Journal of Nursing Management*, *14*, 617–627.

D'Amour, D., Ferrada-Videla, M., Rodriguez, L. S. N., & Beaulieu, M.-D. (2005). The conceptual basis for interprofessional collaboration: Core concepts and theoretical frameworks. *Journal of Interprofessional Care*, *19*(S1), 116–131.

Drake, R. E., Merrens, M. R., & Lynde, D. W. (Eds.) (2005). *Evidence-based mental health practice*. New York: W.W. Norton & Co., Inc.

Eby, L. T., Burke, H., & Birkelbach, D. (2006). *Project merits: Managing effective relationships in treatment services*.

Eby, L. T., McCleese, C. S., Owen, C., Baranik, L., & Lance, C. (2006). *A process-oriented model of the relationship between clinical supervision, burnout and turnover intentions among substance abuse counselors*. Bethesda, MD: National Institute on Drug Abuse. http://projectmerits.wordpress.com

Gaitskill, S., & Morley, M. (2008). Supervision in occupational therapy: How are we doing? *British Journal of Occupational Therapy*, *71*(3), 119–121.

Gilmore, A. (2001). Clinical supervision in nursing and health visiting: A review of the UK literature. In J. R. Cutcliffe, T. Butterworth, & B. Proctor (Eds.), *Fundamental themes in clinical supervision* (pp. 125–140). London, UK: Routledge.

Globerman, J., White, J., & McDonald, G. (2002). Social work in restructuring hospitals: Program management five years later. *Health & Social Work*, *27*(4), 274–283.

Himle, D. P., Jayaratne, S., & Thyness, P. A. (1989). The buffering effects of four types of supervisory support on work stress. *Administration in Social Work*, *13*(1), 19–34.

Hunter, E. P., & Blair, S. E. E. (1999). Staff supervision for occupational therapists. *British Journal of Occupational Therapy*, *62*(8), 344–350.

Hykras, K. (2006). Clinical supervision: How do we utilize and cultivate the knowledge that we have gained so far? *Journal of Nursing Management*, *14*, 573–576.

Jones, J. (2005). Clinical supervision in nursing: What's it all about? *The Clinical Supervisor*, *24*(1/2), 149–162.

Jones, P., & Williams, A. (2009). *An overview of evidence-based practices: Implementing science-based interventions in practical settings*. Silver Springs, MD: Central East Addiction Technology Transfer Centre Network.

Kadushin, A., & Harkness, D. (2002). *Supervision in social work* (4th ed.). New York: Columbia University Press.

King, R., Lloyd, C., & Holewa, V. (2008). Can identified stressors be used to predict profession for mental health professionals? *Australian e-Journal for the Advancement of Mental Health*, *7*(2), 1–7.

Knudsen, H. K., Ducharme, L. J., & Roman, P. M. (2008). Clinical supervision, emotional exhaustion, and turnover intention: A study of substance abuse treatment counselors in the clinical trials network of the National Institute on Drug Abuse. *Journal of Substance Abuse Treatment*, *35*(4), 387–395.

Krueger, R. A., & Casey, M. A. (2000). *Focus groups: A practical guide for applied research* (3rd ed.). Thousand Oaks, CA: Sage.

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York: The Guilford Press.

MorBarak, M. E., Travis, D. J., Pyun, H., & Xie, B. (2009). The impact of supervision on worker outcomes: A meta-analysis. *Social Service Review*, *83*(1), 3–32.

Munson, C. E. (2002). *Handbook of clinical social work supervision* (3rd ed.). Binghamton, NY: Haworth Press.

Pacific Southwest Addiction Technology Transfer Centers. (2008). *Co-occurring psychiatric and substance use disorders in children and adolescents: Diagnostic challenges and treatment options for LA county psychiatrists*.

Powell, D. J. (1991). Supervision: Profile of a clinical supervisor. *The Clinical Supervisor*, *8*(1), 69–86.

Powell, D. J., & Brodsky, A. (2004). *Clinical supervision in alcohol and drug abuse counseling: Principles, models, and methods*. San Francisco, CA: Jossey-Bass.

Proctor, B. (1986). Supervision: A co-operative exercise in accountability. In M. Marken & M. Payne (Eds.), *Enabling and ensuring* (pp. 30–41). Leicester, England: National Youth Bureau and Council for Education and Training in Youth and Community Work.

QSR NUD*IST Vivo. (1999). Australia: Qualitative Solutions and Research Scolari Sage Publications Software.

Shulman, L. (1993). *Interactional supervision*. Washington, DC: NASW Press.

Stoltenberg, C. D., & McNeill, B. W. (2009). *IDM supervision: An integrated developmental model for supervising counselors and therapists* (3rd ed.). London, England: Routledge.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Thousand Oaks, CA: Sage.

Strong, J., Kavanagh, D., Wilson, J., Spence, S. H., Worrall, L., & Crow, N. (2003). Supervision practice for allied health professionals within a large mental health service: Exploring the phenomenon. *The Clinical Supervisor*, *22*(1), 191–210.

Taylor, M. F., & Bentley, K. J. (2005). Professional dissonance: Colliding values and job tasks in mental health practice. *Community Mental Health Journal*, *41*(4), 469–481.