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Evaluation of a youth agency's supervision practices: A mixed-method approach

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ABSTRACT

This research presents the findings from an evaluation and organizational development initiative that was requested by a Canadian youth agency working in a large urban setting. A team of four researchers affiliated with the Center for Research on Educational and Community Services (CRECS) at the University of Ottawa conducted the evaluation. The purpose of the evaluation was to identify the supervision needs and challenges of coordinators and front line staff, assess the efficiency of the current supervision practices, and evaluate the supervisors' and supervisees' satisfaction with these current practices. A literature review was performed to help provide a clear definition of 'supervision' and the different professional roles it encompasses. Additionally, research evidence pertaining both to what contributes to supervision efficacy and supervisor competency was reviewed to distill the most robust findings in the existing literature. The lines of evidence consisted of a document and file review, an online employee survey, group discussions (i.e. focus groups), and interviews with key informants. The results of the evaluation helped the research team formulate recommendations to the agency for the development of enhanced supervision practices across its various service areas.

1. Introduction

Clinical supervision is an activity/intervention provided by a more senior member to more junior members of that same organization. It can be a planned or unplanned activity that occurs one-on-one or in a group format. This relationship is evaluative, extends over time, and has the simultaneous purpose of enhancing professional functioning and supporting the well-being of the more junior members, while monitoring the quality of services/care offered to the client (Falender & Shafranske, 2004). In addition, supervision can be more clinical or administrative in its focus. Clinical supervision more commonly focuses on ensuring accountability for effective services through providing professional development for practitioners, while administrative supervision is more oftentimes viewed as primarily hierarchical and focuses on practitioner performance reviews (Bogo, Patterson, Tufford, & King, 2011).

In many helping professions, clinical supervision is the main vehicle for professional development, which includes the development of knowledge and skills as well as a sense of professional identity. It is through the interaction with their supervisor, and sometimes the observation of supervisors at work, that supervisees gain the necessary knowledge and skills to accomplish their work effectively. In fact, most professionals will spend a large portion of their post-secondary training in supervision. While a majority of professionals agree that clinical supervision is essential for professional development to occur, relatively few studies have been accomplished to help understand which evidence-based theoretical models predict the development of professional competencies, how the different aspects of clinical supervision contribute to professional development, how diversity issues may affect clinical supervision processes, or how to become a competent clinical supervisor (Bernard, 2005; Goodyear & Bernard, 1998; Goodyear, Bunch, & Claiborn, 2005; Kilminster & Jolly, 2000; Watkins, 1995).

In addition, while supervision was common practice in most agencies and publicly funded programs in mental health, recent reviews suggests that the practice of clinical supervision has declined over the last decades (Giddings, Cleveland, & Smith, 2006; Hoge, Migdole, Farkas, Ponce, & Hunnicutt, 2011). The reality of the current work context in many agencies requires clinical supervisors to supervise professionals and staff from different fields of work, where different models of supervision coexist. This means that there are fewer resources assigned to the practice of clinical

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supervision, while its practice has become more complex over time (Bogo et al., 2011; Hoge et al., 2011). For example, the shift from facility-based to community-based services has been linked to increasing caseloads, increasingly complex presentations of clients, and increasing autonomy in service provision (Hoge et al., 2011). At the same time, research indicates that effective supervision can affect job retention and turnover, increase job satisfaction and promote quality of client care (Bogo et al., 2011; Lambert et al., 2003; Mor Barak, Travis, Pyun, & Xie, 2009; Shoenwald, Sheidow, & Chapman, 2009). In this context, some experts have suggested the development of an interprofessional clinical supervision model for mental health and addictions services, to face the challenges related to the contemporary work context by finding common elements to the practice of supervision within and across disciplines (Bogo et al., 2011; D'Amour, Ferrada-Videla, Rodriguez, & Beaulieu, 2005).

The fields of medicine, social work, and counseling have produced the most studies related to clinical supervision, and other fields such as clinical psychology have been heavily influenced by this body of research (Kilminster & Jolly, 2000). That being said, many limitations plague the majority of research studies in this area: it is common for studies not to differentiate between didactic and experiential training in predicting the development of professional competencies; very few studies have used randomized-controlled trials; and there is an overrepresentation of the use of self-reported measures as dependent variables (Goodyear & Bernard, 1998). For example, a systematic review of the research published on clinical supervision between 2000 and 2005 indicated that the vast majority of studies used subjective measures (i.e. participant's perception or satisfaction) to explain what is related to effective clinical supervision (Goodyear et al., 2005). This is a problematic practice, given the well-known discrepancy that exist between self-assessment and observation of professional competency, especially in those with lower observable competency (for a review, see Davis et al., 2006).

1.1. A competency-based approach for clinical supervision

There has been marked progression toward a perspective focused on the development and maintenance of professional competencies in many helping professions. This perspective has led to the development of guidelines for training programs, such as those developed in the domain of clinical psychology (Fouad et al., 2009; Hatcher & Lassiter, 2007). These authors proposed a roadmap for training supervisees that is oriented toward (1) a developmental approach aimed to increase expertise in the different areas of professional competencies, (2) a particular focus on the development of metacognition (the capacity to think reflectively about one's own knowledge) and metacompetence (the capacity to think reflectively about one's own competencies), and (3) the development of a supervisee's ability to work collaboratively to take on challenges in the workplace.

Competency-based clinical supervision is 'an approach that explicitly identifies the knowledge, skills and values assembled to form each clinical competency and develop learning strategies and evaluation procedures to meet criterion-referenced competence standards in keeping with evidence-based practices and the requirements of the local setting' (Falender & Shafranske, 2004, p. 233). It is consistent with a professional development approach that focuses on training for professionalism as a foundation for competent practice. Specifically, using competency benchmarks anchored in a developmental perspective helps supervisees develop an integrated professional identity that is based on the standards in their field of practice (Elman, Illfelder-Kaye, & Robiner, 2005). This is accomplished through the identification of competencies that supervisees must possess to be effective, and the operationalization of their acquisition is demonstrated in the sequence of training (Canadian Interprofessional Health Collaborative, 2010; Fouad et al., 2009). This represents a shift from a more traditional perspective on supervision, which has often been associated with a relative absence of training and weaker professional regulation. Finally, the competency approach is also consistent with an interprofessional model of clinical supervision, which tend to focus on supportive, clinician-focused, content-oriented supervision offered by supervisors who possess the knowledge, skills and attitudes associated with competency in the area in which the service is delivered (Bogo et al., 2011).

1.2. Research on clinical supervision: what makes supervision effective?

Given the many challenges facing this area of research, Proctor (1994) initially suggested the three following recommendations to orient future studies: develop a clear definition of what is meant by 'clinical supervision'; pay particular attention to what distinguishes poor from good supervision; and adopt a developmental perspective with a special emphasis on challenges related to multidisciplinary work. Heeding these suggestions, Kilminster and Jolly (2000) reported in their own literature review methodological problems in studies that focus on clinical supervision in different healthcare fields, while also painting a descriptive profile of the various definitions used in this area of research, the emerging theoretical models used, and the numerous variables that could be linked to clinical supervision efficacy. A systematic review published five years later (Goodyear et al., 2005) identified a total of 49 publications on this topic between 2000 and 2005. The authors concluded that research in this area continues to develop at a very slow pace and that there is an overrepresentation of theoretical and/or conceptual articles published without any empirical support. A new systematic review conducted by the principal author of the current study (Gosselin, Barker, Kogan, Pomerleau, & Pitre-D'Iorio, in press) echoes the same findings.

Despite methodological flaws, the majority of researchers have agreed on several factors judged to be related to good supervision by its recipients (Falender & Shafranske, 2004). According to participants (usually doctoral students in counseling or clinical psychology), a good supervisor establishes rules and expectations at the outset. The good supervisor creates a safe, non-judgmental, supportive work environment where supervision is focused on the here and now. The good supervisor provides structure but also encourages supervisees to reflect on their therapeutic work and supports them in developing their professional identity. The good supervisor lets the patient/client's story unfold and invites supervisees to reflect on their reaction to their patient/client, to ask themselves how they want to broach topics of importance to their clinical work, and to develop insight into aspects they have ignored. Finally, the good supervisor gives concrete support when necessary to help supervisees develop knowledge and/or skills or to help them resolve resistance or impasses (Falender & Shafranske, 2004; Kilminster & Jolly, 2000).

In return, supervisors also benefit from a variety of supervisee characteristics, which can make the supervision process more successful. These include openness to experience and feedback, coming prepared for supervision, capacity to listen to and implement supervisor suggestions and supervisee's capacity to self-reflect (Falender & Shafranske, 2012).

Supervisors and supervisees who do not adhere to these guidelines risk the development of a non-productive work environment where, according to some authors, there could be a negative impact on the professional development of supervisees and the quality of care delivered to patients/clients. Such negative impacts may include personality conflicts, loss of confidence,