

# SUPERVISORS' GUIDE

A resource for  
clinical supervisors

Matua Raki

National Addiction Workforce Development

Kina   
Families & Addictions Trust

# THE SUPERVISOR'S GUIDE: Integrating Family Inclusive Practice into Clinical Supervision for the Addictions Workforce

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# INTRODUCTION

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Kia Ora, Talofa, Welcome to this guide for clinical supervisors in the addiction workforce. Clinical Supervision is highlighted as one of the key mechanisms in fostering practice change towards the inclusion of families and social networks in addressing alcohol and other drug issues.

Kina Trust, in partnership with Matua Raki, has developed this resource to equip clinical supervisors in the alcohol and other drug treatment sector in their work to promote and support Family Inclusive Practice (FIP). This work aligns with other Kina Family Inclusive practice resources and best practice supervision models.

For several years Kina Trust has supported organisations and practitioners to enhance their work with clients, families and social networks. Supervisors can play a key role in promoting FIP, both with their supervisees and services. This resource draws together knowledge from the fields of addiction counselling, clinical supervision and family inclusive practice to enhance relevant supervision practice and to support supervisors, as experienced team members, in promoting FIP.

This manual contains the following sections:

- Overview of Family Inclusive Practice
- Review of theories of clinical supervision
- Integration of Family Inclusive Practice into supervision

These sections are interspersed with reflective questions to help supervisors review current practice, address issues being encountered and consider the means by which FIP can be integrated into supervision practice. Also included is a template that supports the systematic evaluation of supervision practice to be used for self-guided reflective practice, in peer review or in the supervisor's own supervision process.

This resource can be utilised in a number of ways:

- As a reference source for information on clinical supervision issues and FIP.

- To provide a foundation for self-directed learning, with supervisors systematically working through the manual, taking to time to consider the reflective questions and using the template to review supervision practice.
- To provide a resource for peer based learning within services, allowing a group of senior practitioners to collectively enhance confidence and skills, to develop supportive networks and to systematically review and challenge impediments to FIP.
- As a useful tool in clinical supervision, where the sharing of information with supervisees can be used to both enhance supervision and encourage the development of FIP.
- As a prompt for supervisors in their own supervision, providing a focus on the integration of FIP issues into supervisory practice. Taking this manual into any supervisory process can be particularly helpful where either supervisor or supervisee are not knowledgeable about FIP, or lack confidence in their practice, as it supports a non-judgemental, developmental focus in supervision.
- To form a basis for conversations with colleagues and managers, particularly those seen to be resistant to the inclusion of FIP, to begin the process of practice change.
- As a source of information (along with other Kina publications) when leading formal reviews of service development.

Kina Trust provides a range of workshops on Family Inclusive Practice, and supervisors are encouraged to attend these. In preparing this resource, it has been assumed that supervisors have attended introductory workshops on FIP. Also, Kina Trust, with support from Matua Raki, does run workshops on clinical supervision and FIP. Workshop availability, and other resources, can be accessed through the Kina Trust website: [www.kinatrust.org.nz](http://www.kinatrust.org.nz). From time to time other opportunities arise in the addictions sector to attend training on supervision. These can often be accessed through Matua Raki.

The Project Team that guided this work included Anna Nelson (Programme Manager, Matua Raki), Trish Gledhill (Director, Kina Trust), Andrew Raven (facilitator) and Debby Sutton (writer). Several experienced supervisors in the sector, and staff at Matua Raki and Kina Trust, have contributed to the development of this resource: their work is acknowledged and grateful thanks extended.

Kina Trust  
Matua Raki  
September, 2011.

## **FAMILY INCLUSIVE PRACTICE: A REVIEW OF KEY CONCEPTS**

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When supervising staff in Family Inclusive Practice (FIP) it is important that supervisors feel confident and competent in this approach. Training in FIP is therefore essential and maintaining currency in this knowledge and these skills is important. The following section reviews the concepts of FIP, including those developed by Kina Trust in their guide for practitioners and their introductory workshop (Kina Families & Addictions Trust, 2006; 2007).

### **What is Family Inclusive Practice?**

Practitioners who work in addiction and mental health settings are increasingly being asked to include families in their clients' treatment (Alcohol and Drug Treatment Workforce Development Advisory Group, 2001; Ministry of Health, 2008). Traditionally therapeutic work with families has been the domain of trained family therapists using the various family therapy models. Family Inclusive Practice (FIP) is a more recently developed approach, which can include family therapy, but typically refers to a much greater range of family-inclusive interventions for alcohol and drug problems. Generally these interventions do not require family therapy training, although a quicker, less intensive training in the FIP approach is useful.

Any intervention that acknowledges the place of families in a client's life is part of the FIP spectrum as long as it is underpinned by the following guiding principles (Patterson & Clapp, 2004):

- Family inclusive practice is about 'inclusive thinking'. Families can be included as part of the change process when working with clients and/or providing services directly to families
- Families are valued for their expertise
- Strengths, relationships and existing resources within families can be used by services in working with clients with alcohol and drug issues
- Clients are the best judges of who their family is and the extent to which their family should be involved in treatment. This includes extended family and social networks as well as family of origin
- Assisting families, including children, to access support for themselves is important

- Clients are part of multiple and interconnected systems and collaborative approaches align closely with family inclusive work.
- These practices involve models that are solution focused and often behavioural in looking and working ‘forward’ towards positive change
- Family inclusive practice is non-blaming

*Family Inclusive Practice* can be defined as the involvement of significant members of an individual’s social context in addiction treatment. The overall purpose of inclusive practice is better, more sustained outcomes for both the individual and members of their social environment which is often their family of origin.

More specifically, the aims of Family Inclusive Practice might include:

- Facilitating the engagement of families in the treatment process.
- Facilitating the engagement of substance users into treatment.
- Promoting the safety and wellbeing of all family members.

There is a growing body of evidence endorsing the benefits of family involvement in addiction treatment. This is in relation to both the client’s treatment outcomes and other family members’ health (Copello, Velleman, & Templeton, 2005; Kina Families & Addictions Trust, 2006). Working in this way often means that the complexities of families’ experiences and a range of related issues that impact on families are identified. These factors need to be taken into consideration when embarking upon family focused interventions.

## **Appropriateness and Safety of Family Inclusive Practice**

As with family therapy, the appropriateness of using FIP needs to be carefully assessed. Where there are legal constraints limiting contact between family members and/or where there is violence within the family, other forms of intervention should be used.

If family violence is present and not identified, not only is treatment unlikely to be successful, but it can also place family members at greater risk of harm (Centre for Substance Abuse Treatment, 2004, Kina Trust, 2006; Kina Trust & Matua Raki, 2010). The FIP models used should also be congruent with the client’s culture and be able to accommodate differences in family structures, hierarchies, and behavioural norms.

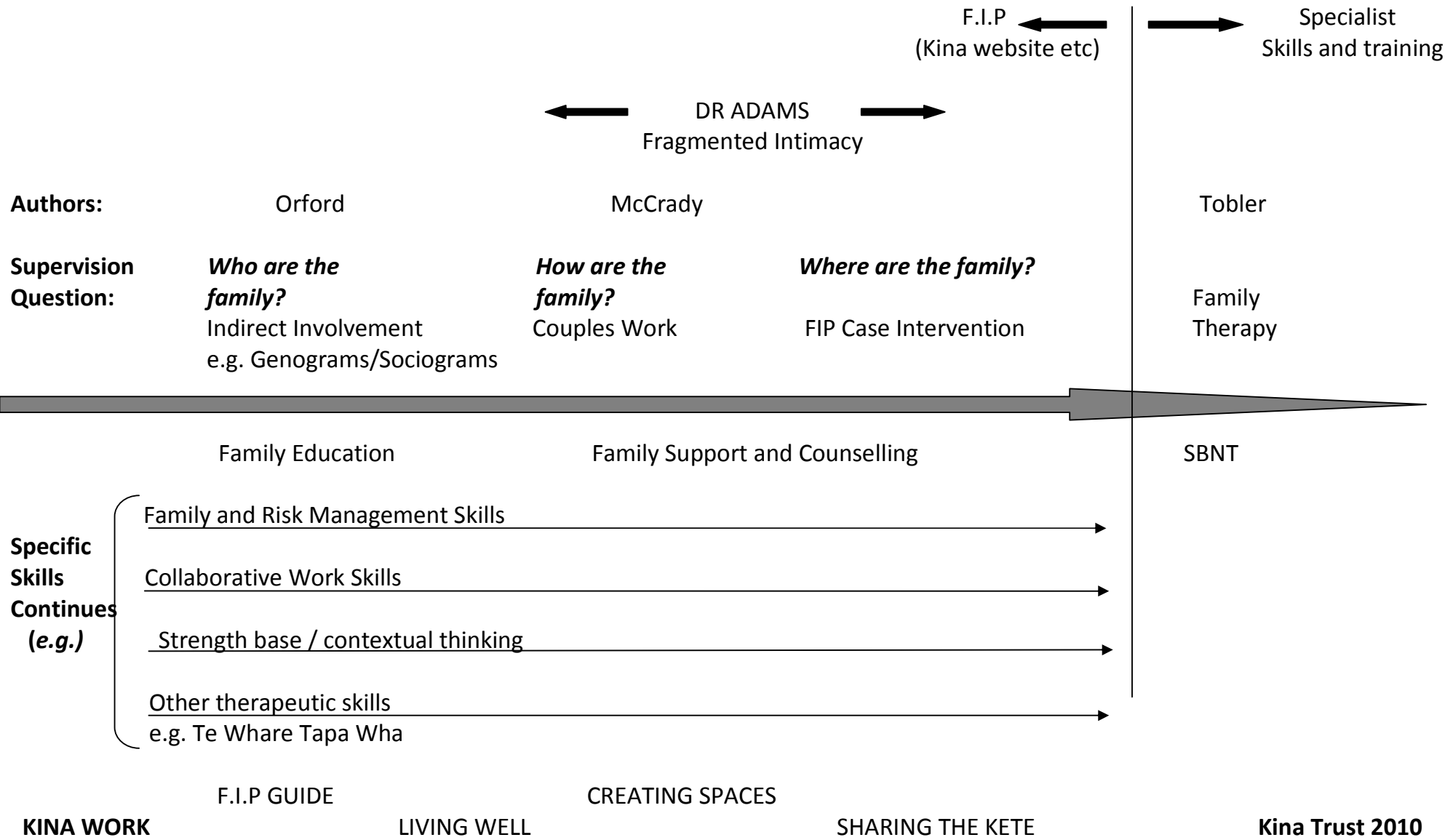
## The Range of Family Inclusive Interventions

The various interventions that involve family members can be placed on a continuum of their level of involvement in the treatment process (Centre for Substance Abuse Treatment, 2004). This has been summarised below:

- 1) Indirect involvement: where practitioners ask clients about their family but they are not directly involved in treatment. For example, using a genogram to identify a client's family support network.
- 2) Family education: where practitioners provide psycho-education and advice to family members. This could be by phone, written information and/or in person and might include for example, using the *Living Well* resource (Kina Families & Addictions Trust, 2009a). Referral to other supports may also be appropriate eg to the self-help group Al-Anon.
- 3) Family counselling: where practitioners provide emotional support to family members (separately or together) and assist them to enhance their skills in areas such as managing stress or conflict. This could be through facilitated groups or individual counselling, again using resources such as *Living Well*.
- 4) Family-oriented case interventions: where practitioners actively involve family in clients' assessment and treatment planning. For example, negotiating with families how they can support a client as part of a relapse prevention plan. An example of this level of intervention might be the use of Social Behaviour Network Therapy approaches (Copello, Orford, Hodgson, Tober, & Barrett, 2002).
- 5) Family therapy: where practitioners, who are trained in family therapy, provide therapy for a whole family. For example, exploring how the role of alcohol impacts on relationships between family members. Typically this is a more specialist level of intervention, provided by qualified practitioners trained in specific family therapy models.

The above can be summarised diagrammatically as a continuum of family inclusive practice. Practitioners can develop confidence in developing their FIP by recognising that they are already engaging in this work by, for instance, asking about the family at assessment interview. Counsellors often assume that FIP is only about having whole families in sessions, and while this is to be encouraged, can build their confidence through initially completing genograms with individual clients, working on to family contact and support and so on. Supervision can be tailored to reflect this development: practitioners commencing family work can be asked who is in the family, progressing to questioning about how the family is managing and, with more experienced practitioners, supervision about family dynamics.

# FIP CONTINUUM

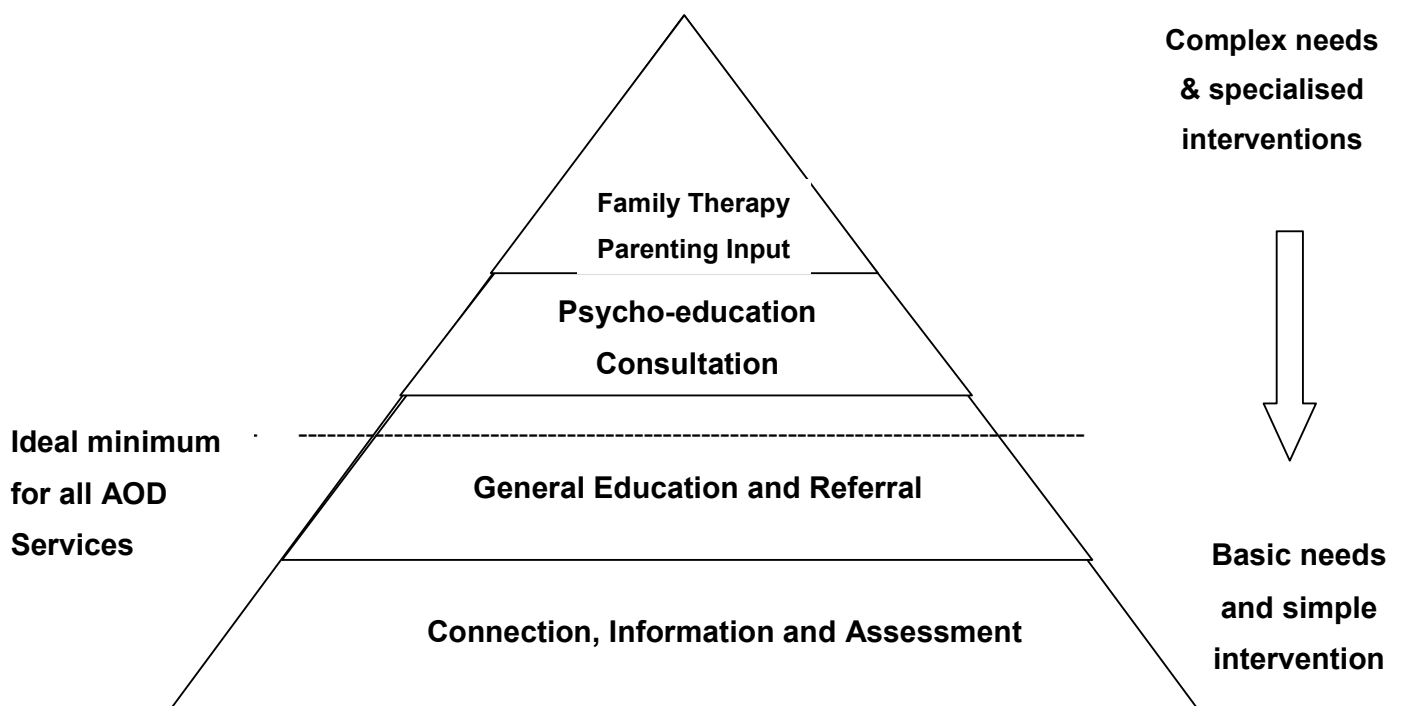




Services can develop their response to families through consideration of the work by Mottaghypour and Bickerton (2005), as represented in their Pyramid of Family Care. Again, there can be an assumption that family work needs to be complex and resource intense. The pyramid requires that all services have capacity to connect with family, provide educational input and can link families to other community resources: these are well within the capacity of services in New Zealand.

## Pyramid of Family Care

Adapted from Mottaghypour & Bickerton, 2005



Selecting the kind of intervention to be used will depend on a number of factors that include:

- The realities of the treatment context and what the service provides.
- The counsellor's training and experience.
- The family's needs and readiness to change.

### **Reflective Questions**

- 1) *Which of these interventions does your service provide?*
- 2) *Which intervention do you feel confident to provide?*

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## **Engaging Clients and Families in Family Inclusive Practice**

Practitioners often need to be pro-active to encourage family involvement. This might involve taking time to clarify who is in a client's support network. Practitioners may also need to promote the benefits of FIP to both clients and their significant others. Benefits of FIP can be demonstrated through the first interactions with families by providing them with empathy, providing hope and credible options. Ensuring that all those involved have appropriate expectations of FIP is an important part of the preparation, both prior to meeting and at the first family meeting.

The clinical skills and tools used to support clients through a journey of recovery are just as applicable to family members. It is useful to assess the level of family engagement in treatment and the barriers that may be limiting this. An understanding of Prochaska and DiClemente's (1982) stages of change model can assist with this and allow practitioners to address the family's needs at their pace. Where family members display some resistance, Motivational Interviewing strategies can be valuable.

Clients and families are more likely to engage in treatment for addiction when practitioners:

- Listen without blame or judgement.
- Clarify that what they can provide matches what the family wants.
- Support the family to find alternative services if they are more appropriate.
- Provide a range of flexible services that families can choose from.
- Build partnerships with families to achieve outcomes.
- Offer a solution focused (rather than problem focused) approach (Patterson & Clapp, 2004).

Just as there is a process of recovery for clients with substance problems, there is also a process of recovery for their families (Centre for Substance Abuse Treatment, 2004). Systems theory suggests that when clients change their use of substances, the dynamics within their families are also affected. Initially the family system will feel unbalanced but hopeful of change. To support the client's change and to create a stable family system, the family will need to adjust and develop a new system of interactions. Consolidation of this new, healthier lifestyle will require both clients and their families to maintain these changes in the long-term (Centre for Substance Abuse Treatment, 2004). Certain FIP interventions may be more appropriate to use with families than others, depending on which stage they are at in this recovery process.

Sometimes families approach a service concerned about a family member's drug use, and ask for assistance to engage them into treatment. There are some specific interventions that, as well as supporting families, are designed to encourage problematic drug users into treatment. Two such interventions that show promising results are:

**A Relational Intervention Sequence for Engagement (ARISE)**. This has evolved out of the discredited confrontational approach; the Johnson intervention (Adams, 2008). Rather than confrontation, ARISE uses certain strategies to mobilise social networks with the aim of engaging the substance user into treatment.

**Community Reinforcement and Family Training (CRAFT)**. This is based on the concepts developed in Azrin et al's (as cited in Kina Families Addictions Trust, 2007) Community Reinforcement Approach. CRAFT focuses on teaching significant others how to influence the substance user's behaviour through reinforcement, how to enhance their own self-care, and how to engage the substance user in treatment (Adams, 2008; Centre for Substance Abuse Treatment, 2004; Meyers & Smith, 1995).

**Reflective Questions**

- 1) *What would be signs that a family had successfully engaged in treatment?*
- 2) *What would be signs that a family is having problems engaging with treatment?*

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**Integrating Family Therapy Models into Addiction Treatment**

Family Inclusive Practice does not require practitioners to be trained family therapists. However, at a minimum, alcohol and drug practitioners should understand the broad concepts of family therapy. An understanding of the key ideas and techniques from family therapy that can be incorporated into treatment for alcohol and drug problems is also valuable.

The Centre for Substance Abuse Treatment (2004) lists the following family therapy approaches as being appropriate to integrate into substance abuse treatments:

- ✦ Structural/strategic family therapy.
- ✦ Multidimensional family therapy (MDFT).
- ✦ Multiple family therapy.
- ✦ Multisystemic family therapy.
- ✦ Behavioural and cognitive-behavioural family therapy.
- ✦ Network therapy.
- ✦ Bowen family systems therapy.

- ✦ Solution-focused brief therapy.

More information on these approaches can be sourced through the original document or from Kina Trust publications. Further details about selecting specific therapeutic models to match the needs of specific populations are also covered in these resources (Kina Families & Addictions Trust, 2006; 2009b; 2010; The Centre for Substance Abuse Treatment, 2004).

Studies of some specific FIP models have found that they do provide effective treatments. For example, Social Behaviour and Network Therapy; McCrady's Couple Counselling; and the Five-Step Stress Coping model have all shown promising results (Copello et al., 2005). These models are briefly described below, but more information is also available in the Introductory Family Inclusive Practice Training Manual (Kina Families & Addictions Trust, 2007).

### **Social Behaviour and Network Therapy (SBNT)**

SBNT aims to develop or enhance positive social network support for change in substance using behaviour (Copello et al., 2002). The practitioner assists the client to identify and engage network members. The network, which includes the client, establishes treatment goals for the client; assists the client to improve their coping and communication strategies; increases their drug-free social activities; and develops relapse prevention plans. Throughout this process, the practitioner has key roles of facilitation and coordination.

### **The McCrady Couples Counselling Model**

In McCrady's model the practitioner supports couples to respond differently and to work together constructively when substance-related situations arise (Kina Families & Addictions Trust, 2007; McCrady, 2004). A behavioural functional analysis is completed for the client's substance use and for the family's coping strategies, from which a treatment plan is developed.

### **The Stress Coping Model**

A key intervention model with family members is the Five-Step Stress Coping Model (Copello et al., 2000). This model recommends the use of a five step process with the significant others of alcohol and drug users, to alleviate the impact on the family of related harm (Kina Families & Addictions Trust, 2007). These five steps are:

1. Listen (to understand the family member and the issues).
2. Provide relevant information.

3. Counsel about coping (explore which of three different coping styles the family member tends to use).
4. Explore and enhance current social supports.
5. Explore the need for further supports and options for specialist help.

### Reflective Questions

- 1) *Do you use any of these models?*
- 2) *Which FIP models are you most familiar with?*

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### Key Family Inclusive Practice Concepts, Tools and Skills

Family Inclusive Practice builds on the concepts and skills commonly used by addiction practitioners, such as Client Centred counselling and Motivational Interviewing. It also utilises many of the concepts and techniques developed in family therapy. For example, understanding how family members take on roles and behavioural patterns to meet the needs of other family members (Centre for Substance Abuse Treatment, 2004).

Some of the family therapy strategies and techniques that are most useful for substance use problems are:

- ✦ Behavioural techniques, for example teaching couples negotiating skills, functional analysis of substance use.

- ✦ Structural techniques, for example raising family awareness about appropriate boundaries by encouraging family members to speak for themselves rather than speaking for others.
- ✦ Strategic techniques, for example using reframing to better understand experiences.
- ✦ Solution-focused techniques, for example eliciting 'hopes and dreams' and identifying and exploring the exceptions to an issue, such as times when the client has been abstinent.

An understanding of protective factors and how to build both individual and family resilience is an important aspect of FIP (Kina Families & Addictions Trust, 2007). Family resilience can be enhanced by encouraging the following factors:

- Optimistic belief systems eg viewing adversity as a challenge.
- Organisational patterns that promote belonging and maintain family functioning e.g. family rituals and routines, flexible roles.
- Constructive communication and problem-solving e.g. collaborative decision-making, expressing a range of feelings (Walsh, 2003).

Generally FIP tools, such as genograms, tend to be interactive and visual. They involve reciprocal processes that allow issues to be externalised and processed (Kina Families & Addictions Trust, 2007).

**Reflective Question**

- 1) *What Family Inclusive Practice tools are you most familiar with?*
- 2) *What could be the next steps for your service to advance their inclusion of families in treatment?*

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# CLINICAL SUPERVISION: A REVIEW OF THEORY AND PRACTICE

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The following section presents the key issues related to clinical supervision. It provides an overview of supervision, describes a range of supervision models, explores how supervision is applied in practice and the focus of supervision content. The material in this section provides the foundation for incorporating family inclusive practice into clinical supervision practices.

## Overview of Clinical Supervision

In the past, many clinical supervisors in addiction treatment services did not receive formal training for their role and were not supervised for it. They learnt about supervision practice while doing the work and based their approach on their counselling practice and on their own previous experiences of being supervised. Fortunately it is now widely recognised that clinical supervision is a specific role that requires unique knowledge and skills to be effective. Many clinical supervisors have attended introductory training in supervision. However, the level of ongoing training and development that supervisors receive beyond this varies greatly. It is with this in mind that the key concepts and models of clinical supervision will now be reviewed, in the context of how these approaches can support inclusive practice.

### Defining Clinical Supervision

In New Zealand the alcohol and drug treatment workforce come from a range of professional backgrounds, each of which have different perspectives on clinical supervision. Historically supervision has been seen by some professions as part of the requirement for trainees only, or it has been used as a way to monitor employee performance.

This document will use the following definition of clinical supervision:

“Supervision is a working alliance between addiction treatment practitioners in which they aim to enhance clinical practice, to meet ethical, professional and best practice standards... while providing support and encouragement in relation to professional practice.”

(Kavanagh et al., as cited in Roche, Todd, & O’Connor, 2007, p.242)

Clarity about what supervision means and what it actually entails is critical to using these processes to best advantage in supporting emerging practice areas such as family involvement.

## **Aims of Clinical Supervision**

There are numerous models and theories regarding clinical supervision, each of them placing greater emphasis on different aspects of practice, including what supervision aims to achieve. Regardless of these differences, it would be currently widely accepted that the ultimate goal of supervision is to enhance the practitioner's work with clients and therefore ensure that it is safe, effective, and satisfactory to clients.

While achieving this primary goal, there are many possible secondary aims of supervision (McKenna, Thom, Howard, & Williams, 2008). For example: reduction in staff "burn out", improving adherence to evidence-based best practice and improving staff retention. Kadushan (as cited in McKenna et al., 2008) suggested that these secondary aims could be summarised by three categories:

1. Administration: for example, ensuring that the practitioner meets management requirements e.g. meeting expected outputs for family involvement and adhering to FIP policy
2. Education: developing skills, knowledge and professional identity e.g. developing knowledge of FIP models
3. Supportive: developing attitudes and feelings to work effectively e.g. addressing personal barriers to family work.

Proctor (as cited in McKenna et al., 2008) has also proposed three very similar functions of clinical supervision. This Supervision Alliance Model includes the following functions:

1. Formative: assisting the supervisee to develop and maintain relevant knowledge and skills (educative).
2. Normative: assisting the supervisee to maintain standards of professional practice and to work in alignment with the frameworks required by organisations and professional bodies. This can include policies, ethics, competencies and national standards (administrative).
3. Restorative: supporting the supervisee to manage emotional responses arising from clinical practice, such as managing stress (supportive).

It is desirable that supervision covers each of these functions, allowing for session based emphasis, rather than focusing on solely on one aspect. In addition, supervisors could consider their role to actively encourage FIP development: this would require the prompt of Provocative to the preceding three functions!

Although clinical supervision may include aspects of roles such as administration, counselling or education, it remains a unique role that is different from being a Line-manager, Therapist, or Teacher. The range of roles relevant for supervisors will be clarified in a later section.

### **Effectiveness of Clinical Supervision**

Very little research has been completed on the impact of clinical supervision within the addiction treatment workforce. Research has been completed in other areas of health, but problems with the research design has meant that conclusions are limited (New South Wales Psychologists Registration Board, 2006; Roche et al., 2007). Some hope is offered by a review of 18 published studies (Wheeler & Richards, as cited in McKenna et al., 2008) that found clinical supervision had a positive impact on practitioner skill development, self awareness, and self-efficacy. Other research has tentatively found that supervision can provide a positive impact on service users (McKenna et al., 2008).

### **Forms of Clinical Supervision**

The traditional format of clinical supervision involves an individual practitioner regularly meeting with a more experienced practitioner in an ongoing collaborative relationship. In this case the supervisor is responsible for facilitating the supervision and usually has some responsibility for the practitioner's practice. Other forms of supervision can be valuable depending on the purpose for which supervision is required. It is important that when establishing alternative forms of supervision that the roles, responsibilities and expectations are clearly established.

#### **Group Supervision**

There are a variety of ways that group supervision can occur, ranging from authoritative models where the supervisor works with individual practitioners and other group members observe, through to more participative models where, although the supervisor facilitates the process, group participants also contribute (McKenna et al., 2008). The supervisor always maintains some responsibility both for the process and for monitoring practitioners' work. This form of supervision is sometimes used to support emerging family inclusive practices within clinical teams.

### Peer (Reciprocal) Supervision

Peer supervision (either in groups or pairs) is non-hierarchical and can provide education and support. Participants have an obligation to address the actions of other practitioners that they have concerns about as per their Code of Ethics, but other than this no formal accountability exists. As no person has responsibility for the work of the others, it has been suggested that it should be called “consultation” rather than “supervision”. This form of supervision is seen to be more appropriate for experienced practitioners.

### Cultural Consultation and Cultural Supervision

Sometimes practitioners need to gain cultural information and advice in relation to specific clients. This would be an opportunity to access consultation from a cultural expert for a limited number of occasions. This is not cultural supervision as the expert is not responsible for the practitioner’s work (McKenna et al., 2008).

Cultural supervision can occur within a clinical supervisory relationship to support practitioners to be culturally responsive and/or to integrate cultural practices that are relevant to the client and the clinical setting. Some culturally specific models of supervision are being developed, for example, Mafile’o and Su’a-Hawkins’ (as cited in McKenna et al., 2008) model for working with Pasifika clients. Kaupapa Māori models of clinical supervision are described in more detail in the next section.

#### **Reflective Question**

- 1. How is supervision defined in your organisation?*
- 2. What forms of supervision are most evident in practice?*

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## Models of Supervision

The use of the term “model” here refers to “a framework or guide for the actual practice of supervision” (van Ooijen, 2003, p.14). Several authors have identified different categories of theories and models related to clinical supervision (Spence, Wilson, Kavanagh, Strong and Worrall, 2001; van Ooijen, 2003). Bernard and Goodyear (as cited in New South Wales Psychologists Registration Board, 2006) proposed the use of 3 categories:

- Developmental models.
- Psychotherapy based models.
- Social role models.

Kaupapa Māori models of supervision have also been included in this guide as they are relevant to supervision within Aotearoa New Zealand. Each of these models will now be explored in more depth.

### Kaupapa Māori Models of Supervision

Tangata whenua (indigenous people of Aotearoa New Zealand) have had processes of supervision in place well before these activities were named as such. Since the introduction of western models of supervision Māori have been integrating these with more traditional practices. More recently Māori have developed written resources, research, and training to support this development. One example, the Powhiri Poutama model, is a Māori mental health training programme based on traditional Māori learning and assessment models that focus on training and mentoring kaimahi/students in the workplace (Huata, Te Ngaru Learning Systems Ltd, as cited in Rangiaho, 2003). As another example, He Tohu Matekite is a model of supervision for Māori nurses that uses Māori cosmology as a metaphor (Broodkoorn & Wahanui, as cited in McKenna et al, 2008). These models are typically designed for Māori supervisors working with Māori practitioners who see Māori clients. One such model is described in more detail below.

#### He Korero Korari (Eruera, 2007)

He korero korari is supervisory framework developed for tangata whenua social workers in Te Taitokerau (Eruera, 2007). This framework utilizes the weaving of a flax kete to bring together traditional supervision concepts, experiences of Māori in contemporary supervisory relationships and literature to produce a guide for developing Kaupapa Māori supervision.

Kaupapa Māori supervision is defined as “an agreed supervision relationship by Māori for Māori with the purpose of enabling the supervisee to achieve safe and accountable

professional practice, cultural development and self-care according to the philosophy, principles and practices derived from a Māori worldview” (Eruera, 2007, p.144).

The philosophical base for He korero korari includes (Eruera, 2007):

- Matauranga Māori (Māori cultural knowledge base)  
The kaiarahi (supervisor) needs to use both cultural knowledge and professional knowledge to support the kaitiaki (practitioner) to develop and apply cultural knowledge into their professional practice within an organizational context.
- Whakapapa (inter-relatedness of spiritual, human and natural dimensions)  
Throughout supervision, both kaiarahi and kaitiaki need to be aware of their own whakapapa, become aware of the connections they have with each other and others in their work settingā and manage possible impacts of this.
- Tikanga (cultural processes and protocols)  
The kaiarahi uses Māori protocols and processes during supervision to ensure that it is meaningful and safe.
- Mohiotanga (the supervisor’s experiences of supervision)  
Kaupapa Māori supervision is influenced by the previous supervision experiences of the kaiarahi, which have often been based on western approaches. It is important for kaiarahi to draw on experiences that have assisted them to integrate cultural knowledge into clinical practice.
- Nga Uaratanga (values and beliefs)  
Kaiarahi need to have continual self-awareness and understanding for the values and beliefs that underpin their Kaupapa Māori supervision practice.
- Pukenga (skills and attributes)  
Many of the skills required for kaupapa Māori supervision are similar to those used with other cultures. There are some skills specific to providing Kaupapa Māori supervision. For example, assisting kaitiaki to balance cultural and professional obligations; and communicating competently in both Māori and English.



family work. Some practitioners may be new to family work but they may have well established more independent levels of development in other practice areas.

2) Journey person: After some experience, practitioners can feel more confident and autonomous. However at this stage they still fluctuate with feeling overwhelmed and rely on supervision. Receiving support and being able to express emotions is important at this stage.

3) Independent Craftsperson: An experienced practitioner has learnt to trust their clinical skills and knowledge. They are not as affected emotionally by clinical challenges. Supervision focuses more on discussing the complexities of situations and supporting the practitioner's self-development rather than direct teaching.

4) Expert: A practitioner at this stage is fully autonomous and is aware of their professional responsibilities and limitations. They utilise self-reflective practice to continue developing and supervision is more of a collegial relationship.

These models suggest that to enhance a practitioner's performance, supervision and training should be matched with their developmental stage. For example, a novice practitioner would benefit from more structured teaching techniques and positive feedback from their supervisor. However, regardless of their stage of development, when learning new techniques, or dealing with stressful situations, practitioners often prefer more structured supervision.

**Reflective Questions:**

- 1) *How can you best support a practitioner who is new to using FIP?*
- 2) *If this practitioner was very experienced, would you adjust your approach?*
- 3) *How would practitioners' need for supervision change as they become more experienced with FIP?*
- 4) *With relatively new approaches, like FIP, clinical supervisors may have similar levels of knowledge and skills as their supervisees. What supervision approaches/models could be useful for working with this situation?*

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### **Psychotherapy Based Models of Supervision**

These models of supervision are based on the same theory and methods used in specific therapies. For example, there are psychodynamic, cognitive behavioural, systemic family therapy and humanistic models of supervision. Supervision is likely to be more effective when the supervision model is congruent with the therapeutic orientation being supervised (Hewson, 2002). However, it has been suggested that supervision should draw from a wider base of models than from just one therapy (Hewson, as cited in New South Wales Psychologists Registration Board, 2006). The examples of psychodynamic and cognitive behavioural models of supervision are described below.

#### The Psychodynamic Model of Supervision

This model regards supervision as a therapeutic process focusing on the intrapersonal and interpersonal dynamics of the counsellor in relation to clients, colleagues, supervisors and significant others. Its goal is dynamic awareness and making therapeutic use of the dynamic in counselling. Psycho-dynamically oriented supervisors seek to refine supervisees' sensitivity to transference, counter-transference, drives and defense mechanisms. Underlying this model is the assumption that similarities between therapy and supervision create parallel processes/dynamics (Powell & Brodsky, 2004; van Ooijen, 2003).

**Reflective Questions**

- 1) *How could transference and counter-transference issues impact on the use of FIP with clients and/ or integrating FIP into supervision?*
- 2) *How could a psychodynamic approach to supervision support practitioners to use FIP with their clients?*

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**Cognitive Behavioural Models of Supervision**

Cognitive behavioural models of supervision seek to enhance practitioners' knowledge, skills and attitudes. Supervision using this approach would firstly establish a positive relationship and then using clinical core competencies would complete a needs analysis with the supervisee to identify areas for development. Together, the supervisee and supervisor would set some goals and make a plan to achieve them. The supervisor could use a number of behavioural techniques to assist the supervisee to develop specific skills. For example; modeling and reinforcement, skills monitoring, observation & feedback, role-playing and simulation, and micro-training (Powell & Brodsky, 2004; van Ooijen, 2003).

**Reflective Questions:**

- 1) *How could a cognitive behavioural approach to supervision assist practitioners to use FIP with their clients?*
- 2) *What do supervisors need to be able to do this?*

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### **Social Role Theories and Models of Supervision**

Evidence suggests that in practice, irrespective of what philosophical background a supervisor has, they will engage in similar supervisory practices (Spence et al., 2001). The 'Supervisor Role' theories and models are more practically oriented models, rather than philosophical. They are specific to the role of a supervisor and describe the tasks, structures, functions and processes required of them. The following section presents a summary of what these theories and models suggest for best practice in supervision.

### **Supervision in Practice**

As has already been mentioned, quality research into the effectiveness of clinical supervision is very limited. Therefore, most of what is considered to be best practice is on the basis of expert experience, reflection and theorising rather than empirical evidence. The success of supervision depends on a variety of factors including the client and their social networks, the setting, and the supervisee. The following section will explore the factors that impact on the effectiveness of supervision that also applies to the supervision of family focused practice.

### **Roles of a Clinical Supervisor**

Being a clinical supervisor consists of a unique combination of various tasks and roles. Although some supervisors may place a greater emphasis on some roles more than others, an effective supervisor would ensure that they fulfill the range of roles most appropriate to the situation at hand. Powell & Brodsky (2004) describe four different kinds of roles that supervisors should undertake:

1. Administrative role (e.g. planning, organising staff, delegating tasks).

2. Evaluative role (e.g. assessing skills, goal setting, supervision planning and providing feedback to supervisees).
3. Clinical skill development role (e.g. enhancing supervisees' knowledge and skills through training).
4. Supportive role (e.g. affirmation, morale building, "burn out" prevention and encouraging supervisees in their personal growth).

### **Reflective Questions**

*1) Which supervisory roles will be most appropriate when supporting practitioners to use FIP?*

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### **Qualities of an Effective Supervisor**

An effective supervisor develops knowledge, skills and attitudes that can assist supervisees to enhance their work with clients and their families. The qualities that effective supervisors possess are overviewed below under the following headings: characteristics, skills in relationship building, approaches to supervision, providing evaluation and feedback, and maintaining professional standards.

### Characteristics

The literature has identified numerous characteristics that an effective clinical supervisor displays. Powell and Brodsky (2004, p. 41) have summarised these personal qualities in the four A's of supervision:

- “Available (open, receptive, trusting, non-threatening);
- Accessible (easy to approach and speak freely with);
- Able (having real knowledge and skills to transmit);
- Affable (pleasant, friendly, reassuring).”

### Skills in Relationship Building

As with counselling, the quality of the relationship between the supervisor and supervisee is probably the single most important factor for effective supervision. A supervisor's behaviour can help build a positive professional relationship, such as being helpful, empathic, and affirming. Or their behaviour can hinder the formation of such a relationship, such as blaming and neglecting the supervisee (Ask & Roche, 2005).

### Approaches to Supervision

An effective supervisor has a clear and coherent approach to supervision (Ask & Roche, 2005). They understand what assists practitioners to change their behaviour and how they can support this. Effective supervisors are clear about what successful supervision looks like and how this can be measured.

Several authors divide the approaches to supervision into two broad categories related to whether the supervisor or supervisee controls the content of supervision. Where supervision is supervisee centered, the supervisor assists the supervisee to identify their own developmental goals and supports them to achieve these (Ask & Roche, 2005). This approach requires a supportive, collaborative style and promotes self-responsibility for the supervisee's development. Encouraging the supervisee to use reflective practice and critically analyse their own clinical practice is an important part of this process.

At other occasions it is appropriate for the supervisor to use a more structured approach where they more closely direct supervision. This approach is useful when the supervisee is learning new skills or when they present complex cases. Heron's six-category intervention model (as cited in McKenna et al, 2008) is useful to describe these approaches to supervision and their various interventions as shown below.

The authoritative approach, where the supervisor maintains control in the relationship, involves the supervisor being:

- prescriptive by offering advice.
- informative by offering information or instructions.
- confronting by challenging unhelpful patterns of behaviour.

The facilitative approach, where the supervisee takes on a lot more control in the relationship, includes the supervisor using:

- cathartic interventions to assist the supervisee to process emotions.
- catalytic interventions to support the supervisee in self-exploration and problem solving.
- supportive interventions to validate the supervisee's qualities, attitudes or actions.

All approaches and interventions are seen as valuable when they are used skillfully to match the issue being discussed, the supervisee's developmental stage, and their cultural preferences. Awareness of the structural power difference between the supervisor and supervisee is required to manage the relationship appropriately (Hewson, 2002).

### **Reflective Questions**

- 1) *Do you have a natural preference for one supervision approach over the other?*
- 2) *If so, how does this influence your supervision process when supporting practitioners to use FIP?*
- 3) *How could you ensure that you take the approach that best suits the supervisee and their situation?*

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### Providing Evaluation and Feedback

Supervisors are often required to monitor supervisees' standard of work. For example: assessing student counsellors; identifying training needs; supporting professional registration; or when a supervisee is being performance managed. The purpose and process of evaluation should be negotiated between the supervisor and supervisee, and preferably specified in a supervisory contract. This is particularly the case when the supervisor will be providing feedback to other parties, such as line managers or lecturers.

For monitoring to occur, supervisees usually present an aspect of their work, either through case presentation, videotape or live observation. The supervisor and supervisee then review it together and often use this information to develop goals and a supervisory plan. Effective supervisors therefore need to be skillful in providing supervisees with feedback to assist them to gain insight and change their behaviour.

### Maintaining Professional Standards

Practitioners learn a lot from experiencing and observing the behaviour of their clinical supervisor. It is therefore important that supervisors model the professional behaviour expected of practitioners. For example: ensuring that they seek out self-care and professional development; using self-reflective practice; acknowledging their limitations; and maintaining professional relationships with clients and colleagues. Gaining support and development for their supervisory role is also important. This can be done through:

- Supervision for their supervision role.
- Referring to a supervisory code of ethics, such as the New Zealand Association of Counsellor's Code of Supervision.
- Supervisory training.
- Evaluating their supervision work e.g. seeking feedback from supervisees.

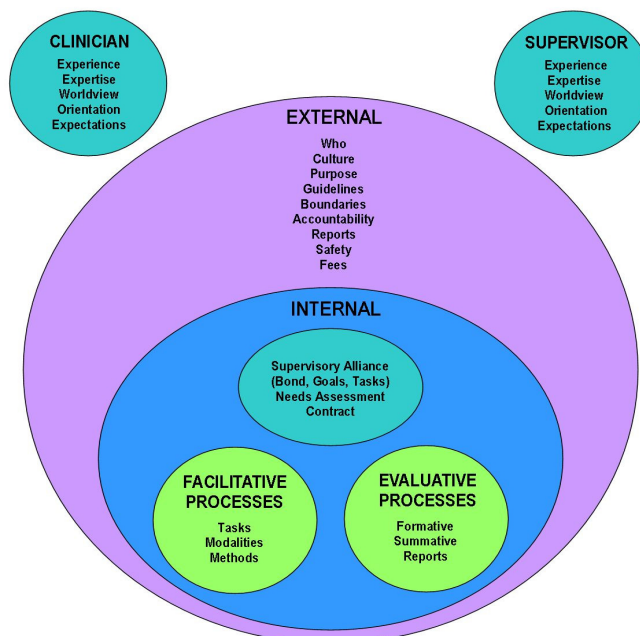
## **Establishing a Supervisory Relationship**

As with a clinical relationship, it is important when establishing a supervisory relationship to clarify its parameters so both parties have a shared understanding. This ensures that clinical supervision is effective and safe. Negotiation of a supervisory contract is essential to ensure that both the supervisee and supervisor understand and agree to the conditions.

Aspects of supervision that need to be clarified in a contract include (Ask & Roche, 2005):

- Establishment of confidentiality (and its limits).
- Frequency and timing.
- Timeframe and review.
- Nature of relationship.
- Dispute/ grievances.

To allow review of a supervisee's progress, it is also useful for supervisory contracts to include the supervisee's goals for further development, such as enhancing their skills in family inclusive practice. Hewson's Structure of Supervision model (as cited in New South Wales Psychologists Registration Board, 2006. p.28) (see diagram below) can assist in establishing a supervisory relationship that meets the needs of all stakeholders. This model provides an overview of all aspects that should be considered when establishing a supervisory relationship, including its wider context. For example, an external supervisor may have quite different roles and responsibilities to that of a supervisor based within an organisation.





Hewson suggests that firstly the supervisor and supervisee both require adequate induction into their roles. External structure is provided by negotiating a contract with all the interested parties, such as employers. Internal structure is established by negotiating a contract between the supervisor and the supervisee. Once these expectations and conditions have been established the tasks of supervision (both facilitative and evaluative) can be conducted safely and effectively (as cited in New South Wales Psychologists Registration Board, 2006).

**Reflective Questions**

- 1) *What structural aspects of your supervisory relationships hinder using FIP?*
- 2) *What structural aspects of your supervisory relationships support using FIP?*

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**Frameworks of Clinical Supervision for Family Inclusive Practice**

Two models most commonly reported being used by clinical supervisors in New Zealand both focus on the content of supervision (McKenna et al., 2008). These two models, a Transactional Analysis model and Hewson’s Supervision Triangle are both applicable in supporting Family Inclusive Practice.

## **The TAPES Model**

This model is based on Transactional Analysis. Using the acronym T.A.P.E.S. it provides a framework for areas that supervision should focus on, namely:

**T**heory

**A**ssessment and intervention planning

**P**arallel Processes

**E**thics and professional practice

**S**trategies and intervention techniques

This model was one of the first supervisory models used for training supervisors in New Zealand and it still remains in use (O'Donoghue, as cited in McKenna et al., 2008). This model is educative and provides clarification of clinical roles. The focus on parallel processes also allows for supportive supervision to occur. Client safety (both emotional and physical) is an important focus for supervision that can be integrated into several of the categories above. For example, it could be included under "Ethics and professional practice" or under "Assessment and intervention planning".

The following table provides examples of questions that may be used as prompts to link this supervision model with family inclusive practice:

<p><b>Theory</b></p> <ul style="list-style-type: none"> <li>▪ What is your understanding of how this work links with family inclusive approaches?</li> <li>▪ What do you know about the role of family, the issues for family members and how family might be involved?</li> <li>▪ Which specific family inclusive models might apply to this work? E.g. SBNT</li> </ul>
<p><b>Assessment</b></p> <ul style="list-style-type: none"> <li>• What do you know about the client’s social structures, supports, their family systems and social networks?</li> <li>• How does your client view the role of family in supporting change?</li> <li>• Who are potential family mediators of change?</li> <li>• What do you know about how the family is impacted upon by the substance use?</li> <li>• What do you know about the risk and protective factors in this family?</li> <li>• What is working now to maintain resilience in this family?</li> </ul>
<p><b>Parallel</b></p> <ul style="list-style-type: none"> <li>• Have you had this experience in relation to family work before?</li> <li>• Does this work remind you of other experiences with families or of your own experiences of families and addictions?</li> </ul>
<p><b>Ethics</b></p> <ul style="list-style-type: none"> <li>• What has been the consent process for this work and how informed is the consent - especially regarding the sharing of information?</li> <li>• Who is the client? Who is not your client and what responsibilities do you hold?</li> <li>• How does this fit with best practice and your professional practice code of ethics and guidelines?</li> </ul> <p><b>Safety</b></p> <ul style="list-style-type: none"> <li>• What are the parameters of your work with this family?</li> <li>• What are the safety issues for the client in their relationships?</li> <li>• What are the safety issues for other family members?</li> <li>• How do you know if the children are safe?</li> <li>• How have you planned to ensure the safety of your client and their family members?</li> <li>• What are the service policies and practices that support your role?</li> </ul>
<p><b>Strategies</b></p> <ul style="list-style-type: none"> <li>• What strategies are you using to promote family involvement?</li> <li>• What tools and strategies work well with your clients to explore family?</li> <li>• What resources do you have available to increase your repertoire of strategies?</li> </ul>

**Reflective Questions**

1) *How could you use this model to integrate Family Inclusive Practice into your supervision work?*

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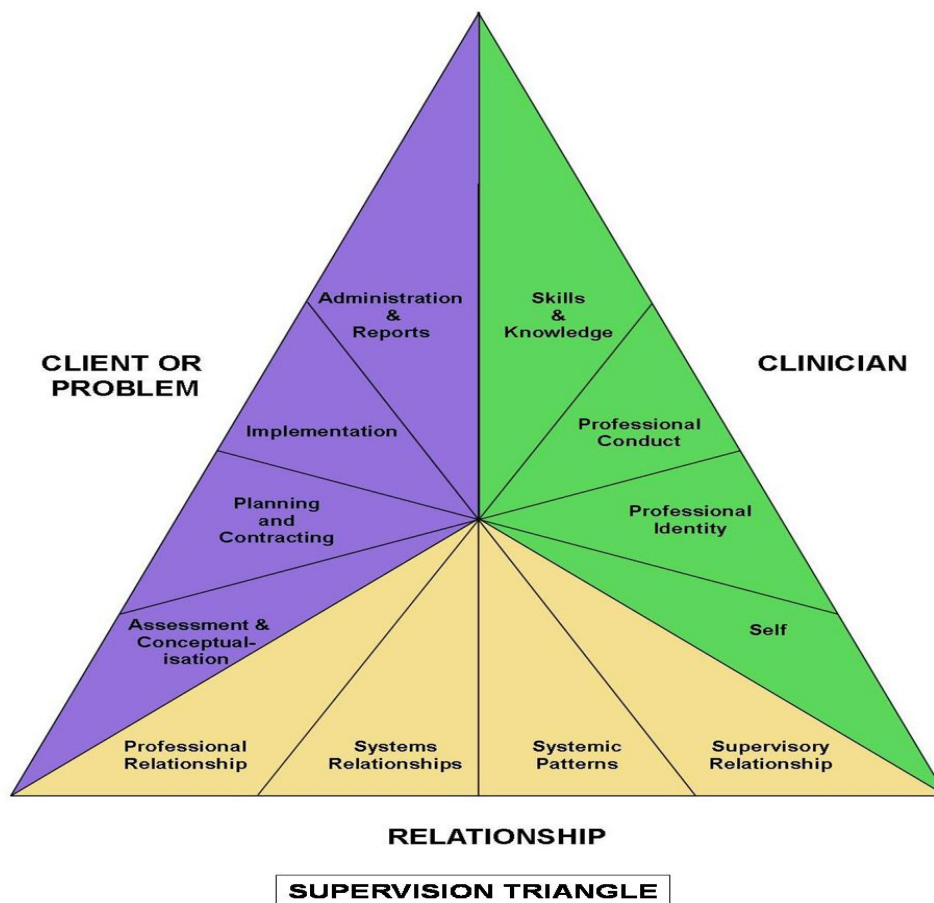
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The Supervision Triangle

The Supervision Triangle model of clinical supervision developed by Daphne Hewson (2002) provides another framework for identifying areas to address in supervision (see diagram below). The three sides of the triangle represent three core dimensions of supervision:

- 1. Client focus: which involves managing counselling work with clients
- 2. Counsellor focus: which involves the counsellor's professional functioning
- 3. Relationship focus: which involves the interactions and boundaries between the wider system of relationships e.g. related to the client, counsellor and supervisor



Hewson, D (2002) Supervision of psychologists: a supervision triangle. In M.McMahon & W. Patton (eds), *Supervision in the Helping Professions: A Practical Approach*. Pearson Education, Frenchs Forest, Australia.

Hewson (2002) observes that a supervisor’s therapeutic orientation is likely to influence which dimension they favour. For example, a psychodynamic supervisor is likely to be relationship-focused, a behavioural supervisor is likely to be client-focused, and a narrative supervisor is likely to be counsellor-focused. Supervisees may also have preferences for which dimension to focus on, e.g. new practitioners are often client-focused. Using the Supervision Triangle allows a broader perspective to be taken to enhance work with clients and it ensures the practitioner is developed in each dimension.

Since the Supervision Triangle was first developed, the many facets of each of dimension have been explored and summarized by 12 components as shown in the following table (Hewson, 2002).

Table 1: Description of the Supervision Triangle (Hewson, 2002)

<b>DIMENSION</b>	<b>COMPONENT</b>	<b>DESCRIPTION OF COMPONENT</b>
<b>Client Focused</b>	Assessment & conceptualisation	Assessing and conceptualising the client's presenting problem and their needs e.g. identify client's strengths
	Planning & contracting	Identifying, negotiating and contracting the goals, structure and methods of counselling with the client e.g. identify who should attend counselling sessions
	Implementation	Ongoing implementation, review and revision of the treatment plan and contract e.g. review goals
	Administration & reports	Ensuring all administrative policies and procedures are completed e.g. file keeping
<b>Counsellor Focused</b>	Skills & knowledge	Ensuring practitioner is sufficiently competent to work with a range of clients or with a particular client e.g. develop a training plan
	Professional conduct	Ethical and professional issues, principles and practices e.g. appropriate boundaries
	Professional identity	Facilitating the development or maintenance of counsellors' professional identity e.g. identify needs of developmental stage
	Self	Awareness of how "self" issues (i.e. values, background and lifestyle) can affect work with clients e.g. conflict between values and role requirements
<b>Relationship Focused</b>	Professional relationship	Ensuring the counsellor's engagement of and ongoing relationship with clients is optimal e.g. maintaining safe relationship
	Supervisory relationship	Ensuring the relationship between the supervisor and counsellor is optimal e.g. clarity about accountability and evaluation
	Systemic patterns	Optimising the impact of systemic patterns such as parallel process, complementary or symmetrical relationships
	Systems relationships	The interactions between sub-systems associated with client, counsellor or supervisor e.g. identifying whether significant others should be involved or not

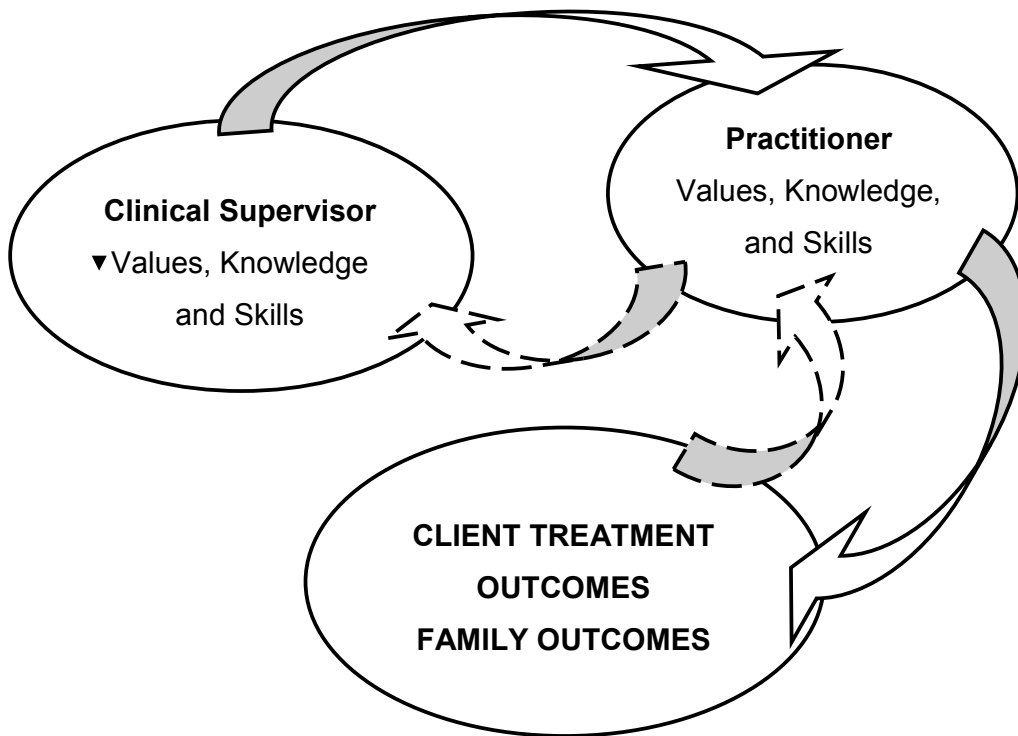






## INTEGRATING FAMILY INCLUSIVE PRACTICE INTO SUPERVISION

This guide aims to support clinical supervisors to enhance their supervisees' effectiveness in using Family Inclusive Practice (FIP), with the aim of improved treatment outcomes for clients. As illustrated below, reciprocal and interactive processes often occur between supervisors, practitioners and clients, which continue to inform practices in working towards best outcomes for clients and their families.



Clinical supervision influences clinical practices that in turn impact on client and family outcomes. Experience from working with families and their clients continues to inform practice and provides material for the practitioner to take to supervision. Ideally with effective supervision this process is ongoing.

The following section aims to draw together an understanding of Family Inclusive Practice, knowledge of clinical supervision best practice, and the experiences of supervisors to develop a framework for how supervisors can integrate FIP into their work. The workshops that accompany this guide will further develop the ideas and their implementation.

## Implementing Family Inclusive Practice

If we reflect on the first section of this guide, it becomes apparent that using Family Inclusive Practice effectively requires particular values and beliefs, attitudes, knowledge and skills.

These have been summarised in the table below.

VALUES BELIEFS AND ATTITUDES	FIP KNOWLEDGE	FIP SKILLS
<b>About Families</b>		
<p>Belief in the value of family systems and their ability to support change</p> <p>Valuing the inclusion of diverse family structures and cultures in the processes of change</p>	<p>The diversity of families in New Zealand including relevant regional demographics re culture, socioeconomic factors migration trends etc</p> <p>Knowledge of the dynamics and issues for various family structures such as same sex parenting, grandparents as caregivers</p> <p>Knowledge of own service and community cultural resources to support practice</p>	<p>Ability to engage with families from diverse cultures and utilise appropriate cultural and other supports when appropriate to address any barriers to accessing AOD services e.g. interpreters</p>
<p>Valuing the potential within clients' families regardless of difficulties and risk issues</p> <p>Demonstrating a willingness to engage with families (<i>taking personal, client and service risk issues into account</i>)</p>	<p>Knowledge of family resilience and solution focused approaches to practice</p>	<p>Ability to elicit hope and forward planning despite complex issues</p> <p>Works to empower clients and families in change processes</p>
VALUES BELIEFS AND ATTITUDES	FIP KNOWLEDGE	FIP SKILLS
<b>About Families and Addictions</b>		
<p>Viewing addiction issues including recovery as located within families and other social systems</p>	<p>Understanding of the processes of change and recovery for individuals in the context of family relationships and the process of change for family members</p> <p>Understanding of motivational processes and how to enhance them for change</p>	<p>Ability to determine 'who' family is and engage family members effectively in response to their readiness for change.</p> <p>Ability to assess and address barriers to pro-actively engage both clients and their families in the change process</p>

	Comprehensive and current knowledge of AOD issues and current interventions	Well established 'core' AOD practice skills e.g. assessment and intervention
A systems view of families and addiction issues	Understanding of systems theory	Ability to assess and work within a system as part of client intervention
A contextual view of addictions and other mental health issues Valuing collaborative approaches to family issues	Understanding of ecological theory  Local service providers and support agencies for families	Collaborative skills to engage and work effectively with a range of agencies and sectors e.g. facilitation, networking, liaison, coordinating
Valuing and supportive of clients' choices about defining family and their involvement in treatment	Knowledge of diverse family structures in NZ, cultural definitions of family and whanau, roles and responsibilities  Awareness of the impact of historical and present MH and AOD issues on family relationships and how this influences current support systems for a client	Ability to explore and assess family and social networks and systems. Use of assessment tools that facilitate client engagement regarding family involvement
Viewing family involvement as a valid AOD intervention	Emerging evidence-based models of FIP e.g. SBNT, Stress Coping Model, CRAFT Understanding of how to apply family inclusive practice in addiction treatment	Ability to transfer models ( or aspects of these)into everyday practice to fit current service delivery
Willingness to expand existing treatment approaches and resources to include families	Knowledge about family inclusive tools, concepts and techniques  Functional analysis of AOD issues from a social perspective  Application of behavioural principles and strategies  Knowledge of group work models and processes	Assessment and planning to include family information and involvement  Using robust tools and strategies to enhance clients' treatment and family well-being using a variety of modalities  Communication and group facilitation skills to support treatment process - setting goals and developing plans  Ability to engage family members in various roles and age groups e.g. children, parents elders
Willingness to sensitively but proactively explore and respond to existing or potential family risk issues	Knowledge of risk factors impacting on families' e.g. family violence.  Knowledge of protective	Assessment of risk and safety planning for clients and families (emotional and physical)

	factors and resources that can be utilised to construct safety plans where applicable	
Valuing of best practice principles	Principles of best practices that include families e.g. ethical, evidence, consumer, cultural  Knowing when aspects of family involvement are contra-indicated	Recognising and responding to best practice issues drawing on appropriate resources
Valuing of organisational services development towards inclusive practices  Willingness to share practice knowledge and skills	Knowledge of the individual and organisational barriers to family inclusive practice  Integration of FIP and Supervision models	Ability to reflect on practices including family involvement  Listening and learning from peers  Mentoring and leading practice developments  FIP Supervision skills
<b>FIP VALUES BELIEFS AND ATTITUDES</b>	<b>FIP KNOWLEDGE</b>	<b>FIP SKILLS</b>
<b>About Self and Families</b>		
Viewing 'self' and therapeutic relationships as part of the change process A willingness to explore emerging issues that influence practice	Self knowledge about family issues that influence practices Awareness of the processes or resources to explore any parallel issues e.g. supervision, peer support or counselling	Ability to reflect on practice and utilise available resources to continue reflection as part of personal and professional development

The range of FIP interventions can be placed on a continuum of family involvement in treatment. When first beginning to use FIP, practitioners may want to use interventions where there are lower levels of family involvement and include other interventions as their skills and confidence develops. Treatment services may also want to adopt this stepped process of change when first introducing FIP interventions.

**Reflective Questions**

- 1) *What would competent use of FIP look like?*
- 2) *How could it be measured?*

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## Constraints and Supports for Inclusive Practice

Both Kina Trust (2006) and Patterson and Clapp (2004) have identified several factors that can limit the use of Family Inclusive Practice. They can be broadly described as:

- Organisational culture and resources e.g. when FIP is not considered standard practice, or there are insufficient resources for family work
- Client motivation e.g. client declines family involvement
- Staff competency e.g. lack of confidence, unclear how to engage families
- Staff motivation e.g. not committed to practice change, uncomfortable sharing responsibility and decision-making with family members
- Staff personal development e.g. lack of awareness of how family of origin issues are impacting on work with clients

As FIP is a relatively recent integration of various models and interventions there is often a lack of clarity and structure about how these factors work together most effectively to promote inclusive service delivery (Centre for Substance Abuse Treatment, 2004). Training and experience is therefore required to determine which interventions are most suited to particular circumstances and how to integrate them coherently. Supervision is a key process in supporting practitioners to undertake this process.

**Reflective Questions**

- 1) *What constraints to FIP have been raised as issues by your staff during supervision?*
- 2) *How does your service support practitioners to implement FIP?*

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Copello et al. (2005) contend that Family Inclusive Practice requires the following understandings to drive practice and service development:

- The social environment is viewed as central to addiction issues - rather than being seen as an adjunct.
- Family is acknowledged as a legitimate unit of intervention – the treatment base is widened to provide more options.
- The potential outcomes of involving family are recognised.

The following conditions support implementation of FIP into treatment:

Competent and Motivated Staff

- Practitioners understand and value the underlying principles of FIP.
- Practitioners understand the FIP tools and strategies and have developed skills and confidence in using them with clients.
- Practitioners are aware of personal issues that may affect their work with families and know how to manage these constructively.

- Practitioners are supported to deal with specific challenges of working with families, for example cultural issues; family safety; managing confidentiality and engagement of families.

#### Supportive Supervisors and Organisations

- Supervisors have sufficient knowledge, skills and confidence in being family inclusive with their own clients.
- Supervisors have knowledge and skills to assist supervisees to integrate family inclusive practices in a coherent way.
- Organisations ensure that their policies and systems encourage practitioners to use FIP.
- Organisations ensure that their physical environments are family friendly.
- Where organisational changes are needed, supervisors advocate for these to occur.

The following ideas are some of the ways that services can support practitioners to effectively use FIP as an intervention:

- Overt recognition that FIP is a key intervention used by the service.
- Common understanding by all staff (receptionists, practitioners, supervisors, and managers) about the benefits of working with families.
- Develop policies and systems that specifically support FIP work e.g. ensure FIP is measured as an output.
- Provide clear understandings of which FIP interventions are being provided by the service.
- Review the physical environments to ensure access for families e.g. child-safe, sufficient space.
- Provide support for clinical staff to receive training and supervision for FIP work.
- Foster the use of a variety of methods to consolidate practitioners' skill development in the work setting e.g. coaching, modelling, co-counselling when working with families.
- Ensure that common practitioner's concerns about FIP are addressed in training and supervision. For example cultural issues; family safety; managing confidentiality and engagement of families.

## **Using Clinical Supervision to Support Practice Change**

The second section of this guide overviewed the wide ranging theories and best practices associated with effective clinical supervision. The main aim of supervision is to support

practitioners to be safe and effective with clients, which includes learning new approaches to clinical work, such as Family Inclusive Practice.

**Reflective Questions**

1) *What do you think supports practitioners to learn a new modality?*

2) *How can supervisors support practitioners' learning?*

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To answer these questions lets summarise some of the key points from the previous section and relate them to Family Inclusive Practice:

- Clinical supervision aims to provide supervisees with:
  - Administration, for example meeting organisational goals for inclusive practice
  - Education, for example developing FIP skills
  - Support, for example processing feelings triggered by working with families
- How to integrate FIP into supervision will depend on the cultural context of the client, the practitioner and the supervisor.
- Practitioners at different developmental stages require different support from supervision, ranging from structured training when first beginning, to collegial discussions of complex cases when very experienced.



- Awareness of relationship dynamics between client, practitioner, and supervisor and the possibility of transference and counter-transference issues may be able to support the practitioner to work more effectively with the client and their family issues.
- Assessing the knowledge and skills that a practitioner has regarding FIP will allow the setting of goals and a supervisory plan to enhance its use.
- All of a supervisor's roles (administrator, evaluator, teacher, and supporter) are relevant to encouraging practitioners to use FIP.
- A coherent approach to supervision and clear understanding of how to support supervisees' behaviour change will be helpful for this practice change.
- Both facilitative and authoritative supervision approaches will be relevant to support practice change, depending on the needs of the supervisee.
- Supervisors could discuss with supervisees whether FIP should be included as a focus for supervision and how this might occur.
- Changes to supervisory arrangements may also need to be discussed with other stakeholders in the practitioner's supervision (e.g. employers, educators, and professional organisations) so that these external structures also support the practitioner to be family inclusive.

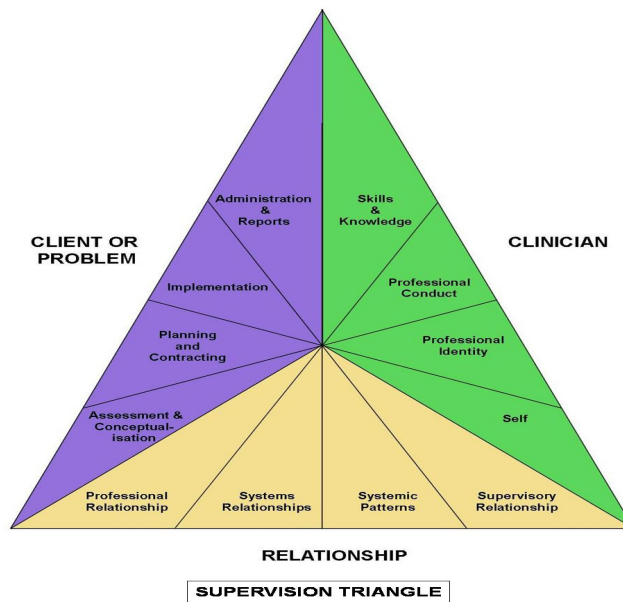
The following section explores how one specific supervision model can be used to focus on FIP during supervision.

## **Applying the Supervision Triangle to Family Inclusive Practice**

The focus of this section is to use Hewson's (2002) Supervision Triangle as a framework of how to integrate Family Inclusive Practice into supervision with clinical staff. Hewson's Supervision Triangle has been chosen for several reasons:

- It is practical, easily applied and transcends different theoretical orientations that supervisors may use.
- It can be used collaboratively with supervisees by making the options transparent.
- It allows difficult issues to be externalised and explored in a non-threatening way.
- It encourages a broader, structured conceptualisation which is appropriate for practitioners developing a new skill base.
- It is useful for all supervisees, regardless of experience or professional background.
- It provides both structure and flexibility.

As discussed in the previous section, the Supervision Triangle has 12 components that supervision can focus on, that relate to three dimensions (client, counsellor and relationships). The issues that are likely to arise in each of these areas in relation to Family Inclusive Practice, and how supervisors could support supervisees will now be explored.



Hewson, D (2002) Supervision of psychologists: a supervision triangle.  
 In M.McMahon & W. Patton (eds), *Supervision in the Helping Professions: A Practical Approach*. Pearson Education, Frenchs Forest, Australia.

### **A) The Client Focused Dimension**

Supervisors can find it helpful to raise the FIP perspective with supervisees in relation to specific clients. This can occur at each of the various stages of treatment.

#### **1) Assessment & Conceptualization**

When practitioners are assessing and conceptualising their clients' counselling needs, it provides a good opportunity to introduce the use of FIP, particularly if the supervisee is feeling stuck with a client and looking for a new approach. Some of the issues that may arise in relation to FIP work are:

- *Have family relationships been included in the assessment process?*
- *Have other potential aspects of resiliency been assessed e.g. personal qualities, interests?*
- *Has the family and social context been included in the case formulation?*
- *What cultural issues might be influencing the client, their family and their substance use?*
- *Has the family been assessed for safety issues e.g. care and protection issues or family violence?*
- *What are the family's concerns regarding risks for the client?*
- *What is the family's view of the client's drug or alcohol use?*

When discussing case conceptualisation supervisors can support practitioners to be family inclusive by:

- Highlighting that practitioners' inclusion of information from family members is an essential part of the assessment process, avoiding the limitations of information being obtained from a single source and resultant improvement in case conceptualisation.

- Sharing tools and resources relevant to being inclusive and strengths-based in the assessment process eg genograms and sociograms.
- Encouraging practitioners to consider contextual views and to examine their underlying paradigms and assumptions of a client's issues and treatment approach.
- Encouraging practitioners to be culturally responsive and seek out cultural consultation as required
- Supporting practitioners to identify current or potential risk of harms in a client's family and to share relevant resources, such as Kina Trust's *Practice guidelines to address safety issues* (Kina Families & Addictions Trust; 2008; Kina Families & Addictions Trust & Matua Raki, 2010). Noting that the inclusion of families views on risk improve the assessment, allow fears to be expressed and allow families to be part of risk management planning.

## 2) Planning & Contracting

How the practitioner negotiates the goals and counselling processes with the client is another opportunity for them to consider inclusive practice. Some of the issues that may arise in relation to FIP work are:

- *Where should the counselling take place?*
- *Who should attend the counselling sessions?*
- *How can the client and/or family members be engaged?*
- *Which issues should be the focus of counselling and what should be prioritised?*

When discussing planning and contracting supervisors can support practitioners to be family inclusive by:

- Teaching skills in pro-active family engagement
- Ensuring they are aware of how to keep themselves and others safe when providing home visits as described in Matua Raki and Kina Trust *Creating Spaces Standalone Guidelines* (Kina Families & Addictions Trust & Matua Raki, 2010).
- Sharing different models of engaging substance users when family members initiate contact
- Co-counselling initial sessions with client to assist in establishing counselling

## 3) Implementation

Lack of progress by the client in treatment can also present an opportunity to introduce FIP as an alternative approach. Some of the issues that may arise in relation to implementing FIP work are:

- *Have the client's family and significant others been included in a treatment plan?*
- *Do methods of treatment need to be reviewed?*
- *What is preventing the client from making changes?*

When discussing implementation supervisors can support practitioners to be family inclusive by:

- Expanding the range of family inclusive treatment options
- Practical arrangements, such as planning a venue, setting up and structuring a session
- Establishing goals related to FIP
- Clarifying the role of a co-therapist
- Identifying and accessing appropriate community resources for referral on
- Sharing resources, such as written material for clients and their families

#### 4) Administration & Reports

When first beginning to implement FIP, policies and procedures for case administration need to be clarified. Once these have been established supervision issues regarding administration often arise less frequently than in other areas. Some of the issues that may arise in relation to FIP work are:

- *When family members are present, who is the client?*
- *How much detail about family members should be recorded e.g. names?*
- *Who requires a file and what information should be collected/recorded?*
- *Should sessions where family members are present be acknowledged statistically and if so, how should this occur?*

When discussing administration supervisors can support practitioners to be family inclusive by:

- Exploring with the practitioner, the potential conflicting agendas or ethical dilemmas that can arise regarding clinical alliances, organisational systems and confidentiality
- Encouraging the practitioner's organisation, either directly or indirectly through the practitioner, to develop appropriate policies and systems

When focused on the "client" aspect of the Supervisor Triangle, a simple way that supervisor's can raise FIP is to always ask at least one of the following questions regarding a client's family for each presented case.

1. Who are the family?
2. How is the family?
3. Where are the family?

The first two questions will assist with assessing the family's needs and starting to develop a treatment plan. The third question will assist with strategy and intervention.

**Reflective Question**

1) *Thinking about your supervisees, what could you use from the “client focused” ideas above to assist them to use FIP with their clients?*

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**B) The Counsellor Focused Dimension**

Raising FIP in supervision is also pertinent to the practitioner and their development, both personally and professionally.

**1) Skills & Knowledge**

As FIP is an emerging approach it is likely that supervisees will need to further develop their knowledge and skills in FIP. Some of the issues that may arise in relation to FIP work are:

- *Is the supervisee sufficiently competent to provide FIP at present?*
- *If not, how can their clients be provided with FIP interventions?*
- *Which skills could the supervisee transfer and build on from other areas of competence e.g. group facilitation skills?*
- *How can the supervisee enhance their FIP skills?*

When discussing skills and knowledge supervisors can support practitioners to be family inclusive by:

- Sharing ideas and written material about FIP.

- Informing of possible training/mentoring/learning opportunities.
- Supporting practitioners to apply their learning into the work context, build confidence and apply it to clients appropriately.
- Encouraging practitioners to connect with their prior learning, and integrate with current practice e.g. building FIP into relapse prevention plans.
- Discussing the range of FIP interventions and set small goals for implementing FIP.
- Clarifying service expectations of the practitioner regarding FIP in their work, both in terms of quality and quantity.
- Assessing the practitioner's level of knowledge and skills in FIP.
- Establishing goals and plan for further development in FIP.

## 2) Professional Conduct

Implementing FIP may require practitioners to deepen their understanding of how to apply some of the ethical and professional issues in more complex situations. For example, appropriate information sharing when working with family members, both in a group and as individuals. Some of the issues that may arise in relation to FIP work are:

- *How can family members be included when work with a client is confidential?*
- *What information can be shared with family members when it has been discussed elsewhere?*
- *Is there risk of violence within this family which would make FIP inappropriate?*
- *How can family members be included when the client declines? What can be done?*
- *If a practitioner is strongly aligned to their client, how can they gain the trust of other family members without the client feeling betrayed?*
- *What happens if a client's family member also wants to see the practitioner for counselling? Would this be a dual relationship?*

When discussing professional conduct supervisors can support practitioners to be family inclusive by:

- Regularly asking practitioners to reflect on the ethical issues that are relevant for clients.
- Encouraging the practitioner to access appropriate policies, codes of ethics and legislation.
- Providing clarity regarding key issues such as confidentiality, consent, privacy and safety.

## 3) Professional identity

Implementing FIP may require practitioners to adjust their professional sense of self either because they need to change their treatment paradigm and/ or they return to being in a novice role. Some of the issues that may arise in relation to FIP work are:

- *How does the practitioner's current stage of development in their professional identity (and their needs at this stage) influence how they are implementing FIP?*
- *What stage of development are they in relation to being competent in FIP?*

- *Does the supervisee perceive that they have sufficient expertise and legitimacy to be family inclusive with their clients?*
- *What role should an AOD practitioner take in a client's network of significant others and how does this relate to other AOD practitioner roles?*

When discussing professional identity supervisors can support practitioners to be family inclusive by:

- Discussing the practitioner's stage of development with them and what they require from supervision to enhance their inclusive practice.
- Supporting them to acknowledge their areas of competency in FIP.
- Assisting practitioners to understand how to integrate their inclusive practice with their other approaches and roles as a practitioner.

#### 4) Self

The use of self in counselling, and a practitioner's personal development, is a key area for supervision to ensure effective clinical practice. Some of the issues that may arise in relation to FIP work are:

- *What are the supervisee's strengths in using "self" when working with families?*
- *In what ways do the supervisee's values, culture, experiences and current context influence their FIP work?*
- *Is the supervisee aware of unresolved family of origin issues that are impeding their FIP work?*
- *In what ways do the supervisee's "self" issues influence their responsiveness to supervision?*
- *Does the counsellor consider it too stressful to work more inclusively?*

When discussing "self" issues supervisors can support practitioners to be family inclusive by:

- Assisting them to identify their personal strengths and constraints to working inclusively
- Raising awareness of systemic patterns, such as parallel processes, and assist the supervisee to explore their personal meaning.
- Supporting supervisees to appropriately address "self" issues when they are hindering their ability to provide FIP effectively to clients.
- Ensuring that any discussion of "self" issues with a supervisee is appropriate within the context of supervision and is negotiated and safe.
- Acknowledging that family inclusive practice may require an initial input of energy, which can be stressful. However, developing a relationship with family and other agencies allows the practitioner to share some of the perceived responsibilities for the client e.g. with regard risk management, support of the client, and allowing the practitioner to operate in their area of expertise knowing that others are also meeting certain client and family needs.

### **Reflective Questions**

1. *Thinking about your supervisees, what could you use from the “counsellor focused” ideas above to assist them to use FIP with their clients?*
2. *How can supervisors ensure that discussing “self” issues with supervisees is appropriate, negotiated and safe?*

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### **C) The Relationships Focused Dimension**

The relationships side of the triangle covers a number of areas not always addressed in supervision but which are highly relevant for practitioners developing FIP.

#### **1) Professional Relationship**

Engaging and maintaining optimal relationships with clients and their families can require some skill. Some of the issues that may arise in relation to FIP work are:

- *Is the culture, of either the practitioner or the client and their family, affecting their relationship?*
- *How to establish and maintain alignment with family members?*
- *How to change alignments to adjust to changing clinical arrangements. For example, when a couple who are normally seen together, want to be seen separately?*
- *When is it appropriate for practitioners to self-disclose to clients about their own family experiences?*
- *Are all the necessary people appropriately informed and involved?*



When discussing counselling relationships supervisors can support practitioners to be family inclusive by:

- Modelling and providing advice about appropriate boundaries and information sharing.
- Supporting the supervisee to self-reflect on dilemmas as they arise.
- Ensuring there are clear procedures and protocols in place and the supervisee is familiar with them.

## 2) Supervisory Relationship

Ideally supervisors are more clinically competent than their supervisees, however AOD treatment is increasingly complex and particularly with the introduction of new approaches such as FIP, it is unlikely that this will always be the case. Optimising the supervisory relationship may therefore require a different approach. Some of the issues that may arise in relation to FIP work are:

- *How could it impact on a supervisee if their supervisor feels defensive about their own level of knowledge in FIP?*
- *Is it the supervisor's role to initiate the learning of a new modality, such as FIP, by the supervisee?*
- *What happens if both supervisor and supervisee are not motivated or resourced to implement FIP?*
- *What supervision methods are most appropriate to assist the supervisee at their stage of development and with FIP?*
- *What supervision methods are most congruent when focused on using FIP in counselling?*

When discussing the supervisory relationship supervisors can support practitioners to be family inclusive by:

- Where the supervisor is not experienced with FIP they can be transparent regarding this and negotiate other processes, such as; arranging someone to be a mentor; a more reflective style of supervision; or a focus on process issues rather than content.
- Discussing with the supervisee whether they want to enhance their FIP skills and build this goal into supervisory plans.
- Using supervision methods that are congruent with a FIP approach and meet the needs of the supervisee's stage of development.
- Reviewing the supervisory relationship in terms of its impact on the supervisee's FIP work.

## 3) Systemic Patterns

Identifying and processing relationship patterns that can develop either within or between subsystems can be a useful part of supervision. This is regardless of whether the supervisory models are psychodynamic or otherwise. Some of the issues that may arise in relation to FIP work are:

- *Is this “problematic” relationship pattern (e.g. between practitioner and client) also found in other relationships that involve these parties (e.g. between the client and family members, or between the practitioner and supervisor)?*
- *If patterns are found, are they helpful or not?*
- *How can systemic patterns be useful in FIP counselling?*

When discussing systemic patterns supervisors can support practitioners to be family inclusive by:

- Assisting supervisees to identify patterns where they exist.
- When clients or practitioners are labelled with a problematic behaviour, considering whether this is a systemic pattern.
- Assisting supervisees to use systemic patterns to benefit the counselling process. For example, interrupting harmful patterns and intentionally creating helpful patterns.

#### 4) Systems Relationships

Wider system relationships are not often included in supervision and yet they are important to ensure supervision models are congruent with Family Inclusive Practice. Some of the issues that may arise in relation to FIP work are:

- *Which professionals and significant others should be involved in the counselling?*
- *Are there professionals or significant others who should not be involved?*
- *What impact is the practitioner’s social and professional network having on their FIP work with clients?*
- *What impact is the supervisor’s social and professional network having on supervision of this FIP work?*
- *How can a practitioner pursue FIP work alone in their team?*
- *What can a practitioner do when clinical space is too small?*
- *Setting up family meetings requires more work and some line managers don’t recognise this, so practitioners worry about being penalised.*
- *Can individually focused services support families by referring them on to more family-focused services?*
- *How can practitioners meet organisations’ Key Performance Indicators of having a proportion of contacts including families when clients decline to have families involved?*

When discussing systems relationships supervisors can support practitioners to be family inclusive by:

- Encouraging supervisees to consider the wider context of their work, in terms of the physical environment, relationships and cultural norms that are influencing it.
- Championing the implementation of FIP within organisations.
- Advocating system changes at a management level to support practice change.



## **Conclusion**

Family Inclusive Practice provides a range of effective interventions when supporting clients with problematic substance use. When implementing FIP, AOD practitioners and addiction treatment services need to make several adjustments to accommodate this way of working. Supervisors are in a pivotal role to support these changes.

The knowledge and skill base already held by clinical supervisors can readily be applied when integrating FIP into supervision with practitioners. There are specific challenges that are likely to arise, such as appropriate information sharing; however addressing these further enhances the current competencies of both supervisors and practitioners. Use of Hewson's (2002) Supervision Triangle can assist supervisors to integrate FIP into all aspects of supervision.



4. The outcome for the supervisee.

5. Reflection, by the supervisor, on the supervision process: learning, development issues, system issues with specific regard to Family Inclusive Practice.

6. Implications for future supervision practice, service development.

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