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Clinical Supervision in Child and Youth Mental Health

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Abstract

The purpose of this research study is to evaluate clinical supervision and clinical supervision training provided by the Ministry of Child and Family Development (MCFD) for team leaders and clinicians in Child and Youth Mental Health (CYMH). This report will recommend best practices for CYMH-specific clinical supervision in order to guide MCFD in the development of a clinical supervision training model. The present study used a mixed methods approach to explore CYMH clinicians' and team leaders' perceived strengths, challenges, and needs for clinical supervision and clinical supervision training. This study involved two mixed methods surveys. One survey was designed for CYMH clinicians to evaluate the effectiveness of clinical supervision; another survey was designed for team leaders to evaluate existing clinical supervision training provided by MCFD. Two focus groups were held via teleconference using semi-structured interview guides to further explore clinicians' and team leaders' perceived strengths, challenges, and needs of clinical supervision and clinical supervision training. Focus group transcripts and survey qualitative responses were analyzed using thematic analysis while quantitative survey data was analyzed for descriptive statistics including univariate and bivariate analyses. Quantitative results indicate that clinicians and team leaders generally reported low satisfaction ratings toward the quality, frequency, and effectiveness of clinical supervision and clinical supervision training to enhance clinical competence, behavioural competencies, and diversity and multicultural competence. Four thematic categories emerged from the qualitative data from the surveys and focus groups related to clinicians' and team leaders' perceived strengths, challenges, and needs for clinical supervision and clinical supervision training, including (a) content and competencies, (b) time, consistency, and access, (c) professional development and expertise, and (d) structural limitations. Based on the study findings, this report produced concrete recommendations toward a systematic, CYMH-specific, and culturally-responsive clinical supervision training model and a clinical supervision structure. These key components may be used by MCFD to guide the future development of clinical supervision training. The five core recommendations include: 1) provide CYMH-specific clinical supervision training to enhance team leaders' competence in clinical supervision; 2) improve team leaders and clinicians' access to training for a wide range of relevant CYMH clinical modalities; 3) separate administrative and clinical supervision roles to improve safety in the supervisory relationship; 4) provide systematic clinical supervision training for team leaders; and 5) prioritize diversity and cultural competence in clinical supervision training. Clinicians face multiple barriers in accessing effective clinical supervision. These barriers include: (a) lack of safeguards for clinicians' clinical supervision, (b) team leaders' dual clinical and administrative roles, (c) prioritization of administrative supervision, (d) lack of systematic clinical supervision training, (d) lack of access to professional development opportunities, (e) lack of training in diversity and cultural competence. This study prompts further consideration and action to improve both clinical supervision and clinical supervision training within CYMH in order to improve treatment outcomes for children and youth in BC.

Keywords: Ministry of Child and Family Development (MCFD), Child and Youth Mental Health (CYMH), clinical supervision, training model, team leaders, clinicians

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Introduction

This research study aims to evaluate clinical supervision and clinical supervision training provided by the Ministry of Child and Family Development (MCFD) for team leaders and clinicians in Child and Youth Mental Health (CYMH), in order to recommend best practices for CYMH-specific clinical supervision and guide MCFD in the development of a clinical supervision training model. CYMH clinicians face challenges in providing effective and evidence-based interventions with the increasing number and complexities of mental health challenges, developmental disabilities, concurrent disorders and experiences of trauma identified among children and youth in BC, especially those of Indigenous heritage who are affected by intergenerational trauma (Bartel & Lampard, 2017; Berland Inc, 2008). Following the implementation of MCFD's The Child and Youth Mental Health Plan in 2003, the final report entitled Promises Kept, Miles to Go: A Review of Child and Youth Mental Health Services in BC called for an improvement in clinical supervision to meet the needs of CYMH clinicians and service users (Berland Inc, 2008). As such, the researchers hypothesized that systematic, CYMH-specific and culturally-relevant clinical supervision training is needed for CYMH team leaders to effectively support clinicians in maintaining quality standards of professional performance and improving health outcomes for the children, youth and families they serve.

Theoretical Framework

This study aims to explore the clinical supervision and training experiences of CYMH clinicians and team leaders, which impact mental health outcomes for children and youth in BC. Given the complexity of engaging children and youth in mental health services, the study will employ ecological systems theory to explore the function and impact of clinical supervision within CYMH services. An ecological systems framework acknowledges the influence of multiple systems, including individual, family, cultural and community contexts on the ways in which individuals think and behave (Crosby, Hsu, Jones & Rice, 2018). Children and youth who access CYMH services are influenced by the relational interactions between systems, including that of their families, communities, CYMH clinicians and team leader, and MCFD.

An anti-oppression framework guides this investigation of the ways in which clinical supervision can support CYMH clinicians to work effectively with and reduce health disparities among marginalized populations. An anti-oppression framework recognizes the impact of systems of oppression on marginalized groups and works toward redressing the balance of power (Corneau & Stergiopoulos, 2012). Imposing dominant values and knowledge on marginalized communities has the potential to reinforce the health inequities experienced by these populations. By recognizing systems of oppression that inherently disadvantage racialized and marginalized children and youth who access CYMH services, this research aims to advocate for changes within CYMH clinical supervision training at MCFD so that clinicians and team leaders can more effectively integrate cultural safety practices and address issues of oppression and health inequity among diverse populations.

Conceptual Framework

The concepts of "child and youth mental health services" and "clinical supervision" will be defined before investigating the research questions.

Child and Youth Mental Health Services. Child and Youth Mental Health (CYMH) services are offered to infants, children and youth up to 18 years of age who are experiencing mental health challenges. CYMH services include referral and intake, initial consultation and brief interventions, case management and consultation, comprehensive mental health assessment, therapy and intervention services, family capacity building and support, and crisis intervention (Bartel & Lampard, 2017; MCFD, n.d.). Specialized CYMH services respond to additional needs, such as Aboriginal populations, infant mental health, early psychosis, developmental disabilities mental health, concurrent disorders and eating disorders (MCFD, n.d.).

Clinical Supervision. Clinical supervision is a distinct professional practice and collaborative interpersonal process through which clinicians receive regular education and training in evidence-based

practices from a supervisor (Falender & Shafranske, 2004). It involves observation, evaluation, feedback, reflection, facilitation of supervisee self-assessment, and the acquisition of knowledge and skills through processes of instruction, modeling, and mutual problem-solving within the supervisory relationship (Falender & Shafranske, 2004; MCFD, 2018; Munson, 2002). Clinical supervision is widely accepted as being important for professional development and to ensure optimal client outcomes (Bambling, King, Raue, Schweitzer & Lambert, 2007; Department of Education and Training, 2018; Finney, Stergiopoulos, Hensel, Bonato, Dewa, 2013; Knudsen, Ducharme, & Roman, 2008).

Literature Review

Through a review of current knowledge in the field, we seek to elucidate some evidence-based best practices in CYMH clinical supervision and demonstrate the knowledge gap in clinical supervision research. This review will focus on the following subtopics related to CYMH clinical supervision: (a) the competency-based clinical supervision model, (b) diversity and multiculturalism, (c) current challenges in CYMH clinical supervision.

Clinical Supervision in Child and Youth Mental Health

In order to support the high complexity of clinical practice in CYMH, clinical supervision is provided to CYMH clinicians to maintain quality standards of professional performance and maximize the benefits for clients. Clinical supervision is widely accepted as being important for professional development and to ensure optimal client outcomes, yet few studies have empirically investigated the impact of clinical supervision on psychotherapy practice and client treatment outcomes (Bambling, King, Raue, Schweitzer & Lambert, 2007). Clinical supervision provides the opportunity for supervisees to regularly review and reflect on their work in order to improve their professional practice (Department of Education and Training, 2018). Clinical supervision is regarded as a protective factor for promoting work performance and work satisfaction, reducing staff turnover and burnout, and promoting quality assurance and best practices for client outcomes (Department of Education and Training, 2018; Finney, Stergiopoulos, Hensel, Bonato, Dewa, 2013; Knudsen, Ducharme, & Roman, 2008).

Competency-Based Clinical Supervision Model

Since MCFD's The Child and Youth Mental Health Plan in 2003, Falender and Shafranske's competency-based model of professional development in clinical supervision has been adopted in B.C.'s CYMH service delivery system (Berland Inc, 2008). Competency theory recognizes that competencies which qualify individuals for specific jobs or functions consist of personality traits and characteristics, in addition to skills, abilities, and knowledge; competency development is a continual process within this learning model (Falender & Shafranske, 2004). Competency-based clinical supervision can be defined as: "An approach that explicitly identifies the knowledge, skills, and values that are assembled to form a clinical competency and develops learning strategies and evaluation procedures to meet criterion referenced competence standards in keeping with evidence-based practices and requirements of the local clinical setting" (Falender & Shafranske, 2007, p. 233).

Competencies can be understood as the habitual use of knowledge, skills, communication, values and reflections in daily practice, to bring about growth in the clinician, and consequently in the client (Falender & Shafranske, 2004). This model involves supervisory contracting, evaluation and feedback, ethical problem-solving, and promotion of self-care strategies and a focus on the supervisory alliance (Falender & Shafranske, 2004; 2008).

While there exists some literature that defines how supervision should be conducted and what tasks should be carried out by the supervisor, there is little focus on the professional competencies that are essential for supervisors to possess in order to be able to fulfill their roles effectively in the field of Child and Youth Mental Health. Using observational coding in their quantitative study, Bailin, Bearman, and Sale (2018) identified frequently-employed supervisory micro-skills that have been shown to enhance therapist adherence and competency in the delivery of evidence-based treatments. These micro-skills include case conceptualization, praise and expression of empathy, supervisor self-disclosure, therapeutic alliance, and administrative tasks (Bailin et al., 2018). Bogo, Rawlings, Katz, and Logie (2014) describe a "Model of Holistic Competence in Social Work" that acknowledges the

interactive complexity of clinical practice. This model integrates knowledge, skills, self-regulation and professional judgment in the professional and community contexts for a systematic review of clinical competence (Bogo et al., 2014; Drisko, 2015).

Barriers that impact the effectiveness of the competency-based clinical supervision model include a lack of consensus on effective supervision competencies and practices, and an absence of systematic training in clinical supervision (Falender & Shafranske, 2004; 2008). To ensure the quality of clinical supervision, evaluation of supervision is recommended (Falender & Shafranske, 2014). Evaluation involves assessing a supervisor's judgment of supervisees' level of clinical proficiency and assessing the success of a training program in developing the competencies of supervisors (Falender & Shafranske, 2008). Evaluation is regarded as extremely important because it provides the necessary feedback to the supervisor, links supervision to its results, and promotes the supervisor's continuing professional development (Falender & Shafranske, 2008).

Diversity and Multiculturalism in Clinical Supervision

Falender, Shafranske, and Falicov (2014) promote the importance of considerations of diversity and multiculturalism in clinical supervision. Supervision diversity competence is defined supervision. Supervision diversity competence is defined as the integration of self-awareness and appreciation of the interaction among the client's, clinician's and supervisor's assumptions, values, biases, and worldviews (Falender et al., 2014). Clinical supervisors must support supervisees to practice appropriate and sensitive assessment and intervention strategies and skills that integrate a critical awareness of cultural, historical and socio-political variables that influence clients' health (Falender et al., 2014). Failing to address cultural diversity and social justice in clinical supervision has a significant impact on clinicians' ability to engage with culturally-diverse service users and confront systems of oppression that affect them (Falender, Shafranske, & Falicov, 2014; Hair & O'Donoghue, 2009; Lee & Kealy, 2018).

Indigenous clinical supervision. Westerman (2004) asserts that models of mental health service delivery have been traditionally "monocultural" and culturally inappropriate for Indigenous service users. In particular, she identifies challenges that clinicians face in engaging Indigenous people, including the use of inappropriate processes of introduction, communication, and assessment (Westerman, 2004). Without evidence-based and culturally-relevant supervision, clinicians are left without empirical guidance on how to provide "culturally sensitive" services. Further, this critique identifies the "failure of mental health services and clinicians to embrace Indigenous conceptualisations of health and well-being" (Westerman, 2004, p. 2). Culturally-relevant supervision is necessary to guide clinician interventions for Indigenous children and youth who are affected by intergenerational trauma and the impact of Canada's history of colonization.

Current Challenges in Child and Youth Mental Health Clinical Supervision

Since 2001, all CYMH clinical supervisors in BC have been trained in the competency-based model of supervision which includes a framework of initiating, developing, implementing and evaluating the process and outcomes of supervision. However, in the Review of Child and Youth Mental Health Services in BC (Berland Inc, 2008), only 68% of 215 surveyed front-line clinicians reported having relevant clinical supervision available to them, and many clinicians and community groups expressed concern about the low level of support available to CYMH clinicians. The report recommended using a holistic approach to evaluate the effectiveness of clinical supervision and build on the current clinical supervision strategy (Berland Inc, 2008).

Lack of culturally-relevant supervision and training. Based on consultation with stakeholder representatives from Aboriginal communities and relevant community agencies, the BC Auditor General's 2007 review of MCFD's Child and Youth Mental Health Plan emphasized the need for culturally-relevant clinical supervision training for CYMH team leaders and Aboriginal cultural sensitivity training for all CYMH clinicians (MCFD, 2007). MCFD has consistently identified that Aboriginal

communities are not accessing CYMH services to the extent that is expected. The BC Auditor General's 2007 review identified that CYMH services were not perceived as culturally sensitive or relevant. Consequently, MCFD provided additional cultural sensitivity training throughout 2006 and 2007 and identified a commitment to enhancing cultural relevance of services for Indigenous children, youth and families (Bartel & Lampard, 2017; MCFD, 2007; 2012). Despite growing recognition that culture sensitivity and social justice must be an integral part of both social work practice and clinical supervision, these considerations are highlighted as a gap in supervision models.

Research Questions

Despite a significant body of literature that has explored the functions, tasks, and responsibilities of a CYMH supervisor, there is limited knowledge of the foundational and functional competencies required of the CYMH supervisor and the self-reported supervisory needs of clinicians in this field. Further, more investigation is required to understand the limitations of the competency-based clinical supervision model in CYMH and the methods used to effectively integrate clinical and multicultural competencies into professional practice. The current study seeks to fill these gaps by exploring the following research questions:

1. What do team leaders and clinicians perceive as the strengths, challenges, and needs in the current competency-based model of clinical supervision in BC?
2. What support and training are needed for clinicians and team leaders to best serve Indigenous children and youth?
3. What clinical competencies are required for CYMH team leaders to provide effective culturally-relevant clinical supervision?
4. What are the recommended best practices in clinical supervision for Child and Youth Mental Health?

Methodology

Research Design

A concurrent triangulation mixed methods approach uses "more than one research method and source of data to study the same phenomena and to enhance validity" where different perspectives will confirm each other, adding weight to the credibility and dependability of qualitative" (Grinnell & Unrau, 2014, p. 684). The study involved two mixed methods surveys and two focus groups which explored clinician's experiences of clinical supervision and team leader's experiences of clinical supervision training. The survey was conducted first and immediately followed by the focus groups.

Sampling

The study population for the survey and focus groups is CYMH team leaders and clinicians employed by MCFD in BC. All current CYMH team leaders and clinicians, both within MCFD and contracted staff-equivalent teams (Intersect and Vancouver Coastal Health), with a minimum of six months working experience in CYMH will be included. Contracted CYMH team leaders and clinicians from non-staff-equivalent teams and those contracted under Delegated Aboriginal Agencies will be excluded as they do not receive the same clinical supervision training. Total population sampling was used to reach as many CYMH clinicians and team leaders in MCFD as possible, with the goal of 100 survey participants for a 95% confidence level and a 9% margin of error. A participant recruitment email was distributed to all CYMH clinicians and team leaders who were employed by MCFD or contracted staff-equivalent teams. A total of 28 team leaders and 53 clinicians completed the surveys. The sample target for the focus groups included two clinicians and two team leaders from each of the five main MCFD programming regions in BC (Interior, Fraser, Vancouver Coastal, Vancouver Island, and North) and at least three representatives from both clinician and team leader groups who are employed by Aboriginal CYMH (ACYMH) agencies for a total of 10-13 clinicians and 10-13 team leaders. A purposive convenience sample of five clinicians and two team leaders voluntarily agreed to participate in the focus groups.

Recruitment

CYMH clinicians and team leaders were recruited via email using a facilitated contact process with the MCFD sponsors of the study and the CYMH staff

listserv. The participant recruitment email included a link to the survey in UBC Qualtrics, a web-based survey platform, and a link to the Demographic Questionnaire for Focus Group Participants (see Appendix D) hosted by UBC Qualtrics where prospective participants indicated their interest in attending the focus groups. Participants consented to voluntarily partake in the survey and focus groups via the UBC Qualtrics surveys and did not receive any monetary incentive for their involvement. Two reminder emails were distributed to potential participants over a period of three weeks. The researchers extended the recruitment time by one week in order to maximize the number of participants. At the end of the survey completion deadline, confirmation emails were sent to focus group participants which included the focus group interview guide and instructions to join the teleconference. Outlook calendar invitations and two email reminders were sent to confirmed participants to encourage attendance at the focus groups.

Data Collection

Surveys. Two surveys were designed and hosted on UBC Qualtrics, including one for clinicians (Appendix B) and one for team leaders (Appendix C). The questions included demographic information and subjective evaluations of previous clinical supervision for clinicians or clinical supervision training for team leaders. The majority of survey questions were quantitative measures using a 5-point Likert scale (Jamieson, 2004). There were 5-6 open-ended questions which explore participants' perceived strengths, challenges and needs within clinical supervision or clinical supervision training. These open-ended questions provide an opportunity for participant-led solutions to emerge. As there is no standardized measurement for evaluating the effectiveness of clinical supervision training, we designed customized questions to explore the relationships between (a) the effectiveness of clinical supervision training as perceived by team leaders; and (b) the effectiveness of clinical supervision as perceived by clinicians. The survey measure was designed by referring to (a) the participant's job requirements, clinical competence, and behavioural competencies listed in job descriptions provided by MCFD; and (b) elements of Falender and Shafranske's (2004) Competency-Based Clinical Supervision model. These questions were designed to investigate the relationship between team leaders' perceived competencies based on their supervision training and clinician's perceived clinical and behavioural competencies based on their supervision. The survey measures were pre-tested by the researchers and MCFD sponsors.

Focus groups. Two focus groups were completed via teleconference, including one for CYMH clinicians and one for CYMH team leaders. Five clinicians and two team leaders from across four MCFD regions attended the focus groups. The demographic information and practice experience of the focus group participants are presented in Table A1. Each focus group was facilitated via teleconference in order to effectively engage participants from across the BC (Allen, 2014). The clinician focus group lasted 1.5 hours and the team leader focus group lasted one hour. For each focus group, the researchers assumed either a moderator or assistant role. The focus groups were audio-recorded for future analysis while the focus group assistant took field notes and recorded participation. Participant engagement guiding principles recommended by Krueger and Casey (2002) were utilized, included sharing the interview questions in advance; taking an active role as a moderator; identifying ground rules at the beginning of the focus group; and using clarifying questions and prompts to elicit discussion. Six semi-structured focus groups questions were designed to explore clinicians' perceived strengths, challenges and needs for existing clinical supervision (see Appendix E for the Focus Group Interview Guide for Clinicians) and team leaders' perceived strengths, challenges and needs for existing clinical supervision training provided by MCFD (see Appendix F for the Focus Group Interview Guide for Team Leaders). At all phases of the data collection process, the researchers took field notes to aid the reflective process and thematic analysis.

Data Analysis

Quantitative analysis. Quantitative analysis of our survey data began by constructing a dataset using

SPSS 12 software. Descriptive statistics were conducted using univariate and bivariate analyses to explore the relationships between variables. For univariate analysis, frequencies and means was run on clinicians' demographic information; "Degree of Satisfaction" associated with the frequency, length, quality of clinical supervision and preferred supervision styles; "Degree of Satisfaction" associated with clinical supervision as it enhances "Clinical Competence of Direct Clinical Services," "Behavioural Competence," and Diversity and Multicultural Competence." For bivariate analyses, the difference of satisfaction on clinical supervision quality among clinicians with different number of years was explored.

Qualitative analysis. Qualitative data from the surveys were separated into transcripts according to each short answer survey question. Focus group audio-recordings were transcribed using naturalized transcription and read over in their entirety to gain familiarity with the information. Data analysis was driven by the research questions and analytic preconceptions informed by the literature review, therefore thematic analysis was conducted to identify emergent themes from the data (Braun & Clarke, 2006). Data analysis was conducted through a series of iterative phases in NVivo version 12. The research team reviewed a section of transcript content for emergent themes by analyzing incident-to-incident segments using initial coding and agreed upon a coding scheme. The goal of initial coding is to "remain open to all possible theoretical directions indicated by your readings of the data" (Charmaz, 2006, p. 46). Using the coding scheme, one researcher conducted initial coding to all the data to identify preparatory codes before a more detailed cycle of coding. Descriptive coding identified the broader topics emerging in the data and categorized the codes to provide a complete summary of coded themes (Saldana, 2003). Structural coding involved applying codes that related to the research question that was used to frame the survey questions and focus group interviews (MacQueen & Guest, 2008). Thematic codes associated with the "strengths", "challenges", and "needs" of clinical supervision and clinical supervision training were identified through structural coding. Finally, axial coding was conducted to reorganize the data set and determine dominant categories and subcategories (Boeije, 2010).

Results

Quantitative Findings

Demographic information. The demographic characteristics of the survey participants are presented in Table 1. Clinicians' backgrounds, compared to team leaders' background, were more likely to have counselling education (41.5% and 28.6% respectively), while team leaders were more likely have social work education than clinicians (35.7% and 17.0% respectively). Most clinicians and team leaders were highly experienced and reported Social Program Officer as their job classification (86.8% and 85.7% respectively). Most clinicians and team leaders came from MCFD CYMH work setting (92.5% and 96.4% respectively) with similar distributions among MCFD regions.

Table 1: *Demographic characteristics of clinicians and team leaders in survey*

Demographics	Clinicians		Team Leaders	
	%	n	%	n
Total (N=81)	100	53	100	28
Education				
Psychology	26.4	14	21.4	6
Social Work	17.0	9	35.7	10
Counselling	41.5	22	28.6	8
Other	15.1	8	14.3	3
Job Classification				
Social Program Officer	86.8	46	85.7	24
Nurse	7.5	4	7.1	2
Licensed Psychologist	5.7	3	7.1	2
Work Setting				
MCFD CYMH	92.5	49	96.4	27
MCFD Aboriginal CYMH	7.5	4	3.6	1
MCFD Region				
Interior	17.0	9	21.4	6
Northern	24.5	13	17.9	5
Vancouver Island	28.3	15	28.6	8
Vancouver Coastal	7.5	4	3.6	1
Fraser	22.6	12	28.6	8
CYMH Experience in Current Position – Years				
< 1	13.2	7	7.2	2
1–3	22.6	12	25.0	7
4–5	9.4	5	17.9	5
6–10	15.1	8	28.6	8
>10	39.6	21	21.4	6
Caseload – Cases				
<10	7.6	4	–	–
11–20	39.6	21	–	–
21–30	37.7	20	–	–
31–40	11.3	6	–	–
41-50	1.9	1	–	–
No. of Supervisees				
<5	–	–	17.9	5
6–10	–	–	67.9	19
10–15	–	–	14.3	4

Clinicians' survey.

Clinicians' evaluation and preferences for clinical supervision frequency, length and supervision style and general quality. For the frequency of clinical supervision, 30.2% of clinicians accessed clinical supervision once per two weeks or monthly with overall satisfaction rating of 58.5% for the frequency, while 45.3% preferred having clinical supervision once per two weeks. For length of clinical supervision, most clinicians accessed clinical supervision for around 60 minutes during each session (56.6%) with 66% of clinicians reporting they were satisfied with the duration of clinical supervision. Meanwhile, 67.9% preferred 60 minutes each time. Overall, 52.8% of clinicians reported feeling satisfied with the quality of clinical supervision received at MCFD. For details, refer to Table A2. Clinicians with more than 5 years of work experience at MCFD reported greater dissatisfied with the quality of clinical supervision than those with no more than 5 years' experiences (58.6% and 33.3% respectively).

Clinicians' preferences of supervision styles. Based on supervision styles adapted by Hung & Smith (2008), most clinicians preferred "Teaching Mentor style" which focuses on supervisee feelings, case conceptualizations, supervisee techniques (64.2%). Further details are shown in Table A2.

Table 3: *The differences of satisfaction on clinical supervision quality between clinicians with up to 5 years' experience and clinicians with more than 5 years' experience*

	Clinicians' Work Experience				Total	
	Up to 5 years		More than 5 years			
	%	n	%	n	%	n
Satisfaction on Clinical Supervision Quality						
Satisfied	66.0	16	41.4	12	52.8	28
Dissatisfied	33.3	8	58.6	17	47.2	25
Total	100.0	24	100.0	29	100.0	53

χ^2 (df) = 3.37, p < .1. df=degree of freedom

Note: Results indicated that a higher proportion of clinicians with more than 5 years of work experience at MCFD were more dissatisfied with the clinical supervision quality than those with no more than 5 years' experiences (58.6% vs 33.3%) and the difference in those with more than 5 years was statistically significant (χ^2 (1) = 3.37, p < .1).

Clinicians' degree of satisfaction for the effectiveness of clinical supervision in enhancing clinical competence. According to clinicians' job descriptions, "clinical competence" was divided into 8 aspects. Overall, clinicians agreed that clinical supervision was effective in enhancing clinical competences which are presented in Table 3. Among these aspects, 50% of clinicians agreed that clinical supervision was effective in enhancing 7 out of 8 clinical competences. Most clinicians reported satisfaction for the effectiveness of clinical supervision in enhancing their clinical competence in "Crisis Intervention and Suicide Assessment" (71.15%), while few clinicians agreed on the effectiveness of clinical supervision in enhancing their clinical competence in "Administering and Scoring Test Instruments" (27.91%). On average, only 54% of clinicians agreed that clinical supervision received at MCFD can enhance their clinical competences. Refer to Table 3 for details.

Clinicians' degree of satisfaction for the effectiveness of clinical supervision in enhancing behavioural competencies. Fewer clinicians reported satisfaction for clinical supervision enhancing behavioural competencies, which were listed in their job descriptions as presented in Table 3. Among the 9 aspects of behavioural competencies, over half of clinicians agreed that clinical supervision was effective in enhancing only 4 out of 9 behavioural competencies. Most of the clinician participants reported satisfaction with the effectiveness of clinical supervision in enhancing "Continuous Development" (63.46%), while only a ew clinicians agreed that clinical supervision enhanced their "Listening, understanding and responding to clients" (37.25%). In general, only around 50% of clinicians agreed that clinical supervision received at MCFD can enhance their clinical competence. Refer to Table 4 for details.

Table 4: *Clinicians' perceived effectiveness of clinical supervision on enhancing their clinical competence and behavioural competencies listed in clinician job description*

Variables	Agree		Disagree		M[a]
	%	n	%	n	
Clinical Competence of Direct Clinical Services					
Intake cases	54.35	25	45.65	21	3.57
Case assessment	57.69	30	42.31	22	3.52
Treatment planning and intervention	63.46	33	36.54	19	3.67
Crisis intervention and suicide assessment	71.15	37	28.85	15	3.81
Consultation/liaison	51.92	27	48.08	25	3.50
Maintaining appropriate records	53.85	28	46.15	24	3.46
Administering and scoring test instruments	27.91	12	72.09	31	2.79
Effective working relationship	52.94	27	47.06	24	3.43
Behavioural competencies					
Listening and responding	37.25	19	62.75	32	3.06
Relationship building with clients	39.22	20	60.78	31	3.14
Self-control and self-regulation	52.94	27	47.06	24	3.29
Problem solving/Judgement	62.75	32	37.25	19	3.59
Service orientation	48.08	25	51.92	27	3.23
Cultural Agility	41.18	21	58.82	30	3.10
Flexibility	52.94	27	47.06	24	3.35
Continuous Development	63.46	33	36.54	19	3.62
Teamwork and Cooperation	48.00	24	52.00	26	3.34

Note: [a]M is the mean score out of 5.

Team leaders' survey.

Type of clinical supervision training received at MCFD & Team leaders' satisfaction on the clinical supervision training quality. Team leaders a range of clinical supervision training provided by MCFD with similar proportions for different trainings: 32.1% of team leaders attended "Competency-Based Clinical Supervision" (provide by Dr. Carol Falender) in 2006 and 17.9% attended the "follow-up video-conferencing sessions" in 2008; same proportion of participants attended "other Clinical Supervision Training" at MCFD (32.1%) which included trainings such as "Cross Discipline - CRS DISC : 2011", "Fierce conversations", "PSA Supervisor Training", "SDA workshops", and "Supervisor Essentials." A total of 25% team leaders attended "General Clinical Supervision Training" and 28.57% independently sought training outside of MCFD. Overall, only 28.6% clinicians reported satisfaction with the quality of clinical supervision training received at MCFD. Table A3 shows that among the team leader participants, those who had attended "Competency-Based Clinical Supervision Training" were more likely to have higher satisfaction on the quality of clinical supervision training with statistically significant.

Team leaders' preference on the length, frequency and format of clinical supervision training. Most team leaders preferred having 15 hours of clinical supervision training per year (35.7%). Team leaders who reported dissatisfaction with the quality of clinical supervision training preferred longer training hours from 15 hours or more than team leaders who reported satisfaction with the quality of training (65% and 25% respectively) and preferred more frequent training (once per year or more) than those who reported satisfaction (70% and 62.5% respectively). Refer to Table A4 for details.

Team leaders' preferences for clinical supervision training content. Adopting from Falender and Shafrankse's (2004) competency-based clinical supervision model, 8 areas were evaluated by team leaders as an indication of their preferred clinical supervision training content (shown in Table A4). Most team leaders preferred learning "technical competence" (23.81%), "supervisory relationship" (15.48%), "structuring" (13.10%) and "evaluation" (13.10%), "ethics and problem-solving" (11.90%), "risk management" (10.71%) (shown in Table A4).

Preferred clinical supervision training format. Team leaders reported the training formats that facilitated the most effective learning: Lecture (64.3%), Role play (50%), Live supervision (50%), Teleconference (32.1%), and Online learning (28.6%) (shown in Table A4).

Table 6: *Team leaders' perceived effectiveness of clinical supervision training on enhancing their clinical supervision competence (listed in team leader job description) and competencies (based on the competency-based supervision model)*

Variables	Agree		Disagree		M[a]
	%	n	%	n	
Clinical Supervision Competence					
Supervising staff	20.83	5	79.17	19	2.46
Providing guidance to staff	8.33	2	91.67	22	1.96
Monitoring and evaluating programs	4.17	1	95.83	23	1.79
Conducting clinical audits	0	0	100	24	1.92
Technical knowledge and ability	4.17	1	95.83	23	1.96
Leadership skills	33.33	8	66.67	16	2.46
Competencies					
Technical Skills and abilities	13.64	3	86.36	19	2.09
Addressing Personal Factors	26.90	6	73.91	17	2.48
Therapeutic and Supervisory Relationships	30.43	7	69.57	16	2.61
Diversity Competence	17.39	4	82.61	19	2.26
Ethics and Problem-solving	21.74	5	78.26	18	2.30
Evaluation and problem-solving solutions	17.39	4	82.61	19	2.13

Note: [a]M is the mean score out of 5.

Team leaders' degree of satisfaction for the effectiveness of clinical supervision training in enhancing competence in clinical supervision listed in job description. Table 6 shows that most of the team leaders, although only around 33.33%, agreed that clinical supervision training can enhance their leadership skills. However, 0% agreed that clinical supervision training can enhance their competence in conducting clinical audits of clinical records and case reviews. Overall, only 12% of team leaders agreed that clinical supervision training can enhance their competence in the clinical supervision work required by their job descriptions.

Team leaders' degree of satisfaction for the effectiveness of clinical supervision training in enhancing competencies based on the competency-based supervision model. Based on Falender and Shafranske's (2004) competency-based clinical supervision model, 6 areas of competencies were evaluated to examine the effectiveness of clinical

supervision training received at MCFD on enhancing team leaders' competencies in providing clinical supervision. Table 7 shown that approximately 30% of team leaders agreed that clinical supervision training provided by MCFD can enhance their competencies in "building alliance in therapeutic and supervisory relationships with clinicians". Only 14% of them agreed that clinical supervision training at MCFD can enhance their skills and abilities to "build technical competence among clinicians". Overall, only 21% of team leaders agreed that clinical supervision training provided by MCFD is effective in enhancing competencies.

Table 7: *The effectiveness of clinical supervision and clinical supervision training on enhancing clinician and team leader participants' diversity and multicultural competence*

	Clinicians						Team Leaders			
	≥ 30%[a]		Agree		Disagree		Agree		Disagree	
	%	n	%	n	%	n	%	n	%	n
Cultural Groups										
Indigenous	45.3	24	32.08	17	67.92	36	39.13	9	60.87	14
Immigrant / Refugees	9.4	5	16.98	9	83.02	44	13.04	3	86.96	20
LGBTQ2S+	30.2	16	32.08	17	67.92	36	17.39	4	82.61	19
Religious minorities	7.5	4	16.98	9	83.02	44	4.35	1	95.65	22
Disabilities	13.2	7	28.30	15	71.70	38	13.04	3	86.96	20
Other	30.2	16	11.32	6	88.68	47	4.35	1	95.65	22

[a] ≥ 30% means the clinician has working with clients come from specific cultural group which occupied at least 30% of the clinicians' caseload

Diversity and multicultural competence. Clinicians and team leaders evaluated clinical supervision and clinical supervision training for its effectiveness in enhancing their diversity and multicultural competence. Among the cultural groups, around 30-45% of clinicians worked with Indigenous clients and LGBTQ2S clients that occupied at least 30% of their caseload. These results indicated that working with diverse groups is common among CYMH. However, only 23% of clinicians agreed that clinical supervision received at MCFD can enhance their diversity and multicultural competence, while only 15% of team leaders agreed that clinical supervision training provided by MCFD can enhance their diversity and multicultural competence.

Qualitative Findings

Four major themes emerged from across the qualitative survey and focus group responses related to CYMH clinicians' evaluation of existing clinical supervision and team leaders' evaluation of existing clinical supervision training provided by MCFD. These themes include: (a) content and competencies, (b) time, consistency, and access, (c) professional development and expertise, and (d) structural limitations.

Content and competencies. Clinicians and team leaders identified content and specific competencies that have been addressed or missed in their clinical supervision and clinical supervision training experiences.

Clinical supervision content. Clinicians reported that existing clinical supervision enhances their behavioural competencies including flexibility, problem-solving and guidance, self-reflection and self-regulation, and teamwork. One clinician identified that clinical supervision "Provides a place to reflect upon the person of the therapist and strengthens awareness of a therapeutic presence." Another clinician reported: "Particularly in areas of problem-solving and flexibility, supervision adds another perspective or more information that may be useful." Many clinicians agreed that existing clinical supervision enhances their clinical competencies in case consultation and treatment planning, and system navigation. Meanwhile, clinicians consistently identified the need for clinical supervision that addresses their personal process and opportunities to openly discuss their experiences of burnout, vicarious traumatization, and countertransference. One clinician expressed a desire for: "the ability to openly discuss stresses and challenges facing clinicians specifically around vicarious trauma, countertransference, etc."

Clinical supervision training content. Team leaders reported that existing clinical supervision training enhances their supervision competencies in building the supervisory relationship and leadership skills. One team leader stated, "The broader training did address personal bias with staff, building alliances, and evaluation strategies." Another team leader stated, "I feel more comfortable offering clinical supervision to my staff - I understand language to use and ways to formulate questions." Team leaders consistently reported that clinical supervision training through MCFD was "generic" and "not specific to the CYMH service line." Team leaders agreed that generalized clinical supervision training covered basic elements of

clinical supervision but failed to address the specific competencies and needs of CYMH team leaders. One team leader stated: “The training I attended was far too broad and did not directly address the standards, ethics, and case distribution for CYMH.” Team leaders identified essential competency areas that clinical supervision training content should prioritize, including addressing personal factors, building the supervisory relationship, building technical competence, cultural and diversity competence, policy and standards, and supervisory and evaluation skills. Further, many team leaders highlighted the need to address countertransference in clinical supervision training.

Time, consistency, and access. Time, consistency, and overall access to clinical supervision and clinical supervision training were identified as a significant challenge among both clinician and team leaders.

Consistency of clinical supervision. Clinicians reported challenges of “time constraints,” “rare supervision,” and “interruptions” which hindered their ability to address clinical and behavioural competencies in clinical supervision. Team leaders identified challenges in “finding the time” and having “not enough time” to prioritize clinical supervision amidst their busy schedules. Many clinicians identified the need for “consistent” and “regular scheduled time” for clinical supervision. One clinician reported: “I would welcome the opportunity to have regular, consistent clinical supervision. I think it is essential and vital to good clinical work.” Another clinician reflected: “What happens when a problem is 'brewing' on my caseload that I am failing to recognize. Hence, the need for regular clinical supervision that discusses every client on the clinician’s caseload.”

Access to and consistency of clinical supervision training. Team leaders consistently identified an overall lack of access to clinical supervision training provided by MCFD. Many team leaders reported that they have received “no training” or received training “over 10 years ago!!!” One clinician emphatically reported: “Do you realize we get NO TRAINING? NONE.” Team leaders reported the need for annual or bi-annual clinical supervision training, “on-going” and “consistent follow up.” One clinician recommended “yearly follow up training to allow for processing and integrating of experiences and new information/research.” Another team leader recommended “on-going” training to enhance supervision competencies: “I think if there’s a way to spread it out it would be lovely, where you do a little bit and you go away and you reflect on it and you integrate it and then you come back and you do another day or something, . . . on-going like that.” Due to the lack of formal training offered, team leaders reported relying on alternative clinical supervision training including external training, peer consultation, and experiential learning. One team leader explained that they utilize several types of alternative clinical supervision training: “There's been little or no clinical supervision training in 10 years, some of the skills above have been gained through experience, consultation with others, self study or other learning opportunities within the Ministry.”

Professional development and expertise. Team leaders’ expertise and access to professional development emerged as significant themes in clinicians’ and team leaders’ experiences of clinical supervision and clinical supervision training.

Clinical supervision, team leaders’ expertise, and access to clinical training. Clinicians consistently reported challenges related to their team leaders’ lack of clinical experience, knowledge in specialized areas, knowledge of the local community or demographic, and clinical expertise. One clinician identified experiencing challenges in their supervision experience because of “Supervisors with far/less experience/expertise clinically, than those they supervise.” Clinicians reported needing clinical supervision that facilitated access to professional development, clinical training on technical skills, and clinical supervision to develop those skills in practice. Clinicians consistently reported that their team leaders “don’t have extensive training in specific modalities necessarily” and therefore they do not receive ongoing support in the development of technical skills. Team leaders consistently identified the challenge of providing clinical supervision to clinicians without regular professional development opportunities: “Like EFT [Emotionally Focused Therapy training] has come out, but I’m not, I’m not going to get to learn that, and I’m going to have to

supervise my staff in doing that. That doesn't work for me, right. We need to have that education as well." Further, clinicians reported that clinical and psychotherapeutic modalities that are supported by MCFD are often not appropriate to meet the needs of their clients. One clinician reported "theoretical modalities that we use within CYMH are not always transferable to Indigenous communities . . . they don't necessarily fit the CBT [Cognitive Behavioural Therapy] or DBT [Dialectical Behaviour Therapy] modality that we can use."

Clinical supervision training and access to professional development. Team leaders consistently identified the need for access to professional development in the form of clinical training and clinical supervision as a supplement to clinical supervision training. One team leader reported: "some of us as supervisors don't get all of the trainings that our clinicians get and I think that that needs to change, . . . as part of our clinical supervision training, we should be given access to those basic training programs." Team leaders identified the lack of clinical supervision for team leaders and limited benefits to access external clinical supervision as a significant gap in their professional development. One team leader stated: "I think the biggest piece missing is my own supervision. Receive work related supervision, but I have had no clinical supervision through a mental health lens. This is crucial to the development of my practice as a clinical leader."

Structural limitations. Clinicians and team leaders consistently reported structural barriers to effective clinical supervision and clinical supervision training including (a) team leaders' dual roles, and (b) lack of a clear clinical supervision framework.

Clinical supervision and team leaders' "dual role". Both clinicians and team leaders reported that team leaders are expected to conduct dual administrative and clinical supervisory roles which strains the supervisory relationship. Clinicians reported a "lack of safety" in the supervisory relationship which impacts their supervision experience negatively. One clinician stated "you can't say how you're really feeling about anything. It gets interpreted the wrong way, it's filed for later use, like sorry, to use against you." Some clinicians reported that their team leaders took a "directive rather than collaborative stance" to clinical supervision. Team leaders reported that "managing performance issues at the same time as the elements necessary for a supportive open supervisory relationship (they aren't compatible)." The dual role simultaneously impacted the content of clinical supervision sessions, where team leaders are more likely to focus on administrative supervision than clinical or therapeutic supervision to address clinician's personal process: "It helps focus on the bureaucratic but some times at the expense of therapeutic." One clinician reflected: "So while we do work in mental health we don't have really any support for our own mental health."

Structural alternatives for clinical supervision. The separation of team leaders' dual administrative and clinical supervisory roles was identified to be a significant need to improve clinicians' experience of clinical supervision and sense of safety. Some clinicians reported recommended a "two-pronged approach" wherein clinical supervision is provided by MCFD but not by an administrative team leader: "I think that having. Clinical supervisor that is not also the person the is in charge of disciplinary action could lead to a safer more in-depth experience." Many clinicians reported the need for external clinical supervision, not provided by MCFD: "Clinical supervision, done ethically and responsibly, should be done by neutral 3rd party with demonstrated expertise." Others reported the need for clinical supervision in specialized areas and peer consultation. Some clinicians identified that existing clinical supervision fails to respond to professional diversity among the CYMH team. One clinician reported: "I would love to have access to appropriate supervision at my level (Psychologist), but since moving to a new team I don't have access to that. . . . Our work is different and our approach is different, so we need different supervision."

Clinical supervision training framework. Clinicians reported needing a clear framework and guidelines for clinical supervision sessions. One clinician reported the need for "a rubric that can be used as a check-in too to ensure that all elements of supervision are

discussed in a balanced manner." Team leaders further reported that clinical supervision training failed to provide a clear framework and guidelines for clinical supervision sessions. Training must provide a clear clinical supervision model or framework for team leaders to follow for consistency to meet the needs of the clinicians they supervise. One team leader identified that "A clearly articulated model that is supported by MCFD, with standards that are clear, along with consistent follow up regarding the training would be beneficial." Another team leader identified a clinical supervision model as a gap in current training: "I think maybe what I'm missing is an overarching model and, and just a way of feeling kind of um structured in my approach or knowing that I have, that I'm not missing some pieces."

Discussion

This study evaluated clinical supervision and clinical supervision training for CYMH clinicians and team leaders. Six primary barriers to effective clinical supervision were identified across the quantitative and qualitative findings.

Primary Barriers to Effective Clinical Supervision.

There is no system to safeguard clinicians' clinical supervision opportunity and quality. Clinicians reported that the overall provision of clinical supervision was irregular, rare, and inconsistent; there are no guidelines, no structure, no time frame, and no feedback system for both team leaders and clinicians to implement. Most clinicians received clinical supervision once per month or more. Senior clinicians were more likely to received less frequent supervision and report less satisfaction with their experience of clinical supervision. The lack of a clear framework for clinical supervision diminishes clinicians' opportunities to learn, release stress from a heavy caseload, and receive support to prevent burnout. Developing a supportive and consistent supervision structure can aid in responding to the high turnover rate of CYMH clinicians that is reported in existing literature (Berland Inc, 2008). Effective clinical supervision can be considered a protective factor for reducing staff turnover and burnout, and promoting best practices for client's outcomes (Finney et al., 2013; Knudsen et al., 2008). CYMH services are characterized as clinical practice which rely on professional development and continuous clinical training. Relationship-building, youth-centered and family-centered clinical skills are emphasized for successful engagement of this complex population. The effectiveness of engagement and accuracy of assessment of mental illness relies heavily on clinicians' training and clinical experiences, therefore clinical supervision in CYMH must be considered a priority.

Supervisors' dual roles strain the therapeutic supervisory relationship. There has been no previous discussion of team leaders' dual clinical and administrative roles as a barrier to competency-based clinical supervision in existing literature. The findings of this study highlight the dual role as a significant source of tension and "lack of safety" in the supervisory relationship. The therapeutic presence, congruence, unconditional positive regard, and empathetic understanding are behavioural competencies that are well regarded as the essence of therapeutic alliance with clients and determine the effectiveness of the intervention (Fallender & Shafranske, 2004). Clinicians in this study reported dissatisfaction with the overall effectiveness of clinical supervision to enhance behavioural competencies. To enhance these personal and sensitive behavioural competencies, clinicians require a safe alliance in the supervisory relationship to be open to vulnerability and therapeutic change. Some clinicians shared a possible solution of creating a "two-pronged approach" where one team leader provides administrative supervision and one team leader provides clinical supervision in order to increase the sense of safety and support in the supervisory relationship.

The lack of clinical supervision training has pushed team leaders into primarily administrative roles. The overall lack of clinical supervision training has created a disconnect between CYMH team leaders' expertise and the clinical supervisory expectations of their role. Team leaders face a dilemma because they do not receive adequate training in the competencies of clinical supervision, but they are expected to perform as a clinical supervisor and enhance clinicians' technical knowledge as listed in their job description. Team leaders face challenges in providing clinical

supervision to clinicians with diverse and different professional backgrounds than their own. Some team leaders reported concerns that it is unethical for them to train clinicians when they have received proper training. This disconnect in training and role expectations may cause team leaders to shift their roles of clinical supervision into primarily "administrative supervision" and prioritize administrative tasks such as supporting clinicians to "keep on track of paperwork" which was identified in qualitative findings. This alteration of the nature of clinical supervision creates unmet needs, disappointment and tension between clinicians and team leaders which may cause further strain to the therapeutic supervisory relationship.

The lack of access to systematic clinical supervision training negatively affects the provision of clinical supervision. The findings of this study align with existing literature that identifies the absence of systematic training in clinical supervision as one of the most significant barriers that impact the effectiveness of the competency-based clinical supervision model (Falender & Shafranske, 2004; 2008). Team leaders in our study reported receiving very limited clinical supervision training and had consistently low satisfaction ratings in the effectiveness of clinical supervision training on all aspects of clinical supervision competence and competencies. Without adequate support and training, team leaders may begin a maladaptive cycle of prioritizing the administrative supervision roles, as discussed previously. This was reflected in team leaders' preferences of training content. Establishing a comprehensive and systematic clinical supervision model is necessary to renew the purpose and value of clinical supervision.

Lack of access to clinical training and professional development. The ability of clinical supervision training to enhance "technical knowledge and ability" was rated poorly by team leaders. This finding is consistent with the qualitative findings that participants believed that their supervisors were not able to provide effective clinical supervision related to specific clinical modalities. The findings of this study are congruent with existing academic literature that , expresses concern over the low level of clinical supervision accessible to CYMH clinicians (Berland Inc, 2008). Clinicians are expected to provide extensive clinical services to clients with complex psychological needs, involving diagnosis assessment, and treatment. Team leaders are therefore expected to have their own clinical training and technical skills to supervise and support the ongoing development clinician's clinical skills. As such, access to clinical training and "supervision to supervisors" should be prioritized in CYMH to promote team leaders' continuing professional development (Falender & Shafranske, 2008). Team leaders who attended Competency-Based Supervision Model Training show higher satisfaction ratings on the quality of clinical supervision training which might indicate that Competency-Based Supervision Model training is effective.

Lack of diversity and cultural competence in clinical supervision training. The majority of clinicians in our study reported dissatisfaction with the effectiveness of clinical supervision in enhancing cultural competence and preparing them to serve Indigenous children and youth. Further, the majority of team leaders disagreed that clinical supervision training enhances their cultural competence and prepares them to supervise clinicians who serve Indigenous children and youth. These results verify the findings of MCFD's (Berland Inc, 2008) report, Promises Kept, Miles to Go: A Review of Child and Youth Mental Health Services in BC, which identified that existing MCFD clinical supervision training fails to address the need for culturally-appropriate supervision for clinicians who serve Indigenous children and youth. Our findings that clinical modalities supported by MCFD "are not always transferable to Indigenous communities" and not considered culturally-appropriate for Indigenous children and youth echoes the work of Westerman (2004) who points to the "monoculture" of the mainstream mental health system that is unresponsive to the specific needs of Indigenous peoples. Understanding clinical supervision training through an anti-oppressive framework calls for MCFD to prioritize the development of "Diversity Competence" for CYMH team leaders in clinical supervision training, support

the enhancement of "Cultural Agility" in CYMH clinicians, and offer professional development training in culturally-responsive clinical modalities in order to guide culturally safe interventions and reduce health disparities for Indigenous children and youth in BC.

Limitations

Internal Validity

Time constraints and design of the study. Due to the time constraints of the UBC research methods course, the researchers were limited in their ability to investigate the research objectives thoroughly. Clinical supervision training is an under-researched topic which led to challenges in the design of the study measures. In the design of the survey tool for clinicians, measures which evaluated the effectiveness of clinical supervision to enhance clinical competence and behavioural competencies might not reflect clinicians' needs and preferences. While clinicians reported low satisfaction related to the effectiveness of clinical supervision in those areas, clinicians may have performed well in those areas already therefore their team leader may not address those competencies in clinical supervision sessions. To improve the design of the survey tool, the researchers recommend additional measures to evaluate clinicians' preferences related to the content of clinical supervision to obtain more accurate data that demonstrates a cause-and-effect relationship.

High percentage of missing values and recall bias. The percentage of missing values in the team leaders' survey is relatively higher than that in the clinicians' survey. This may contribute to the irregular and insufficient data on the provision of clinical supervision training provided in the past years, the most relevant trainings based on the Competency-based Clinical Supervision Model was held in 2006 and 2008. Those who did not attend the training might think it is irrelevant to evaluate the effectiveness of clinical supervision training and therefore tend to choose "N/A" or "Neither agree or disagree." For team leaders who attended the training, it might be difficult for them to recall the learning 10 or more years ago. Their responses may have been based on frustration from not having received training for decades after. This recall bias poses a threat to internal validity.

External Validity

Sample size and sample selection. Due to the time limitations of the project and the uncontrollable factor of participants involvement, we were not able to obtain a sample of 120 participants to achieve a 95% confidence level with an acceptable 8% margin of error. The recruitment emails were forwarded to all clinicians and team leaders directly instead of going through a random sampling process, therefore participants who have stronger opinions might be more motivated to join the study. This may have created a bias in the study results and affect the generalizability.

Non-validated tool. There is no prior study on clinical supervision training and no validated measurement tool to evaluate the effectiveness of clinical supervision training. We designed our survey tool which affects the content reliability of this study.

Proportion of participants from different regions in quantitative data. As we are not aware of the exact proportion of CYMH clinicians and team leaders across various work settings and MCFD regions, we cannot determine whether the data collected is representative of the clinicians and team leaders in those work settings and regions. As such, it is difficult to produce specific recommendations for those unique work setting and regions. For example, there is only 3-8% of participants from the Vancouver Coastal region, but this may not be proportional to the percentage of clinicians and team leaders in their geographical regions, and thus might not able to be a representative sample of their voices. Similarly, the low percentage of participants working in MCFD Aboriginal CYMH does not adequately reflect the voices of clinicians in MCFD Aboriginal CYMH.

Transferability of qualitative data. The limited responses to our focus group recruitment methods produced a non-representative sample of clinicians and team leaders for focus groups and negatively affects the transferability of qualitative data.

Implications

Based on our findings and from the unique experiences of our participants, we have produced recommendations for MCFD to improve upon existing clinical supervision training programs or design a

clinical supervision training program that is tailored to CYMH. Improving clinical supervision training and clinical supervision is an essential step toward improving the overall support for CYMH clinicians and improving treatment outcomes for children and youth in BC.

Recommendations

Based on current findings, recommendations for a clinical supervision training model are identified in terms of clinical supervision training content, length, frequency and format and the clinical supervision structure. Five core recommendations for clinical supervision training within CYMH are detailed below:

1. *Provide clinical supervision training that is tailored to CYMH and responsive to the unique needs of CYMH team leaders and clinicians.*

Based on the study findings, a specific clinical supervision training model is recommended to cater to the unique needs and challenges of CYMH team leaders and clinicians: (a) content: team leaders would prefer to enhance competencies in "technical skills," "supervisory relationship," "structuring," "evaluation," "ethics and problem-solving," and "risk management". Addressing all competencies from Falender and Shafranske's (2004) competency-based clinical supervision model and clinical supervision competences is recommended; (b) format: team leaders would prefer to learn through lecture, role play and live supervision, teleconference and online learning.

2. *Improve access to training for relevant CYMH clinical modalities.*

In order to provide effective clinical intervention to clients with complex mental health challenges, we recommend both team leaders and clinicians obtain access to clinical trainings. Team leaders should be encouraged to develop their own expertise in specialized modalities to more effectively support clinicians' needs and build technical competence.

3. *Separate administrative supervision and clinical supervision and provide options for clinical supervision.*

We recommend providing access to a wide range of opportunities for clinical supervision within CYMH to meet the specialized needs of clinicians : (a) choices: provide access to individual and group clinical supervision with alternative MCFD team leaders and external supervisors that have expertise in specialized areas of CYMH practice; (b) peer consultation: coordinate a peer clinical consultation group for both clinicians and team leaders for mutual support and learning in specialized areas, including technical skills or practice experiences with specific cultural groups; (c) framework: provide a clear framework and guidelines for the provision of clinical supervision to ensure both team leaders and clinicians have clear expectations for clinical supervision, including an evaluation and feedback mechanism to facilitate and improve their clinical supervision experiences.

4. *Provide regular and consistent clinical supervision training for team leaders.*

We recommend that MCFD provide access to regular and consistent clinical supervision training for ongoing professional development of team leaders in CYMH. Based on the findings of this study, team leaders would prefer to access 15 hours of clinical supervision training per year.

5. *Enhance clinical supervision training to build diversity and cultural competence.*

We recommend providing regular access to clinical supervision training on diversity competence, Indigenous cultural safety, and culturally-responsive interventions in CYMH. We recommend identifying clinicians and team leaders with rich experiences working with diverse groups to form specific working/sharing groups to promote and share practice wisdom and clinical experiences to enhance competencies in specialized areas and build peer support networks.

Future Directions

The researchers recommend for MCFD to proceed to the next step of research, to have a jurisdictional scan of clinical supervision models across Canadian provinces and territories to support the development of a clinical supervision training model tailored to CYMH. A jurisdictional scan may seek to address concerns raised by our findings, prior to designing a comprehensive training program based on the competency-based clinical supervision model for team leaders in CYMH. Further research is also

recommended on culturally-responsive and Indigenous models of clinical supervision.

Conclusion

This research study responded to reports indicating the increasing number and complexities of mental health challenges among children and youth in BC, high turnover rate of clinicians, and concerns about the inadequacies of clinical supervision for clinicians in CYMH (Berland Inc, 2008). The study was designed to evaluate clinical supervision and clinical supervision training provided by MCFD, in order to make recommendations for CYMH-specific clinical supervision training in BC.

The study explored both team leaders and clinicians' experiences and perceived strengths, challenges and needs of the current clinical supervision and clinical supervision training. Specific clinical competence and competencies required for CYMH team leaders to provide effective clinical supervision to clinicians were identified. Based on the study findings, this report produced recommendations toward a systematic, CYMH-specific, and culturally-responsive clinical supervision training model and a clinical supervision structure.

Concrete recommendations are provided, relating to the structure, frequency, length, format, and preferred content of clinical supervision and clinical supervision training to build on relevant clinical competence and competencies. These key components may be used by MCFD to guide the future development of clinical supervision training, in order to prepare CYMH team leaders and clinicians to meet the increasingly complex needs of children and youth in BC. The researchers hope that this final report will be used to improve upon clinical supervision training for CYMH team leaders and ultimately to both provide further support for CYMH clinicians and improve treatment outcomes for children and youth in BC.

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Appendix A

Tables of Results

Table A1

Participant Demographic Information and Practice Experience (N=7)

Demographics	n
Job Title	
Clinician	5
Team Leader	2
Education Background	
Master's Degree in Social Work	1
Master's Degree in Educational Counselling	2
Master's Degree in Clinical Psychology	2
Master's Degree in Child and Youth Care	0
Master's or Bachelor's Degree in Nursing	0
Ph.D. in Clinical/Applied Psychology	0
Other - Master's Degree in Counselling Psychology	1
Other - Master's Degree in Counselling	1
Job Classification	
Social Program Officer	7
Nurse	0
Licensed Psychologist	0
Work Setting	
MCFD CYMH	6
MCFD Aboriginal CYMH	1
Contracted CYMH Agency – Vancouver Coastal Health	0
Contracted CYMH Agency – Intersect	0
MCFD Region	
Interior	1
Northern	0
Vancouver Island	3
Vancouver Coastal	1
Fraser	2
Number of Years Employed in Current Position	
< 1	0
1-3	2
>3-5	3
>5-10	2
>10	0

Table A2

Clinicians' Overall Evaluation on Clinical Supervision and Preferences

Variables	Clinicians	
	%	n
Total no. of Clinicians	100	53
Frequency of Clinical Supervision		
Every week	5.7	3
Every two weeks	30.2	16
Every three weeks	1.9	1
Every month	30.2	16
Every two months	13.2	7
Quarterly	9.4	5
As needed	5.7	3
Never	3.8	2
Satisfaction on the Frequency of Clinical Supervision		
Satisfied	58.5	31
Dissatisfied	41.5	22
Preferred Frequency of Clinical Supervision		
Every week	18.9	10
Every two weeks	45.3	24
Every three weeks	1.9	1
Every month	18.9	10
As needed	11.3	6
Other	3.8	2
Length of Clinical Supervision – Minutes		
≈30	24.5	13
≈60	56.6	30
≈90	9.4	5
≈120	5.7	3
As needed	3.8	2
Preferred Length of Clinical Supervision – Minutes		
≈30	1.9	1
≈60	67.9	36
≈90	18.9	10
≈120	1.9	1
As needed	7.5	4
Other	1.9	1
Satisfaction on the Length of Clinical Supervision		
Satisfied	66.0	35
Dissatisfied	34.0	18
Quality of Clinical Supervision		
Satisfied	52.8	28
Dissatisfied	47.2	25
Preferred Supervision Style		
Technical Director[a]	5.7	3
Teaching Mentor[b]	64.1	34
Supportive Mentor[c]	5.7	3
Delegating Colleague[d]	3.8	2
Other	20.7	11

[a] Technical Director is the type of supervision style that primarily provides directions on issues, little attention for feelings.
[b] Teaching Mentor is the type of supervision style that focuses on supervisee feelings, case conceptualizations, supervisee techniques.
[c] Supportive Mentor is the type of supervision style that focuses on supervisee feelings, not case conceptualization, watches supervisee techniques used with clients.
[d] Delegating Colleague is the type of supervision style that expects supervisee to exhibit an emotional awareness and possess adequate counseling skills and techniques, little support or direction is given.

Table A3

The Difference of Satisfaction on Clinical Supervision Quality Between Clinicians With Competency-Based Supervision Model Training and Clinicians Without Competency-Based Supervision Model Training

	Clinicians' Work Experience				Total	
	With CBSM[a] Training		Without CBSM Training			
	%	n	%	n	%	n
Satisfaction on Clinical Supervision Quality						
Satisfied	66.7	6	10.5	2	28.6	8
Dissatisfied	33.3	3	89.5	17	71.4	20
Total	100.0	9	100.0	19		

χ^2 (df) = 9.43, $p < .01$. df=degree of freedom

Results indicated that clinicians with Competency-Based Supervision Model Training were more likely to dissatisfied with the clinical supervision quality than those without (66.7% vs 10.5%) and the effectiveness of Competency-Based Supervision Model Training was statistically significant (χ^2 (1) = 9.43, $p < .01$).

[a] CBSM is Competency-Based Supervision Model Training.

Table A4

Team Leaders' Overall Evaluation on Clinical Supervision Training and Preferences

Variables	Team Leaders	
	%	n
Total no. of Team Leaders	100	28
Type of Clinical Supervision Training Received		
Competency-Based Clinical Supervision Model[a]	32.1	9
Video-conferencing Sessions[b]	17.9	5
General Training[c]	25.0	7
Other Training[d]	32.1	9
Non-MCFD Training[g][d]	28.6	8
Satisfaction on the Quality of Clinical Supervision Training		
Satisfied	28.6	8
Dissatisfied	71.4	20
Preferred Clinical Supervision Training Hours per year – Hours		
≤5	17.9	5
≤10	28.6	8
≤15	35.7	10
≤20	10.7	3
>20	7.1	2
Preferred Frequency of Clinical Supervision Training –		
Twice per year	3.6	1
Once per year	60.7	17
Once per two years	28.5	8
Once per three years	3.6	1
Other	3.6	1
Preferred Clinical Supervision Training Content		
Technical Competence[f]	23.8	20
Structuring[g]	13.1	11
Supervisory Relationship[h]	15.5	13
Cultural and Diversity Competence	3.6	3
Risk Management	10.7	9
Ethics and Problem-solving	11.9	10
Evaluation[i]	13.1	11
Self-care Strategies	3.6	3
Other	4.7	4

[a] Competency-Based Clinical Supervision Model (by Dr. Carol Falender) was provided for CYMH Clinical Supervisors at MCFD in 2006.

[b] Videoconferencing Sessions was the follow-up sessions of Competency-Based Clinical Supervision Model (by Dr. Carol Falender) for CYMH Clinical Supervisors at MCFD in 2008.

[c] General Training was the general clinical supervision training provided by the Justice Institute at MCFD.

[d] Other Training is the clinical supervision training of other modalities at MCFD, including "Cross Discipline - CRS DISC : 2011", "Fierce conversations" , "PSA Supervisor Training" , "SDA workshops" and "Supervisor Essentials" etc.

[e] Non-MCFD Training is the training obtained by team leaders themselves outside MCFD.

[f] Technical competence is the technical competence related to CYMH clinical practice.

[g] Structuring refers to how to "structuring the supervisory experience" including contract, log, formative evaluation, summative evaluation, and feedback.

[h] Supervisory Relationship refers to supervisory alliance building, countertransference management.

[i] Evaluation refers to the use of deterrents, strategies, outcome measures in process of supervision, identifying and problem-solving solutions.

Appendix B

Clinical Supervision in Child and Youth Mental Health: Survey for Clinicians

1. Job Title: Are you *currently* a CYMH clinician or team leader?
   - ❑ CYMH Clinician
   - ❑ Team Leader

Demographic Information

2. Education background:

   - ❑ Master's Degree in Social Work
   - ❑ Master's Degree in Educational Counselling
   - ❑ Master's Degree in Clinical Psychology
   - ❑ Master's Degree in Child and Youth Care
   - ❑ Master's or Bachelor's Degree in Nursing
   - ❑ Ph.D. in clinical/applied psychology
   - ❑ Others: _____

3. Classification:

   - ❑ Social Program Officer
   - ❑ Nurse
   - ❑ Licensed Psychologist

4. Work Setting:

   - ❑ MCFD CYMH
   - ❑ MCFD Aboriginal CYMH
   - ❑ Contracted CYMH Agency – Vancouver Coastal Health
   - ❑ Contracted CYMH Agency – Intersect

5. The number of years working at MCFD or a contracted agency:
   - ❑ Less than 6 months (The survey will be ended)
   - ❑ 6-12 months
   - ❑ 1-3 years
   - ❑ 3-5 years
   - ❑ 5-10 years
   - ❑ 10+ years

6. Over the past 6 months, how many hours of clinical supervision have you received **per month** from your team leader **on average**?
   - ❑ 1) 0 hours
   - ❑ 2) 1-2
   - ❑ 3) 2-4
   - ❑ 4) 4-8
   - ❑ 5) 8+

7. How satisfied are you with the average number of hours of clinical supervision received per month from your team leader?
   - ❑ Very satisfied
   - ❑ Satisfied
   - ❑ Neither satisfied nor dissatisfied
   - ❑ Dissatisfied
   - ❑ Very dissatisfied

8. How many hours of clinical supervision **would you prefer** to receive **per month** from your team leader?
   - ❑ 0 hours
   - ❑ 2) 1-2
   - ❑ 3) 2-4
   - ❑ 4) 4-8
   - ❑ 5) 8-10
   - ❑ 6) 10-12
   - ❑ 7) 12+

9. How satisfied are you with the quality of clinical supervision received per month from your team leader?
   - ❑ Very satisfied
   - ❑ Satisfied
   - ❑ Neither satisfied nor dissatisfied
   - ❑ Dissatisfied
   - ❑ Very dissatisfied

10. Over the past 6 months, which groups made up a significant proportion (30% or more) of your caseload? Check all that apply.
    - ❑ Indigenous
    - ❑ Immigrant/Refugee
    - ❑ LGBTQ2S+
    - ❑ Religious minorities
    - ❑ Disabilities
    - ❑ Other: _____

Survey Questions For Clinicians

There are no right or wrong answers. Please provide your honest and candid responses to the following questions.

Part 1: Clinical Competence

Please indicate how much you **agree or disagree** that the **clinical supervision you received enhances the clinical competence of your Direct Clinical Service** provided in CYMH:

Clinical competence can be defined as the **ability** to accomplish a task. It refers to a complex **practice behavior** which combines skills, knowledge, self-regulation, and judgement, in the organization/community and professional context.

"N/A" means either "you have not received clinical supervision through MCFD" or "you do not need to perform the work listed in job description".

Clinical Competence of Direct Clinical Services listed in Job Description	N/A	1 Strongly Disagree	2 Disagree	3 Neither Agree nor Disagree	4 Agree	5 Strongly Agree
11. Clinical supervision enhances my clinical competence in **intake cases.**						
12. Clinical supervision enhances my clinical competence in **case assessment.**						
13. Clinical supervision enhances my clinical competence in **treatment planning and intervention, including individual, group, and family therapy.**						
14. Clinical supervision enhances my clinical competence in **crisis intervention and suicide assessment.**						

15. Clinical supervision enhances my clinical competence in **consultation/liaison with community agencies, schools, hospitals, and other ministry programs.**						
16. Clinical supervision enhances my clinical competence in **administering and scoring mental health-related test instruments.**						
17. Clinical supervision enhances my clinical competence in **maintaining appropriate clinical, client, and administrative records.**						
18. Clinical supervision enhances my clinical competence in **promoting and maintaining effective working relationships** with clients and families, physicians, schools and hospitals to coordinate services, secure input, cooperation, resolve conflicts, influence outcomes, provide community consultation and provide educational services and training on emotional and behavioural disturbances.						

Question:

19. Consider the elements described in the above questions. How does clinical supervision strengthen your **clinical competence** at work?

Part 2: Behavioural Competencies

Please indicate how much you **agree or disagree** that **clinical supervision you receive enhances your Behavioural Competencies** in CYMH:

Behavioural Competencies include knowledge, skills and values.

"N/A" means either "you have not received clinical supervision through MCFD" or "you do not need to perform the work listed in job description".

Behavioural Competencies listed in Job Descriptions	N/A	1 Strongly Disagree	2 Disagree	3 Neither Agree nor Disagree	4 Agree	5 Strongly Agree
20. Clinical supervision enhances my competency in **Listening, Understanding and Responding** to clients from diverse backgrounds, including their spoken, unspoken or partly expressed thoughts, feelings and concerns.						
21. Clinical supervision enhances my competency in **Relationship Building** with clients, counterparts, and colleagues, by demonstrating a genuine, non-controlling approach, integrity and transparency as well as keeping a high level of self-awareness.						
22. Clinical supervision can enhance my competency in **Self Control and Self-Regulation** for keeping my emotions under control and restrain negative actions when provoked, faced with opposition or hostility from others, or when working under stress, and also maintain stamina under continuing stress.						
23. Clinical supervision enhances my competency in **Problem Solving/Judgement** for analyzing problems systematically, organizing information, identifying key factors, identifying underlying causes and generating solutions.						

24. Clinical supervision enhances my competency in **Service Orientation** for maintaining/ fostering my desire to identify and serve clients and focus my efforts on discovering and meeting the needs of the clients.						
25. Clinical supervision enhances my competency in **Cultural Agility** for working respectfully, knowledgeably and effectively with diverse cultural groups, particularly Indigenous peoples, by appreciating diverse cultural knowledge, noticing and readily adapting to cultural uniqueness in order to create a sense of safety for all, and continually reflecting upon and assessing my own level of cultural humility and self-awareness.						
26. Clinical supervision enhances my competency in **Flexibility** by promoting my ability and willingness to understand and appreciate different and opposing perspectives on an issue, adapt my approach as situations change and accept changes within my work.						
27. Clinical supervision enhances my competency in **Continuous Development** by enhancing my willingness to assess my own level of development or expertise relative to my work.						
28. Clinical supervision enhances my competencies in **Teamwork and Co-operation** by increasing my ability to work co-operatively within diverse teams, work groups and across the organization to achieve group and organizational goals.						

29. Consider the elements described in the above questions. How does clinical supervision enhance your **behavioral competencies** at work?

_____

_____

30. Please indicate how much you **agree or disagree** that the **clinical supervision you receive prepares you to serve diverse clientele and enhances your diversity and multicultural competence** in CYMH:

CULTURAL OR MINORITY GROUPS	N/A	1 Strongly Disagree	2 Disagree	3 Neither Agree nor Disagree	4 Agree	5 Strongly Agree
Indigenous						
Immigrant/Refugee						
LGBTQ2S						
Religious minorities						
Disabilities						
Other: _____						

PART 3:

Please answer the following questions.

31. What **challenges** do you experience in your clinical supervision?

_____

_____

32. Is there anything that could be added into clinical supervision to enhance your experience or **improve your clinical work**?

_____

_____

33. Please describe the **clinical supervision styles** in which you learn best, using your own words or from the examples below:

For example:

Technical Director style - primarily provides directions on issues, little attention for feelings;

Teaching Mentor style - focus on supervisee feelings, case conceptualizations, supervisee techniques;

Supportive Mentor style - focuses on supervisee feelings, not case conceptualization, watches supervisee techniques used with clients;

Delegating Colleague style - expecting supervisee to exhibit an emotional awareness and possess adequate counseling skills and techniques, little support or direction is given

(Adapted from Hung, L., & Smith, C. S. (2008). Supervision styles that are perceived and preferred by supervisors and supervisees: Case studies. Proceedings from ACA Annual Conference & Exhibition. Honolulu, HI. Retrieved Dec 15, 2018, from http://counselingoutfitters.com/vistas/vistas08/Hung.htm)

_____

_____

Appendix C

Clinical Supervision in Child and Youth Mental Health: Survey for Team Leaders

Clinical Supervision in Child and Youth Mental Health: Survey for Team Leaders

Note: This survey is for CYMH Team Leaders (including those in temporary assignments for 6 months or more). If you are a CYMH Clinician, please switch to the following survey: http://ubc.ca1.qualtrics.com/jfe/form/SV_3WwmiRK4lVf5WJf

This survey has five parts and will take approximately 20 minutes to complete.

Part 1 is comprised of 7 multiple choice questions related to your demographic information.

Part 2 is comprised of 5 multiple choice questions related to your overall impressions of clinical supervisors' training on clinical supervision.

Part 3 is comprised of 6 rating questions and 1 short answer question to evaluate the effectiveness of MCFD training on enhancing your competence in clinical supervision.

Part 4 is comprised of 7 rating questions and 1 short answer question to evaluate the effectiveness of MCFD training on enhancing your competencies required for clinical supervision.

Part 5 is comprised of 3 short answer questions and 1 multiple choice question for you to consider potential improvements to clinical supervision training.

There are no right or wrong answers. Your honest and candid responses are greatly appreciated.

Part 1: Demographic Information

Part 1 is comprised of 7 multiple choice questions related to your demographic information.

1. Are you **currently a CYMH Team Leader** who has worked at MCFD or a contracted agency for **6 months or more**?

- ❑ Yes
- ❑ No

2. What is your **Education Background**?

- ❑ Master's Degree in Social Work
- ❑ Master's Degree in Educational Counselling
- ❑ Master's Degree in Clinical Psychology
- ❑ Master's Degree in Child and Youth Care
- ❑ Master's or Bachelor's Degree in Nursing
- ❑ Ph.D. in clinical/applied psychology
- ❑ Others: _____

3. What is your **Job Classification**?

- ❑ Social Program Officer
- ❑ Nurse
- ❑ Licensed Psychologist

4. Which **Work Setting** are you employed at?

- ❑ MCFD CYMH
- ❑ MCFD Aboriginal CYMH
- ❑ Contracted CYMH Agency – Vancouver Coastal Health
- ❑ Contracted CYMH Agency – Intersect

5. Which **MCFD Region** are you employed in?

- ❑ Interior
- ❑ Northern
- ❑ Vancouver Island
- ❑ Vancouver Coastal
- ❑ Fraser

6. **How many years** you have been employed as a CYMH Team Leader at MCFD or a contracted agency?

_____

7. **How many clinicians** do you currently supervise?

_____

Part 2: Clinical Supervision Training

Part 2 is comprised of 5 multiple choice questions related to your overall impressions of clinical supervisors' training on clinical supervision.

1. During your time as a Team Leader employed by MCFD or a contracted agency, **what types of clinical supervision training** have you received? (Choose multiple responses, if applicable.)

- ❑ CYMH Clinical Supervisors' Training on Competency-Based Clinical Supervision by Dr. Carol Falender – provided by MCFD (2006) (7 hours X 3 days = 21 hours) Please indicate the number of hours you have attended: _____
- ❑ CYMH Clinical Supervisors' Training on Competency-Based Clinical Supervision: video-conferencing sessions with Dr. Carol Falender - provided by MCFD (2008) (1.5 hours X 4 sessions = 6 hours).
  Please indicate the number of hours you have attended: _____
- ❑ General Clinical Supervision Training at the Justice Institute - provided by MCFD. Please indicate the number of hours you have attended: _____
- ❑ Other Clinical Supervisors' Training on Clinical Supervision provided by MCFD. Please indicate the type of training and number of hours you have attended: _____
- ❑ Non-MCFD Clinical Supervisors' Training on Clinical Supervision.
  Please indicate the type of training, training provider, and number of hours you have attended:
  _____

2. How satisfied are you with the **quality of clinical supervision training** you have received **through MCFD**?

- ❑ Very satisfied
- ❑ Satisfied
- ❑ Neither Satisfied nor dissatisfied
- ❑ Dissatisfied
- ❑ Very dissatisfied

3. **How many hours** of clinical supervision training **would you would prefer** to receive **per year** from MCFD?

- ❑ Up to 5 hours
- ❑ Up to 10 hours
- ❑ Up to 15 hours
- ❑ Up to 20 hours
- ❑ More than 20 hours

4. **How often** would you prefer to receive **clinical supervision training** from MCFD?

- ❑ Twice per year
- ❑ Once per year
- ❑ Once per two years
- ❑ Once per three years
- ❑ Other: _____

5. What content would you prefer to cover in clinical supervisors' training on clinical supervision? Please select your top three (3) choices.

- ❑ Technical competence related to CYMH clinical practice
- ❑ Structuring the supervisory experience - contract, log, formative evaluation, summative evaluation, and feedback
- ❑ The supervisory relationship - supervisory alliance building, countertransference management
- ❑ Cultural and diversity competence
- ❑ Issues in risk management
- ❑ Ethical issues and problem-solving
- ❑ Evaluation - deterrents, strategies, use of outcome measures in process of supervision, identifying and problem-solving solutions
- ❑ Self-care strategies
- ❑ Other: _____

Part 3: Competence in Clinical Supervision

Part 3 is comprised of 6 rating questions and 1 short answer question to evaluate the effectiveness of MCFD training on enhancing your competence in clinical supervision.
There are no right or wrong answers. Please provide your honest and candid responses to the following questions.

Please indicate how much you **agree or disagree** that the **training for Clinical Supervision received through MCFD enhances your competence in the provision of clinical supervision** for CYMH clinicians.

Competence can be defined as the **ability** to accomplish a task. It refers to a complex **practice behavior** which combines skills, knowledge, self-regulation, and judgement, in the organization/community and professional context that contribute to the accomplishment of clinical supervision.
(Adapted from Bogo, M. (2018). Social work practice: Integrating concepts, processes, and skills. (2nd ed.). New York: Columbia University Press.)
"N/A" means either "you have not received clinical supervision training through MCFD" or "you do not need to perform the work listed in job description".

Competence in Clinical Supervision listed in Job Description	N/A	1 Strongly Disagree	2 Disagree	3 Neither Agree nor Disagree	4 Agree	5 Strongly Agree
1. Clinical supervision training received through MCFD enhances my competence to **supervise staff** including assignment of work, development and evaluation of performance plans.						
2. Clinical supervision training received through MCFD enhances my competence in **providing guidance** to staff on the interpretation of Acts, regulations, standards and procedures.						
3. Clinical supervision training received through MCFD enhances my competence in **monitoring and evaluating the effectiveness** of mental health programs and policies at the local level.						
4. Clinical supervision training received through MCFD enhances my competence in **conducting clinical audits** of team's clinical records and case reviews.						
5. Clinical supervision training received through MCFD enhances my **Expertise** by helping you to expand and use technical knowledge, and to distribute work-related information to others.						
6. Clinical supervision training received through MCFD enhances my **Leadership** by helping you to lead diverse teams.						

1. Consider the elements described in the above questions. How has clinical supervision training provided by MCFD **strengthened your competence in clinically supervising** CYMH Clinicians?

_____

_____

Part 4: Competencies required for Clinical Supervision

Part 4 is comprised of 7 rating questions and 1 short answer question to evaluate the effectiveness of MCFD training on enhancing your competencies required for clinical supervision.
There are no right or wrong answers. Please provide your honest and candid responses to the following questions.

Please indicate the extent to which you **agree or disagree** that the **training in Clinical Supervision received through MCFD enhanced your competencies in Clinical Supervision.**
"N/A" means "you have not received clinical supervision training through MCFD".

Competencies required for Clinical Supervision based on Competency-Based Supervision Model	N/A	1 Strongly Disagree	2 Disagree	3 Neither Agree nor Disagree	4 Agree	5 Strongly Agree
1. Clinical supervision training received through MCFD enhanced my skills and abilities to **Build Technical Competence** among clinicians including general and specialist knowledge, theoretical and empirical knowledge, and the use of outcome measures in the process of supervision.						
2. Clinical supervision training received through MCFD enhanced my competency in **Addressing Personal Factors** in supervision, including emotional self-regulation, reflection, self-awareness, counter-transference management and self-care strategies.						
3. Clinical supervision training received through MCFD enhanced my competency to build **Alliance in Therapeutic and Supervisory Relationships** including the repair of strains and ruptures in the relationship.						
4. Clinical supervision training received through MCFD enhanced my **Diversity Competence** including my beliefs, knowledge and skills on cultural safety and agility.						

4. Clinical supervision training received through MCFD enhanced my **Diversity Competence** including my beliefs, knowledge and skills on cultural safety and agility.						
5. Clinical supervision training received through MCFD enhanced my competency in **Ethics and Problem-solving** including critical thinking, risk management, and ethical decision-making.						
6. Clinical supervision training received through MCFD enhanced my competency in **Evaluating** strategies, and identifying and problem-solving solutions.						

1. Consider the elements described in the above questions. How has clinical supervision training provided by MCFD **enhanced your clinical competencies required for clinical supervision**?

_____

_____

2. Please indicate the extent to which you **agree or disagree** that **clinical supervision training provided by MCFD** prepares you to supervise clinicians who serve diverse clientele by **enhancing their diversity and multicultural competence** related to the following cultural groups or communities:

CULTURAL OR MINORITY GROUPS	N/A	1 Strongly Disagree	2 Disagree	3 Neither Agree nor Disagree	4 Agree	5 Strongly Agree
Indigenous						
Immigrant/Refugee						
LGBTQ2S						
Religious minorities						
Disabilities						
Other: _____						

Part 5: Improving Clinical Supervision Training

Part 5 is comprised of 3 short answer questions and 1 multiple choice question for you to consider potential improvements to clinical supervision training.
There are no right or wrong answers. Please provide your honest and candid responses to the following questions.

1. What **challenges** do you experience in the provision of clinical supervision for CYMH Clinicians?

_____
_____

2. Is there anything that you wish could be **added to clinical supervisors' training to improve your competency** in the provision of clinical supervision for CYMH Clinicians?

_____
_____

3. If you have received clinical supervision training outside of MCFD, what aspects of those trainings were useful for you?

_____
_____

4. Please select the **styles and/or formats of clinical supervision training** that you find most effective, or describe it by using your own words.

- ❑ Lecture
- ❑ Teleconference or Videoconference
- ❑ Role Play and/or Live Demonstration
- ❑ Live Supervision
- ❑ Online Training Modules (e.g. videos, slides)
- ❑ If the above styles do not fit your preference, please describe your preferred training style:

_____

Appendix D

For the Research Project: Clinical Supervision in Child and Youth Mental Health
Demographic Questionnaire for Focus Group Participants

Please complete the following questionnaire and return it to the researchers by email with the "Consent Form for Focus Group Participants".

1. Job Title:

- ❑ Team Leader
- ❑ Clinician

2. Education background:

- ❑ Master's Degree in Social Work
- ❑ Master's Degree in Educational Counselling
- ❑ Master's Degree in Clinical Psychology
- ❑ Master's Degree in Child and Youth Care
- ❑ Master's or Bachelor's Degree in Nursing
- ❑ Ph.D. in Clinical/Applied Psychology
- ❑ Others: _____

3. Classification:

- ❑ Social Program Officer
- ❑ Nurse
- ❑ Licensed Psychologist

4. Work Setting:

- ❑ MCFD CYMH
- ❑ MCFD Aboriginal CYMH
- ❑ Contracted CYMH Agency - Vancouver Coastal Health
- ❑ Contracted CYMH Agency - Intersect

5. Programming Region:

- ❑ Interior
- ❑ Northern
- ❑ Vancouver Island
- ❑ Vancouver Coastal
- ❑ Fraser

6. The number of years working at MCFD or the contracted agency under MCFD:

- ❑ Less than 6 months
- ❑ 6-12 months
- ❑ 1-3 years
- ❑ 3-5 years
- ❑ 5-10 years
- ❑ 10+ years

Appendix E

Focus Group Interview Guide - Clinician

Self-introduction: Please introduce yourself to the group.

1. The name you would like us to call you here.
2. Which CYMH work setting are you working in?
   - ❑ MCFD CYMH
   - ❑ Social Program Officer
   - ❑ MCFD Aboriginal CYMH
   - ❑ Contracted CYMH Agency - Vancouver Coastal Health
   - ❑ Contracted CYMH Agency – Intersect
3. Which region are you from?
   - ❑ Interior
   - ❑ Fraser
   - ❑ Vancouver Coastal
   - ❑ Vancouver Island
   - ❑ Northern
4. What is your classification?
   - ❑ Social Program Officer
   - ❑ Nurse
   - ❑ Licensed Psychologist

Questions: There are no right or wrong answers. Please provide your honest and candid responses to the following questions.

1. What are the biggest challenges you face in your work? How does clinical supervision help you to tackle them?
   - ❖ Probing question: Can you give an example of techniques or processes in clinical supervision that you have found useful?
   - ❖ Probing question: What are the strengths of the clinical supervision that you received?
2. What challenges have you encountered during clinical supervision? How did you and your supervisor resolve them?
3. What kind of practical or emotional support are you looking for in clinical supervision? Is anything missing from your current clinical supervision experience?
4. Which cultural groups do you primarily work with? How well does clinical supervision prepare you to address challenges among these diverse groups?
   - ❖ Probing question: What kind of supervision would you like to receive for preparing you to address the needs of Indigenous children and youth or other diverse groups?
5. What qualities and processes are essential for effective clinical supervision in Child and Youth Mental Health?
6. Is there anything that I did not ask that you think it would be important for me to know your clinical supervision experience?

Appendix F

Focus Group Interview Guide - Team Leader

Self-introduction: Please introduce yourself to the group.

1. The name you would like us to call you here.
2. Which CYMH work setting are you working in?
   - ❑ MCFD CYMH
   - ❑ MCFD Aboriginal CYMH
   - ❑ Contracted CYMH Agency - Vancouver Coastal Health
   - ❑ Contracted CYMH Agency – Intersect
3. Which region are you from?
   - ❑ Interior
   - ❑ Fraser
   - ❑ Vancouver Coastal
   - ❑ Vancouver Island
   - ❑ Northern
4. What is your classification?
   - ❑ Social Program Officer
   - ❑ Nurse
   - ❑ Licensed Psychologist
5. How many clinicians do you supervise?

Questions: There are no right or wrong answers. Please provide your honest and candid responses to the following questions.

1. What are the challenges you face in providing clinical supervision to clinicians at MCFD? How did clinical supervision training received through MCFD help you to address the challenges?
   - ❖ Probing question: Can you give an example of how clinical supervision training received through MCFD helped you supervise clinicians?
2. What are the strengths of the current clinical supervision training that you received through MCFD?
3. What kind of practical support are you looking for in clinical supervision training? What is missing from the current clinical supervision training through MCFD?
4. Which diverse cultural groups do your supervisees work with? How well does clinical supervision training prepare you to help supervisees work with diverse groups?
   - ❖ Probing question: What kind of cultural safety or culturally-relevant clinical supervision training you have received to support clinicians to address the needs of Indigenous children and youth?
   - ❖ Probing question: What kind of clinical supervision training would you like to receive to prepare you to support supervisees who serve Indigenous children and youth or other diverse groups?
5. What elements are essential for effective CYMH clinical supervision training?
6. Is there anything that I did not ask that you think it would be important for me to know about clinical supervision training?