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The Exploration of Clinical Supervision for Substance Abuse Social Workers in Bermuda

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Abstract

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MSW, Clark Atlanta University, 2011

BA, Boston University, 2006

Project Submitted in Partial Fulfillment

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Abstract

As specialists who bridge the gap between the social work and substance abuse treatment fields, substance abuse social workers are expected to develop themselves as social workers by designation, substance abuse counselors by occupation, and deliver competent therapeutic services that align both professions seamlessly. As documented in the National Association of Social Workers Code of Ethics, their support in achieving this feat is clinical supervision. Despite this documentation, a review of the social work literature revealed an absence of information on clinical supervision between the social work and substance abuse fields, their supervisory alliance, and outcomes. Accordingly, this project was undertaken to fill these gaps in the literature by exploring the significance of clinical supervision for substance abuse social workers in Bermuda. The practice-focused research questions for this study were guided by Fiedler's Contingency Theory and Vygotsky's Collaborative Theory and a qualitative action research method was used to conduct hour-long, semi structured interviews with eight randomly selected master's level substance abuse social workers. Data collected via this methodology were processed, sorted, and charted by way of framework analysis, and after identifying like subjects, the findings revealed that substance abuse social workers had positive experiences with supervision that were consistent with the collaborative theory. The findings of this doctoral project establish the importance of clinical supervision for substance abuse social workers and address the education and training required to ensure ethical reasoning and competency on the micro, mezzo, and macro levels of clinical social work practice for positive social change.

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Section 1: Foundation of the Study and Literature Review

Introduction

Clinical supervision has become significantly prominent within the substance abuse and social work fields (Madson & Green, 2012). Scholars, such as Culbreth (1999, 2011), Fulton et al. (2016), Juhnke and Culbreth (1994), Powell (1993), West and Hamm (2012), and Whitley (2010), have published articles on the significant impact that clinical supervision has on a social worker's knowledge, competency, and development in the treatment of clients with substance abuse issues. Additionally, Cashwell and Dooley (2001), Hadjistavropoulos et al. (2010), Milne et al. (2011), O'Donovan et al. (2017), Shulman (1993), and Tebes et al. (2011) established that through the use of training, consultation, and evaluation, clinical supervisors have the capacity to support social workers in their roles as substance abuse professionals and ensure that they have the skills to administer their services effectively. For these reasons, clinical supervision has been designated the central method to ensure that substance abuse social workers are apt in providing quality client care.

As reported by Holt et al. (2015), clinical supervision establishes a fundamental means of teaching, applying, and protecting treatment fidelity. It stresses the importance of self-reflection, is competency-based, and focuses on the development of the therapeutic relationship (Falender & Shafranske, 2008; Holloway & Neufeldt, 1995). Data provided by Reese et al. (2009) demonstrated that the receipt of clinical supervision enhances the effectiveness of treatment decisions, outcomes, and interventions, and the

authors acknowledged that clinical supervision carries a responsibility to the professionals that span both the social work and substance abuse fields.

Despite the research provided by Culbreth (1999, 2011), Culbreth and Greene (1997), Fulton et al. (2016), Juhnke and Culbreth (1994), Madson and Green (2012), Powell (1993), and West and Hamm (2012) that noted the remarkable benefits of clinical supervision for substance abuse social workers, Ellis (2006), O'Donovan et al. (2017), and Watkins (2014) discovered that limited resources have caused a hindrance to its facilitation. A high demand for clinical services and the increased acuity and complexity of substance abuse clients are other factors that have been noted as a hindrance to the provision of clinical supervision for substance abuse social workers. Furthermore, gaps regarding the supervisory alliance between the social work and substance abuse fields that have resulted in insufficiencies in the receipt of clinical supervision for substance abuse social workers have been exposed (Creaner, 2014; Dilworth et al., 2013; Falender, 2014; Ladany et al., 2013). These insufficiencies have created less than desirable outcomes for the formation of the supervisory relationship.

In this study, I employed a qualitative research approach to explore clinical supervision for social workers working in substance abuse addiction. Through the literature review, clinical supervision within the social work and substance abuse professions was explored historically and internationally. Individual interviews were used to explore how the researched historical and international practices influence the significance of clinical supervision for substance abuse social workers in Bermuda. This doctoral study has potential positive social change implications for the field of social

work by offering a multidisciplinary framework of clinical supervision that supports practice innovation, collaboration, participation, and critical engagement across both the social work and substance abuse fields.

The four sections of this study begin with an introduction to the social work research topic, its problem statement, purpose statement, research questions, variables, and concepts, as applicable. I then describe the nature of the research project, the theoretical frameworks that were used to inform the study, and the National Association of Social Workers (2017) Code of Ethics related to the clinical social work problem as well as provide a review of the related academic and professional literature published within the past 5 years. In the second section, I will present detailed information on the action research study and its participants. The existing and prospective data, the instrumentation used to collect that data, methods for data analysis, and the ethical principles related to the clinical social work problem will then be discussed. In Section 3 of this research study, I will report the data analysis findings as related to the practice-focused research questions, and in Section 4, I will make recommendations on how this project can be applied to professional social work practice and offer implications for social change.

Problem Statement

Clinical supervision has a direct impact on the clinical practice and professional well-being of persons in both the social work and substance abuse fields; as such, its facilitation has been a continuing mandate for research within each division individually (Creaner, 2014; O'Donoghue & Ming-sum, 2015). The body of literature produced by

Barnett (2014), Borders (2014), Creaner (2014), Dilworth et al. (2013), Ellis (2006), Falender (2014), Ladany et al. (2013), O'Donovan et al. (2017), O'Donoghue and Ming-sum (2015), and Watkins (2014) contributes to the knowledge of the overwhelming benefits of clinical supervision for both the social work and substance abuse professions. However, Creaner, Dilworth et al., Falender, Ladany et al. exposed that differences in the provision of clinical supervision between the social work and substance abuse fields make the exploration of clinical supervision for substance abuse social workers a complex endeavor and a challenging field of inquiry. Resultantly, gaps in the literature exist. Among those gaps acknowledged are the absence of studies regarding the facilitation of clinical supervision between the social work and substance abuse fields (Vallance, 2004), the supervisory alliance between these fields (Watkins, 2014), and clinical supervisor and substance abuse social worker outcomes (Falender, 2014).

Because of the lack of research conducted in Bermuda on this social issue, in this study I reviewed the literature on international studies to provide evidence to support its relevance to social work practice. A broad review of the literature published in the past 5 years revealed limited peer-reviewed journals and articles on the topic (Caras & Sandu, 2014; Fisher et al., 2016). Most of the peer-reviewed journals and articles located using clinical supervision as a specifier were conducted in other helping professions (White & Winstanley, 2014), such as counseling (Borderset al. 2014), mental health (Pack, 2015), psychology (Polychronis & Brown, 2016), and nursing (Cutcliffe & Sloan, 2014). Others found were conducted internationally in Denmark (Magnussen, 2018), Europe (O'Donoghue et al., 2018), England (Morley, 2017), Australia (Egan et al., 2018), and

New Zealand (Beddoe, 2016) or in both another helping profession and internationally (Aladağ & Kemer, 2016; Creaner & Timulak, 2016). To provide evidence that the topic of this research study was relevant and significant to the professional practice of social work nationally, I conducted a more detailed review of the literature on clinical supervision for substance abuse social workers in the United States that was published within the past 5 years, and this search revealed even more limited peer-reviewed journals and articles (Holleran Steiker & Malone, 2010; Whitley, 2010). A final search was conducted to provide evidence that this research study was relevant and significant to the professional practice of social work in Bermuda, and this search revealed that no studies on clinical supervision for substance abuse social workers had been conducted to date.

Exploring reasons for this gap in literature, Creaner (2014) hypothesized that variations in professional or supervisory experiences, levels of education, or methods of delivery between the social work and substance abuse fields were the cause. Notwithstanding, Creaner's research efforts yielded limited results with respect to clinical supervision for substance abuse social workers and demonstrated how the lack of support and direction for these professionals has resulted. The lack of support and direction regarding clinical supervision for substance abuse social workers raises questions about their professional preparedness and level of competency related to the skills necessary for servicing substance abuse clients. Therefore, this study makes an original contribution to social work practice by building upon the previously published findings of clinical supervision for substance abuse social workers conducted in the last 5 years.

Purpose Statement and Research Questions

Substance abuse social workers in Bermuda concede the significance that clinical supervision plays in their ongoing success as professionals that span both the social work and substance abuse fields (Vallance, 2004). As such, substance abuse social workers have expressed how clinical supervision is necessary to their unique line of social work and how the absence of this essential service has a direct impact on the advancement of social work practice locally and internationally (Toriello & Benshoff, 2003). Considering this information, the social work practice problem, or phenomena that I addressed in this doctoral study was the provision of clinical supervision for substance abuse social workers in Bermuda.

The practice-focused research questions for this doctoral study were:

RQ1: How do substance abuse social workers in Bermuda describe their experiences related to receiving clinical supervision?

RQ1a: How are these experiences consistent with concepts of the collaborative theory?

RQ1b: How are these experiences consistent with concepts of the contingency theory?

RQ2: What challenges or barriers do substance abuse social workers in Bermuda face related to receiving clinical supervision?

RQ2a: How do the challenges or barriers reflect micro, mezzo, or macro levels of social work and substance abuse practice?

There is a lack of research on the facilitation of clinical supervision between the social work and substance abuse fields (Vallance, 2004), the supervisory alliance between these fields (Watkins, 2014), and clinical supervisor and substance abuse social worker outcomes (Falender, 2014). For this reason, the purpose of exploring these practice-focused research questions was to understand the significance of and barriers to clinical supervision for substance abuse social workers in Bermuda with the aim to use this knowledge to improve the receipt of that clinical supervision.

Action Research Terms

Clinical supervision: A formal, relationship-based support system of practice and development (Milne, 2007).

Clinical supervisor: A clinically licensed social worker or addictions counselor who provides supervisory services (Fulton et al., 2016).

Substance abuse social worker: A master's level social worker (MSW) employed within the substance abuse treatment field (Fulton et al., 2016).

Nature of the Doctoral Project

The action research design of this project aligned with its purpose statement by focusing on local substance abuse social workers' perceived experiences with clinical supervision and subsequently incorporated those experiences into real-life situations so that effective solutions are constructed. The action research design also aligned with the research questions by using the experiences of the local substance abuse social workers, their real-life situations, and effective solutions to understand the significance of clinical supervision for substance abuse social workers in Bermuda (see Stringer, 2014). The use

of action research in this study ensured that local substance abuse social workers were involved in the process of research investigation regarding clinical supervision and created a reciprocal platform between the social work and substance abuse fields while working towards resolutions for matters of personal, professional, and community growth (see Stringer, 2014).

I used the action research design and individual interviews to collect qualitative data from potential research participants. Action research is based on the premise that all members of a research community are affected by the research process (Stringer, 2014). Therefore, a systematic approach was used to enable each substance abuse social worker to find solutions to their unique localized situation. Using action research, potential participants were afforded the opportunity to be heard and have their contributions integrated into the research project (see Bradbury & Reason, 2015).

By way of the action research framework, I contacted resident substance abuse social workers to gauge their interest in participating in this research project. Those who wished to participate were invited to share their experiences, and if interested, propose collaborative ways to develop solutions to this problem. Such participation by the island's social work community was consistent with a social workers' professional commitment to engage in changing individual and community behavior (NASW, 2017).

All the substance abuse social workers in Bermuda are a part of a network that focuses on providing treatment services to clients who suffer from the abuse of or dependence on alcohol and/or illicit substances (Bermuda Department of National Drug Control, 2017). Given my work at the Bermuda Government's Department of Court

Services Assessment and Treatment Division, being a part of this network afforded the opportunity to invite all eligible substance abuse social workers employed by local substance abuse agencies to become participants of this action research study. It was my expectation that the data collected from local substance abuse social workers would help to understand the barriers to and significance of clinical supervision in Bermuda and that working through those barriers would help to improve the receipt of that clinical supervision on island (see McNiff & Whitehead, 2010).

Individual interviews with substance abuse social workers provided qualitative data for this study. Each interview was audio recorded and then transcribed by me without identifying data. Following transcription, I organized the qualitative data collected using framework analysis to identify, categorize, and program significant data points. The goal of using this method of data analysis was to decode the data and introduce it in a way that exemplified the material collected during each individual interview.

In this study, my commitment to the sources of data and potential participants was based on an epistemological approach that understands knowledge to stem from individual, collective, and collaborative experiences (see Stringer, 2014). My role was to facilitate the expression and negotiation of that knowledge and to organize it for community benefit. Without potential participants there could be no research that was representative of local substance abuse social workers' interests and, hence, no community enrichment would result from this research.

The collaborative efforts of this project afforded potential participants the opportunity to become stakeholders in social change (see McNiff & Whitehead, 2010). Questions asked of each potential participant focused on clearly defining their role as substance abuse social workers as well as the skills used to overcome barriers to clinical service provision as employees of the substance abuse field. This study was meant to influence participant learning by action research and provide insight, on a larger scale, through the advancement of clinical social work practice. Therefore, understanding the significance of and barriers to clinical supervision for substance abuse social workers in Bermuda is a call to action encouraging continued research in this area until these disparities are resolved (McNiff & Whitehead, 2010).

Significance of the Study

Exploring clinical supervision for substance abuse social workers in Bermuda through action research advances social work practice knowledge by helping to shape the future of integrated social service care. The NASW (2017) Code of Ethics stresses the importance of competence in social work through the enhancement of a social worker's professional knowledge and by adding to the general body of social work knowledge. Therefore, this action research project has meaning in the field of social work practice because it provided a platform for substance abuse social workers to share the significance of and barriers to clinical supervision in Bermuda with the aim to use the knowledge of their experiences to improve the receipt of that clinical supervision.

As stated by Dilworth et al. (2013), gaps in the research literature related to the clinical supervision of substance abuse social workers indicate a lack of higher quality

studies that provide detailed working practices and definitive professional roles. Consequently, I conducted this research project to fill these gaps in literature and social work practice via a research methodology that was information specific to the substance abuse social worker's experiences with clinical supervision. Participants in this study were eight master's level social workers currently employed by 1 of the 14 government or private substance abuse programs in Bermuda that offer outpatient, inpatient, or residential nonhospital services (see DNDC, 2017). Each participant had the opportunity to contribute to the field of social work knowledge through the collaborative work of defining clinical supervision in their substance abuse roles. Potential implications for positive social change in this area begin with an informed clinical supervision practice (see Whitley, 2010). Relatedly, it was my hope that as substance abuse social workers shared their experiences on clinical supervision within the substance abuse field, the knowledge offered by their experiences would improve their receipt of clinical supervision as substance abuse social workers in Bermuda.

Theoretical/Conceptual Framework

I used Fiedler's (1967) Contingency Theory and Vygotsky's (1978) Collaborative Theory to frame the significance of clinical supervision for substance abuse social workers in Bermuda. In the contingency theory, Fiedler stated that for an organization or any of its subunits to be effective, there must be a solid relationship between the two. Therefore, if the social work and substance abuse fields in Bermuda are constrained by their own structural designs, their scope of choice to facilitate clinical supervision to substance abuse social workers will be extremely limited (Hickson et al., 1971).

Moreover, Hickson et al. (1971) stated this lack of congruence will precipitate into a lack of clinical supervision and a lack of substance abuse social worker performance overall. When Fiedler's Contingency Theory was applied by Schmidt et al. (2013), clinical supervision was emphasized as critical to the professional development of all substance abuse social workers. Sias et al. (2006) agreed that the instruction and training provided by clinical supervision is essential to maintaining a substance abuse social worker's proficiency within both fields. For this reason, Beddoe (2016), Davys and Beddoe (2010), and Kerwin et al. (2006) accentuated how the NASW (2017) has made clinical supervision the tool of quality assurance for the professional autonomy of substance abuse social work practitioners and that its facilitation is mandated for substance abuse social workers to remain licensed as substance abuse professionals.

In 1978 Vygotsky defined his collaborative theory as a continual process between two or more individuals who collaborate for the purpose of one common goal. It is absent of any form of hierarchy and is instead an effort between equals to obtain solutions that cannot be obtained individually. Theorists Bosque and Caitlin (2011) and Gray (1989) offered five basic principles that illustrate how Vygotsky's Collaborative Theory is related to the clinical supervision of substance abuse social workers, stating that the theory: (a) centers around individuals working together; (b) involves an ongoing process, not a destination, to determine a solution; (c) establishes relationships of trust and develops strong alliances between stakeholders; (d) follows an order of assembly, performance, and adjournment; and (e) completion is imperious to community action.

Specific to this action research project, I used Fiedler's (1967) Contingency Theory and Vygotsky's (1978) Collaborative Theory to guide the interactive process as Bermudian social workers joined together to engage in mutual decision-making surrounding their experiences with clinical supervision as professionals in the substance abuse field. In mobilizing the Bermuda social work community to address the significance of clinical supervision for their substance abuse social workers, this study was driven by the central features of Fiedler's Contingency Theory and Vygotsky's Collaborative Theory to create a problem-solving process that addressed a community need unresolvable by a single individual or entity acting alone.

Values and Ethics

The NASW (2017) Code of Ethics was established as a guide that dictates the professional conduct of social workers. As the social work field believes that ethics is the root of social work, this profession has a responsibility to voice its standards, principles, and values. These standards, principles, and values, set forth by the NASW Code of Ethics, are applicable to all social workers and social work students in every function, irrespective of the setting in which they work and the clients that they have the privilege serve.

The NASW (2017) Code of Ethics states that social workers must perform within their areas of competence and develop those areas accordingly. This means that social workers should only provide services within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience. When generally recognized standards do not exist with respect

to an emerging area of practice, as related to this clinical social work problem, the NASW Code of Ethics guides clinical social work practice in this area and mandates that social workers exercise careful judgment and take responsible steps. These steps are further education, research, training, consultation, and supervision to ensure the competence of their work and to protect their clients from harm. Clinical supervision has been established by the NASW for a social worker's maintenance and the elevation of high standards of practice. Therefore, by agreeing to become participants of this study, substance abuse social workers were afforded the opportunity to endorse the social work knowledge, mission, ethics, and values within their substance abuse agencies while dually protecting, enhancing, and improving its integrity.

Alternatively, the substance abuse field offers an assortment of therapists whose designations range from social work to psychology, counseling, and sociology. Notwithstanding the undeniable benefits of professional diversity in this field, each of these designations has their own ethical codes of conduct (Fisher & Harrison, 2008). For example, professionals may hold certifications specifically related to the practice of substance abuse counseling like the Certified Alcohol and Drug Addiction Counselors certification, which adheres to the National Association for Alcoholism and Drug Abuse Counselors Code of Ethics (2016), or any of the professional counseling degrees. These professional counseling degrees adhere to the five ethical principles established by the American Counseling Association (2014) Code of Ethics (a) nonmaleficence, (b) justice, (c) fidelity, (d) beneficence, and (e) autonomy (Gladding, 2009).

It is the compilation of these ethical codes of conduct that become problematic for substance abuse social workers and was the reason why this project supported the values and principles of the NASW (2017) Code of Ethics (2017). Presently, in times of ethical dilemma, professionals within the substance abuse field perform within their individual codes of ethics, according to the jurisdictions where they received their degrees or their agency of employment. It was essential then that this study established the significance of clinical supervision for substance abuse social workers in Bermuda to create unity among ethical decision-making when the social work and substance abuse fields are combined.

Review of the Professional and Academic Literature

The clinical social work practice problem of this project was the prevalence of unsupervised social workers providing substance abuse treatment in Bermuda. The purpose of this study was to explore the needs of substance abuse social workers in Bermuda and use action research to improve the understanding of the clinical supervision provided to social workers in substance abuse settings. Relevant data bases, such as PsycARTICLES, PsycBOOKS, PsycEXTRA, PsycINFO, Social Work Abstracts, SocINDEX with Full Text, were the research tools used to retrieve peer-reviewed journals, articles, and academic literature on relevant topics published between 2013 and 2018. Each data search for this research project contained the following or a combination of the following terms: *clinical, supervision, substance abuse,* and *social worker*. Specific keyword searches for this research project included the terms: *clinical supervision for social workers, clinical supervision for substance abuse social workers, clinical supervision in Bermuda, substance abuse social workers in Bermuda*, and a host

of variations surrounding the research project theme. My searches using these words and themes generated limited results that ranged from 252 to 481 articles. For this reason, I extended the data search to include terms related to the research topic ,including *counselors, professionals*, *field*, *treatment*, and *addiction*. Expanding this data search increased the research results to 646 articles.

In the following literature review, I detail pertinent information concerning social work theory and empirical data. Theories germane to disciplines, such as psychology, counseling, sociology, and nursing, throughout the 18th, 19th, and 20th centuries were reviewed in the United States and internationally in Australia, Ireland, Turkey, New Zealand, and Bermuda. The articles synthesized throughout the literature review represent a broad spectrum of professional interests that were analogous in nature to this research project; however, none reflected an integrative approach that aligned with the research priorities of this project. Hence, specific areas of focus for this project began with theoretical literature aimed at exploring clinical supervision for substance abuse social workers. This research project expanded on this literature by identifying, educating, collaborating, advocating, preparing, communicating, evaluating, and improving this research topic.

Clinical Supervision

A basic online search for the word “clinical supervision” yields half a million hits (White & Winstanley, 2011) and searching for the word via peer-reviewed journals and articles yields the scholarly contributions of authors like Bernard (2006), Edwards (2013), Kadushin (1977), Milne and Dunkerley (2010), and Munson (2002). Each of

these authors of clinical supervision has contributed to its value among the counseling, social work, and psychology professions and has worked to provide specialist services to a skilled work force whose goal is to raise the principles of practice to an exemplary standard. In general terms, although the definition of clinical supervision has not gone without uncertainty, challenges, and international differences, it has been accepted as a formal, relationship-based support system of practice and development (Milne, 2007). This relationship-based support system is provided by approved supervisors to their social service staff with the goal of maximizing the best possible outcomes for respective clientele (White & Winstanley, 2014). For this reason, clinical supervision is regarded as an essential component of international social service practice (Australian Association of Social Workers, 2020; British Psychological Society, 2010; U.S. Department of Health and Human Services, 2009).

The art of clinical supervision has been practiced throughout the history of social services implementing skills for competency, ensuring an experienced workforce, and raising professionals to the required standard for specialist service (White & Winstanley, 2014). Because of its documented importance, clinical supervision has been recognized as one of the most distinct disciplinary roles throughout social service literature (Schmidt, 2012). It provides a valued context for ethical principles in practice and serves as the signature pedagogy by which trained professionals are developed into learned professionals in the workplace (Shafranske & Falender, 2016).

The definition of clinical supervision serves as a starting point to the explanation of its functions, relationships, and processes (Bernard & Goodyear, 2019), and a review

of the literature offered a variety of descriptions that highlight its distinct features. For example, its roles, functions, and competencies (Falender & Shafranske, 2004); skills and outcomes (Bambling & King, 2014); ethics and training (Barnett & Molzon, 2014); multiculturalism and diversity (Falender et al., 2014); evidence-based practices (Milne & Dunkerley, 2010); and the supervisory relationship (Beinart, 2014). This plethora of information reflects the overall complexity of clinical supervision and establishes its practice expectations and implementation standards across the spectrum of supervisory settings (Shafranske & Falender, 2016). Examining and compiling each supervisory feature the American Psychological Association (2015), which now serves as American Psychological Association policy, provided a solution to this conceptual morass by supplying the following definition:

> Supervision is a distinct professional practice employing a collaborative relationship that has both facilitative and evaluative components, that extends over time, which has the goals of enhancing the professional competence and science informed practice of the supervisee, monitoring the quality of services provided, protecting the public, and providing a gatekeeping function for entry into the profession (p. 5).

The History of Clinical Supervision

Germany-18th Century

The inception of modern clinical supervision can be traced back to 1853 where a system of social assistance was developed in Germany by Daniel von der Heydt (Crooker, 1917; White & Winstanley, 2014). At the time of this development, the city of

Hamburg had a total of 7,000 poor and 2,500 of those poor were hospitalized (Crooker, 1917). To ensure the provision of adequate social services, 180 respectable gentleman called “overseers” were appointed to provide instruction to the workers responsible for their care (von Voght, 1796, p. 451). Crooker (1917) also reported that city authorities in Hamburg entrusted the dissemination of the poor’s assets to 150 “burghers” who were taxed with the “watch and ward” of the charity services in their surrounding neighborhoods (von Voght, 1796, p. 451).

England-19th Century

The Nightingale School of Nursing was established in 1860 at the St. Thomas Hospital in London (Newton, 1952). It was named after Florence Nightingale, a renowned pioneer of the Crimean War (1853–1856), and her numerous contributions to the field of nursing (Selanders & Crane, 2012). At the Nightingale School of Nursing, Florence Nightingale facilitated weekly informal meetings with all her nursing staff and pooled ideas for the general welfare of the clientele (Newton, 1952). It was also through this group that Florence Nightingale popularized the concept of primary nurses assisting secondary nurses in clinical practice. This concept, later termed “apprenticeship” was a foreshow of the group supervisory process and modern clinical supervision (Russell, 1990).

Considering the works of Florence Nightingale, charitable work expanded in London in 1869 under the direction of social activist Octavia Hill (Crooker, 1917). Hill founded the Charity Organization Society (COS) that was tasked with the administration of charitable donations and community visits. This workforce was credited with various

philanthropic community accomplishments and rumored to have established the beginning of modern social work (White & Winstanley, 2014). In 1964, Hill's COS was retitled the Family Welfare Association, and this group still operates in England today as Family Action, a registered family support charity.

United States-19th Century

In 1878, European ideas of clinical supervision were introduced in the United States (White & Winstanley, 2014). They were presented in Buffalo, New York, circulated to the Boston Associated Charities, and adopted by Mary Richmond of the COS of Baltimore, Maryland and the Family Counseling of Greater New Haven, Inc. in Connecticut (Yale University, 2012). In 1881, the Organized Charities Association (OCA) implemented the same objectives as the London COS and the groups developed a strong scientific emphasis on learning principles of assessment and treatment from one another (Hansan, 2013). This shared learning experience signaled the origins of modern charitable works as well as laid the foundation for clinical supervision as the medium for staff support and professional development.

England-20th Century

The psychoanalytic culture in Europe has long accepted clinical supervision as one of the most indispensable components of professional development. Their experience began in 1902 with Sigmund Freud who held weekly meetings of the Psychological Society, later renamed The Vienna Psychoanalytic Society (White & Winstanley, 2014). These meetings were referred to as "psychotherapy supervision" (Urlic & Brunori, 2007, p. 163). Successively, Berlin psychoanalyst, Max Eitington, reiterated Freud's sentiments

when proposing that psychoanalysts in training undergo “supervised psychoanalyst sessions” in the early 1920s (Urlic & Brunori, 2007, p. 163). These milestones were the beginning of clinical supervision as it is understood in present day and have been confirmed by the doctoral scholarship of Harkness and Poertner (1989) and Leddick and Bernard (1980). It was also during this period of history when the foundational principles of clinical supervision were understood to be applicable and transferrable to other social service fields, such as teaching, nursing, sociology, social work, and psychology (Vandette & Gosselin, 2019).

In 1954, Dr. Thomas Percy Rees, Physician Superintendent of Warlingham Park Hospital, Surrey, England, seconded two pioneering psychiatric nurses to become early adopters of clinical supervision (White & Winstanley, 2014). Rees was motivated by the absence of trained social workers. And, as such, hired Lena Peat and Arthur Groves who became members of a multidisciplinary team of professionals intended to help manage the complex emotional interactions between service providers and clients within institutional settings (Hunter, 1974). This clinical practice group, later termed the Community Psychiatric Nurses Association, was devised under the direction of Mike Smith and was responsible for providing adequate, administrative, and educational clinical supervision as a mandatory component of the hospital’s supervisory structure (Hunter, 1974). The successes of the Community Psychiatric Nurses Association were published by White (2001) who recorded that according to the Third Quinquennial National Community Psychiatric Nursing Survey, 77% of community mental health nurses received clinical supervision, and according to the Fourth Quinquennial National

Community Mental Health Nursing Census of England and Wales, 87% of community mental health nurses received clinical supervision.

United States-20th Century

In 1913, the U.S. OCA developed from a society to a professional organization, and during this shift, a committee was formed to supervise the case load of individual workers (White & Winstanley, 2014). The Secretary of the OCA, John Dawson (1926), devised the following list of responsibilities for the supervisors of case workers: (a) promoting and maintaining good standards of casework, (b) coordinating case work practice with idealistic administration, (c) utilizing the case work experience for the development of policies and intervention methods, (d) developing case workers educationally by realizing their possibilities and usefulness within the field, and (e) cultivating a spirit of loyalty among staff members (Dawson, 1926).

Conducting their research on the history of clinical supervision throughout the helping professions, White and Winstanley (2014) established affinities among the early works of charity, social work, and nursing that allowed for a cross-pollination of professional practices. The retrospective work of Brown (1994) observed that until the 1970s, British social work academics and practitioners relied on U.S. social work literature. Equally, Jones (2006) observed that the clinical practices of U.S. nurses had been defined by those in Australia, Turkey, Ireland, and New Zealand. Hence, a historical review of the inception of clinical supervision practice owes provenance to a variety of key professionals in U.S. charitable organizations and their international heritage. These U.S. authors and others who followed in their footsteps had the forethought to draw on

the published scholarship of international professionals when establishing the foundations of clinical supervision. This forethought has been documented throughout the social work, counseling, and psychotherapy disciplines (Ellis, 2006; Goodyear & Bernard, 1998; Milne & Westerman, 2001; Watkins, 1997).

Developments of Clinical Supervision

Australia

Competency-based clinical supervision in Australia is the established standard of practice across the disciplines of psychology, counseling, social work, sociology, and nursing (Falender & Shafranske, 2017). It reflects a growing impetus towards its implementation in multiple international jurisdictions. This competency-based clinical approach was adopted by the Psychology Board of Australia in 2013 and since, peer consultation and supervisor accreditation has been mandated for each of the social service professions. The development of these professional regulations and the formation of clinical supervision guidelines encouraged other professional associations and authoritative bodies to engage in efforts to enhance the accountability of professional training and ensure overall competence (Falender & Shafranske, 2012; McNamara, 2013). In line with this, the literature is replete with arguments in favor of competency-based education and training (Falender & Shafranske, 2012, Fouad & Grus, 2014, Grus, 2013), and clinical supervision has been designated as the way to introduce this distinct professional competency in scholarly practice (American Psychological Association, 2015).

Ireland

The development of clinical supervision in the Republic of Ireland has been enhanced through its Department of Counseling Psychology (Creaner & Timulak, 2016). Clinical supervision is highly valued within its social service community and therefore recognized as an essential continuous professional development activity monitored by the Psychological Society of Ireland (McMahon & Errity, 2014). Generally, receiving clinical supervision in the Republic of Ireland is considered good practice and an expectation of those in the counseling profession; but until recently attendance was considered a condition of an individual's agency of employment (Ellis, et al. 2015). Remedying this, the Health Service Executive (2015) introduced its first supervision policy under the Public Health Sector guidance document on Supervision for Health and Social Care Professionals. This supervision policy required that all health and social care professionals, including counseling psychologists, engage in "regular, high quality, consistent and effective supervision that is appropriate to their profession" (p. 5). In addition, the Health Service Executive also implemented that clinical supervision should continue across the career span of all social service professionals no matter the organization.

Turkey

In Turkey, the counseling profession commenced 60 years ago via specialists who received training in the United States (Aladağ & Kemer, 2016). It was through these specialists' efforts that Turkish counseling professionals (a) established services in schools, (b) initiated graduate and undergraduate supervisory programs, (c) founded the

Turkish Psychological Counseling and Guidance Association, and (d) developed ethical standards for the profession (Kurtyılmaz, 2015; Meydan & Denizli, 2018). As a result of these efforts, clinical supervision is now considered a professional service in Turkey and is provided to trainees by an educator or senior peer for the purposes of enhancing competencies and professional functioning (Aladağ & Kemer, 2016). Because of the growing importance of clinical supervision in Turkey, substance abuse social workers have strengthened their identity and presence in it, receiving the attention of both counseling educators and practitioners.

As reported by Aladağ (2014), Aladağ and Bektaş (2009) and Atik (2015), clinical supervisors in Turkey focus their supervisee feedback on three main areas: basic counseling skills, case conceptualization, and self-awareness. However, basic counseling skills is the competency that receives the most focus. Many Turkish clinical supervisors reported that they provide an even balance of positive/negative and supportive/corrective feedback to their supervisees while paying special attention to fostering their growth and confidence (Aladağ & Kemer, 2016). Moreover, the two main evaluation criteria reported by Turkish substance abuse social workers were the completion of supervision requirements (number of sessions, attendance at sessions, and participation), and the demonstration of professional behaviors that include process and intervention skills. Following this criterion most clinical supervisors described the nature of their supervisory relationships as close, sincere, genuine, and trusting (Aladağ, 2014; Kurtyılmaz, 2015). Likewise, supervisees described their supervisors as teachers, counselors, advisors, and mentors (Meydan & Denizli, 2018).

New Zealand

Clinical supervision is a hot topic of discussion in New Zealand (Beddoe, 2016). The country held three national supervision conferences in 2000, 2004, and 2010, and each of these conferences made significant contributions to clinical supervision through advocacy, educational development, and the expansion of research. The New Zealand Social Workers Registration Board (2013) is responsible for issuing practicing certificates to registered social workers, and has a formal clinical supervision policy that outlines the expectations of this relationship. The policy states that "supervision is a universally accepted practice standard in the social work profession and considered by the board to be an essential element ensuring competent social work practice" (p. 2).

The New Zealand Social Workers Registration Board (2013) also states that clinical supervisors should be registered social workers "who have completed training in professional supervision and who practice in accord with accepted professional standards of experience and qualifications" (p. 2). In kind, the Aotearoa New Zealand Association of Social Workers (2019) Code of Ethics details that core social work supervision should be facilitated by qualified social work supervisors who use their sessions as the major training tool for social work practice. This demonstrates that both the New Zealand Social Workers Registration Board and the Aotearoa New Zealand Association of Social Workers Code of Ethics believe that clinical supervision demonstrates a commitment from supervisors to the social work profession and aligns with the standards of practice, code of ethics, and the standards of the International Federation of Social Workers.

Bermuda

The Bermuda Addictions Certification Board (BACB) (2013) is tasked with the responsibility of ensuring a highly skilled and professionally credentialed substance abuse workforce governed by uniform professional standards. Under this umbrella the professionals who provide counseling and addictive services are required to meet rigorous, quality standards reflecting competency-based knowledge, skills, and attitudes. To assist with this level of credentialing, the BACB has been a member of the International Certification and Reciprocity Consortium since 1997 (DNDC, 2017). The BACB believes that this credentialing process is based on the highest standards set by professionals in the substance abuse field, as all professionals are required to undergo specific education, training, and supervised practice prior to a written examination, case presentation, and oral examination. This certification process enables the island's drug and alcohol social workers, and clinical supervisors the ability to demonstrate the professional competencies necessary to provide quality substance abuse treatment services.

The BACB mandates that treatment and prevention professionals recertify every 2 years (DNDC, 2017). Statistics from this recertification process showed that as of 2016 Bermuda has 54 certified persons in substance abuse treatment and prevention occupations, 34 of whom are International Certified Alcohol and Drug Counselors (ICADC), 8 who are Certified Clinical Supervisors (CCS), 6 who are Associate Alcohol and Drug Counselors, and 6 who are Certified Prevention Specialists. Unfortunately,

among those 54 certified persons in substance abuse treatment and prevention occupations only 26 are registered social workers (DNDC, 2017).

The BACB (2103) states that the clinical supervision of Bermuda's alcohol and drug professionals is a disciplined and defined activity. It outlines that clinical supervision is linked in relationship to teaching, consulting, administering, and researching and is a necessary, significant, and meaningful aspect of the delivery of competent, humane, ethical, and appropriate services to their clientele. In line with this statement, the BACB mandates that International Certified Alcohol and Drug Counselors and Associate Alcohol and Drug Counselors must receive 300 hours of clinical supervision, CCSs must receive 200 hours of clinical supervision, and Certified Prevention Specialists must receive 300 hours of clinical supervision prior to their (re)certification.

Substance Abuse Social Workers

Laschober et al. (2013) estimated that between 2008 and 2018 social workers within the substance abuse field will grow by approximately 21%. According to the Bureau of Labor Statistics (2010) this rate is exponentially faster than any other occupation. In substance abuse facilities, social workers are the foundational staff who work with the clients daily and are therefore taxed with the responsibility of providing crisis intervention, family support, referrals, networking, and community outreach services (Laschober et al., 2013). They are expected to teach individual tools such as, daily living skills, treatment planning, supportive services, and other elements necessary to transform clients into productive citizens within their communities.

As a result of their array of individual and communal skills, substance abuse social workers develop an awareness of social problems that are unique to this specialized population (National Institute on Drug Abuse, 2009). For this reason, they define substance addiction as a chronic illness that affects one's health, requires long-term behavioral or pharmaceutical intervention and involves recovery, relapse, and recurrent treatment. Substance abuse social workers understand that the provision of treatment includes withdrawal, detoxification, cravings, and compulsions and that these elements are just as important to address when providing effective service. In line with this, Martino (2010) emphasized how critical it is for substance abuse social workers to be proficient in a plethora of different treatment modalities to provide optimal care with evidence-based options that may delve outside of the realm of traditional social work practices.

In the substance abuse field, social workers encounter clients with concurrent and co-morbid disorders (Substance Abuse and Mental Health Services Administration, 2014). Because this population is highly susceptible to infectious diseases and mental health disorders, substance abuse social workers must understand the ecological perspective of their client's lives. They must also have knowledge of interventions for at-risk behaviors, family involvement, employment, environment, and community. Treating substance addicted individuals is composite and requires a team of competent and confident professionals for its seamless execution.

Policy makers in the substance abuse field are strongly encouraged to empirically support the social workers who provide substance abuse treatment and strive to improve

the care of each client (Reickmann, et al., 2009). Accordingly, substance abuse social workers require support and training in the skillful use of psychosocial evidence-based practices to ensure the accurate delivery of treatment services and the overall improvement of client outcomes (Glasner-Edwards & Rawson, 2010; Martino, 2010). Irrespective of this, the substance abuse literature has noted that some social workers enter the field without the tools necessary to effect change (Weissman et al., 2006) and this has been attributed to their teaching style which occurs on the job, after formal coursework has been completed, and careers have already started (Kerwin et al., 2006).

Researching this point, current substance abuse studies have shown that to improve social worker's implementation skills their support and training needs to include competency-based supervision (Kerwin et al., 2006). This style of teaching allows substance abuse social workers to be directly observed by supervisors who provide constructive criticism and feedback via coaching (Beidas & Kendall, 2010; Herschell et al., 2010; Olmstead et al., 2012) while thoroughly evaluating their supervisee's performance and propensity for practice in the substance abuse field (Miller & Koerin, 2001). For example, any deficits or shortcomings that may need to be remediated. It is through competency-based supervision that supervisors can guarantee that the substance abuse profession is fostering social workers who are able to interact with their clientele and associated communities in an ethical and competent manner.

Clinical Supervision in Social Work

Clinical supervision has been regarded as an integral practice in social work since the profession's early stages of development in 18th Century Germany (Beddoe, 2016).

As such, it has been rooted in the process of professionalization in the field and used as the primary vehicle for the development of a social worker's identity, values, and skills (Beddoe, 2015; Busse, 2009). It maintains its place as a significant facet of practicing social work as it is the medium through which ongoing reflective practice and learning is facilitated (Tsui, 1997, 2005).

As stated by Runcan et al. (2012), clinical supervision is an attempt to bridge the gap in the social work profession through education, practice, text, and reality. It supposes a surveillance relationship between two persons that concerns observable and measurable developmental activities and is an important training tool considering the varying dynamics of theory and how it relates to practice in the social work field (Munson, 2002). A review of the historical literature on clinical supervision in social work yielded publications by Kadushin (1977), Munson (1981, 2002) and Shulman (1993). Each of these scholars established a function of clinical supervision in social work and were consequently termed educational, supportive, and administrative. Munson (1981, 2002) posited that the educational portion of supervision seeks to establish one's self-awareness, develop a knowledge base for the field, improve decision-making sills, and discuss client assessment, diagnosis, and referrals. Kadushin (1977) spoke of the supportive portion of supervision that addresses emotional support and aids social workers during times of burnout, discouragement, and dissatisfaction. Lastly, Shulman (1993) elaborated on the final portion of supervision that addresses dimensions of rapport and trust.

As a result of these past works, supervision in social work has continually been regarded as an important method for staff to refine and develop their skills post academia, to facilitate reaching conclusive outcomes for clients, and to build confidence and experience in supervisees through dialogue (Bourn & Hafford-Letchfield, 2011).Through its skillful practice, senior practitioners offer guidance to enhance staff morale, improve overall effectiveness, and increase sensitivity to client's rights and the delivery of effective clinical services (Holleran et al., 2010). Moreover, when ethical dilemmas arise due to personal belief versus professional conduct issues, social workers engaged in clinical supervision have a platform to resolve their issues and generate ways of exploring operable solutions.

Clinical Supervision in the Substance Abuse Field

Historically, the substance abuse field has acquired systems and methods from other helping professions (Schultz et al., 2002) and as such their styles and practices have mimicked those for whom mainstream supervisory literature has been written: social workers, psychiatrists, and psychologists (Thielsen & Leahy, 2001). This existing literature on supervision makes its function in the field of substance abuse challenging; because most clinical supervision models, research, studies, and improvements have been focused in the educational setting not the work environment (Krause & Allen, 1988; Ladany et al., 1999; Worthington & Roelke, 1979). In a field where post educational supervision has been included in directorial models, there have been little studies that have observed the development of clinical supervision in the field of substance abuse (Holloway, 1995; Schultz et al., 2002), in

the post educational setting (Loganbill et al., 1982), and in the rehabilitation counseling literature (Baker & Meyer, 1978; Herbert, 2004).

The absence of training as well as the organized research to support its vitality suggests that substance abuse supervisors may be under or uninformed about clinical supervision theories, techniques, and strategies specific to the field (Kerwin et al., 2006). It also suggests that clinical supervision in substance abuse may be practiced inconsistently or ineffectively. Furthermore, due to the limited research on this topic, many clinical supervisors within the substance abuse field may not know what constitutes effective supervision and have the knowledge that is provided and learned through professional training and literature (Kerwin et al., 2006). Due to the lack of research in this area, and its impending impact on the personal and professional development of substance abuse counselors, the knowledge of clinical supervision in the field of substance abuse needs to be developed (Schultz et al., 2002).

Since the advancement of substance abuse counseling as a reputable occupation, supervision has been vital to the continuing education process as it plays a major role in the preservation of skills (Schultz et al., 2002). It is also the critical component that supports the transition from substance abuse education to practice in the work environment. Schmidt (2012) discerned that the purpose of clinical supervision within the substance abuse field was to promote the development and therapeutic competence of the professionals responsible for the provision of treatment services to addicted individuals. He also informed that clinical supervision within substance abuse was developed to equip

all substance abuse professionals with the advanced skills, knowledge, and self-awareness needed to increase overall effectiveness.

Agreeing with Schmidt's account of clinical supervision in substance abuse, Vallance (2004) published that the increase in competence and effectiveness of substance abuse social workers has a positive relationship on the efficacy of the counseling provided. For this reason, clinical supervision has been established as imperative not only to the advancement of substance abuse professionals but for the continuous improvement of substance abuse treatment services (Culbreth, 1999). Accepting that the overall purpose of clinical supervision is to train substance abuse professionals on best practice methods, researchers like Blair and Peak (1995), Hillman et al. (1997), Stoltenberg, (1981), and Worthington (1987) have devoted considerable time and effort to explaining the benefits received by the supervisee and how this is directly attributed to the supervisory process (Culbreth & Cooper, 2008). Additionally, Herbert (2004), Delworth (1995), and Schultz et al. (2002) proposed models of supervision specific to substance abuse professionals in their field.

Social Workers in the Substance Abuse Field

Van Wormer (1987) noticed that the number of students enrolling in schools of social work with the hope of working in the field of substance abuse increased. Thereby, prompting universities to develop programs to train social work students in effective interventions with clients who have problems with substance abuse. Since then, social workers who have been formally educated have entered the substance abuse field but still struggle to receive the clinical supervision necessary to reinforce evidence-based

practices and receive on the job training. According to Anderson (2000), all substance abuse social workers regardless of formal designation require knowledge of theories, skills, and access to resources to maintain their professional competence. These necessities can be provided through effective clinical supervision.

The receipt of clinical supervision is the norm in social work professional agencies as it is required for credentialing and licensing practices (Whitley, 2010). Consequently, social workers who enter the substance abuse field not only expect but seek supervision as they have been trained to regard it as one of the most essential aspects of employment (Bogo & McKnight, 2005; Kadushin, 1977). In contrast to the social work profession and its teachings, historically, the field of substance abuse has regarded supervision as a one-on-one outreach format from a singular person in recovery to another (Whitley, 2010). As such, when the substance abuse field was first developed it relied heavily on recovering addicts and paraprofessionals, who most often lacked the appropriate education in substance abuse counseling to provide substance abuse treatment services and supervision (Ham et al., 2013; West & Hamm, 2012). In this instance, the individual and professional needs of the recovering addicts easily went unrecognized.

In consideration of the implications of the social work profession, the substance abuse field has begun to rapidly recognize the importance of implementing clinical supervision and it is now an expectation for the substance abuse social workers (Substance Abuse and Mental Health Services Administration, 2014). Investigating the outcomes of this implementation, Knudsen et al. (2008) discovered that substance abuse social workers who received clinical supervision reported on the positive correlation

between it and their perceptions of job autonomy, procedural justice, emotional support, decreased incidences of staff turnover, and occupational well-being. Considering the overwhelming benefits to both the social work and substance abuse fields, clinical supervision should be provided for social workers who exemplify the role of substance abuse counselors as well (Knudsen et al., 2008; Whitley, 2010).

The complex nature of social work challenges professionals to maintain their competency while in the substance abuse field, manage ethical challenges, and fill the gaps in education and training (Fulton et al., 2016). To reinforce this, Fulton et al. informed that this cannot be met without effective clinical supervision as it is essential to the prosperity of the social worker, client, public, and profession. Equally then, maintaining social worker competence through constant assessment and intervention is a primary supervisory duty necessary to preserving the integrity of the field of substance abuse (Schmidt et al., 2013; West & Hamm, 2012).

The Importance of Clinical Supervision for Substance Abuse Social Workers

Research on the importance of clinical supervision for substance abuse social workers revealed a shortage of social workers trained in the screening, assessment, and treatment of addicted persons and as a result, the capacity for treatment agencies to provide exclusive care for this specialized population lessened (D'Ippolito et al., 2013; Institute of Medicine, 2006; Krull et al., 2011; Lundgren et al., 2011; Martino, 2010). Exploring these statistics further, D'Ippolito et al. (2013), Krull et al. (2011), and Lundgren et al. (2011) informed that clinical supervision is purposed for the implementation of the evidence-based practices employed to treat substance abuse

disorders. This is paramount to resolving the challenges faced by community-based substance abuse agencies. Similarly, research within the past 5 years provided by Ducharme et al. (2016), Jobli et al. (2015), Novins et al. (2016), Robertson et al. (2015) Smith (2013), and Smith and Liu (2014), measured the variability of community-based substance abuse agencies to implement evidence-based practices for treatment and their research highlighted staff preparation, skills, training, and reinforcement as key factors in its success.

Lundgren et al. (2013) conducted a national study of 349 substance abuse social workers from community-based substance abuse treatment agencies. The social workers in their study indicated that programs lacked staff capacity, experience in facilitating empirically supported treatments, identified barriers to implementing evidence-based practices, and had even greater supervision needs. They also revealed the shortages in treatment programs as well as highlighted their difficulties and inadequacies. Lundgren and Krull (2014) also confirmed the importance of social workers being appropriately supervised and trained in the policies and procedures effective for substance abuse treatment.

Providing insight into the need for clinical supervision for social workers within the substance abuse field, Giddings et al. (2007) reflected on the earlier works of Veronica Bishop and her experiences as a clinical supervisor in 2001. In their article, Giddings et al. (2007) highlighted how Bishop (2001) observed that social workers in the substance abuse field appeared to lack confidence in their knowledge and skills specific to substance abuse and therefore struggled to convey ideas regarding client development

and the change process. A more detailed review of Bishop's work revealed that he attributed this lack of professional confidence to the poor quality or lack of clinical supervision. He also reported that to remedy this social issue clinical supervision needs to be promoted as necessary to the practice experience in the substance abuse field as well as focus on case conceptualization, disposition, knowledge-practice integration, teaching strategies, and role modeling.

The Absence of Clinical Skills in Substance Abuse Social Workers

Despite the understanding of the importance of self-efficacy when working with persons in substance abuse, clinical skills remain inconsistent across the field (Russett & Williams, 2015). Verifying this, Fragkiadaki, et al. (2019) conducted a study on various social workers across the substance abuse discipline and published that many lacked the basic clinical competencies needed to address addictive issues. This apparent lack of preparation and consistency while working within service-provision environments demonstrated a need for competency trainings to impart the knowledge necessary for this demographic of individuals. Operating under this belief, the need for trained professionals to administer substance abuse counseling services became more pronounced.

Over the past three decades an increased number of social workers have entered the field of substance abuse with the necessary licensing and qualifications to provide clinical supervision (White, 2001). In the absence of sufficient numbers of licensed clinical alcohol and drug counselors social workers with a license in clinical social work have offered their services to counselors and have supervised across this professional

divide (Substance Abuse and Mental Health Services Administration, 2014). Licensed clinical social workers (LCSWs) who bridge this gap have supported the professional development of substance abuse social workers and the progress of their clients while dually promoting the policies and procedures of substance abuse's agencies and the cohesion of the substance abuse profession overall (Whitley, 2010).

Bina et al. (2008) disclosed that social workers who received clinical supervision during their work with addicted persons demonstrated an increase in knowledge and preparedness. Another study conducted by Amodeo (2000) revealed that after MSWs received 9 months of substance related training, there was a statistical difference in how they connected, intervened, and provided treatment to said individuals. Lastly, Amodeo et al. (2002) learned that if the same group of master's level social workers who completed 9 months of training were afforded an additional certification program for working with clients with substance abuse issues, they used their certifications to provide training and supervision to others within their agencies.

Summary

It is surprising that given the increased literature on the benefits of clinical supervision and developing a supervisee, more consideration has not been given to producing research that strives to expound on the exploration of clinical supervision for substance abuse social workers (Baker et al., 2002; Russell, 1994). Additionally, Culbreth (1999) and Watkins (1995) noted that there is a remaining gap in the social work literature surrounding the recognition of clinical supervision from the perspective of the supervisor. They further stated that the supervisor's view of clinical supervision for

substance abuse social workers becomes significant when considering other unexplained areas related to this social work practice problem.

Clinical supervision is the platform where clinical reasoning, ethical decision-making, the application of knowledge and skills, and the development of the values of the social work and substance abuse professions are modeled, developed, reinforced, and enhanced (Barnett, 2014). It is where a substance abuse social worker's identity is defined and as such its importance should not be underestimated because it has a profound effect on how social workers view their role as clinicians in the substance abuse field (Handelsman et al., 2005). Irrespective of the noted benefits of clinical supervision for substance abuse social workers, gaps in the literature and unexplained areas exist related to this social work practice problem like a failure to receive timely, effective, and competent clinical supervision (Barnett, 2014). Barnett also detailed how these unexplained areas can have a direct and deleterious effect on the quality of clinical services that substance abuse social workers provide. The range of topics addressed in section one of this research project and the combination of depth and breadth of coverage of relevant topics and issues related to clinical supervision for substance abuse social workers will hopefully be an essential primer to future research.

Section 2: Research Design and Data Collection

Introduction

The purpose of this doctoral study was to add to the current body of social work knowledge on clinical supervision for substance abuse social workers in Bermuda through education and practice. The following research question guided this study: What is the significance of clinical supervision for substance abuse social workers in Bermuda? However, in addition to my basic research question, several ancillary issues arose when conducting this study and needed to be addressed. The first was to determine how interested substance abuse social workers were in addressing their need for clinical supervision and how deep that need will go.

In Section 2 of this project, I discuss the existing and prospective data primarily generated for the purpose of the study, the strategies used to identify and recruit potential participants, the tools and/or techniques used to collect the data from the principal participants, how the data were analyzed to answer the research questions, and the procedures used to ensure their ethical protection.

The action research recommendations produced by this project were intended to serve local substance abuse social workers and incite a collection of these social workers to collaborate on a social issue that is important to their community (see Cyr, 2016). Potential participants for this project were 26 Bermudian substance abuse social workers and from this group, principal participants were those social workers who agreed to participate in the project. I designed a qualitative, semi structured interview guide to determine the clinical social work problem as the principal participants perceive it (see

Appendix) and their role was to provide the data essential to address the research questions of the project.

Principal participants had the opportunity to contribute to the field of social work knowledge and improve clinical practice through the collaborative work of defining clinical supervision within their community. The NASW (2017) Code of Ethics stressed competence as a social work value through the improvement of a social worker's professional knowledge and adding to the general body of social work knowledge. This project empowered substance abuse social workers to learn from and with each other while developing their professional competence (see NASW, 2017). The collaborative efforts of this qualitative action research methodology provided an opportunity for this study to identify the barriers and challenges that substance abuse social workers experience regarding their receipt of clinical supervision and encourage continued research in this area until the inconsistencies experienced no longer exist.

Methodology

Prospective Data

After receiving approval for this study from the Walden University Institutional Review Board, number 12-06-19-0491476, I used qualitative, semi structured interviews with participants to collect the data for this study. This method was chosen because of its popularity (see Kallioet al., 2016), versatility, flexibility, ability to be combined with individual and group methods (see DiCicco-Bloom & Crabtree, 2006), and its rigidity, which can be varied depending on the study purpose and research questions (see Kelly, 2010). One of the advantages of the qualitative, semi structured interview in this study

was that it was successful in enabling reciprocity between me and research participants (see Galletta & Cross, 2013) by allowing me to improvise follow-up questions based on participant responses (see Rubin & Rubin, 2005). It also allowed space for participants' individual verbal expressions.

The qualitative, semi structured interview questions (see Appendix) were determined prior to the interview process and formulated using an interview guide (see Kallio et al., 2016). This guide covered the main topics of the study and offered a focused structure for the interviews. The interview guide was used with the goal of collecting similar types of information from each research participant (see Gill et al., 2008). The qualitative, semi structured interview method aligned with the research questions of this study because the interaction between social workers from separate, yet similar, substance abuse agencies led to in-depth insights on the significance of clinical supervision within each agency. I used this method of collecting data to glean those insights from principal research participants and provide a more personal account of clinical supervision for substance abuse social workers in Bermuda (see Silverman, 2000).

When designing this qualitative research interview guide, it was essential for me to use questions that addressed the aims and objectives of this research topic with the goal of generating as much data as possible about clinical supervision for substance abuse social workers in Bermuda (see Showkat & Parveen, 2017). During the qualitative, semi structured interviews, I asked questions that were open ended, neutral, simply worded, and able to be understood by all participants. Showkat and Parveen also advised that the

qualitative, semi structured interview guide start with close-ended questions that participants could answer with ease and fluidly and then progress to more stimulating questions that contain more sensitive material (see Appendix). According to Showkat and Parveen approaching the research interview in a closed- and then open-ended manner helps participants to build confidence in the rapport and this confidence assists in the development of the qualitative, semi structured interview and generation of rich and meaningful data.

Participants

Potential participants for this research project were 26 MSWs employed at the time of the study by 1 of the 14 government or private substance abuse treatment facilities in Bermuda (see DNDC, 2017). Of these 14 substance abuse treatment service facilities, four facilities are private, nonprofit agencies; four facilities are private, for-profit agencies; and six facilities are agencies funded by the Bermuda Government. Additionally, of these facilities, five provide substance abuse counseling services, two provide assessment and referral for substance abuse treatment services, three are specialized court programs that provide support to offenders in need of treatment, and four provide inpatient or outpatient substance abuse treatment services.

Considering the diverse nature of these treatment agencies, the DNDC (2017) hosts an annual Bermuda Drug Information Network (BERDIN) conference that integrates all substance abuse treatment providers who provide yearly statistics from their respective agencies, review performance quality improvement measures, and present agency plans for the impending year. Given this work connection and the ability to

network with these individuals during the BERDIN conference, I emailed the Director of the BACB to receive access to the contact list of substance abuse social workers in Bermuda. After the receipt of this correspondence, each substance abuse social worker listed was identified as a potential participant; sent an introductory letter; a consent form and qualitative, semi structured interview guide (see Appendix); and asked to email me about their willingness to assist with the study or for additional information on the study. Those substance abuse social workers who expressed interest in participation in the study were then identified as principal participants and were invited to meet with me in person to provide further project details before the interview was conducted.

The type of sampling strategy that was used for this research project was purposeful sampling (see Berg & Lune, 2004). It is the most common type of sampling strategy in qualitative research where potential participants are selected or sought after based on the preselected criteria outlined in the research question(s) (Marshall, 1996). For example, the use of substance abuse social workers as the principal participant sample aligned with the practice-focused question on the significance of clinical supervision for substance abuse social workers in Bermuda. Purposeful sampling was suitable for this study because it provided a wide range of nonprobability sampling techniques to draw on that provided justifications for making theoretical, analytical, or logical generalizations about the sample being studied (see Marshall, 1996).

Of this wide range of nonprobability sampling techniques, I chose maximum variation or heterogeneous sampling for this study. Maximum variation or heterogeneous sampling captured a wide range of participant perspectives related to the research

questions and could be used to search for variation in those perspectives ranging from viewpoints that are deemed to be typical to those that are more extreme in nature (see Coyne, 1997). The use of maximum variation or heterogeneous sampling demonstrated a wide range of attributes, behaviors, experiences, incidents, qualities, and situations experienced by each participant and helped me gain insight into the research questions by looking at them through the perspectives of each person. The maximum variation or heterogeneous purposeful sampling techniques also helped me identify common concepts that were evident across the participant sample (see Coyne, 1997).

Instruments

The tool used to collect data for this research project was the qualitative, semi structured interview guide (see Appendix). I developed the interview guide questions based on the work of Kallio et al. (2016) who performed a systematic methodological review on developing a framework for a qualitative, semi structured interview guide. Kallio et al. reported that rigorous data collection influences the results of research studies profoundly; therefore, the qualitative, semi structured interview guide must contribute to the reliability and validity of the research study. During the literature review for this research topic, I was able to find several scholars (i.e., Culbreth, 1999, 2011; Fulton et al., 2016; Juhnke & Culbreth, 1994; Powell, 1993; West & Hamm, 2012; Whitley, 2010) who concluded the benefits of clinical supervision in substance abuse field, but there was sparse available research specific to clinical supervision for social workers in the substance abuse field. Accordingly, the qualitative, semi structured interview guide for this research project was developed as a data collection tool to

understand the significance of and barriers to clinical supervision for substance abuse social workers in Bermuda with the aim to use this knowledge to improve the receipt of that clinical supervision.

The techniques used to collect the qualitative data from the semi structured interviews with participants were as follows. To begin the interview, I welcomed each participant and provided them with a handout of the qualitative, semi structured interview guide for reference throughout the interview process. I then reviewed the informed consent and expectations of confidentiality and allowed participants the opportunity to ask any questions before the informed consent was signed. Participants could also exercise their right to withdraw from the study at that time. Following the review of the qualitative, semi structured interview guide, I continued with introductions and basic demographic questions, including participant degrees earned and their years of experience as a substance abuse social worker (see Appendix). Successive transitional questions were related to places of employment within the substance abuse field, policies and procedures on clinical supervision, and barriers to and supports of clinical supervision, which were all meant to promote participant responses that triggered additional perceptions and experiences on the research topic.

Kallio et al. (2016) supported this use of questioning because it evoked purposeful conversation using introductory, transitional, one-dimensional, closed, open, and ending questions. In the last question of the interview guide (see Appendix), I asked participants to make recommendations on how to improve the receipt of clinical supervision for substance abuse social workers. This question was used to encourage them to consider

the research topic from a communal perspective and was considered the final question by Kallio et al. used to assess each person's willingness to collaborate on future social service issues.

Data Analysis

The analysis and interpretation of qualitative action research data follows a rigorous set of procedures, such as exploring and categorizing data, identifying concepts, and developing a framework system (Ritchie & Spencer, 1994; Stringer, 2014). The data collected in this qualitative study were audio recordings and transcribed interviews; therefore, it contained internal content, accounts of experiences, descriptions of observations, and personal interactions.

I audio recorded the interviews for this study, which allowed me to be present during the facilitation of the interview and exceptionally specific with the interpretation of all types of data (i.e., addressing relevant nonverbal observations). Following the completion of the interviews, I transcribed each recording using Microsoft Word on a personal computer, ensuring that all identifying information was omitted for confidentiality purposes and comparing the audio recordings with the typed data three times to check for accuracy after transcription (see Boyatzis, 1998). Post transcription, I employed a participant checking technique where the typed transcriptions were provided to research participants to see if there were any additional thoughts that they would like to add or any misinterpretations they would like to correct. Once participant checking was complete and the information transcribed was confirmed as precise, I organized and

sorted the qualitative data collected using framework analysis to identify, categorize, and program significant data points.

Framework analysis involves the methodical processing, sorting, charting, and sifting, of data to answer the research question(s) (Srivastava & Thomson, 2009). It is an analytical process that relies on creative and conceptual abilities to determine the meaning of the qualitative data set and establish the connections between it. The strength of this type of analysis is that this research data can be reworked if needed because it has been audiotaped and transcribed and is therefore always accessible. Once I obtained the qualitative data from this research project, they were sifted, sorted, and charted so that their key issues and concepts directly related to the significance of clinical supervision for substance abuse social workers in Bermuda. This method of data analysis presented it in a way that exemplified the material collected during each individual interview.

Action research is about identifying a social issue that needs to be resolved and then justifying why resolution needs to happen (McNiff & Whitehead, 2010; Stringer, 2014). So, it was my intent, during my action research process, to establish the significance of clinical supervision for substance abuse social workers in Bermuda, then improve upon the receipt of that clinical supervision.

McNiff and Whitehead (2010) and Stringer (2014) reported that action research should be widely accepted under four main principles: credibility, transferability, dependability, and confirmability. They also informed that credibility is established from prolonged engagement with participants during the research study (i.e., a relationship that develops from an enduring encounter). In line with this, I established credibility during

this research project when I engaged each participant in the qualitative, semi structured interview process and developed relationships of reciprocity (see Galletta & Cross, 2013). According to Stringer (2014), transferability is the probability that the data collected from a study is pertinent to the resolution of another social issue. I established transferability during this research project when I made note of participant verbal and nonverbal cues during the qualitative, semi structured interview process, and improvised follow-up questions based on participant responses (see Rubin & Rubin, 2005).

Dependability and confirmability are the degree to which this project followed the research process as described in the methodology section of this report; that the research was conducted, not faked (see McNiff & Whitehead, 2010). I established dependability during my research project when each participant expressed their feelings about the interview process as well as their perspectives on data collection (see Stringer, 2014). I established confirmability during the project when I incorporated that feedback into the ideas and concepts that resulted from the data analysis (see McNiff & Whitehead, 2010).

I used process documentation and rigor in this study to outline the steps necessary for data analysis. The transparency of this documentation showed how the data were collected and yielded logical conclusions in line with the practice-focused research questions (see Stringer, 2014). For example, guided tour or open-ended questions gave participants the opportunity share their experiences related to clinical supervision; these questions were the primary source of data collection (see McNiff & Whitehead, 2010); (see Appendix). I then used task or closed-ended questions to petition specific information through simple yes or no answers (McNiff & Whitehead, 2010); (see

Appendix). The data that I collected through guided tour and task interview questions allowed me to collect the information necessary to answer each research question(s) as well as capture the personal experiences of each participant of this study (see McNiff & Whitehead, 2010).

Ethical Procedures

The NASW (2017) Code of Ethics requires that social workers treat all information shared by participants in their study as confidential. I implemented this principle by protecting each participant's disclosure during the facilitation of the qualitative, semi structured interview and by ensuring that only the material pertinent to the purpose of this study was collected. The Code of Ethics also mandates that each participant understands their right to confidentiality and is appropriately informed of any exceptions related to it. For this reason, I completed an informed consent with each participant of this study during their preliminary research meeting.

Qualitative, semi structured interviews involve minimal risk to research participants via the emotional and personal content asked by the interview questions (see Kallio et al., 2016). Acknowledging this risk to participant safety and wellbeing, I employed protective factors to respect and safeguard each individual's privacy. I demonstrated with my research participants by conducting each qualitative, semi structured interview in a timely manner, remaining transparent throughout the interview process, and actively listening to each interviewee (see DiCicco-Bloom & Crabtree, 2006). I also demonstrated respect by providing a clean, safe, and comfortable environment for them to share their experiences.

The substance abuse field in Bermuda is extremely close knit, making its spectrum of care cyclical, and requiring substance abuse social workers to liaise with each other on a frequent basis (see DNDC, 2017). When a client initially seeks substance abuse treatment services, they are referred by external agencies to the Department of Court Services, Bermuda Assessment and Referral Centre (DNDC, 2017). It is this agency that provides triage services for each treatment recipient as well as provides the receiving treatment agency with a comprehensive report inclusive of diagnoses and treatment recommendations. Upon completion of the Bermuda Assessment and Referral Centre report, substance abuse social workers within the Department of Court Services contact the substance abuse social workers at the recommended treatment agency to request an intake appointment for the client (DNDC, 2017). Once the intake appointment is attended, a case conference is held between the referring agency, assessment agency, and the treatment agency to discuss the continuum of care. This same pattern is repeated for clients referred to outpatient treatment services, inpatient treatment services, relapse prevention treatment services, and aftercare treatment services. If at any point during the treatment process a break down in services occurs, the client is immediately referred back to the Bermuda Assessment and Referral Centre for an updated assessment and treatment recommendations (DNDC, 2017).

Due to the tapered size of the research community in Bermuda, i.e., 26 registered substance abuse social workers among 14 substance abuse treatment facilities, and the cyclical spectrum of care described above, the likelihood that participants of this study knew each other or had interacted with each other prior to the study was high (see

DNDC, 2017). Therefore, I ensured participant privacy through the following guidelines as noted by Fritz (2008): (a) transcribed interview notes did not contain any personal attributes or participant identifying factors, (b) data were only obtained for the purposes of the study and kept in a locked file cabinet and under password on my personal computer at home, (c) the keys for the file cabinet were kept in a location known only to me and the password to the computer was only known by me, (d) the data collected for this research study were only shared with Walden University's capstone research project committee, (e) the data collected for this research study will be kept for a maximum of 5 years after the completion of the project and subsequently deleted from my personal computer and vacated from my home, (g) if I became aware of any additional participant risk or protective factors during the study, I immediately ceased all data collection and sought guidance from the university capstone project committee members.

Summary

The information that I provided in Section 2 details the methodology of this research project and includes descriptions of its prospective and existing data, data collection, instrumentation, potential and principal participants, and ethical procedures. Following, I begin Section 3 with an analysis of the data collected in Section 2, an outline of the data analysis procedures, and the time frame for data collection. Continuing, I report on the statistical analysis findings of the research and describe how these findings answer the practice-focused research questions. Finally, I discuss the limitations of the study along with any findings that were revealed unexpectedly.

Section 3: Presentation of the Findings

Introduction

I conducted this doctoral research project because several Bermudian social workers employed in the substance abuse treatment field raised concerns that their receipt of and access to clinical supervision was limited. Acknowledging these concerns, the social work practice problem, or phenomena that I studied in this doctoral project was the significance of clinical supervision for substance abuse social workers in Bermuda. Participants in this study were 8 MSWs employed at the time of the study by 1 of the 14 government or private substance abuse programs in Bermuda that offer outpatient, inpatient, or residential nonhospital services. As substance abuse social work colleagues, each participant had the opportunity to contribute to the field of social work knowledge through the collaborative work of defining clinical supervision in their substance abuse roles. These shared experiences may help to improve the receipt of clinical supervision for substance abuse social workers whose duties span both the substance abuse and social work fields.

There were six female and two male participants whose careers spanned a minimum of 5 years and a maximum of 25 years as social workers in the substance abuse treatment field. All 8 substance abuse social workers were ICADCs, but as we discussed additional licensures and certifications in their interviews, it was revealed that one participant went beyond their alcohol and drug certification and was a CCS, one participant was a LCSW, two had foundational backgrounds in business, one was a certified family therapist, and the population also included a nationally certified

counselor and a registered behavior technician. Two of the participants were employed by a private agency and six participants were employed by the Bermuda Government or its quango.

The following data analysis was based on raw data collected from qualitative, semi structured interviews with the participants. The presentation of these findings includes the data analysis procedures used in the study, the validation procedures for quality control, and any limitations or problems encountered when conducting the study. In this section, I also report on the descriptive statistics of the research sample, the statistical analysis findings and how these findings answered the research questions, identify any unexpected findings, and summarize the findings as related to the practice-focused research questions.

Data Analysis Techniques

Participants for this capstone project were master's level social workers employed by 1 of the 14 government or private substance abuse treatment agencies in Bermuda that offer outpatient, inpatient, or residential nonhospital services. Data drawn from this group were based on three groups of emailed research packets that consisted of an introductory letter; consent form; and a qualitative, semi structured interview guide (see Appendix).

After removing the substance abuse social workers who presented a conflict of interest due to already established working relationships from the participant pool, I sent the first email to 12 randomly selected participants on January 13, 2020. Of those 12 participants, two (17%) responded and 10 did not. Therefore, a follow-up email was sent to the remaining 10 participants on January 21, 2020. Of the 10 sent a follow-up email,

five (50%) responded and five did not. On a final attempt to reach the required number of participants for this study, I sent one last email to the remaining five possible participants on February 14, 2020. Of those five, one person (20%) responded and four did not.

The 8 substance abuse social workers who expressed interest in participating in this study were invited to meet with me in person for a 10-to-15-minute preliminary meeting at the Department of Court Services. During this meeting, each participant was given the opportunity to ask any research-related questions after reviewing the previously emailed introductory letter; consent form; and a qualitative, semi structured interview guide (see Appendix). I also provided them with additional project details on (a) the privacy and location of the qualitative, semi structured interviews; (b) how their confidentiality would be maintained during the interview process; (c) the device to be used to record each interview; (d) the descriptors that would be used in the presentation of the findings. Once this preliminary meeting was completed, each participant was given the opportunity to review the information shared on their own; sign the consent form; email me a copy of the signature page; and then schedule their qualitative, semi structured interview. In the end, all eight interviews were scheduled and conducted between the dates of Tuesday, January 28, 2020 and Thursday, February 20, 2020.

The hour-long, qualitative, semi structured interviews for this study were held in the Bermuda Department of Court Services group room. Respecting each participant's privacy and confidentiality, I scheduled the interviews when the group room was empty of other office personnel. To eliminate unexpected contact, each participant was personally escorted to the interview room. To begin the interview process, I greeted each

participant; thanked them for their participation; and provided them with a copy of the qualitative, semi structured interview guide as a reference throughout the interview process. Following this, I began the interview with educational questions on participant degrees, credentials and licensure, and years of experience in the field. The interview continued with questions related to places of employment under the identifiers of government or private, agency policies and procedures on clinical supervision, barriers to and supports of clinical supervision, and recommendations on how to improve the receipt of clinical supervision for substance abuse social workers. All of these questions were meant to promote the open discussion of participant experiences directly related the research topic.

Due to the small participant size of the study, 8 master's level substance abuse social workers, I did not use any software for the data analysis. I manually transcribed, organized, and analyzed all qualitative information guided by the action research principles of McNiff and Whitehead (2010) and Stringer (2014). The eight hour-long interviews were audio recorded, and after the interviews were complete, I typed each recording into a Microsoft Word document on a personal computer. This process equated to approximately 80 hours of work. Finally, each Microsoft transcription was compared to its original audio recording and proofread on separate days to ensure accuracy. This process was estimated to take an additional 35 hours of work.

During transcription, I completed all work in a secure manner and kept it in a secure setting. The Microsoft Word documents did not contain personal attributes or

identifying factors, and all data were kept in a locked file cabinet under password protection. Only I had access to the computer password and keys to the file cabinet.

Validation Procedures

As reported by Berger (2015), reflexivity is a substantial approach to quality control in action research. Berger studied three types of reflexive challenges: (a) when the researcher shares the experiences of the participants, (b) when the researcher shifts their role from outsider to insider during the study, and (c) when the researcher has no previous experience with the research. Owing to the small population size of Bermuda and its effect on the size of the potential participant pool of this study, I was acquainted with the issues on which this study was based. Therefore, of Berger's three reflexive challenges, I experienced the first during this study, that of shared experiences.

To prevent any undesirable biases or skewedness of the data because of these shared experiences, I kept a journal of any participant expectations or predetermined ideas that I held while conducting the research. The purpose of this journal was to alleviate any influence that I may have had on any research outcomes from identifying the problem statement through writing the implications for social work change. During the proposal phase, specifically while writing the significance of the study, I journaled about how the capstone project was designed to encourage substance abuse social workers to see the benefits of clinical supervision. However, on reviewing this journal entry during the data analysis and ethical procedures phase of the writing, I realized that this intent had the potential to influence the questions constructed for the qualitative, semi structured interview guide.

For example, I found that the first draft of qualitative, semi structured interview questions asked participants to share a success story of their experience with clinical supervision. This question would have been more focused on the participants' personal benefits to receiving clinical supervision rather than the research question that asked about its overall significance to substance abuse social workers. To address these unconscious biases, I read the interview guide aloud to a clinical supervision group, which consisted of two LCSWs, one MSW one ICADC, and one psychologist, and used their feedback on each question to make improvements to the interview guide. None of these colleagues were eligible to participate in the study. Admittedly, these were not the most extensive validation procedures because they do not include statistical software, but the intent was to present the findings of this research in its original state to understand each substance abuse social worker's "truth" concerning the significance of clinical supervision for substance abuse social workers in Bermuda.

Limitations

Trustworthiness and Rigor

Action research is appreciated for its methodical analysis of subjective data gained from ethical principles (Fenge, 2010). An important part of its approach is to consider the participants and researcher as equal. Due to this subjectivity and equality, however, action research is often questioned with respect to its trustworthiness and rigor. Trustworthiness and rigor are action research concepts intended to validate the work of the researcher. Trustworthiness is defined as the way in which the researcher ensures that dependability, confirmability, credibility, and transferability are evident in the research,

and rigor is defined as the soundness or precision of a study to meet the criteria for data collection, analysis, and reporting (Stringer, 2014).

Dependability

Using more than one method of data collection would have strengthened the dependability of these research results. For example, conducting two sets of focus groups with the eight participants would have improved the reliability of the data. I addressed dependability in this study by describing the research design in its entirety and providing a detailed description of the data collection process. To conclude, I reviewed and evaluated each research process and its effectiveness with the peer clinical supervision group while the research was being carried out.

Confirmability

A major limitation to the conformability of this study was my bias as an influence throughout. This undoubtedly impacted the outcomes of this research irrespective of the measures put in place to prevent it. For example, the qualitative, semi structured interview guide was reviewed by my peer clinical supervision group as well as a clinical supervisor, who has a LCSW, ICADC, and CCS; yet, I still cannot verify that the guide and its questions were solely objective. I addressed this concern by making the study reflective and transparent through presenting all information used to summarize its results and all data used to make its findings, recommendations, and implications.

Credibility

Limitations on the credibility of this study were associated with the use of nonprobability sampling instead of probability sampling for data collection. Additional

methods of data collection, such as focus groups, would have strengthened the results of this study because subgroups of the potential participant pool would have been used as the sampling unit rather than individuals. I addressed the credibility of this study by familiarizing myself with clinical supervision for substance abuse social workers globally, as indicated in the literature review, and using qualitative interviewing to collect data from the perspective of each participant. Lastly, I addressed credibility by requesting and responding to the constructive feedback of a peer clinical supervision group and Walden University's action research committee.

Transferability

I was not able to demonstrate that the findings, recommendations, and implications of this study can apply to additional populations entirely because the participant population size of eight was too small to generalize such results. At the onset of this study, the total potential participant pool was planned to be 26 registered, local, substance abuse social workers, but by the time data collection commenced, one potential participant had relocated overseas, three were no longer employed in the substance abuse or social work fields, and two requested to be excluded for conflicts of interest. With 20 actual participants now in the pool, I chose to conduct qualitative interviews with eight subjects.

Having only eight participants for this study allowed for more time with each interview and for a more in-depth conversation, commented on by one of the peer clinical supervision attendees as "informative and relatable." I attempted to enhance the transferability of the study data by supplying contextual information to the reader and,

with this information, allowing them to make transfer inferences on their own. For this reason, transferability did not have to come from the findings, recommendations, and implications of this research, it could come from the reader's own interpretations of it.

Findings

I explored the significance of clinical supervision for substance abuse social workers in Bermuda for this capstone research project. I focused on five practice-focused research questions and used them as concepts for the qualitative, semi structured interviews. They were as follows:

RQ1: How do substance abuse social workers in Bermuda describe their experiences related to receiving clinical supervision?

RQ1a: How are these experiences consistent with concepts of the collaborative theory?

RQ1b: How are these experiences consistent with concepts of the contingency theory?

RQ2: What challenges or barriers do substance abuse social workers in Bermuda face related to receiving clinical supervision?

RQ2a: How do the challenges or barriers reflect micro, mezzo, or macro levels of social work and substance abuse practice?

The findings of this research project are synonymous with the role of master's level social workers employed in the substance abuse field and are focused primarily on their receipt of clinical supervision as a means of practical support. Clinical supervision provides this support through reflection and communication with substance abuse social

workers and helps them to deliver ethically sound community services within the realm of best practice standards (see Whitley, 2010).

I based this capstone project on the collaborative and contingency theories and potential implications for positive social change began with an informed clinical supervision practice (see Whitley, 2010). As social work colleagues, each participant had the opportunity to contribute to the field of social work knowledge through the collaborative work of defining clinical supervision in their substance abuse roles. Each participant received a qualitative, semi-structured interview guide (see Appendix) to use as an aid in the interview process and to help remember the three concepts and two theories while exploring the practice-focused research question. The three concepts that I used for this study were (a) positive experiences related to clinical supervision; (b) challenges and barriers related to clinical supervision; and (c) clinical supervision on the micro, mezzo, and macro levels of social work practice; and the two theories that I used were Vygotsky's Collaborative Theory and Fiedler's Contingency Theory.

I analyzed each concept according to participant response this revealed that 63% of participants had positive experiences receiving clinical supervision, leaving 37% of participants who reported experiencing challenges and barriers receiving clinical supervision. Similarly, 63% of participants noted how their experiences were consistent with the concepts of the collaborative theory, but only 37% were able to acknowledge that their experiences were consistent with the concepts of the contingency theory. Lastly, of the 8 participants interviewed, all 8 detailed that there were barriers within the profession that prevented substance abuse social workers from receiving supervisory

roles and this lack of availability made it difficult for them to achieve certification as a clinical supervisor. Additionally, participants shared that there were challenges to receiving their clinical license in social work if they were without permanent residence in the United States and a social security number. This data directly correlates to my research question: What is the significance of clinical supervision for substance abuse social workers in Bermuda?

Participants for this research project significantly agreed that they had positive experiences receiving clinical supervision based on the percentages above. I validated this statement on reviewing the results of the qualitative, semi structured interview transcripts which placed the concept positive experiences as the highest frequency of use. For this study I used the definition of positive experiences noted by Milne (2007), a formal relationship-based support system of practice and development. Participants of this study described their positive experiences with clinical supervision as "structured, supportive, helpful, welcoming, and focused" and its frequency was reported as "weekly," by two participants, "twice per week" by one participant, "externally once per week and internally every other week," by one participant, and "a minimum of once per month" by the last participant. One of the participants who identified their receipt of clinical supervision as "weekly" continued saying:

> Thankfully, my clinical supervisor was my job supervisor. They were in the space that I was working in and provided weekly supervision on a clinical level where we talked about case consultation, being competency based, ethics, and a wide range of different things. It was actual clinical supervision.

The participant who confirmed that they received clinical supervision twice per week explained this level of frequency as:

> I have sessions twice per week for an hour and a half, so 3 hours a week, and it is based on my high caseload. We focus on how to observe behavior, assess it, data collection, how to engage clients, interact with them, and how to develop treatment plans. It is slightly different from the traditional role which is more educational and deals with providing support.

One participant who described their supervision as "a minimum of once per month" explained their statement as follows:

> For all our outpatient treatment staff, clinical supervision is mandated, and it has to be a minimum of once per month. Some staff get supervision twice per month, it is really based on their need. If we have a senior person, they may be once per month but somebody new entering the role and finding their way is usually twice per month. The twice a month includes if one supervision session is missed, then they at least still have the minimum requirement of once per month.

Vygotsky's (1978) Collaborative Theory tied with the term positive experiences for frequency of use by participants during the qualitative, semi structured interview and is defined as a continual process between two or more individuals who collaborate to address a community need that has been unresolvable by a single individual or entity acting alone. When describing how the collaborative theory was consistent with substance abuse social worker experiences with clinical supervision, one participant defined this role as,

> We have a particular team that meets on a weekly basis here. There are representatives from local inpatient and outpatient treatment facilities, assessment and referral agencies, there are drug and alcohol counselors, case managers, social workers, the Magistrates and their staff, Defense Council, Prosecutions, and we also have a psychologist on staff. With everyone coming out of their individual silos on a weekly basis to attend this meeting, we are talking about the perfect example of collaboration. Everybody comes together to have a case management meeting about each of the clients involved with the team before they move forward and conference with the clients themselves.

Another example of the collaborative theory as expressed by a second participant was:

> Where I work, I am in a silo. I am my team because I do not have one and my direct report is to someone who isn't clinically trained; that is the only other person. So, what I do a lot is network and call contacts that I have made previously. I called other addictions professionals to help with community resources and I called other social workers who are familiar with the laws around child protection, things like that. The fact that I can call people and bounce things off them is very convenient and is collaboration.

The last participant interviewed gave a unique overview of their experiences as it relates to the collaborative theory,

> Every other year my coworkers and I go to the NASW conference. I implore anyone who is looking at a clinical designation in social work or addictions,

> because they overlap, to go overseas for the collaboration, networking, and the educational piece. It keeps your skill sets fresh. Especially because of what is coming down the pipeline with clinical social work and addictions. I wish that my agency would make it a policy, but I find that every year I go even if I have to pay for it out of pocket.

Similarly, Fiedler's (1967) Contingency Theory tied with the term challenges and barriers for frequency of use by participants during the qualitative, semi structured interview. This theory informs that for an organization or any of its sub-units to be effective, there must be a solid relationship between the two. When speaking about the concepts of the contingency theory and how they were related to their experiences as substance abuse social workers, one of the participants informed that,

> We recently had a discussion across the organization about clinical supervision for everybody. How does that happen regardless of what discipline you are in, where you work, and who your supervisor is? That discussion was held within the last 2-3 months, with individuals from each group, and we now have a fresh draft of a clinical supervision policy for the entire organization. I am happy to say that my department's policy on clinical supervision was used as one of the templates to set the standard. It always seems to come down to who is going to do it, who is trained to do it, who feels most comfortable doing it, and how the organization selects people who are most appropriate? That was a big part of our discussion so this is exciting because organizations usually do not have this opportunity even though most people would agree that they need clinical supervision.

When I asked participants about their receipt of clinical supervision during this study, the term challenges and barriers was used less frequently than positive experiences and found to be reported by only three participants. Again, I used the definition of challenges and barriers noted by Milne (2007) which was reported as a formal relationship-based support system of practice and development. In line with this definition, participants described their challenges and barriers to receiving clinical supervision as "not helpful, inconsistent, and minimal."

The following quotes from participants expanded on these descriptors as follows:

> "I did not have a positive experience with my clinical manger because I found that a lot of time I was coming in there, being one of the senior clinicians, they would ask me a lot of questions. It was almost like I was doing clinical supervision with them, then they were actually doing it with me."

A subsequent participant shared:

> "It feels like none, but I would call it minimal supervision. It is not the way I would like to see it, for a number of reasons, but mostly because my role is an administrative role, and it limits my availability. That is my challenge."

The final participant added, "If I am honest, I don't have a clear outline of what that supervision looks like here and that's simply because it has been inconsistent."

To conclude these findings, I asked participants if there were any challenges or barriers to receiving clinical supervision reflected in the micro, mezzo, or macro levels of social work and substance abuse practice in their agencies and all 8 agreed that there were. This overwhelming response was established with words like, "integration,

availability of resources, network support, and accessibility." Starting with the micro level of social work and substance abuse practice, one participant shared their own barrier to receiving clinical supervision within their agency, "Unfortunately, resources are so far stretched that I am wearing four hats. Because I am stretched too thin the importance of supervision gets minimized compared to the overwhelming responsibility of everything else."

Next, on the mezzo level of social work and substance abuse practice, a participant combined their challenges receiving clinical supervision with Vygotsky's Collaborative Theory.

> In the last question we talked about a level of unity, people coming together, and sharing thoughts. I think that applies here on an even larger professional scale. When we speak about co-ops, we talk about a base for clinical supervisors to come together and share information, not just as to what they do, but how we can do things collaboratively. We need a collaborative network where we work together for our substance abuse social worker community. Maybe form a group directory of who is available for clinical supervision.

A separate participant reiterated this point by saying,

> There should be a database or somewhere you have to register as a clinical supervisor for easy access. You do not want to get supervision from just anybody so it should also monitor licenses and CEUs. I think a central location where you can find this information would be helpful.

The last two participants spoke about how their barriers to clinical supervision were reflected on the macro level of social work and substance abuse practice.

> I feel that the governing bodies over addictions and social work need to provide clinical supervision for substance abuse social workers, whether it is readily available from the organization that they work in, or if they provide it externally. We also have a private governing body in Bermuda where you have to be registered if you are providing substance abuse counseling or education, irrespective of designation. This governing body can also provide a way for substance abuse social workers to receive clinical supervision.

Expanding upon this point, the final participant that spoke about macro level challenges receiving clinical supervision said that,

> The International Certification and Reciprocity Consortium (IC and RC) is the governing body for all addiction's professionals. They are located in Bermuda, the United States, Canada, all over the world, and they are the ones who govern the addictions certifications. To address the challenges that we have in Bermuda, we can use the IC and RC to bring in individuals from other jurisdictions to provide substance abuse interventions. This is what I would love to see expand, where we are and how we can bring additional resources in house. We have the resources, but it is about getting people the qualifications.

I identified a discernible need amongst the substance abuse social worker population in Bermuda through this capstone project, and its most unexpected findings came when I conducted the qualitative, semi structured interviews. All participants

addressed how essential it was to have regular clinical supervision as a means of tangible support, and to be effective in their roles as substance abuse social workers, but they also spoke about the "barriers within the hierarchy of the profession that prevent us from performing to capacity in our roles." Relatedly, all participants agreed that the more clinical support a substance abuse social worker has in their role, the more effective they are in addressing those barriers, improving the level of treatment for the clients, and influencing the quality of local social service care.

Summary

The findings of my project demonstrated how positive experiences, challenges and barriers, the micro, mezzo, and macro levels of social work and substance abuse practice, and the collaborative and contingency theories, are distinctly connected with respect to the significance of clinical supervision for substance abuse social workers in Bermuda. Noting these similarities, the final section of my study focuses on the key findings of the research and how those findings inform social work practice, the principles of the NASW (2017) Code of Ethics and how they relate to this social work practice problem, action steps for clinical social work practitioners specific to this area of focus, the usefulness of my findings to the broader field of social work practice, and recommendations for further research.

Section 4: Application to Professional Practice and Implications for Social Change

Introduction

This action research project was purposed to explore the significance of clinical supervision for substance abuse social workers in Bermuda and to add to the current body of social work knowledge through the collaborative work of defining clinical supervision in their substance abuse roles. Improvement of these services began with an understanding the following research question: What is the significance of clinical supervision for substance abuse social workers in Bermuda? This was expanded to include the following practice-focused research questions:

RQ1: How do substance abuse social workers in Bermuda describe their experiences related to receiving clinical supervision?

RQ1a: How are these experiences consistent with concepts of the collaborative theory?

RQ1b: How are these experiences consistent with concepts of the contingency theory?

RQ2: What challenges or barriers do substance abuse social workers in Bermuda face related to receiving clinical supervision?

RQ2a: How do the challenges or barriers reflect micro, mezzo, or macro levels of social work and substance abuse practice?

The focus of this study was on the experiences of clinical supervision for local substance abuse social workers, and the intention was to explore the challenges and barriers that they faced, while providing social services across both fields of practice, and

how these challenges or barriers were reflected in the micro, mezzo, or macro levels of social work and substance abuse practice. My hope for this study was to use the resulting data to inform future social work and substance abuse education and support clinical supervision for substance abuse social workers and the local clientele that they serve.

The key findings of this study were three concepts that included positive experiences; challenges and barriers; the micro, mezzo, and macro levels of social work and substance abuse practice; and the collaborative and contingency theories, all related to the receipt of clinical supervision for substance abuse social workers. The participants of this study established that the more clinical support a substance abuse social worker has in their role, the more effective they are in addressing the challenges or barriers that they face related to receiving clinical supervision and improving the quality of local social service care. With these research results in mind, the final section of this study is focused on the application, recommendations, and the implication of these results on social work practice and change.

Application to Professional Ethics in Social Work Practice

The relationship between clinical supervision and ethical social work practice is clearly detailed in the NASW (2017) Code of Ethics. This code of ethical conduct is identified as the primary authority when conducting clinical supervision because they clearly speak to the supervisory relationship, the evaluation of supervisees, and the provision of supervisory feedback (O'Donoghue & O'Donoghue, 2019). In this research project, I explored the relationship between clinical supervision, social work, and substance abuse practice. The findings supported the claim that clinical supervision was

an influential part of ethical resolution and that it contributed to a substance abuse social worker's ethics education, behavior, and ethical development.

The NASW (2017) Code of Ethics addresses two specific principles related to this social work practice problem under the heading of a social worker's ethical responsibilities in practice settings: (a) supervision and consultation and (b) education and training. These principles mandate that all social workers must perform within their areas of competence and develop those areas accordingly. This means that social workers should only provide services within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience.

When generally recognized standards do not exist with respect to an emerging area of practice, as related to this clinical social work problem, the NASW (2017) guides clinical social work practice in this area and mandates that social workers exercise careful judgment and take responsible steps. These steps are detailed as further education, research, training, consultation, and clinical supervision to ensure the competence of their work and to protect their clients from harm. Clinical supervision has been established by the NASW for a social worker's maintenance and the elevation of high standards of practice. True to this statement, the findings of this action research project impact social work practice, particularly in relation to the area of professional ethics, by developing the significance of clinical supervision for substance abuse social workers; endorsing the missions and values of local substance abuse treatment agencies; and protecting, enhancing, and improving social services through ethical integrity.

Recommendations for Social Work Practice

Action Steps for Clinical Social Work Practitioners

As mentioned in the literature review of this capstone project, I conducted a broad review of the literature published within the past 5 years that revealed limited peer-reviewed journals and articles on the significance of clinical supervision for substance abuse social workers (see Caras & Sandu, 2014; Fisher et al., 2016). The majority of the peer-reviewed journals and articles located using related specifiers were conducted in other helping professions (White & Winstanley, 2014), such as counseling (Borders et al., 2014), mental health (Pack, 2015), psychology (Polychronis & Brown, 2016), and nursing (Cutcliffe & Sloan, 2014) and internationally in Denmark (Magnussen, 2018), Europe (O'Donoghue et al., 2018), England (Morley, 2017), Australia (Egan et al., 2018), and New Zealand (Beddoe, 2016) or in both another helping profession and internationally (Aladağ & Kemer, 2016; Creaner & Timulak, 2016). Therefore, with this research project I sought to integrate the social work and substance abuse treatment fields equally while expanding the knowledge of clinical supervision through both via research-based inquiry and outreach.

In the findings of this study, the solutions for this clinical social work setting are connected to the education of all clinical, social work, and substance abuse staff within this paired work environment. Therefore, based on the findings of this study, the first action step for clinical social work practitioners who work in this area of focus is for substance abuse treatment agencies to focus on the education and training of all staff members on the importance of regular clinical supervision. Participants of this study

agreed “that clinical supervision is a valuable resource not only to us as professionals but the clients we serve.” Relatedly, one of the participants suggested that “regardless of field of origin, all staff should have to attend yearly webinars or conferences on clinical supervision, like continuing education units for licensure.” The education of all staff on the micro, mezzo, and macro levels of substance abuse social work addressed the insular hierarchical experiences identified by the participants of this study above. Their belief is that “when every agency is educated uniformly, we speak with a single voice regarding clinical supervision, and it is that voice that enables us to affect local practice, research, and policies concerning clinical supervision agency wide.”

Another finding of this study that can be used as an action step for clinical social work practitioners that impacted this area of social work practice as an advanced practitioner is to promote the use of clinical supervision as a means of collaborative support for social workers employed in the substance abuse treatment field. “Personal and professional support” were 2 words used to describe the significance of clinical supervision by a substance abuse social worker during their qualitative interview. “It reminds us to see the value in what we do and that we need to take care of ourselves in order to do it,” another participant shared.

The findings of this project uncovered that 63% of participants engaged in peer supervision just as regularly as clinical supervision. Reviewing the literature on this topic, I found that several researchers had articulated the benefits of peer supervision and its impact on employees and services (Benshoff, 1993; Borders, 1991; Remley et al., 1987; Wagner & Smith, 1979; Wilbur et al., 1991). Most recently, however, Staempfli and

Fairtlough (2019) reported that peer supervision helped supervisees gain a critical perspective on social work practice specific to their employment settings, like the substance abuse treatment field. This level of supervision opened supervisees up to different explanations and perspectives on their clients as well as encouraged them to challenge their assumptions and unconscious biases and acknowledge how they can change their behavior in practice situations. Through their research, Staempfli and Fairtlough demonstrated how peer supervision helped validate supervisees' responses to their clients. It boosted their self-confidence and had a direct effect on the quality of services provided to service users. Their research also indicated that when employees are supported in navigating occupational difficulties by their peers, it provides a degree of personal and professional support that helps them to reconnect with their service users, something their participants shared is easy to forget when inhabiting a day-to-day professional mentality.

Like those in Staempfli and Fairtlough's (2019) study, a participant of this study detailed their experience with peer supervision as follows:

> In terms of peer supervision, that is where everybody on the team comes together and you go through your cases. So clinically if you have a client and they may be a little bit out of the ordinary, a bit more complex than what you would normally see come through the doors, that is what you would bring to peer supervision. One person presents and the group has a guide to what we are looking at. It follows the SNAP (i.e., the strengths, needs, abilities, preferences) assessment and we tie in research, clinical ideas, and best practice, but we also get feedback from the team

> on other things that you can use to assist with the case. Peer supervision is where it is beneficial to have people wearing different hats because we can all share our perspectives and experiences from our backgrounds.

Additional participants of the study discussed how peer supervision provided them with the ability to "find support and support others" and reported how they "learned from each other" and "can take away something helpful."

My hope was that the results of this study would revive dormant professional engagement in clinical supervision for substance abuse social workers in Bermuda. Evidence of this revival began through the qualitative, semi structured interviews where I found the research participants engaging, open to the style of questioning, and agreeable to the prospect of contributing again. During their interviews, several participants provided details about and insights into their experiences with clinical supervision at great length, and as they spoke about these experiences positively, I became inspired by their stories and grew more confident in the purpose and importance of the work. In the same way, as participants spoke about their experiences negatively, I grew more confident that the project provided an opportunity for open expression and for participants to be heard in a way that allowed them to speak their truth without consequence.

The results of this project confirmed what I knew was needed but not yet available: consistent and appropriate clinical supervision for substance abuse social workers in Bermuda. The discovery of 26 registered substance abuse social workers in Bermuda, 8 of whom agreed to be personally interviewed for this study, was remarkable

and surpassed my expectations for resource assistance. Each participant's verbal commitment to the study combined with their multifaceted experience bodes well for the action steps of this project for clinical practitioners and the future of its ideas. For a long time, I felt alone in having this concern about clinical supervision for substance abuse social workers in Bermuda, but through the facilitation of this project, I have been able to identify multiple substance abuse social workers and bring to life Vygotsky's Collaborative Theory in every sense of the term.

Transferability to Clinical Social Work Practice

The last action step for clinical social work practitioners that aids in the transferability of the findings from this study to the field of clinical social work practice was through an online database or directory of all local substance abuse and social work clinical supervisors for easy access and visibility. Two participants spoke to this action step directly when detailing the challenges and barriers they faced related to receiving clinical supervision, with the first saying,

> There should be a database or somewhere you have to register as a clinical supervisor for easy access. You do not want to get supervision from just anybody, so it should also monitor licenses and CEUs. I think a central location where you can find this information would be helpful.

The second participant spoke similarly, stating,

> We need a central location where clinical supervisors come together not just from a government standpoint, or a private standpoint, but as clinicians period. We do not have a directory. Maybe we can create one that has who is available for

clinical supervision. Right now, as a substance abuse social worker where do I go if I want to be supervised? I do not know.

This last action step can also be transferable to clinical social work practice by way of hiring practices. For example, a substance abuse agency may recruit LCSWs by identifying individual competencies that they are looking for to meet their organization's supervisory needs, and alternatively, a social work agency may recruit a CCS who specializes in the drug and alcohol competencies of supervision to meet their organization's supervisory needs.

Usefulness to the Broader Field of Social Work Practice

The research findings of this study reiterate the social work knowledge found in the literature published over the past 5 years and add to the body of literature produced by Barnett (2014), Borders (2014), Creaner (2014), Dilworth et al. (2013), Falender (2014), Ladany et al. (2013), O'Donovan et al. (2017), O'Donoghue & Ming-sum (2015), and Watkins (2014). Additional substance abuse social work characteristics, competencies, and role responsibilities shared by the participants in interviews aspired to extend current social work knowledge and fill gaps within the literature on this social issue. An extension of social work knowledge from this study is applicable to all integrated clinical practices through improving education and training, implementing peer support, building innovative job descriptions, informing hiring practices, and creating policies to blend related fields. The more knowledge that can be offered with respect to this social issue, the more qualified social workers will be when entering multiple facets of the helping

profession, thus positively affecting their impact on all community services for underserved populations.

Limitations

Bermuda is a small British overseas territory, measuring 21 square miles, with a population of 62,000 people (DNDC, 2017). Of those 62,000, 54 of them are certified persons in substance abuse treatment and prevention occupations, and 26 are registered social workers. Typical of an island of such modest size and means, Bermuda relies on its own resources to address and resolve its social service needs and although this culture is as admirable as it is necessary, we experience limitations with respect to our receipt of clinical supervision for substance abuse social workers as a result.

I identified a lack of research and literature needed to address the clinical supervision of substance abuse social workers in Bermuda through this capstone project. As detailed in the problem statement section, I identified these gaps following a diligent search of pre-existing research and literature and having uncovered a need for but a lack of both concerning this social issue, a local participant pool was formulated to provide insight towards a solution. The research data from this study's qualitative semi structured interviews supported its findings on the significance of clinical supervision for substance abuse social workers, and as a result I convened a group of professionally trained social work colleagues who agreed to commit their time and experience to addressing this social situation. As a result of this commitment, the findings of this study rendered applicable solutions to a significant social work practice problem.

Recommendations for Further Research

The first recommendation grounded in the strengths and limitations of this doctoral project is for further research on self-care for substance abuse social workers. Evidence of persons willing to engage on this research topic was obtained during the qualitative semi structured interviews. When I asked about participant individual experiences with clinical supervision, I observed that they did not consider this question invasive. In fact, several persons provided details about deeply personal experiences discussed in clinical supervision without prompting. For example, one participant shared that clinical supervision was significant to them because of issues of transference. Their experience was detailed as follows,

> When I talk to my clinical supervisors, I let them know that there could be a possibility of transference. I was in a relationship with an addict and in trying to save them I almost destroyed my own life. My acknowledgement of this is first, but what do I do after I have acknowledged it? I need to have a clinical supervisor who supports me and then guides me through it.

Similarly, another participant spoke about their struggles with self-care,

> The clinical support needs to be there. As social workers we go into the community to help others but when we need the help where do we go? We also need the support of our clinical supervisors to refer us for our own mental health and well-being. I think that social work is needed at any level and for everybody, not just the clients, we have to make sure that we use social work for ourselves too.

As each participant spoke about their history and involvement with clinical supervision, I noted a genuine interest about this research topic but also the prospect of what the next researcher could study because of it. With this, I realized that this project was giving substance abuse social workers a chance to partake in a noteworthy activity regarding the significance of clinical supervision for substance abuse social workers in Bermuda. Also, that it may have been the catalyst for their decision to contribute to any further research related to this study.

The second recommendation for further research grounded in the strengths and limitations of this study is for Bermuda to reestablish their National Association of Social Workers. One participant explained,

> If we have the Bermuda National Association of Social Workers we have a board of social workers who can determine who has their license for clinical supervision and who does not. We also have a form of guidance for social workers who would like to get their clinical license but, have barriers to doing so like a social security number.

Participant's verbal commitment along with their shared experiences, suggestions for action steps, and dedication to future research bodes well for the longevity of social work practice in Bermuda. Before this project took place, I was unaware of how invested additional colleagues would be regarding the improvement of clinical supervision for substance abuse social workers in Bermuda. Now there is evidence-based research to show that there are many of us, a collaborative team of substance abuse social work

professionals committed to the advancement of the field of social work and the clients that we have the privilege to serve.

Recommendations and Dissemination

Once this project is complete, each participant will receive a two page summary of the research findings. These findings will be shared with the DNDC and BACB and will speak to improving policy and practice on the clinical supervision of substance abuse social workers in Bermuda. Next, I will disseminate the findings of this study by meeting with the Council for Allied Health Professionals. This presentation will focus on recommendations for education and training, peer support, an online directory, hiring practices, and how the implementation of each of these will demonstrate the scope and depth of macro level social work practice commitment to the substance abuse social work community.

The third strategy used will be local publication. The lack of academic material related to this research project emphasized the importance of the action steps needed to have this data published. The first choice of publication for this information is within the annual BERDIN report and the secondary choice of publication is at their annual conference. Having attended these conferences in the past, I am aware of the persons in attendance and the value that this platform holds. At each conference micro, mezzo, and macro level stakeholders are privy to each presentation and invest in those they believe have something exemplar to offer. I am confident that the findings of this research project meet this standard of investment.

Implications for Social Change

The future implementation of these action research recommendations seek to positively affect the micro, mezzo, and macro levels of clinical social work practice, research, and policy in Bermuda. The micro level of clinical social work practice addresses the effects that clinical supervision has on social workers in substance abuse social work settings and their service users. Therefore, the practice-focused research questions were used to understand the social worker's professional role and competencies while employed in the substance abuse field (see Whitley, 2010). Research participants cited several uses of collaborative support, specifically through peer supervision, and reported that the use of both in clinical supervision was linked to the personal and professional development of substance abuse social workers in the addictions field. Understanding that the substance abuse social worker role is meant to improve service delivery through clinical supervision, and increase micro level awareness of its overall significance, the more data that is added to the current body of social work knowledge with respect to this research topic, the more we can assist the way future researchers distinguish how the significance of clinical supervision for substance abuse social workers has a direct impact on the improvement of integrated healthcare outcomes.

The mezzo level of clinical social work practice begins with the acquired knowledge that clinical supervision improves integrated healthcare outcomes and addresses the education and training required to ensure ethical reasoning and competency on every level of clinical social work practice. As researchers Beidas and Kendall (2010), Herschell, et al. (2010), and Olmstead, et al. (2012) reported, it is through competency-

based supervision that supervisors can guarantee that the substance abuse profession is fostering social workers who are able to interact with their clientele and associated communities in an ethical and competent manner. Similarly, participants of this study agreed that, “my clinical supervisor provided weekly supervision on a clinical level where we talked about case consultation, being competency based, ethics, and a wide range of different things. It was actual clinical supervision.”

Each research participant highlighted how substance abuse social workers are providing community services from an integrated healthcare model and how their focus is on improving a client’s quality of life in accordance with their agency’s policies, procedures, and mission. “We are the only ones on the island who provide certain substance abuse interventions. So, we are pretty much the first step for anybody who wants to get into treatment.” The information that I gleaned from my research participants during their qualitative semi structured interviews provides information specific to the education and training of substance abuse social workers in an integrated healthcare environment. As mentioned in the application for professional ethics section of this report, there was a lack of education and training for substance abuse social workers in integrated healthcare. Therefore, the findings of this research project inform clinical social work practice on the future education and training of substance abuse social workers.

The findings of this capstone research project contributed to improving substance abuse social work on a macro level island wide. They stressed the collaboration of helping professionals to provide quality treatment interventions across the substance

abuse and social work fields and stressed the importance of removing any challenges and barriers to the receipt of that care. Understanding the role of substance abuse social workers on the micro level, the education and training needed to fill the gaps in literature on the mezzo level, and the positive impact on social change on the macro level, was how this capstone research project ultimately contributed to the wider body of social work knowledge.

Summary

As specialists who bridge this gap between the social work and substance abuse treatment fields, substance abuse social workers are required to develop themselves as social workers by designation, substance abuse counselors by occupation, and provide competent treatment services that align the substance abuse and social work professions seamlessly. Their support in achieving this feat is clinical supervision, and their prolonged access to this measure of support is essential to addressing the ethical challenges that occur during the facilitation of their work.

Acknowledging this, I sought to explore the significance of clinical supervision for substance abuse social workers in Bermuda through this action research project which afforded stakeholders the opportunity to add to the current body of social work knowledge, on an otherwise unresearched topic, and improve clinical social work practice through the concepts of the collaborative and contingency theories. I presented the problem statement, purpose statement, research questions, data analysis, recommendations for social work practice, and implications for social change of this project, all with guidelines on how to engage the micro, mezzo, and macro levels of

clinical practice so that clinical supervision is effective in all forums. Moving forward, it is the combination of these features, coupled with careful research planning and execution, that will allow this study to serve as a template for other communities facing clinical supervision for substance abuse social workers as a vulnerability.

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Appendix: Qualitative, Semi structured Interview Guide

1. What is your highest-degree earned? Bachelors? Masters? Doctorate?
2. How long have you been employed as a substance abuse social worker? 1-10 years? 10-20 years? Over 20 years?
3. Who is your current employer?
4. What is your agencies' policy on clinical supervision?
5. Is clinical supervision provided to you by your agency?
    a. If no, what are the challenges or barriers to you receiving clinical supervision from your agency?
        i. How do they reflect micro, mezzo, or macro levels of social work and substance abuse practice?
    b. If yes, who provides you with this clinical supervision?
        i. How long have you received clinical supervision?
        ii. How many times per week/hours per week do you receive clinical supervision?
6. If clinical supervision is not provided to you by your agency. Do you receive clinical supervision from an external source?
    a. If no, what are the challenges or barriers that you face related to receiving clinical supervision from an external source?
        i. How do they reflect micro, mezzo, or macro levels of social work and substance abuse practice?
    b. If yes, who provides you with this clinical supervision?

i. How long have you received clinical supervision?

ii. How many times per week/hours per week do you receive clinical supervision?

7. Do you currently provide clinical supervision to others?
    a. If no, what are the challenges or barriers to you providing clinical supervision to others?
        i. How do they reflect micro, mezzo, or macro levels of social work and substance abuse practice?
    b. If yes, to whom do you provide clinical supervision? Persons within your agency and/or persons outside of your agency?
        i. How long have you provided clinical supervision?
        ii. How many times per week/hours per week do you provide clinical supervision?
8. Please describe your experiences related to providing and/or receiving clinical supervision.
9. Fiedler's (1978) Contingency Theory informs that for an organization or any of its sub-units to be effective, there must be a solid relationship between the twos. Thus, if the social work and substance abuse fields in Bermuda are constrained by their own structural designs, their scope of choice to facilitate clinical supervision to substance abuse social workers will be extremely limited. What are your opinions on Fiedler's Contingency Theory in relation

to the receipt of clinical supervision for substance abuse social workers in Bermuda?

10. Vygotsky's (1987) Collaborative Theory is defined as a continual process between two or more individuals who collaborate to address a community need that has been unresolvable by a single individual or entity acting alone. What factors do you feel would improve the receipt of clinical supervision for substance abuse social workers in Bermuda?