Contemporary Issues on Supervision in Community Mental Health Practice

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ABSTRACT
This article will introduce and provide examples of two broad contemporary approaches that supervisors can use to strengthen mental health practice: reflective supervision and recovery-oriented supervision. Reflective supervision supports supervisees’ capacity for deep reflection and intentional action, and recovery-oriented supervision applies concepts from the recovery model to supervision, to empower supervisees to embrace the recovery model in practice.

LEARNING OBJECTIVES
After reading this article, you should be able to:
1. Recognize key principles and processes of recovery-oriented and reflective supervision approaches
2. Differentiate recovery-oriented and reflective supervision approaches from administrative and clinical supervision
3. Identify recovery-oriented and reflective supervision approaches that apply to practice dilemmas

INTRODUCTION
Supervision is defined as a “formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their practice, and enhance protection and safety of care in complex clinical situations” (National Health Service, 1993, 1998, 2000, as cited in Gaitskell & Morley, 2008, p. 119). Depending on the purpose, supervision may focus on supporting clinical and/or practice reasoning or administrative practices, such as ensuring attention to specific care; or it may be more reflective in nature through a personal exploration of the practitioners’ own experiences in doing their work. Despite the supportive nature of some of these purposes, supervision has sometimes been criticized as a surveillance and/or confessional practice (Gilbert, 2001).

Mental health practice has a long tradition of practitioner reflection within a supervisory relationship (Parham, 1987; Schön, 1983). In the 1960s to 1970s, reflection through supervision was a common practice for occupational therapy practitioners in mental health settings. In particular, Parham (1987) introduced Schön’s (1983) framework to occupational therapy practice. This framework differentiates between types of reflection: reflection-in-action—reasoning in the moment of practice and reflection-on-action—reflecting on practice outside the actual care encounter and sometimes within the context of a supervisory relationship. In addition, the relational turn in psychoanalytic theory was a key influence for these supervisory practices in occupational therapy mental health practice (Fidler & Fidler, 1963). This perspective considers that humans are motivated by the desire for human contact and relatedness, not just sexual or sensual pleasure, and focused on exploring the “enduring patterns of interpersonal functioning in intimate relationships and the cognitive and emotional processes that mediate those patterns” (Westen, Gabbard, & Ortigo, 2008, p. 67). The psychoanalytic perspective for providing supervision in occupational therapy has reemerged, particularly in the United Kingdom (Daniel, 2013; Nicholls, 2013), and it informs the two supervisory perspectives that are reviewed in this article.

Unfortunately, over time, access to this type of supervision has decreased in the mental health practice context. Occupational therapy practitioners seeking opportunities for thoughtful, mentored reflective experiences have had to create their own relationships and locations for such supervision, often outside of their practice settings. However, in recent years there has been a renewed interest in supervision in contemporary community mental health settings (Heller & Gilkerson, 2009) informed by two particular workforce developments—(1) growth in the inclusion of non-degreed staff who often learn by doing, and indigenous providers or “experts by experience” (e.g., peer specialists, parent partners), who are valued for their lived experience, and (2) the growth in and expectation for incorporating and adopting evidence-based practices. In the first instance, supervision is seen as supporting experts by experience as they engage in care encounters, given their level of pre-practice training (e.g., certificate courses) and defined roles. In the second, supervision is seen as critical beyond initial training to sustain practitioner engagement and implementation fidelity in delivering evidence-based practices (Bond et al., 2014).

This article will introduce two broad contemporary approaches to supervision in the community mental health context—reflective supervision (Shahmoon-Shanok, 2009)
and recovery-oriented supervision (Yerushalmi & Lysaker, 2014). These have been identified from both the literature and from practice contexts in which this article’s authors have supported fieldwork students and clinical doctorate residents.

**REFLECTIVE SUPERVISION**

Reflective supervision is “a relationship-based supervisory approach that supports various models of relationship-based service delivery” (Heffron & Murch, 2010, p. 5). This approach involves creating “a relationship whose aim is to improve professional practice” (Shahmoon-Shanok, 2009, p. 11). Initially used in infant mental health programs to support providers working with vulnerable families, reflective supervision has expanded in programs for infants, toddlers, and families, extending the practice of reflection to non–mental health delivery systems.

Reflective supervision is distinguished from administrative and clinical supervision. Administrative supervision may involve ensuring that the supervisee is following correct protocols for documentation and service delivery, as well as meeting productivity expectations; and clinical supervision may focus on determining what to do in a given practice situation. Reflective supervision, in contrast, focuses on exploring the provider’s experiences doing the work, while building their capacity to be reflective and think more deeply about practice scenarios (Heller & Gilkerson, 2009; Parlakian, 2001). We believe that reflective supervision is applicable to supervision in other contexts—in particular, community mental health—because of a renewed interest in accessing psychoanalytic perspectives that emphasize supporting the clinician to process their internal experiences as a way to improve practice (Weigand, 2007). In this article, we offer some of the key principles of reflective supervision that we believe may be helpful in engaging in supervision in community mental health.

**Key Principles of Reflective Supervision**

Key principles underlying reflective supervision include creating a collaborative relational approach, emphasizing reflection during supervision sessions, and meeting regularly (Heffron & Murch, 2010).

**Collaborative Relational Approach**

Under this approach, the supervisor and supervisee contribute their own perspectives and expertise, “thinking together” about the work, in contrast to the supervisor providing their expertise to the listening supervisee. The supervisee and supervisor may provide different types of knowledge to this exchange, but both forms of expertise are acknowledged (Heffron & Murch, 2010, p. 8).

**Emphasis on Reflection**

A key focus of this type of supervision is building the supervisee’s capacity for reflection, by intentionally slowing down the problem-solving process to consider the motives, feelings, and perspectives of clients, as well as those of the supervisor and supervisee. After exploring what was previously unspoken, the supervisee and supervisor then start to consider what to do. They reflect first, then move toward action (Heffron & Murch, 2010).

**Regular Meetings**

Another key principle is that supervision is held at a predictable time, whether scheduled weekly, bi-weekly, or monthly. This is in contrast to supervision on an as-needed basis—for example, when crises occur or when both supervisor and supervisee happen to have the time. Unpredictable supervision can lead to a reactive tone, as supervisee and supervisor rush to respond to problems that have arisen. In contrast, keeping a regular routine creates a thoughtful and reflective tone in the supervision sessions (Heffron & Murch, 2010).

**Key Processes of Reflective Supervision**

Shahmoon-Shanok (2009) presented several key processes embedded in reflective supervision that illuminate what actually happens during supervision to build the supervisee’s reflective capacity. These include focusing on the process, creating a parallel process, providing a sense of safety, making “visible” what was “invisible,” regulating emotion, and attending to relationship rupture and repair (Shahmoon-Shanok, 2009).

**Process of Reflection**

Reflective supervision focuses on engaging participants in the process of reflection, as opposed to quickly moving to solutions. Through reflection, the supervisor and the supervisee first imagine and consider the ramifications of potential action. Instead of automatically devising solutions to dilemmas, they reflect first to more deeply understand the situation.

**Parallel Process**

Shahmoon-Shanok (2009) proposed that a parallel process is created between the supervisor and supervisee that extends to the supervisee and the caregiver they are working with, and then from the caregiver to the client. For example, the supervisor offers non-judgmental empathy when listening to the supervisee share information about a mistake they believe they made with a family. Instead of correcting the supervisee for this behavior, the supervisor listens to the supervisee discuss the shame and regret they feel about their mistake. In a parallel process, this then supports the supervisee’s practice of offering empathy without judgement when listening to, for example, a mother recount how she snapped at her child at bedtime. In turn, the mother, having been heard empathically by the supervisee, may be better able to empathize with her child when they throw a tantrum before bedtime.
Sense of Safety
Reflective supervision involves the supervisor creating a sense of safety so that the supervisee can share the sometimes very painful events they witness in their work, as well as their own challenging emotions and thoughts. The supervisor, through empathic, non-judgmental listening and a warm demeanor, fosters an environment where the supervisee feels comfortable sharing vulnerable thoughts and feelings (Shahmoon-Shanok, 2009).

Making Visible the Invisible
Reflective supervision is intended to help the supervisee become more aware of that which has been previously been given much consideration. That might include the supervisee's own history, feelings, intentions, and emotions, or those of the caregiver or the client. The idea is that through becoming more aware of these previously invisible forces, the supervisee can more deeply understand what is happening and, thus, make more informed decisions. The supervisor helps the supervisee become aware of the invisible by asking questions intended to help the supervisee think more deeply about the perspectives of the various individuals they are working with (Shahmoon-Shanok, 2009).

Emotional Regulation
Given the emotional nature of working with people, assisting supervisees to regulate emotion is another key part of the process of reflective supervision. Many supervisees face emotions such as despair, hopelessness, disgust, or rage during the challenging situations they experience and witness in their work. In reflective supervision, the supervisor, by remaining calm, listening empathically, and emphasizing reflection, helps the supervisee to regulate strong emotions that arise and take steps to engage in self-care.

Rupture and Repair
Given that all relationships involve rupture and repair, the supervisor pays particular attention to ruptures within the supervisory relationship and repairs them, thus modeling a parallel process that the supervisee can use with the caregivers they work when relationships are ruptured (Shahmoon-Shanok, 2009). Through these principles and processes of reflective supervision, supervisors and their supervisees dedicate “space, time, and trust to foster transformations that motivate and become growth—growth of providers, parents, children, and programs so they may flourish” (Shahmoon-Shanok, 2009, p. 20). To improve practice, “the reflective partners discuss what each one notices, exchange perspectives, widen each other’s horizons and, often, plan the next steps for the supervisee to take” (p. 7).

RECOVERY-ORIENTED SUPERVISION
Recovery-oriented supervision involves applying key principles of the recovery model to the process of supervision, so that the supervisee can internalize the recovery-oriented approach by experiencing it themselves (Yerushalmi & Lysaker, 2014). It is grounded in a firm belief that recovery-oriented practice is profoundly different from mental health practices informed by the medical or clinical models (Tondora, Miller, Slade, & Davidson, 2014). Early influences on the recovery perspective were first-person accounts of lived experience that proliferated in the 1980s and 1990s and empirical findings that challenge more pessimistic beliefs about prognosis, especially for schizophrenia (Davidson, 2003; Ridgeway, 2001).

Pat Deegan (as cited in Ralph, 2000, an internationally recognized “expert by experience” who contributed considerably to our understanding of what it means to be recovery-oriented practitioners, argued that:

Recovery is a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup, and start again. The need is to meet the challenge of the disability and to reestablish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and love in a community in which one makes a significant contribution. (p. 481)

Over the last 3 decades, there have been contrasting views regarding what counts as recovery—most often presented as dichotomous, informed by different foundational views regarding the recovery experience, and framed as either an outcome or process. On the one hand is clinical recovery (Slade, 2009), informed by medical model frames and used by researchers and in public policy to standardize recovery outcomes. On the other is personal recovery (Slade, 2009), which focuses not just on the outward behavioral manifestations of recovery, but the inner experiences and journey of recovery as well.

Bellack et al. (2011) as cited in Tondora et al. (2014) conducted a systematic review and narrative synthesis and found that for many people, recovery means:

No longer defining oneself by the experience of mental illness; being a full participant in the community with valued roles, such as worker, parent, student, neighbor, friend, artist, tenant, lover, and citizen; running one’s own life and making one’s own decisions; having a rich network of personal and social support outside of the mental health system; celebrating the newfound strength and skills gained from living with and recovering from mental illness; and having hope and optimism for the future. (p. 2)

The recovery perspective or paradigm has become a guiding philosophy promoted by many national mental health authorities, and must be deeply understood and “taken-up” to “become a recovery-oriented practitioner” (Roberts & Boardman, 2014, p. 37). Davidson, Tondora, Lawless, O’Connell,
& Rowe (2009) in their Practical Guide to Recovery-Oriented Practice: Tools for Transforming Mental Health Care identified recovery-oriented care practice principles that align well with Bellack and colleagues' (Tondora et al., 2014) recovery processes and the recovery-oriented supervision guidance outlined in this article. They argue for practitioners to see themselves as a “recovery guide” (p. 151) and deliver care that is strengths based, is community focused, is culturally responsive, is grounded in the person’s life context, is relationally mediated, is oriented to promoting recovery, allows for reciprocity in relationships, addresses the socioeconomic context of the person’s life, and optimizes natural supports.

Yerushalmi and Lysaker (2014) described the challenges of helping professionals to internalize the recovery approach and offered supervision as a means by which this can be accomplished:

One of the important ways to supervise professionals interested in internalizing the recovery approach in psychiatric rehabilitation is to implement its major principles in the supervision work itself. (p. 59)

They proposed key tenets to shape this sort of supervision; all involve the supervisor engaging with the supervisee in a way similar to how the supervisee would engage with consumers if they were embodying a recovery perspective—specifically, (1) developing and discovering the “selves” of the person in recovery, (2) attaining mutuality and negotiating authority, and (3) promoting positive and empowering narratives and self-perceptions.

**Recovery Tenets That Shape Recovery-Oriented Supervision**

**Developing and discovering the selves of consumers of rehabilitation services**

This tenet emphasizes supporting consumers to rediscover their sense of self, because this rediscovery can then guide them to develop a sense of agency, enabling them to make choices about their lives (Yerushalmi & Lysaker, 2014). Yerushalmi and Lysaker (2014) emphasized that “consumers must have their own story, and although it has to be something that others can grasp, there is not one ‘right’ story that they should find” (p. 63). Recovery of agency has been identified as a key aspect of the recovery process, given the major disruption in sense of self often experienced by persons labeled with mental illness (Davidson & Strauss, 1992; Roe & Chopra, 2003).

Supporting choice requires practitioners to challenge notions of readiness (Farkas, Soydan, & Gagne, 2000), awareness of illness (Amador, Strauss, Yale, & Gorman, 1991; Roe, Hasson-Ohanyon, Kravetz, Yanos, & Lysaker, 1996), and managing risk (Burns-Lynch, Salzer, & Baron, 2011), which have historically been a part of community-based mental health practice. In Pat Deegan’s recovery workforce development initiatives (see www.patdeegan.com), she argues that we practice within a “recovery zone” between two opposing perspectives—neglect and coercion—as we consider supporting self-determination and choice. Neglect is when we take a position to support the individual in whatever they want to do, regardless of our concerns, and coercion is when we get the person to do what we want, regardless of their viewpoint.

In using this tenet to guide supervision, the supervisor helps the supervisee better understand their professional self and strengthen their own sense of agency, so that the supervisee can in turn support the consumer to rediscover their sense of self and take actions that develop a sense of agency, such as making informed choices about their lives (Yerushalmi & Lysaker, 2014).

**Attaining mutuality and negotiating authority**

This tenet is informed by the important stance of reciprocity that recovery-oriented practitioners need to take in their work with persons labeled with mental illness. A stance of reciprocity means that practitioners “treat [persons labeled with mental illness] as equals, accepting their appropriate gestures of reciprocity” (Davidson et al, 2009, p. 163). This challenges “traditional client-clinician therapeutic boundaries and roles [that] forbid such a two-way street” (Davidson et al, 2009, p. 163). Borg and Kristiansen (2004) described this as “breaking the rules.” In their research, their informants “often mentioned unexpected, even surprising, acts and gestures … that may be seen as on the edge of what is typically considered ‘professional conduct’” (p. 499).

Using this tenet, the supervisor strives to attain a mutual relationship with the supervisee that balances the power differential between them, allowing for exchanging knowledge and experience. The supervisor may have more power and authority in their particular role; however, for a true dialogue to occur, the expertise and knowledge of the supervisee also needs to be recognized. Although the supervisor may have more theoretical or clinical knowledge, only the supervisee has the expertise of actually doing the practice work. The supervisor must negotiate a mutual exchange, so that both can share their expertise as they dialogue and make decisions. This then translates to the supervisee engaging in the same negotiation with the consumers they work with.

The process for the supervisee and the consumer is parallel; the supervisee has authority granted by academic and social institutions, and bears more responsibility in maintaining the relationship, but the consumer remains the expert of their own experience. If the expertise of both can be recognized and shared, a stronger dialogue can be created (Yerushalmi, 2010; Yerushalmi & Lysaker, 2014).

**Promoting positive and empowering narratives and self-perceptions**

This recovery tenet is informed by the power of stories and narrative in shaping our meaning making in everyday life, especially for the development of the self and identity. Yerushalmi...
In supervision, the supervisor supports a shift in the supervisee’s narrative to support a more complex and empowered professional self. For example, supervisees’ narratives may constantly focus on areas of weakness that are particularly distressing to them. To mediate these narratives of weakness, the supervisor might remind the supervisee of times when they acted in a way that contradicted those weaknesses. For instance, if a supervisee thinks they constantly struggle to set boundaries with the consumers they work with, resulting in distress, the supervisor might use strategic questioning to help the supervisee remember times when they set reasonable boundaries with someone else.

**CASE EXAMPLE: INCORPORATING PRINCIPLES INTO PRACTICE**

This example was inspired by qualitative research conducted by Pitts (2012) exploring the practice reasoning of personal service coordinators (PSCs) in what is known in California as a full-service partnership (FSP).

For PSCs,

> **Whatever it takes** means finding the methods and means to engage a client, determine his or her needs for recovery, and create collaborative services and support to meet those needs. This concept may include innovative approaches to “no-fail” services in which service provision and continuation are not dependent upon amount or timeliness of progress, or on the client’s compliance with treatment options, but rather on individual needs and individual progress and/or pace on their path to recovery. Clients are not withdrawn from services based on predetermined expectations of response. (Innes-Gomberg, 2011, p. 12)

FSPs are considered the highest level of outpatient care in the California public mental health system, and they are informed by the evidence-based assertive community treatment (ACT) team approach (Substance Abuse and Mental Health Services Administration, 2008). Although the recovery-orientation of ACT teams has been disputed (Salyers & Tsemberis, 2007), the practice setting where Pitts conducted her research was immersed in the recovery tradition and often served as the training site in how to implement recovery-oriented practices. Notice how the supervisor in this example uses components of reflective supervision and recovery-oriented supervision to help supervisees on a team more deeply reflect on a situation before taking action and to help them embody the recovery perspective more fully in their work.

> **The baby needs diapers**

You are leading a weekly group supervision meeting with some PSCs you supervise at Vanguard, a community-based mental health organization that has adopted a recovery perspective in their work to support individuals labeled with mental illness. A key principle of reflective supervision is that the meetings should be held regularly, and not just when crises occur, to prioritize a spirit of reflection; therefore, this meeting is held every Wednesday at 9 a.m. All team members intentionally block out their schedules for the meeting. Only occasionally do team members miss it. During the meeting today, there is a tension-filled discussion about whether to continue to buy diapers for one of the members, Margot, who cares for her 16-month-old baby with her boyfriend. One of the PSCs, Vanessa, comments that the team has been buying diapers “left and right” for this member. She complains that Margot manipulates different PSCs into buying diapers: “We’re coming up to the first of the month, and what usually happens is that the Margot’s boyfriend gets his check first and he blows it. On what, I’m not sure, I know that he doesn’t use drugs or anything. Well, we know he smokes a little pot, but we just don’t know for sure on what else he spent his money.” Vanessa adds, “I know that the boyfriend gets a certain amount of money and that Margot gets a certain amount of money.” Vanessa knows how much the rent is, and therefore she believes that the couple is capable of budgeting for and purchasing the diapers on their own, but they “just aren’t doing it,” and instead are relying on Vanguard members to purchase them. She is clearly quite frustrated by the situation.

At this point, another member on Vanessa’s team, Michaela, erupts in dismay—she can’t believe that Vanessa would consider letting the baby suffer because of the parents’ trouble with budgeting. Michaela stammers, “What’s next, not helping them with the formula, just because the parents aren’t doing their jobs? The baby needs diapers.” A few other members roll their eyes.

Vanessa grows defensive, explaining that she believes Margot needs to face some natural consequences to learn how to provide for her child. She says that the next time they ask for diapers, she should say, “No—you and your boyfriend are going to have to figure it out.”

As you listen, you begin to grow concerned by the reactivity and the judgment expressed toward Margot and her boyfriend as parents. Your supervisees are each pushing for the solution they believe is best; emotions are high. It’s hard to think, let alone be reflective. You decide to demonstrate empathy for all involved to promote regulation of emotion and to slow...
down the discussion, emphasizing the process of reflection, which is aligned with key processes of reflective supervision (Shahmoon-Shanok, 2009). You calmly acknowledge that this is a tough situation to work in, but that you are starting to feel worried for both the parents and the baby. In this way, you demonstrate your empathy for your supervisees and the consumers and call attention to the need to slow the process down and reflect before taking action.

Then you encourage the group to pause for a moment and consider what feelings this dilemma invokes in them—what does this situation remind them of or make them think of? This reflects the process of regulating emotion in reflective supervision, as you are helping the group members become more aware of their intense emotions and feelings, to help them better manage them so they can problem solve in the situation (Shahmoon-Shanok, 2009).

Vanessa shares that this situation makes her feel very frustrated; she also feels angry that “limts” are not being set with this family. She shares that it reminds her of growing up, when her mother, who was addicted to drugs, was given repeated chances by her father to rejoin the family, despite her repeated relapses. Michaela shares that this dilemma brings up sadness and fear for her; she previously worked with the Department of Social Services and has painful memories of working with children who had been neglected. She observed that this neglect was exacerbated by poverty and the lack of support provided to parents in our society. It makes her feel ill to think that she could inadvertently be a part of that neglect as a provider. A few other PSCs also share their thoughts and feelings, which range from frustration to helplessness to fear for the baby. You empathize with their thoughts and feelings, creating a sense of safety through an environment where they can share their darkest thoughts without fear of judgement (Shahmoon-Shanok, 2009). You hope that in doing so you are setting in motion a parallel process in which the team members will be able to create a sense of safety for the consumers they work with when strong emotions arise.

You notice that as these emotions are voiced, the team members start to calm down. Reflecting on their feelings helps regulate the emotion in the group. According to key processes of reflective supervision, group members become more aware of their intense emotions and feelings to help them better manage them to problem solve in the situation (Shahmoon-Shanok, 2009).

Now that group members seem more regulated, you encourage them to consider additional perspectives. You ask questions such as, “How do you suppose Margot sees this situation? What feelings is she likely experiencing? What do you think her boyfriend thinks or feels? If the baby could express their feelings on the matter, what would they say?” This reflects another key process of reflective supervision—slowing down the process to make visible what was previously invisible (Shahmoon-Shanok, 2009). You support the group to examine perspectives that may not have previously been seen or acknowledged—Margot’s perspective and her feelings, as well as the group members’ own preconceived notions. In this way, you help the supervisees develop deeper insight into the situation. This also reflects the process of regulating emotion within reflective supervision; the supervisor notices agitation and conflict in the room, and helping the supervisees explore the situation more reflectively may help regulate their emotions (Shahmoon-Shanok, 2009).

You then encourage the team to reflect more on the history of this situation and all the potential strategies for supporting Margot by asking more questions such as, “What led up to this? What have they tried so far? What are all the possible ways you could support Margot?” Aligned with the processes of reflective supervision, you continue to focus the team on the process of reflection (Shahmoon-Shahnook, 2009) by trying to facilitate the supervisees considering the behaviors and actions that have led up to this moment so they can more clearly understand the story and the process that has led to this dilemma. Through understanding the history of this team’s relationship with Margot and the actions that led up to this current moment, they may be able to better consider the many ways they can support her. You continue to support the team to pause and reflect on the process.

Now you guide the team to consider how continuing or discontinuing to provide the diapers could affect Margot’s sense of agency—how might it further or hinder her development? You encourage them to also consider Margot’s interests, goals, and values—and compare those with their own interests, goals, and values. This reflects recovery-oriented supervision because it empowers the supervisees to better understand and thus support Margot’s sense of agency. Many consumers experience a diminished sense of self and agency; the recovery approach involves strengthening both, through considering how the providers’ actions may strengthen or diminish self and sense of agency. For example, by facilitating consumers’ decision making as opposed to dictating solutions, a provider can support agency (Yerushalmi & Lysaker, 2014). Instead of identifying a solution, you ask the supervisees to consider it themselves—therefore also promoting the agency of the supervisees. Through having them consider Margot’s interests, goals, and values versus their own, you also help the supervisees better understand their own professional selves, while more deeply understanding Margot so they can avoid projecting their own desires and fears on to her. This reflection on developing the self—of the provider and the consumer—is a key tenet of seeking selves and developing agency in both providers and consumers in recovery-oriented supervision (Yerushalmi & Lysaker, 2014).

Finally, you engage the team in a discussion about how the PSC and Margot can negotiate with one another to come to a mutual understanding. This reflects a recovery-oriented approach to supervision because it helps the supervisees to consider how the PSC might seek mutuality with Margot to negotiate her power and authority in this situation. Despite
apparent power differences, understanding the expertise and responsibility that both bring to the situation may help the PSCs come to a more of a constructive dialogue with Margot. You help the supervisees to explore what Margot’s expertise in the situation is—perhaps in having lived in poverty for most of her life, she has developed strategies to get her needs met and is using those strategies now. Note that instead of lecturing to your supervisees, you are also negotiating your own authority in the supervision meeting by trying to explore the supervisees’ expertise to come to a better understanding (Yerushalmi & Lysaker, 2014). This also aligns with the collaborative relational approach underlying reflective supervision. Throughout the supervision session, you sought to support a collaborative atmosphere, with you and the team contributing your own perspectives and expertise, and thinking together about the work, as opposed to you simply providing expertise (Heffron & Murch, 2010, p. 8). In addition, through providing support to the team as they worked through their differences in opinion, you have hopefully modeled engaging in rupture and repair, so they might do the same with the consumers they work with, when they run into conflict (Shahmoon & Shanok, 2009).

CONCLUSION
Reflective supervision and recovery-oriented supervision are two approaches that can support the development of a resilience and recovery-oriented workforce for community mental health practice. Given that the development of resilience and recovery for persons at risk for and labeled with mental illness is well understood as deeply relational work (Longhofer, Kubek, & Floersch, 2010), each of these approaches is grounded in the relational “turn” in psychodynamic perspectives and it’s implication for building therapeutic alliances. Further, each of these perspectives obligates occupational therapy practitioners to reflect on their own experiences with and reactions to their work with individuals, and to use those reflections to facilitate the next actions they take. Their principles and processes can encourage supervisees to think more deeply about their practice, and to more fully adopt recovery as a model for practice. In this way, they may address the need for supervision of occupational therapy practitioners, new and experienced, who are interested in more guided mentoring; of non-degree staff; and of those interested in adopting evidence-based practices. Engaging in these approaches takes time and must therefore be supported by organizational management in order for frontline practitioners and their supervisors to engage in these thoughtful practices.

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REFERENCES


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**Learning Level:** Intermediate

**Target Audience:** Occupational Therapists and Occupational Therapy Assistants

**Content Focus:** Professional Issues: Supervision

1. Supervision is best understood as a formal process of support and learning to:
   A. Make sure practitioners do the “right” thing.
   B. Protect clients from inexperienced practitioners.
   C. Help practitioners develop knowledge and competence.
   D. Ensure that supervisors know what practitioners are doing.

2. Which workforce development trend did not influence renewed interest in supervision?
   A. Challenges in recruiting enough skilled practitioners
   B. Sustained use of evidence-based practices post initial training
   C. Increased use of non-degreed staff
   D. Using “experts by experience” as service providers

3. A permanent supportive housing occupational therapist responds to a referral for hoarding behaviors. Which process _best_ represents Schöns’s (1983) concept of _reflection-on-action_?
   A. Just before knocking on the client's door, the therapist wonders “how bad it will be.”
   B. While meeting with client in his unit, the therapist worries about their safety.
   C. After seeing the client, the therapist compares the client's situation with others.
   D. Reviewing the visit later, the therapist wonders if they said and did the right things.

4. Reflective supervision is best represented by:
   A. Sharing perspectives and “thinking together”
   B. Meeting only when a supervisee requests it or problems arise
   C. Providing the supervisee with direct instruction about what to do
   D. Reviewing agency policies
5. A supervisee shares a mistake they think they’ve made. Which supervisor action best represents reflective supervision’s parallel process and sense of safety?
   A. Identify the supervisee’s problematic actions and point out what to do in future.
   B. Refer the supervisee to the client’s chart to ensure the treatment plan is being followed.
   C. Listen empathically as the supervisee shares thoughts and feelings about the mistake.
   D. Encourage the supervisee to review the agency’s employee handbook.

6. During a full-service partnership (FSP) reflective supervision, the supervisee expresses frustration with an unmotivated client, acknowledging that they’ve tried to think about what they could do differently. Which supervisor action best represents reflective supervision’s “making visible the invisible?”
   A. Encourage the supervisee to consider the client’s perspective.
   B. Remind the supervisee that doing “whatever it takes” is part of the FSP philosophy.
   C. Suggest the supervisee pull back to let other team members work with the client.
   D. Review the etiology of motivational problems (e.g., negative symptoms).

7. Which statement does not represent recovery-oriented supervision?
   A. Supervisees internalize recovery orientation by experiencing it themselves.
   B. It is informed by personal or consumer recovery, not scientific or clinical recovery.
   C. Only licensed mental health professionals do it.
   D. Recovery-oriented care differs profoundly from medical model-oriented care.

8. Which recovery tenet does not inform Yerushalmi and Lysaker’s (2014) perspective on recovery-oriented supervision?
   A. Rediscovery of sense of self
   B. Reciprocity in relationships
   C. Positive and empowering narratives
   D. Optimizing natural supports

9. In an FSP “do-whatever-it-takes” recovery-oriented supervision session, a supervisee shares that they want to invite one of their clients to their home for a 4th of July party. Which supervisor action most aligns with a recovery-oriented approach?
   A. Review the agency’s policies on relationship boundaries.
   B. Explore with the supervisee the meaning to them of having a client at their home.
   C. Suggest that they join the client in a public celebration.
   D. Verify that the treatment plan includes a community-integration goal.

10. A supervisee in recovery-oriented supervision regularly focuses on their own weaknesses that worry them. Which supervisor action best fits with “building a positive and empowering narrative?”
    A. Elicit the supervisee’s reflections about times in which they felt successful.
    B. Remind the supervisee that they need to feel confident to do good work.
    C. Share that everyone feels this way from time to time.
    D. Tell them about your experiences of not feeling very effective.

11. In a recovery-oriented supervision session, a therapist complains that their supervisor won’t give them direct instruction on what to do in a particular situation. Which recovery-oriented tenet best reflects this supervisor’s actions?
    A. Rediscovery of a sense of self
    B. Attaining mutuality and negotiating authority
    C. Building a positive and empowering narrative
    D. Being community-focused and strengths-based

12. In what ways are reflective supervision and recovery-oriented supervision similar?
    A. They both rely on reflective dialogue.
    B. They’re both grounded in the “relational turn” in psychoanalytic theory.
    C. They’re both intended for use with non-degreed and “experts with experience” supervisees.
    D. They both draw on the expertise of both the supervisor and supervisee.