A Solution-Focused Approach to Mental Health Supervision

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In recent years, an increased number of child and family services agencies have undertaken extensive training programs for their staff in brief solution-focused therapy. As mental health workers begin to apply a solution-focused approach to their work, there is a growing need for current supervisory practices to incorporate these new approaches so that they are consistent with the therapy models being employed. Mental health supervision, however, has been an administrative practice primarily focused on mental health worker developments and has lacked the client-focused approach necessary to adapt solution-focused methods. This paper introduces solution-focused mental health supervision as a new vision for supervisory practices that will have the flexibility to facilitate mental health worker development along with a more direct therapeutic role. It is suggested that when a solution-focused supervisory process ensures the definition of supervisory goals in terms of concrete client conceptualizations of goals and solutions, client outcomes significantly improve. Data from a small exploratory study in a children's mental health agency are included here as preliminary support for this theoretical position. These theoretical concepts have been used to develop practical guidelines for the implementation of solution-focused supervision.

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Introduction

The recent recession in Canada has resulted in federal and provincial governments becoming increasingly restrictive with their funding of mental health care services. The economic climate has resulted in cutbacks in counselling and mental health care services at the very time that there is an increased need in the community for these same services. It is in this atmosphere that agencies have undertaken extensive training programs for their staffs in brief solution-focused therapy (de Shazer, 1984, 1985, 1988, 1991). One of the underlying organizational hopes for these efforts is that the tools solution-focused therapy offers will enable mental health care practitioners and their supervisors to become more effective in meeting the increased demands that these agencies are mandated to deliver.

As mental health workers become trained in the solution-focused approach and begin to apply it in their practice, mental health supervision will begin to play an increasingly crucial role "as an integrative linkage between theoretical knowledge and applied skills" (Everett & Koerpel, 1986, p. 62). However, mental health care supervisors "guide the practice of the profession with scant empirical literature" (Harkness & Poertner, 1989, p. 506). The purpose of this paper is to review mental health care supervision practices in light of the current trend of training mental health care staff in solution-focused theory. Research in mental health care has begun to investigate client-focused approaches in the supervisory process as a means of improving client outcome. It is upon this basis that four models of solution-focused supervision will be reviewed. This paper will make new suggestions for the applicability and integration of solution-focused mental health supervision.

Mental Health Care Supervisor

Kadushin (1992) provides a clear description of the mental health care supervisor's role:

> [A mental health care] supervisor is an agency administrative staff member to whom authority is delegated to direct, co-ordinate, enhance, and evaluate on-the-job performance of the mental health worker for whose work he is held accountable. In implementing this responsibility the supervisor performs *administrative*, *educational*, and *supportive* functions in interaction with the supervisee in the context of a positive relationship. The supervisor's ultimate objective is to deliver to the agency clients the best possible services, both quantatively and qualitatively, in accordance with agency policies and procedures. (p. 22)

In research literature dealing with supervision and its definition, the emphasis usually falls on the supervisory roles of educator (Pettes, 1979) or administrator (Miller, 1977). Poertner and Rapp's (1983) research shows that 63% of all supervisors' tasks were administrative in nature and focused on worker control, organizational maintenance, and case management, while 17% of the tasks are community development oriented, and 20% are supportive and educational in nature. In fact, the literature indicates that mental health workers do not perceive the supervisory process as being supportive to the degree that supervisors might think (Granvold, 1977; Fleishman & Hunt, 1973). The use of supervisory models of management that have empowered managers to control worker performance (Grasso & Epstein, 1991) inevitably take a problem resolution stance to mental health worker development. The focus in supervision will thus be on the mental health worker's mistakes or the disabling patterns that may exist between a confused mental health worker and their client. As Wetchler (1990) states: "A problem orientation serves to reinforce a supervisee's feelings of inadequacy as they attend to the mistakes which further support feelings of confusion. A continuous focus on

problems can lead to feelings of therapeutic inadequacy rather than feelings of clinical success" (p. 131).

Helping mental health workers by focusing on problem resolution inevitably involves a supervisor's fundamental beliefs about blame and control. Michlitsch (1992) defines *blame* as "attributing responsibility for problems" and *control* as "attributing responsibility for solutions" (p. 21). Brickman et al. (1982) present four models of managerial supervision:

(i) *Self-generating model:* Individuals are responsible for their problems and for creating their own solutions and just need to be properly motivated.
(ii) *Direct guidance model:* Individuals are responsible for their problems but need direct guidance from those in authority to ensure the problem is recognized and then create correct solutions.
(iii) *Expertise model:* Individuals are *not* responsible for either problems or solutions but should rely on the advice of those trained to recognize problems and prescribe solutions.
(iv) *Empowerment model:* Responsibility for the problem is attributed to the situation of environment. Helping is providing the resources for individuals to see that the successful solution to problems lies with the individual.

In an effort to minimize issues of blame and control, mental health supervision would benefit from the use of an empowerment approach to the management of mental health workers, as would the general approach of mental health care practice. However, this is easier said than done given the nature of mental health care. The way workers have been trained and supervised to help individuals and families involves techniques and methods adopted from traditional psychotherapies and models of family therapy (see Corsini & Wedding, 1989; Olsen & Stern, 1990). These traditional approaches are often characterized by an imbalance between client and therapist where problem recognition and guidance

about *appropriate* solutions to problems are exclusively expert-based. Thus, a pattern of interaction within the supervisory system can develop that is isomorphic (Liddle, 1988) to "the pattern that exists between confused mental health workers and their clients which may maintain clinical incompetency, low self-esteem" (Wetchler, 1990, p. 131) and poor client-outcome. Caligor (1984) suggests that this pattern may even reach higher organizational levels in terms of the way in which the supervisor relates to his/her own supervisor. Inevitably, great pressure is placed on the mental health worker to resolve problems and, when this is unsuccessful, the client or family who has sought service is either blamed, labeled resistant, or dismissed as being beyond help. The client and family in turn blame the mental health worker and larger system, and inevitably perpetuate their own difficulties. A system of shifting accountability emerges where client, mental health worker, supervisor, and agency all shift accountability for problem resolution onto each other and "interact in their daily activities in such a way as to frustrate each other's progress and in the process, they destroy in varying degrees the lives of individuals or hamper their ability to improve their lives" (Termini, 1991, p. 387). Therefore, the continued practice of mental health supervision as being primarily an administrative process that is focused on mental health worker development (Kadushin, 1992; Munson, 1993) through problem resolution offers little for mental health workers with regard to improving performance (Grasso & Epstein, 1987), and thus little for improving accountability in their service to the client.

Solution-Focused Supervision

A review of the literature in family therapy supervision reveals the development of four articles on the subject (Selekman & Todd, 1995; Marek, Sandifer, Beach, Coward, & Protinsky, 1994; Thomas, 1994; Wetchler, 1990). As Thomas (1994) outlines, this approach to supervision is based on family therapy models known as *solution-focused*

(Berg & Miller, 1992; de Shazer, 1988, 1991; Furman & Ahola, 1992), *solution-oriented* (O'Hanlon & Weiner-Davis, 1989), *narrative* (White & Epson, 1990), *competency-based* (Durrant, 1993), and *possibility therapies* (O'Hanlon, 1992). The recognition and amplifiction of successes and competencies are fundamental in these models (O'Hanlon & Weiner-Davis, 1989; Weiner-Davis, de Shazer, & Gingrich, 1987; Thomas, 1994) and their subsequent approach to supervision. Wetchler (1990) and Marek et al. (1994) both propose intial frameworks for supervision that could be adapted to mental health supervision. A solution-focused approach in mental health supervision would assist mental health workers to make the linkage between their theoretical training in solution-focused therapy and their actual mental health care practice.

Wetchler's (1990) model of solution docused supervision divides supervision into two parts: solution focus and clinical education. Supervision becomes largely focused on the identification and acknowledgement of a *supervisee's* strengths, successful interventions, and behaviours, and a search for successful exceptions that can be used to resolve the problem in the future.

In their work, Marek et al. built upon the solution-focused component of Wetchler's (1990) supervisory model. Marek et al. (1994) propose a practical framework based on the solution-focused techniques of goal setting, looking for exceptions, identifying hypothetical solutions through the use of the "miracle question" (de Shazer, 1988) and the asking of scaling questions.

Selekman and Todd (1995) further incorporate the use of presuppositional questions and "change talk" (de Shazer, 1988, 1991; Gingerich, de Shazer, & Weiner-Davis, 1988; O'Hanlon & Weiner-Davis, 1989), as well as the intervention task of "doing something different" (de Shazer, 1985). Selekman and Todd (1995) also highlight the importance of amplifying small changes and supervisee's exceptional behaviour through the use of compliments and cheerleading. Indeed, implicit in the solution-focused approach to

supervision is the use of sincere compliments that are based on what the supervisee is already doing that is useful or right in some way (de Shazer, 1988).

A fundamental assumption of solution-focused supervision is that "recognizing capabilities is more important than accentuating the intractable deficits, experiences, and beliefs" (Thomas, 1994, p. 14) which the supervisee associates with past therapeutic interventions that have been ineffective. However, Wetchler (1990) does identify a clinical educational component in his model that "deals with the supervisee's problems stemming from a lack of clinical knowledge rather than a failure to recognize solutions" (Wetchler, 1990, p. 133). This educational component has been incorporated by other models of solution-focused supervision (Marek et al., 1994; Thomas, 1994).

Solution-focused supervision seeks "to set up a cooperative, goal-oriented relationship that assumes the supervisee possesses the strength, resources, and ability to resolve a complaint and achieve training goals" (Thomas, 1994, p. 13). Selekman and Todd (1995) assert that the supervisee take the lead in identifying and establishing their learning and treatment goals for each supervisory session.

Each model that has been presented emphasizes the use of solution-focused supervision in defining goals based on the *supervisees' perceptions* of what is needed in their practice. There is an underlying assumption that since the mental health workers' practice will be solution-focused that this will facilitate the identification of supervisory goals that are directly related to client-focused outcomes. However, I believe that this is not necessarily the case. The models as they are presented describe a mental health worker-focused supervisory process that has the flexibility of dealing with a variety of mental health worker defined goals whether they be clinical, administrative, personal, or educational in nature *regardless of whether or not they are directly related to client outcome*.

This inherent flexibility in the solution-focused supervisory process may help facilitate an empowered helping

relationship between mental health worker and supervisor which research has shown is a "medium through which the supervisor influences outcomes of practice" (Shulman, 1983, p. 92). It may even serve to meet the long term professional and relationship needs between the mental health worker and supervisor. However, it still remains that even these models of solution-focused supervision are primarily focused on mental health worker development and assume client-focused outcomes as being secondary.

A client-focus could easily be incorporated by having solution oriented supervisors guide mental health workers to *concretely define client problems and evaluate their own practice in the context of specific client defined goals and outcomes*. Thus the primary focus of a solution-focused approach to mental health supervision would be client-outcome, with mental health worker development as a secondary result.

Client-Focused Mental Health Supervision

There has been a recent shift towards re-examining mental health supervision's therapeutic role (Towle, 1954; Austin, 1952; Hamilton, 1955) by refocusing on client needs (Rapp & Poertner, 1992; Harkness & Hensley, 1991).

Harkness and Poertner (1989) concluded in their review of empirical supervision literature that the literature primarily addresses supervisors and workers and, in fact, found no study that had met a client-focused standard of relevance. Harkness and Hensley (1991) demonstrated in an innovative study that mental health worker supervision itself has a direct effect on client outcome. Their work shows the significant increase in client satisfaction when supervisors abandon the traditionally mixed focus on administration, training, and clinical consultation in favour of their "client-focused" supervision.

In fact, the questions in Harkness and Poertner's (1991) client-focused approach are similar to the solution-focused questions discussed earlier in that they strive to clarify goals:

"What does the client want help with? What are you doing to help the client? Does the client say you're helping?," look for exceptions: "*Does the client say there has been a successful outcome? What else can you do to help the client?"* and explore hypothetical solutions: "*How will you and the client know you are helping? How does the client describe a successful outcome?"* (p. 507). Such questions are effective at increasing a mental health worker's attention to their clients' conceptualizations of the presenting problem, goals, and solutions and prompting workers' evaluation of practices in light of their clients' conceptualizations.

In replication studies Harkness (1995a, 1995b) was able to identify the supervisory skills of problem solving and maintaining a client-focus both to have direct, independent causal effects on client outcome in terms of the client's management of problems, control of his or her environment, and quality of life. These goals attainment factors have been highly correlated with clients, ratings of treatment outcomes in mental health settings (Lebow, 1983; Conte, Plutchik, Buckley, Spence, & Karasu, 1989). Harkness (1995a) also found that shifting to a client-focused supervisory process positively impacted the client's view of their mental health worker. The *"client-focused supervisee"* was more likely to be seen as attentive, supportive, empathic, collaborative, and more encouraging of self-determination and change. In addition, it was this client-focus shift that also increased mental health workers' use of basic communication, problem solving, and relationship skills all of which Shulman, Robinson, and Luckyj (1981) and Shulman (1979, 1982) have argued build a positive relationship on which helping and ultimately client outcome depends. By defining supervisory goals in the context of client-conceptualizations and, in my view, integrating a solution-focused supervisory process, an important therapeutic link between mental health care supervision practice and client outcome is established.

Becoming Client Focused in Solution-Focused Supervision

The Guidelines for Solution-Focused Supervision (see Appendix A) represents an attempt to integrate these new approaches into a practical format for the practice of mental health supervision. These guidelines are an adaptation of the supervision models proposed by Wetchler (1990) and Marek et al. (1994). They also incorporate techniques from solution focused therapy (The Brief Family Therapy Centre, 1991; The Brief Family Therapy Centre & Miller, 1993; Walter & Peller, 1992; Kowalski & Kral, 1989; Kowalski & Durrant, 1990; Thomas, 1994) and emphasise the client-focused approach by Harkness and Hensley (1991).

The suggested format of the supervision involves four parts: (1) establishing an atmosphere of competence, (2) a search for client based solutions, (3) feedback to the supervisee, and (4) follow-up supervision.

Establishing an Atmosphere of Competence

This intial phase of the supervision focuses on the supervisees' strengths and resources rather than deficits and problems (Wetchler, 1990). The supervisees begin by describing interactions, interventions, and behavioural sequences between themselves and their clients that have led to successful outcomes. In turn, the supervisor responds with direct and/or indirect compliments that serve to acknowledge the supervisees' strengths and client based successes. The knowledge of what the supervisees do "correctly is more imporant to the overall development of personal competency and the well-being of their clients than is a continual focus on clinical mistakes" (Wetchler 1990, p. 129). This approach represents a proactive shift from mental health supervision which has traditionally been an administrative process focused on supervisee development and control by reacting to clinical mistakes and failures. The supervisor is able, in a supportive and co-operative manner, to help facilitate the

development of a core foundation of conceptual, perceptual, and executive skills (Cleghorn & Levins, 1973; Tomm & Wright, 1979). This process provides the supervisees with a positive compliment context upon which to build on further therapy successes (Gentry, 1989) within a variety of client situations.

The Search for Client-Based Solutions

The second phase of the supervision involves case presentation and a search for client-based solutions. This involves a solution-focused process of clarifying goals, looking for exceptions, exploring hypothetical solutions, and also utilizing scaling and percentage questioning methods (Walter & Peller, 1992; Marek et al., 1994). The process goal is to help the supervisees define their supervisory goals in terms of their clients' conceptualizations of problems, goals, and outcome (Harkness & Hensley, 1991). The supervisor helps the supervisees to concretely focus on their clients' problems. Supervisees are further helped to evaluate their interventions, particularly in relation to whether their *clients* directly indicate that such interventions are in some way useful to overcoming or coping with their problem situation. Thus the primary focus of this supervisory process is client outcome. Mental health worker development and institutional maintenance are a secondary result.

Feedback to the Supervisee

The third component of the supervision is a time for feedback to the supervisee (de Shazer, 1985; O'Hanlon & Weiner-Davis, 1989; Walter & Peller, 1992). It is suggested that prior to providing feedback both supervisor and supervisees engage in a period of reflection. A pause, a deep breath, or even a brief intrasession break can serve this purpose and help set the stage for a formal feedback process. The feedback is organized around compliments, a clinical educational component, and the formalizing of supervisory

goals or possible tasks. Compliments are used to reinforce and enhance the supervisees' strengths, resources, and client-based successes. The supervisor once again actively facilitates the evolution of a cognitive structure and self-identity as a mental worker that recognizes competence and the ability to facilitate solutions and change. Included in the feedback is a clinical educational component that allows the supervisor an opportunity to give the supervisees an alternative perspective of what they can do differently to achieve success. The supervisor may in the process of the supervision identify theoretical concepts and techniques that may need to be better understood and utilized. This component allows the supervisor the flexibility to adapt their patterns of supervision to the developmental needs of the supervisees (Cross & Brown, 1983; Wetchler, 1990; Marek et al., 1994) and his/her own evolving abilities as a supervisor (Thomas, 1994).

The final part of the feedback process involves the establishment of supervisory goals. The suggested framework for the supervisees' goals are a client-focused adaptation of the basic tasks developed by de Shazer and Molnar (1984) and further developed in *Clues* (de Shazer, 1988). The supervisees in this case are helped to define their own practice goals as they relate to their clients' needs. They can be assigned the tasks of observing their clients' behaviours for positives, helping the clients do more of the positives or exceptions, finding out how their clients' spontaneous exceptions are happening or helping their clients do a very small piece of the hypothetical solution. It is also suggested that the supervisees can focus on their own behaviour as it relates to the above tasks. The purpose of structuring supervisory goals in this manner is to assist supervisees to construct their solutions in this client-focused manner. In situations where the supervisees express that they are not on track with their clients and nothing is working, then it is suggested that supervisory goals be established in a manner that allows the supervisees to give themselves permission to try something totally different with their clients. Included in the guidelines

are such suggested tasks that may help the supervisees trigger the solution process, discover and/or create exceptions, or interrupt problematic interactions (The Brief Family Therapy Centre & Peacock, 1992; Walter & Peller, 1992).

Follow-up Supervision

The follow-up supervision is based on a suggested format by The Brief Family Therapy Centre & Miller (1993) for initiating the next supervision session. The process goal is to elicit, amplify, reinforce, and start again (The Brief Family Therapy Centre & Miller, 1993). The supervisor asks about positive changes and amplifies the discussion by asking for specific details which are then reinforced in order to make sure the supervisees notice and value these positive changes. In expectation of this supervisory focus, the supervisees begin to increasingly attend to the positive changes, interactions, and interventions between themselves and their clients. In so doing, the supervisees positively reinforce *successful client behavior* and create their own positive expectation of change for the clients. Repeated solution-focused supervision fosters positive expectations for change in both supervisees and clients. The supervision process thus becomes complete and it can once again return to establishing an atmosphere of competence or to case presentation and a search for client-based solutions.

This outline for solution-focused supervision has included a spectrum of possible questions or tasks for each component of the process. The extensive nature of the proposed guidelines should not be interpreted to suggest a prescriptive approach to supervision. Each supervisory situation is indeed unique. The format and content utilized only reflects an effort to ensure the applicability of this process to a variety of clinical solutions. These guidelines are meant to be used in a manner that reflects both the supervisor's style and purpose.

The key implication being made is that the supervisory skills of being solution-oriented and the ability to maintain a

client focus are both of central importance to effective supervision. It is proposed that by adopting a solution-focused supervisory process that ensures the definition of supervisory goals in terms of client conceptualization of problems, goals, and outcomes, a supervisor can have a two-fold therapeutic effect. A supervisor can not only indirectly influence client outcome through the supervisory relationship, but can also have a *direct causal effect* on the client's ability to attain his/her goals, manage problems, and improve his/her quality of life. This type of supervisory process reflects an empowering approach for the supervisors and supervisees but also for the supervisees' clients. Helping becomes more clearly defined in terms of individuals utilizing their own abilities and reosources to overcome their problems.

Putting theory into practice: pilot testing a solution-focused supervision training program

Purpose

This approach to mental health supervision has been included as part of a solution focused training program for a privately owned children's mental health agency located in Dundas, Ontario, Canada. This agency is composed of eight residential facilities, four contained educational classrooms, and a system of staff-supported foster homes. This therapeutic community provides long-term care and treatment for both male and female children and youth from ages six to eighteen and has a total capacity of seventy beds. The purpose of this effort has involved determining whether training in solution-focused therapy and supervision can positively impact supervisor and staff practices as well as client outcomes.

Clientele

The children and youth typically served by this agency have family histories characterized by abuse, neglect, marital difficulties, and parent child conflict. Upon admission, most

residents have been deemed by the courts to be society wards or crown wards in need of protection and long-term care.

This private mental health system is usually a last resort for most government placement agencies who first try to place these children and youth in substitute foster family systems. Higher levels of worker-supported foster care or residential care setting are considered viable only after a number of these less intrusive settings have been unable to meet the child/youth's needs for a sustainable period of time.

The most common presenting client diagnoses involve depression, hyperactivity, stress, anxiety, and oppositional behaviour. Treatment variables include a variety of intellectual, emotional, and control difficulties (Strochak, 1987). In particular, the children/youth display frequent, acute episodes of aggression and anti-social behavior.

Residential Care

A fundamental function of the long-term care setting is the delivery of normative services which the nuclear family customarily provides to children/youth (Lavine & Wilson, 1985). There are many practical difficulties that need to be considered in achieving this goal. One of the most basic difficulties in residential care is milieu regression. This condition is characterized by chronic conflict, paradoxical communication, conflicting authority, stagnation, boredom, covert and overt anger, chaos, and rigidity (Fleck, Cornelison, Norton, & Lidz, 1957; Hayley, 1969; Steinfield, 1970; Bradshaw & Burton, 1976; Sluzki, 1985; Blotcky, Dimperio, Blotcky, & Looney, 1987). Due to the nature of the problems brought to the milieu and abetted by regressive tendencies, staff and residents often have difficulties maintaining the growth forces in the milieu (Stocks, 1968). What results is a decreased capacity for effective staff inverventions with residents (Blotcky et al., 1987). It is in this context that a training program in solution-focused therapy was introduced.

Training Program

The training program involved four, three-hour weekly sessions. The initial sessions focused on introducing the solution-focused model. Subsequent sessions focused on the application of specific solution-focused techniques to suicide prevention, anxiety/arousal disorders, motivational issues, anger management, crisis intervention and supervision. The training also included the presentation of case scenarios, role playing and intense practical experiences. Incorporated into the training package were relevant background reading materials including Wetchler's (1990) and Marek's (1994) articles on solution-focused supervision. Between training sessions participants were given the task of applying their new knowledge and skills by conducting solution-focused counselling sessions with their residents. In addition, supervisory staff were assigned the task of conducting solution-focused supervision with their staff on an individual basis as well as at a team level. The results of these formal and informal experiences were shared as a group at the beginning of each training session.

Participants

Participants in the training program included all 14 of the agency's supervisory and management staff. As a group, they had a mean of 5.1 years of experience in the field and a minimum three-year child and youth worker college diploma or related university degree. Ten direct care workers were also involved in this study. As a group, they had a mean of 5.6 years experience in the field and had a minimum child and youth worker degree, related university degree, or five years practical experience.

Seven of the direct care workers in this study composed the entire staff team of one residential program that serves the treatment needs of six latency-aged boys. This staff team along with their supervisor were chosen as a pilot project for the entire agency. The effectiveness of the training program

was carefully measured in terms of staff and client outcome within this program in order to determine relevance for any future training of the agency's entire complement of direct care workers. Attendance for all four training sessions, including the session devoted to solution-focused supervision, was 98%.

Despite the fact that only a few of the supervisory staff and child and youth worker staff are specifically trained in social work, the solution-focused model of supervision is appropriate when one considers the similar nature of the actual work that is carried out. Supervisors of these residential programs perform administrative, educational, and supportive functions similar to those of social work supervisors as outlined by Poertner and Rapp (1983). These residential supervisors are also in positions where they have to "delegate, co-ordinate, enhance, and evaluate the on-the-job performance" (Kadushin, 1992, p. 22) of a team of child and youth worker staff. Supervision plays a crucial role in their efforts to help their team members implement and carry out treatment programs for the residents.

An important difference between residential supervisors and more traditional social worker supervisors is their greater degree of direct involvement with both clients and staff. The child and youth workers in turn would themselves also have a greater therapeutic role than social workers. In addition to their counselling role, child and youth workers also perform the duties of case manager, role model, disciplinarian, life skills teacher, and parental surrogate. The child and youth worker staff are the ones primarily responsible for the daily implementation of therapeutic programming directly to clients.

Method

A. Subjective Outcome Measures

The evaluation of the solution-focused therapy training progam's effectiveness included participants' responses to a

Client Satisfaction Survey (Larsen, Attkisson, Hargreaves, & Nguyen, 1979). The survey's questions focused on the impact of the training on job satisfaction, use of compliments, supervision practices, and desire for further professional development in solution-focused therapy.

B. Objective Outcome Measures

As previously discussed, the clients served by residential treatment programs often display acute episodes of aggression and anti-social behaviour. In extreme situations where the residents are deemed to have lost self-control to a level where they may pose a danger to themselves/others or may damage property, physical restraints are used by staff. These restraint procedures are aimed at safely containing the child/youth until they have calmed down and have had an opportunity to process their emotions/thoughts with staff. In severe situations, police intervention and/or brief periods of hospitalization are also utilized. If clients display prolonged episodes of such intense and potentially self-destructive rage, their treatment plans shift towards the serious consideration of drug therapy, usually in the form of anti-psychotic and/or anti-depressant medication.

The increased frequency of serious incidents or the use of increased use of psychotropic medication was assumed to be a strong indication that the residents were finding it harder to cope with their problems and their associated feelings of sadness, anger, or frustration. In addition, the increased staff reliance on physical restraint, police involvement, hospitalization, or use of psychotropic medication was assumed to be a good indicator that the staff team might be experiencing serious difficulties in helping their clients successfully cope with their problems. The staff's inability to alleviate their clients' tendencies to reach such dangerously heightened levels of anxiety and anger sometimes results in a negative cycle in which the staff's use of physical intervention and medication reinforces the clients' view that they are indeed impulsive and lack self-control. In most

cases, if this cycle is not reversed, placement breakdown is inevitable.

Most residential programs are required by law to document the occurrence of restraints in a type of *Serious Incident Report* format. In addition, residential licensing provisions also outline the required documentation of the dispensing of any psychotropic medication to residents. These two variables were used as objective measures in our evaluation of the impact of the solution-focused training on client outcome.

Results

A. Client Satisfaction Survey

Two of the survey's questions were explicitly focused on the evaluation of the solution-focused supervision training session. In response to the question, "*In comparison to other models/practices of supervision, how would you rate the Solution Focused Model?*", 69% of the supervisors rated the model "*above average*" and 31% of the supervisors chose the top rating of "*clearly superior*." None of the supervisory staff rated the solution-focused model of supervision as "average" or "less than average." Anecdotal comments from supervisors in response to this question included the following:

It's a far more positive approach;
Staff feel more positive and confident in their performance;
It lowered the anxiety level of the supervision process by focusing on strengths and resources;
More of a sharing process and exchange of ideas as opposed to a confrontation;
Has brought about a tremendous change in clients, staff and management;
To date, I have not encountered any set models of supervision, so this was a very exciting tool to have.

In response to the survey question, "*Has the attempt to use the Solution Focused Model in supervision with your workers improved your effectiveness?*", 69% of the supervision staff responded with a rating of "*considerably*" and 7% responded with a rating of "*significantly*." Anecdotal comments from these supervisors were again quite positive and illustrated by the following responses:

I've found my time in supervision to be more productive;
It allows me to compliment and support my staff team, to build on strengths and identify areas of progress, breaking down the us versus them mentality;
When I have tried it in supervision, not only do I walk away feeling O.K., it seems that staff are more enthusiastic;
Staff should be trained in it as well.

A total of 7% of supervisors rated the impact of this model on their effectiveness as "*somewhat*", while 15% assigned a rating of "*minimal or none*." Anecdotal comments from these supervisors indicated that they had not had time to implement this approach in their practice or that the solution focused approach to supervision was very similar to the approach they already used.

Despite not having supervision duties, a few direct-care staff members also responded anecdotally to these two questions. Staff anecdotal comments were also quite favourable and reflected by the following responses about the supervision model and its impact:

It focuses on positives and concrete evidence with which to work on;
It provides an ongoing goal setting routine;
It gives you a basic approach for dealing with specific problems;
The staff team tends to be more positive, and I have noticed significant changes in the house morale;
I'm getting four compliments for each problem!

The direct care staff are indeed active participants in the supervisory process. Their responses serve to reinforce their supervisors' assessment of the positive impact the solution-focused model of supervision has made in their practice. When asked on a separate survey that focused on evaluating the helpfulness of the reading materials chosen, 83% of the supervisors and also 72% of the staff responded that they found the Guidelines For Solution-Focused Supervision and the accompanying worksheet to be either "*very helpful*" or "*extremely helpful*" as compared to ratings of "little help" or "plan to read in the future."

Two questions on the survey had more indirect implications with respect to the effects of solution focused supervision. In response to the question, "*Has there been any change in how frequently you give compliments on (individual) strengths and resources?*", approximately 70% of both supervisors and staff responded with ratings of "*considerably*" or "*significantly*." Anecdotal comments from supervisors reflect a greater ability to highlight strengths in a specific and sincere manner. Staff's anecdotal comments about their use of compliments largely focused on the impact in the residential milieu. Staff commented that compliments enabled them to be more specific and explicit about their clients' strengths and abilities. According to some staff, the increased use of this specific skill has enabled them to become more positive and effective in their interactions with the residents. This, in turn, has resulted in a more positive atmosphere or milieu between staff and residents within the programs.

The survey question, "*What difference has the training made on how you interact with residents or staff?*" produced the clearest anecdotal statements from both supervisors and staff. Supervisory comments about the training also centred around the theme that the training had created a more positive outlook and atmosphere within their programs. Some of their specific responses included:

[This training] has helped me to focus on strength areas with staff;

Less blame and control, more co-operative on my part;
I more often look for positives with staff and residents to help them feel good about themselves and successful;
I can really see how when morale is down in staff it trickles down to the kids; and it is important especially as a supervisor that I remain solution focused so that my attitude can trickle down to staff.

This improvement in morale and empowered atmosphere within the residents and staff was echoed by the staff's anecdotal responses:

There has been a pressure taken off the kids . . . instead of getting caught up in issues you can get caught up in the positives;
There is less stress and the kids are reacting to our gentler approach;
I've stabilized my interactions with residents, and improved staff self-esteem;
The children are feeling more positive and recognizing that I am more positive.

B. Serious Incident Reports and Psychotropic Medication Outcomes

As outlined, the solution-focused training involved four, three-hour weekly sessions including a session on solution-focused supervision. Participants included all the agency's residential supervisors along with the entire direct-care staff team of *one* of the agency's residential programs. The residents of this particular program served as a treatment group. Their ages range from ten to 14 years of age, and four of the five residents have a minimum 15-month length of residency in the program. The frequency of client serious incident reports and client use of psychotropic medication were investigated to determine the impact of the solution-focused training.

After the four-week training program and a follow-up period of 16 weeks, initial results indicate that the average

number of serious incidents per client in the treatment group (x=2.50) has decreased 65.5%, as compared to the four month pretreatment period (x=7.25). These results would indicate that the solution-focused training had a positive impact on client outcome within this residential program.

This treatment group was then compared to a control group of seven clients chosen from the agency's other residential programs. The control group clients were matched to treatment group clients in terms of age, presenting difficulties, and a minimum 15-month length of residency in their current placement. The control group clients differed from the the treatment group clients in that the entire direct care staff teams involved in their care *did not* participate in the solution-focused training along with their program's residential supervisors. Nine-month pretreatment period data also indicated that the treatment and control groups were similar in terms of the average number of serious incidents per client.

The control group's current treatment period results (x=10.14) show a 10% reduction in the average number of serious incidents per child as compared to the group's own four-month pretreatment period figure (x=11.25). The data suggest only slight treatment effects with the control group clients as a result of their residential supervisors' training in solution-focused therapy and supervision.

In comparison, the treatment group's average number of serious incidents per child for the treatment period (x=2.50) is 75.3% less than that of the control group's (x=10.14). This result is even more impressive given that there was a reduction in the treatment group's total use of psychotropic medication. All four treatment group clients were on psychotropic medication and during the testing period two of the clients were totally withdrawn from their medication. In contrast, of the six clients in the control group on psychotropic medication during the test period, 17% decreased in dosage, 17% remained at the same dosage, and 66% increased in their dosage. For all clients, decisions regarding the prescriptive use of psychotropic medication were made by an independent child psychiatrist unaware of the treatment variables.

These preliminary results give support for the following contentions:

(a) solution-focused training that included a session on solution-focused supervision had a positive impact on client outcome in terms of reducing both the average number of serious incidents per resident as well as the utilization of psychotropic medication to control behavioural outburst, and
(b) the inclusion of entire direct care staff teams in the training on solution-focused supervision increased the supervision's effeciveness in terms of reducing client incident reports and decreasing reliance on psychotropic medication.

It should be noted that this research effort was primarily designed as a pilot study. As such, the methodological limitations of this study, including the small sample sizes, warrant caution in drawing definitive conclusions or generalizations based on the data. However, when viewed in the context of existing client-focused research, this study and its preliminary findings are supported. This pilot study does indeed highlight the need for further research in this area to more fully explore the implications of the data.

Implications for Practice

The proposed Guidelines for Solution-Focused Supervision (appendix) represent a proactive shift towards the examination of supervision's therapeutic role in mental health care practices. The supervisory skill of being solution oriented and maintaining a client focus ensure a supervision process that helps supervisees better understand and evaluate their helping behaviour in terms of what their clients define as goals and solutions.

This model of solution-focused supervision was included in the training session for residential supervisors and staff of a children's mental health agency. Treatment effects indicate

that solution-focused supervision can lead to reductions in the frequency of client episodes of aggression and anti-social behaviour, as well as to reductions in the use of psychotropic medication to control these episodes. Subjective outcome measures from both supervisors and staff also reflect overwhelming support of solution-focused supervision in terms of its applicability and effectiveness at empowering supervisors, staff, and clients to overcome the regressive tendencies associated with residential systems.

It is crucial that the effectiveness of these preliminary measures be validated by longer term research with more subjects and situations. Future research sustaining solution-focused supervision's positive impact on both mental health worker efficiency and client outcome would have implications for mental health care. The current results suggest that despite increasingly limited resources, supervisors can maximize their therapeutic role by incorporating a solution-focused supervisory process. This research serves as a practical guide for those in the field who are attempting to incorporate an empowerment approach to helping in their supervisory practices.

Appendix: Guidelines for solution focused supervision

Part A: Establishing An Atmosphere of Competence

1. M.H.W. describes successful interactions, interventions, and outcomes with their clients(s)
   • *What has worked for you this week? Mental Health Worker to try and quote their client's own words as much as possible.*
2. Supervisor compliments successful M.H.W. behavior
   • *Focus is given to positive changes: the differences in the M.H.W.'s practice that have made a difference to client outcome: write down the impacts your compliments have on the M.H.W.*

Direct Compliment:
• *Build upon M.H.W's "I statements" that say what they are doing that is successful.* • *I like the way you …* • *What can I say positively about this M.H.W.?* • *What things is he/she doing already that are working, positive or exceptional?* • *How can I highlight and encourage it?* • *How can I give this M.H.W. credit for changing? trying?* • *Are there any fears or expectations about personal change or client change that I might want to alleviate?* • *Are there any fears about being judged that I might want to support?*

Indirect Compliment:
• *Instead of "That's Good," How did you decide that was good for the client? For you?* • *How did you know that would help?* • *How have you managed to help the client be successful?* • *What other times have you applied this stategy?* • *You may find this hard to believe, but in my experience as a supervisor, I would say that this (client-based success) is particularly impressive given the fact that you …* • *Not everyone would have been able to say/do that. So you're the kind of person …*

Part B: Search for Client-Based Solutions

• *Define supervisory goals in terms of client-conceptualizations*

Clarifying Client Goals:
• *What does the client want to change or want help with?* • *What client goals do you want to focus on for this supervision?* • *What would the client like to change about this?* • *So what does the client want to be doing instead?* • *If the client were on track to (making this decision, solving this problem …), what might he/she say they would be doing differently? What would you be doing differently?* • *How will you know when things have improved for your client? What client behaviors will indicate to you that this problem is on track to being solved?* • *Is that what the client says he/she wants?* • *What would the client say are his/her strengths?* • *Are*

there any times when the client has used these strengths to successfullly cope or overcome their problem?

Exceptions:
• *Does the client say there has been a successful outcome?* • *How does the client describe a successful outcome?* • *What does the client say you're doing that is helping them be successful? It is working? How does the client say you're helping? What else can you do to help the client? How will that work? Does the client say that would help?* • *When has your client experienced change? How did you help the client do that? Could you do more of that?* • *How is your client's goal happening now? Is any part of your client's goal happening some now?* • *Are there times when the client indicates that their problem is less frequent (intense, severe)? A little different?* • *When isn't the client's problem happening?* • *Has the client had similar situations in the past? What happened? What did he/she do then?* • *Are there times when you would expect the client's problem to occur, but it doesn't? What would the client say were different about these times?* • *When is the client doing some of what he/she wants to do in relation to this problem? How does the client explain this?*

Solution Frame:
• *If a miracle happened overnight and your client's problem was solved, what would the client's next day look like?* • *What signs would let the client know that the miracle really happened?* • *How will you and the client know you are helping?* • *What will you and the client be doing differently if the problem was on track to being solved? When the client's problem is solved what will he/she be doing differently? How will you be helping the client differently if you were on track to solving this problem? How will you get that to happen? What will you and the client have to continue to do to make that happen more often?*

Scaling:
• *Consider the following: on a scale of 1 to 10, where 10 is the goal (desired state) and 1 is the worst (problem state): Where is the client right now? What would the client say needs to happen to move from a 2 to 3 on the scale? What would the client say they would be doing differently? What will be the smallest sign that the client has moved up the scale 1 step? What small change can the client make that will help them move one step?* • *On a scale from 1 to 10 with one being "failure" and ten being "complete success," how would you rate your efforts now in terms of helping your client with his/her problem? When you are one or two steps higher what will you be doing differently? Does the client say that would help?*

Percentage:
• *What percentage of the time is the problem not happening? What percentage of this would the client say is normal?*

Intersession Break:
• *Is there anything else that I should know before I take a short break to reflect on your situation and return back with some feedback and suggestions? (2–5 min. break)*

Part C: Feedback to M.H.W.

Compliments:
• *Indirect and direct compliments are given* • *Record M.H.W.'s reactions.*

Clinical Education:
• *Focus on giving the M.H.W. an alternative perspective of what he can do differently to achieve success.* • *Help M.H.W. to concretely identify those theoretical concepts and techniques that may need to be better understood and utilised.*

Establishments of Supervisory Goals:

1. *observe client behaviour for positive*
2. *help client do more of the positive or exceptions*
3. *find out how client's spontaneous exceptions are happening*
4. *help client do a very small piece of the hypothetical solution*
5. *M.H.W. focuses on his own behaviour as it relates to the above tasks(s)*
6. *M.H.W. defines his own practice goals as they relate to his client's needs.*

Other Suggested Tasks:

• *Between now and next time we meet, do something different and tell me what happened. Try something the client will least expect from you.* • *The situation is very (difficult, complex, volatile, etc …). between now and the next supervision; try to identify why the situation has not gotten worse for the client? For yourself?* • *What will be a small sign, something you might notice this week that will tell you that things are looking up for the client in this problem area? For yourself? What is a small step you could help the client make in this direction?* • *Is there something the client is doing now that is worth continuing to have happen?* • *Pretend to experience a small part of the solution or experiment with a desired behaviour. What small step could you make in this desired direction?* • *On a scale of 1–10, predict what you will experience with the client tomorrow. The following evening, evaluate your day with the client and see if there is any difference between what you have predicted and what actually happened. Explain the difference.*

Part D: Follow-up Supervision

1. What's better? • *What does the client say is better or different?* • *Since our last supervision what client changes have you noticed with respect to the (problem situation)?*

(i) if better:

• *How is this different from the client problem which brought you in?* • *Is this the kind of change the client is looking for? That you're looking for?* • *When things are better (with regard to the complaint), what is the client doing differently? What are you doing differently?* • *What is the client continuing to do this week to perpetuate the change? What else can you do to help the client keep up with the change?* • *As the client continues to do more of the same (successful behaviours) will he/she be satisfied? Will you be satisfied?*

2. (When, where, how) did this happen? • *lots of details*
3. Wow! Incredible! Amazing! *You're kidding? Tell me that again? The client did what?* • *How did the client do that? How do you account for the client's ability to do this? Was this easy for the client to do or was it difficult?* • *You did what? How did you do that?* • *What does the client say you've done that's helped them decrease their complaint since our last supervision?* • *What did your client notice about you when you had an influence on this problem? Did you know you would be able to influence the client's problem?*
4. Go back to "What else is better for the client?" *until M.H.W. says there is nothing more or you have no more time.*

(ii) not better

a) if complaint:

• *What would the client like to do about that?* • *What does the client say will be happening differently when his/her complaint is better?* • *Tell me about the times when the problem is not happening.*

b) if set back:

• *How come things aren't worse?* • *What has helped the client continue to try? What has helped you to continue to try?* • *How has the client managed to cope? And yourself?* • *What would the client say he/she learned? What have you learned?* • *What would the client say has been better this time?*

(iii) no changes:

- *Return to Search for Client-Based Solutions*.

N. Triantafillou & R. Warner, 1995 (adapted from de Shazer, 1985; Kowalski & Kral, 1989; Kowalski & Durrant, 1990; Wetchler, 1990; Harkness & Hensley, 1991; The Brief Family Therapy Centre, 1991; The Brief Family Therapy Centre and Miller, 1993; Walter & Peller, 1992; Marek et al., 1994; Thomas, 1994).

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