Reflections regarding Australian music therapy supervision: Guidance and recommendations for establishing internal and external supervisory arrangements aided by cross-national reflection

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Abstract
Although literature regarding student supervision is expanding, information about how to establish supervisory arrangements for clinicians remains scarce. According to results from a large-scale survey in America, not all music therapists participate in supervision. Also, those that do participate in supervision may receive it from someone who works alongside them in their own organisation. In this paper, the international music therapy supervision literature is reviewed, and research findings that have emerged from America are considered in relation to the development of supervision in Australia. Results from a large-scale survey in America indicated that the most common reason for not receiving supervision was “lack of access”. In response, considerations and strategies for establishing internal and external supervisory arrangements are offered in this paper. The limitations involved in reflecting upon American findings in relation to the development of supervision in Australia are also noted. Cross-national reflections prompt questions regarding clinicians’ access to and choices regarding supervision. A number of strategies for clinicians, supervisors and employers are outlined to aid the development of supervisory arrangements, and support the ongoing and important development of supervision for all music therapists.

Key Words: Supervision, music therapy, standards

Introduction
Within music therapy, the importance of supervision is palpable. For example, research articles focussing on experiences and concerns of students during training can be found (e.g., Knight, 2008; Wheeler, 2002; Young, 2009), and reflective articles regarding student supervision have been offered (e.g., Edwards & Daveson, 2004). In addition, texts focusing on a wide scope
of topics about supervision are available (e.g., Forinash, 2001; Odell-Miller & Richards, 2009), and research regarding reflexive group supervision for clinicians within the field of palliative care have been published (O’Callaghan, Petering, Thomas & Crappsley, 2009). Also, documents produced by regulatory and advisory bodies in the UK, Australia and America advise that supervision (and/or reflection) is useful when practising (e.g., American Music Therapy Association, 2009a, 2009b, 2009c; Association of Professional Therapists, 2008; Australian Music Therapy Association, 2008; Health Professions Council, 2007).

However despite this emphasis, research regarding clinicians’ supervision is lacking. A review of three music therapy journals via SCOPUS database indicated that information regarding clinician supervision is absent (involving The Australian Journal of Music Therapy, The Journal of Music Therapy and Music Therapy Perspectives). Search terms used were “music therapy” AND superv* . The review resulted in little literature regarding supervisory arrangements for clinicians being found, perhaps indicating that research regarding supervision, including research into supervisory arrangements, is under-developed. Research that was found mostly involved the use of survey methodology. One such survey highlighted that not all clinicians have access to or choose to participate in supervision (e.g., Jackson, 2008). This lack of research and evidence-based guidance is in direct contrast to the increasing number of clinicians in Australia.

Survey results regarding supervision in America

In the SCOPUS database search a large-scale researcher-designed survey was found (Jackson, 2008). In this survey 2000 music therapists were invited to participate in a survey about supervision. The 2000 music therapists were randomly selected from 2366 registrants of the registry of the Certification Board of Music Therapists Incorporated in the USA. Eight hundred and twelve therapists responded to the email invitation to participate. One hundred and thirty-five respondents were not practising clinically, meaning that data from only 677 clinicians was analysed. For the purposes of the survey, clinical music therapy supervision was defined as supervision from another music therapist including peer supervision (Jackson, 2008).

Overall, results showed that 36% of respondents received some form of clinical music therapy supervision while 62% did not receive any clinical music therapy supervision. The most common reason for not participating in supervision was a “lack of access” (p. 203). Of those who did not receive any clinical music therapy supervision, 69% indicated that they did not receive any supervision at all, while 31% indicated that they received supervision from someone in a related field (e.g., art therapy, social work, psychology). Seventy-six percent of this smaller group (i.e., 76% of the 31% that received supervision from someone in a related field) indicated that they received
supervision from someone in a related field because this person was their supervisor at the facility or agency in which they worked. The majority of these (65%) reported they were satisfied with this supervision. However, a smaller percentage (35%) indicated that they were not satisfied with this arrangement mainly because their supervisor had a lack of knowledge/understanding about music therapy (Jackson, 2008).

Clinicians were also questioned about the reasons why they participated in supervision, and a list of 10 categories resulted. The greatest number of respondents (56.6%) indicated that they participated in supervision to help understand their own clinical responses and relationships. The second most common reason for supervision (55.4%) was to “process difficult or puzzling things that happen in sessions with clients” (Jackson, 2008, p. 201), and the third most common reason was “to get help with ideas” (53.6%). About 25% indicated that they participated in supervision because it was a requirement of the facility or their employer (Jackson, 2008).

Further investigation indicated that clinicians with a greater number of years of clinical experience and higher education levels were significantly less likely to participate in supervision because it was required of their employer or to get help with their ideas. But rather this group participated in supervision to ensure that personal and ethical issues were not interfering with their clinical work. Also, clinicians with higher levels of education reported that they were more likely to seek out supervision to assist with transference and counter-transference issues, and to aid their understanding of the client’s and their own responses (Jackson, 2008).

The growing need for supervision in Australia in relation to American findings

Admittedly, there are many limitations regarding the ways these results from America can be related to the experiences of Australian-based therapists for a number of reasons, including difference in healthcare structures between the countries, the notable difference in size of the professions in Australia and America (America’s profession is larger in number), and the different models of practice and training available in the two countries. Nevertheless these results do prompt reflections on the state of supervision in Australia, and questions regarding clinicians’ access and choices regarding supervision in Australia.

Jackson’s findings (2008) showed that a number of clinicians received supervision from someone in a related field because this person was their supervisor at the facility or agency in which they worked. The majority of these (65%) were satisfied with supervision from a colleague who was not a qualified music therapist although a smaller percentage indicated that this arrangement was not satisfactory to them, reporting that a lack of knowledge/understanding about music therapy contributed to their dissatisfaction.
Reflection upon Jacksons’ findings highlights the need for non-qualified music therapy supervisors to hold knowledge and understanding about music therapy as this may contribute to improved satisfaction of this type of arrangement.

In addition, Jackson’s results (2008) indicated that clinicians with a greater number of years of clinical experience and higher education levels were significantly less likely to participate in supervision because it was required of their employer or to get help with their ideas. But rather this group participated in supervision to ensure that personal and ethical issues were not interfering with their clinical work. Also, clinicians with higher levels of education reported that they were more likely to seek out supervision to assist with transference and counter-transference issues, and to aid their understanding of the client’s and their own responses (Jackson, 2008). This finding also indicates the importance of the supervisor’s competence regarding the process of supervision which is aided by knowledge of music therapy and therapeutic process.

Competency development in non-qualified music therapist supervisors is therefore important and may improve the quality of the supervision provided. As the number of departments in Australia continues to grow and as the size of these departments expands it is logical to suggest that clinicians may more frequently receive supervision from a music therapist line-manager who is also working in their organisation. This type of internal supervisory arrangement is already in use in a number of organisations that employ clinicians in Australia and the United Kingdom (e.g., Calvary Healthcare Bethlehem Melbourne, the Royal Children’s Hospital Brisbane, and the Royal Hospital for Neuro-disability, UK). The establishment of music therapy departments inclusive of this type of arrangement may assist in improving clinicians’ sense of satisfaction with internal supervisory arrangements, and is an investment in infrastructure to support music therapists’ work within organisations. The development of a competency-based framework to enable supervisory development in these scenarios may assist in the quality of the supervision.

American results indicate that the number of clinicians who work in private practice has grown (Silverman & Hairston, 2005). In Australia the number of clinicians working in private practice is also growing. External supervisory arrangements are arrangements where supervisors employed externally to the organisation supplies supervision to the music therapist. It is plausible to suggest that external supervisory arrangements in Australia may, similarly to internal arrangements, become more frequently required.

In addition, to the need for supervision from a growth in workforce perspective, the recent emergence of research regarding supervisory practice in Australia is also evident. Research regarding reflexive group supervision involving a group of music therapists practising in Australia has recently
been published (O’Callaghan et al., 2009); providing an example of and research about supervisory practice within the Australian context. While this publication is very important, conclusions regarding supervision and supervisory arrangements in Australia are unable to be drawn due to the lack of an established evidence base regarding this topic. Even though it is vitally important that we begin to develop evidence-based supervision in Australia (through, for example, the work of O’Callaghan and her colleagues), the American perspective has shown us that for some clinicians the most common reason not to participate in supervision is related to “access” difficulties. The underlying reason for these access difficulties remains unknown. For example it may be due to a lack of evidence to support the prioritisation of funds to pay for supervision thus highlighting the need to prioritise research into this topic. Or, it may be due to a lack of guidance regarding how to establish supervisory arrangements, highlighting the need for practical guidance regarding how to establish supervisory arrangements. Alternatively, it may be due to a combination of both of these reasons.

Nevertheless, supervision is a workforce topic that holds relevance for Australian-based clinicians, and two types of supervisory arrangements are currently in use: internal and external supervisory arrangements. Plus, research into supervision in the Australian context is beginning to emerge in the literature. It is therefore timely to reflect upon the relevance of American research results in relation to Australian supervision and respond to these findings. The number of clinicians within Australian healthcare and community setting is growing, and this growth is perhaps suggestive of a future corresponding growth in supervisory need in Australia.

The primary aim of this paper is to explore and highlight internal and external supervisory arrangements for music therapy clinicians. A secondary aim is to draw attention to governance requirements to aid the development of supervisory arrangements for clinicians and organisations. It is hoped the reflections provided here are useful in equipping clinicians in responding to challenges regarding access, and that this guidance is helpful in establishing supervisory arrangements conducive to improving practice.

**Internal supervisory arrangement: Manager as supervisor**

**Considerations**

When considering various roles that an individual may hold when engaged in supervision, Hawkins and Shohet (2002) suggested that that when supervisors hold dual or multiple roles, complexities can arise, and that these complexities may cause conflict within the supervisory relationship. They highlight that some of these complexities may result from the difference in power between the supervisor-employee and the supervisor-manager that in turn may influence the connectedness of mutual trust and confidentiality;
sometimes described as essential to the success of a working collaborative supervisory relationship. Axten (2002) commented that “one of the most difficult issues which frequently arise in supervision is the impact of dual relationships” (p. 110), drawing attention to the issue of the evaluative impact on the relationship when the supervisor holds the position of examiner or assessor of skills and competencies.

In relation to student supervision involving dual roles, Dileo (2000) discussed the role of ethics regarding education and supervision while also referencing the power differential between educator-supervisor and student-supervisee. Dileo shared that clinicians may not feel comfortable in disclosing information regarding their clinical caseload for fear of retribution from the supervisor. Implications for non-disclosures were highlighted.

While some authors have commented on the negative aspects of the dual-role relationship in supervision, others have reported a different perspective. A study of post-degree counsellor supervisees by Tromski-Klingshirn and Davis (2007) reported that 82% identified no problems with having a supervisor maintain a dual role of both administrative and clinical supervisor. Explanations given as to why these relationships were successful included comments relating to the trust and confidence established in the supervisory process, the maintenance of confidentiality, and being open to receiving feedback and having a broader understanding of what is involved across all dimensions of the workplace (i.e., clinical and administrative dimensions). The other 18% listed their concerns regarding how to trust the relationship particularly when counter-transference issues were apparent which may also impact on their professional standing. Conflicts of interest and the use of exploitation by supervisors were also noted as relevant concerns. On the issue of their general views of the dual clinical/administrator role, 48% responded with the comment “it depends on the individuals involved” (p. 302). Perhaps this finding suggests that they believed that this type of supervisory arrangement was neither right nor wrong in and of itself, but rather it was dependent on the ways in which the arrangement was used by those involved in the process.

**Dimensions to enable internal supervisory arrangements: Boundaries, confidentiality, negotiation, reporting and evaluation, considerations and contracts**

Thus, a dimension for clinicians to consider when participating in internal supervision with a line-manager involves what to and what not to share during supervision. For example, the clinician might wonder whether or not to share examples of both good-established practices along with areas that require assistance (and are in need of development). To enable the sharing of these different types of information, it may be useful to have some discussion before supervision commences about the ways information is shared in
sessions (i.e., boundaries and confidentiality). Also, in practice, this process may be aided by the clinician considering what it is they require from the supervisor, and how they can optimise the manager-supervisor’s knowledge and experience during supervision. The following questions may aid this process: “What areas of my practice do I need to develop further?”; “How can supervision help me in developing these areas?”; and “What can my supervisor offer to me regarding this?”

In addition and in complement to this, the supervisor may be aided by working out what is required by the clinician and when. Shohet (2008) explained that often supervisors perform the function of different roles including that of being a manager, educator and supporter, while also maintaining a balance and perspective throughout the process of negotiating a supervisory relationship of trust, security and rapport. Clear negotiation and education regarding the use of information shared within supervision can aid trust between the supervisor and clinician within the supervisory arrangement. In addition, the supervisor may need to establish clear lines of reporting regarding the evaluation of practice standards. Clarity improves transparency and transparency assists accountability. Accountability in turn aids governance requirements.

To minimise risks of non-disclosure, the manager should ensure that separate opportunities for monitoring the delivery of practice standards are in place; ones that do not rely on supervision to check standards of practice (e.g., audit of the clinical record might be used to examine standards of practice rather than using supervision as a means to audit practice). Axten (2002) suggests that a clear written contract which outlines roles, duties and responsibilities, discusses conflict of interest issues, boundaries within the relationship, and the importance of confidentiality may aid this process. Dileo (2000) writes that the supervisor must maintain an ethical and moral balance between all aspects of the relationship so that issues such as conflicts of interest, boundary confusion and breakdown and breaches of confidentiality are kept to an absolute minimum.

The quality of supervision provided is also integral to the effective use of internal supervisory arrangements. Thus, it is helpful to consider a) how the supervision will be monitored in terms of quality assurance; and b) how the supervisor will be supported in their development as a supervisor. In addition, it is possible that there may be times when the clinician is dissatisfied with the supervision, or the supervisor has concerns regarding the supervisory process. Clear guidance about the options available to both in these scenarios may aid the continuation of the supervisory arrangement, and work toward enabling a different arrangement if this is what’s required. For example, a grievance procedure alongside written criteria or contract will aid the clinician and supervisor in evaluating the quality of the service together,
and what to do should difficulties arise. This information is required before supervision commences.

In summary, when internal supervisory arrangements are in place power differential and governance risks can be influenced through clear systems of accountability; well-defined boundaries; contracts and negotiation regarding the arrangement; systems of evaluation that are different to the supervisory relationship; and support for the supervisor. Flexible supervisory practice, a focus on the quality of the supervision, along with the quality of the supervisory relationship may be required, including an emphasis on collaboration, mutual trust, respect, rapport and open communication.

Internal supervisory arrangements should not exclude the concept of the dual role, but rather concentrate on developing sound governance systems and procedures to enable the supervisory relationship. The quality of the supervision provided is key and a competency-based framework may aid the quality of the supervision.

**External supervisory agreements: Supervisor external to workplace**

*Considerations*

The need to establish external supervisory arrangements are numerous, including scenarios where a) a topic emerges from clinical work that requires a second opinion to the one able to be provided internal to the organisation; b) there is an individual/s within the organisation that is suitably qualified, experienced or able to engage in supervision, however workplace relationships aren’t conducive to the supervisory process; c) there is no-one within the organisation that is suitably qualified, experienced or able to supervise the clinician; and d) the clinician is working as a solo practitioner as is possible in private practice. This list is not exhaustive however it is representative of some of the reasons that a clinician or an employer may seek out external supervision.

Many of the issues relevant to internal supervisory arrangements are relevant to external supervisory arrangements and need to be considered when establishing external supervisory arrangements. For example, well-established boundaries and the need for confidentiality are relevant regardless of the context in which supervision is provided. Negotiation regarding the clinician’s needs should still form part of the supervisory process, as supervision must involve clinician-focused work. Lines of reporting are still required to reduce governance risks to both the supervisor and clinician. In addition, evaluation is required to ensure quality of service, and support and training for the supervisor will aid the quality of service provided. Competency-based development may aid supervisor development.

Additional considerations for the clinician include how to select a supervisor. Items that may be useful to consider include the following: a)
whether or not the supervisor is registered with their peak professional body; b) the supervisor’s level of competency in the clinician’s area/field; c) the potential supervisor’s experience of providing and receiving supervision, and their level of supervisory competence; and e) the supervisor’s ability to assist with governance requirements. While it may be likely that the supervisor may be someone more senior than the clinician, this is not a requirement but rather it is the level of competency, skill-set and knowledge that is important; not the number of years of experience the supervisor holds.

The organization and supervisor also need to consider the following: data protection requirements regarding information that emerges from the supervisory process; the procedures for terminating or ending supervision; and the reporting requirements of the organization while supervision is underway. Grievance or complaint procedures also need attention. For example, would a concern from the clinician be directed to the organization employing the clinician or the supervisor’s registering relevant professional body? It is advisable to establish these procedures before supervision commences.

In summary, there are similarities regarding internal and external supervisory arrangements, including power differential and governance risks, boundaries, contracts and negotiation regarding the arrangement, and systems of evaluation. External supervisory arrangements should be viewed as adjunctive to other workplace conditions and arrangements, rather than separate or alternative to what has already been established. This approach will promote an integrated system of supervision optimising the ways that supervision can enable clinical development and delivery. The quality of the supervision remains key to this arrangement and the clinician may be aided by a supervisor who they themselves receives supervision.

**Conclusion**

The reasons why clinicians choose not to participate in supervision remain unknown and research into this phenomenon is required. Qualitative research may aid the development of knowledge regarding this. Despite this lack of evidence, internal and external supervisory arrangements exist despite difficulties regarding access. Well-designed supervisory arrangements supportive of the needs of clinicians, supervisors and employers, may result in supervision becoming a preferred option for clinicians while simultaneously addressing governance requirements. Developing successful supervisory relationships and training may be aided through education regarding the importance of role clarity, duties, responsibilities alongside additional considerations highlighted in this paper. Cross-national reflections are useful in aiding the development of the music therapy profession on a national level. Well-designed, integrated and transparent supervisory arrangements are useful to clinicians, and guidance regarding how to
establish supervisory arrangements will assist clinicians in accessing supervision. The existing importance attached to supervision within the music therapy profession needs to be underpinned by guidance and research, alongside investment in infrastructure to support supervisory arrangements. A cohesive and strategic approach to this topic will aid the development of supervision in Australia.

References


