

The Qualitative Study of Recovery-Oriented Care in Clinical Supervision: A Methodological Overview

Winetta A. Oloo, Ph.D

Department of Counseling and Family Sciences
Loma Linda University
24851 Circle Dr, Loma Linda, CA 92354, USA.

Nakisha Castillo, DMFT

Department of Counseling and Family Sciences
Loma Linda University
24851 Circle Dr, Loma Linda, CA 92354, USA.

Curtis A. Fox, Ph.D

Department of Counseling and Family Sciences
Loma Linda University
24851 Circle Dr, Loma Linda, CA 92354, USA.

Horatius Gittens

Department of Counseling and Family Sciences
Loma Linda University
24851 Circle Dr, Loma Linda, CA 92354, USA.

Abstract

Over the last several years, implementation of Recovery-Oriented Care in the treatment of severely-mentally ill persons has transformed California's educational requirement for mental health professionals and the state's public mental health system. As a result of this transformation, a spotlight has been turned toward the ways in which mental health professionals can incorporate the core principles of Recovery into treatment. To date, little attention has been given to the crucial role of clinical supervisors in fostering the learning of these principles by their supervisees. Qualitative inquiry as a methodology lends itself well to exploration of this area of study given its newness and the focus of individual experience underpinning the Recovery-Oriented Care approach. This paper outlines the specific methodology used during the course of this investigation and shares the researchers' observations of the process. In addition, the paper offers suggestions for future empirical studies of clinical supervision in Recovery-Oriented Care.

Keywords: Recovery-Oriented Care, Recovery, Severely-mentally ill, Qualitative, MHSA, Supervision

Background of Recovery-Oriented Care

In recent years, the California mental health system has been transformed significantly by the Mental Health Services Act (MHSA); an Act that has its roots in President George Bush's New Freedom Commission on Mental Health (United States Department of Health and Human Service, 2003). The president commissioned a thorough study of mental health service delivery within the United States and subsequently called for a change in the services delivered by mental health professionals. The commission recommended the following: (1) those with mental illness be called consumers and not clients, (2) treatment plans look beyond the symptoms and at the person, (3) clinicians work collaboratively with the consumers, and (4) there be peer support groups as well as inclusion of family members in treatment (Cohen, Abraham, Burk, & Stein, 2012; Peebles, Mabe, Fenley, Buckley, Bruce, Narasimham, Frinks, & Williams, E., 2009; Torrey, Rapp, Tosh, McNabb, & Ralph, 2005).

These changes in service delivery represent what is referred to as Recovery-Oriented Care (ROC). In 2011, the Substance Abuse and Mental Health Services Administration (SAMHSA) utilized feedback from mental health practitioners and consumers to revise the initial definition of ROC and it is now defined as “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (United States Department of Health and Human Services, 2011).

Along with the initial definition of recovery, 10 principles were provided that were meant to guide the work of ROC. These principles are self-direction, individualized and self-centered, empowerment, responsibility, holistic, non-linear, strength-based, peer support, respect, and hope. The principles are utilized as a way to collaboratively work with consumers on their journey towards recovery from mental illness. Each of the principles are defined below.

Self-direction is defined as consumers taking the lead and choosing their path to recovery. This principle gives consumers maximum autonomy. In the principle individualized and self-centered, practitioners are tasked with considering and utilizing the unique strengths and experiences of each consumer. Empowerment is the third principle in ROC. With this principle clinicians are collaborating with consumers as both participate in all of the decisions that affect the consumers’ lives. Responsibility focuses on consumers being in control of their wants, their needs, and their own goals therefore; they become responsible for the steps they take toward their own recovery. The principle holistic recognizes that each consumer is a whole person and addresses areas of treatment for the person’s physical, spiritual, mental, and environmental wellbeing illness (United States Department of Health and Human Services, 2011).

Non-linear refers to the ongoing process of growth. That is, practitioners view growth as continual and anticipate setbacks, allowing them to incorporate learning from setbacks as a part of treatment. Strength-based is one of the principles in which practitioners are utilizing the strengths of the individual’s and appreciating the multiple capacities, talents, coping skills and resiliencies of each consumer. In the principle peer support consumers are able to share their experience with other consumers, thereby encouraging and supporting their fellow consumers. Respect focuses on practitioners demonstrating respect for the consumer. Hope emphasizes individuals being able to overcome their obstacles and live a fulfilling life despite the presence of mental illness (Patton, 2005, United States Department of Health and Human Services, 2011).

In response to the recommendations of the commission, a 1% tax on California millionaires for every dollar earned over one million dollars was proposed. Approved by voters in 2004, the proposition later became known as the Mental Health Services Act (MHSA) and all funds collected via this act were designated for mental health treatment of unserved and underserved populations. The MHSA funding source created tremendous opportunities within the public mental health system for engaging and treating the severely mentally ill in non-traditional and more consumer-oriented ways. As an example, individuals presenting with co-occurring disorders prior to ROC would be required to cease use of substances before receiving treatment for other diagnoses. In a ROC treatment setting, a person diagnosed with a major depressive disorder could decide that s/he did not want to stop smoking marijuana during treatment and s/he would not have to be drug-free in order to receive services.

Incorporating these and other consumer-oriented forms of service-delivery required some adjustment in training on the part of mental health professionals. As such, California’s licensing board, the Board of Behavioral Sciences (BBS), implemented a curriculum change for graduate programs in Marital and Family Therapy. In schools across the state, greater emphasis was placed on gaining an appreciation ROC and learning how to embed its principles into work with consumers (Board of Behavioral Sciences, 2009). The next step in training of clinicians became translating the ROC principles from the classroom to the clinical setting.

Recovery-Oriented Care in Clinical Supervision

Traditionally, the task of helping clinicians to translate classroom education into practice has rested on the shoulders of clinical supervisors. Experts in the field of clinical supervision assert that the supervisor-supervisee relationship provides the structure and framework for learning how to apply knowledge, theory, and clinical procedures (Falender & Shafranske, 2004). The focus of clinical supervision is on “the supervisee’s clinical interventions that directly affect the consumer, as well as those behaviors related to the supervisee’s personal and professional functioning” (Bradley & Kottler, 2001, p. 5). Despite the importance of the supervisor’s role, several disturbing facts are found in the supervision literature. The first of these is that little attention has been given to the ways in which supervisors develop competence (Bernard & Goodyear, 2009).

Secondly, many supervisors practice without the benefit of education and training beyond the minimum qualifications required by their licensing boards (ASPPB Task Force on Supervision Guidelines, 1998, Bernard & Goodyear, 2009, Falender & Shafranske, 2004, Scott, Ingram, Vitanza & Smith, 2000). In the state of California, this means (1) holding a license for two years, (2) practicing for two years prior to beginning supervision, and (3) completing a 6-hour supervision course that covers topics including law and ethics as they relate to supervision and supervisor responsibilities. Last, but certainly not least, without further education and training, supervisors tend to rely on their personal experiences – as a supervisee with past supervisors, etc. – to guide their interaction with their supervisees (Falender & Shafranske, 2004, Pearson, 2006).

Coupling the newness of recovery-oriented care in California with the Board of Behavioral Sciences' requirement to incorporate it into training curriculum, as well as the public mental health system's wide adoption of its principles in treatment, two major questions arise. The first, how are supervisors training interns and trainees to provide this care? Related to this question is the second – how do researchers conduct an empirical study of supervisors in recovery-oriented care settings? To date, no such empirical investigations of supervisors' experience in this area have been made available. With the increased attention that recovery-oriented care services have received within California and other states, supervisors face a need to develop appropriate techniques with little empirical information as a foundation. It is for this reason that an increase in empirical studies of clinical supervisors utilizing ROC principles becomes vital for the advancement of supervisor knowledge and supervisee development.

This empirical investigation of clinical supervisors in recovery-oriented care settings was developed in an attempt to respond to the first question above. The study's methodology will be shared with commentary on its strengths and limitations as well as suggestions for the undertaking of future empirical studies of clinical supervision. This report is presented as a starting place in responding to the second major question mentioned above - how do researchers conduct an empirical study of supervisors in recovery-oriented care settings – in the hope of filling the empirical study gap within the recovery-oriented care literature.

Qualitative Inquiry Design and Recovery-Oriented Care

According to Strauss & Corbin (1998), qualitative research is any form of research in which results are not yielded from a “statistical analysis or from any form of quantification” (p.55). In qualitative research one is able to conceptualize how persons construct their environment (Hesse-Biber, 2010) as well as deconstruct how individuals make meaning of their experiences (Denzin, Lincoln & Giardina, 2006). In a qualitative study the process of meaning is important, it is not one that can be measured or replicated (Daly, 2007).

Qualitative methodology is exploratory (Creswell, 2003). It allows the researcher to take a particular population that has not yet been studied and develop theories or ways in which to conceptualize how to work with the population. Additionally, it allows for the researcher to examine individuals in their own milieu (Denzin & Lincoln, 2008), have an understanding of their lives, intricate experiences, reactions, social movements, and cultural phenomena (Strauss & Corbin, 1998). Using qualitative data, researchers hypothesize about shared meaning among individuals in their particular context (Creswell, 2003; Denzin & Lincoln, 2003).

In qualitative research there are a number of different inquiries including ethnography, phenomenological inquiry, narrative inquiry, grounded theory methodology, critical inquiry, and participatory action research (Daly, 2007). In this study, we choose to follow a grounded theory course. According to Charmaz (2006) and Strauss & Corbin (1998), grounded theory derived from sociologists Barney Glaser and Anselm Strauss and is defined as a systematic process of data collection and analysis where theory develops from the data. When utilizing a grounded theory approach the researcher goes in with no predetermined notion or model of the population that they will study (Charmaz, 2006). Instead, the researcher learns about the world of the participant and develops theory from this learning. The goal of grounded theory is to conceptualize what is occurring in a particular population that is not studied (Hunter, Murphy, Grealish, Casey, & Keady, 2011).

While a thorough search of the behavioral science literature suggests that attention has been given to the processes of clinical supervisors who make use of a ROC approach, studies that attempt to illuminate general clinical supervision processes appear to privilege a qualitative methodology (Ellis, 2010; Pearson, 2006). Qualitative inquiry and grounded theory were especially well-suited for the purposes of this study as they offered supervisors an opportunity to voice their unique understanding of what is needed to successfully implement ROC. This form of inquiry allowed the individual supervisors to share their own experiences in their supervision processes including the ways in which they construct meaning associated with ROC in supervision.

We believe that qualitative inquiry was well suited as it reflected the ROC ideas of individualized and self-centered attention, focus on the uniqueness of each individual, and empowered them to share their story of ROC. The use of the grounded theory process fit this research study as it allowed us, the researchers, to develop theories and models derived from the experiences of supervisors who are already incorporating the principles of ROC into their practice.

Study Management

This project originated at a health sciences institution in Southern California. The primary investigator is a faculty member with a background as administrative and clinical director of MHSA-funded clinics. Working collaboratively with the Department Chair and two doctoral students earning their degrees in Marital and Family Therapy, the primary investigator had responsibility for the management of the study. Each of the authors has been exposed to the changes occurring as a result of MHSA in clinical and educational settings. Study personnel met on numerous occasions to develop the study protocol, assign participants to interviewers, discuss the coding of transcripts, and manage study progression.

Recruitment of Participants

This investigation was conducted with clinical supervisors in the state of California. Its purpose was to clarify the ways in which clinical supervisors train their supervisees in the use of ROC principles. Supervisors were recruited via online listings of California public mental health clinics, professional consortia, and snowball sampling. Once online listings of public mental health clinics were located, emails were sent to directors and supervisors at these clinics to request participation in this study. The study was also announced and a request for participants was made at professional consortia within Southern California. Also, at the end of interviews, participants were asked for suggestions of other supervisors who may be open to involvement with the study.

There were two inclusion criteria for participants. First, each participant had to be conducting clinical supervision of Marital and Family Therapy, Counseling, and/or Social Work trainees or interns in a recovery-oriented treatment setting. Secondly, these supervisors needed to be supervising at least one trainee or intern who had been working with at least one severely mentally ill consumer within the last year. These requirements were meant to narrow the population focus to those persons who were actively involved in supervision within a setting that employs ROC principles and treats consumers who are diagnosed with severe mental illness.

Participant Interviews

After supervisors initially agreed to participate in the study, a face-to-face interview was scheduled. Interviews were scheduled at the supervisor's convenience and at a location of their choice. As such, interviews were held in supervisors' places of employment, private practice offices, coffee shops, restaurants and supervisors' homes. Keeping with the philosophy of ROC, flexibility of the interviewer along with willingness to meet in non-traditional locales was key in completing the study. At the beginning of each interview, supervisors were provided with an informed consent document. This document was fully explained by the interviewer and supervisors were given an opportunity to decline participation. Those who agreed signed the document and proceeded with the interview.

A semi-structured interview guide (see Appendix A) was used to elicit supervisors' experiences during meetings. The interview began with general questions about ROC language, e.g. "What is your understanding of the word 'consumer'?" and progressed into questions about the supervisor's understanding and utilization of the ten principles of ROC. For example, questions asked for the principle 'Hope' were "What is your belief about the ability of consumers to live with severe mental illness?" and "Please share the ways in which you help your supervisees to understand and communicate the message that people can and do overcome their obstacles?" The following table presents all questions asked for each principle along with researcher observations.

Table 1: ROC Principle Questions and Researcher Observations

Principle	Question(s)	Researcher Comments
Self-Direction	There may be many ways to communicate to your supervisee that the consumer determines her/his own recovery. In what ways do you encourage or support your supervisees to allow consumers to determine their own path of recovery?	Responses to questions asked of these two principles had a fair degree of overlap. This may be a result of similarities in supervisors' understanding of these two principles. Follow-up questions were helpful in teasing out the differences in supervisors' experiences with these two principles. During data collection, these four principles seemed to generate the surest responses from supervisors. The researchers hypothesized that of the ten principles, these four may be most clearly understood and/or practiced by the clinical supervisors who participated in this investigation.
Empowerment	When working with supervisees, what are the ways that you support consumers participating in the decisions that affect their own lives?	
Individualized and Person-Centered	How do you work with your supervisees to promote the individual strengths and uniqueness of each consumer?	
Holistic Care	To the extent that persons with severe mental illness often present with needs in multiple areas, e.g. housing and employment how do you help your supervisee to be a resource for consumers in all areas of need?	
Strength-Based Perspective	During supervision, how do you assist your supervisees in developing and maintaining an outlook of the consumer as being resilient, that is, having multiple capacities, talents, and coping skills?	
Hope	What is your belief about the ability of consumers to live with severe mental illness? Please share the ways in which you help your supervisees to understand and communicate the message that people can and do overcome their obstacles?	
Non linear	Clinicians who work with the severely mentally ill tend to develop an understanding that there may be ups and downs in the process of change. As a supervisor, how do you communicate that growth is a continuing experience that is often accompanied by setbacks and apparent failures?	

Responsibility	Please share with me your thoughts about who is responsible for change in the therapist-consumer relationship? How do these thoughts come to life in your supervisory relationships?	Separating the questions with an initial focus on the supervisor's own beliefs proved to be helpful, giving supervisors an opportunity to fully consider and explain their own thoughts about the principle and then to specify the ways in which these thoughts show up in supervision.
Respect	As a supervisor, what does the term "respect for the consumer" mean to you? How does this meaning show itself in conversations with your supervisees?	
Peer Support	Participating in the recovery of others may go a long way in helping to solidify a consumers' own recovery. How might you say you are able to help your supervisees to explore these possibilities with their consumers?	During interviews, supervisors often requested clarification of the question. Clearer wording of the question may have assisted in greater ease of response from supervisors, e.g. "Participating in the recovery of others may go a long way in helping to solidify consumers' own recovery. How do you help your supervisees to engage consumers in supportive activities with other consumers?"

Lastly, the third section of the interview asked supervisors to numerically rate their beliefs about the importance of each ROC principle in clinical treatment. This section of the guide is duplicated in the table below:

Table 2: Numerical Assessment of the Importance of ROC Principles

	Not important	Low Importance	Slightly Important	Neutral	Moderately Important	Very Important	Extremely Important
Self Direction	1	2	3	4	5	6	7
Individualized and Self-Centered	1	2	3	4	5	6	7
Empowerment	1	2	3	4	5	6	7
Responsibility	1	2	3	4	5	6	7
Holistic Care	1	2	3	4	5	6	7
Non-linear Care	1	2	3	4	5	6	7
Strengths-Based	1	2	3	4	5	6	7
Peer-Support	1	2	3	4	5	6	7
Respect for Consumer	1	2	3	4	5	6	7
Hope	1	2	3	4	5	6	7

Although this measure was ultimately helpful in encouraging supervisors to discuss their experiences with all of the principles rather than each principle separately, there was some initial confusion during interviews. Upon initial inspection of this scale, most supervisors assumed that they were being asked to rate the principles on a continuum, so that if one principle was rated at a 5, the others could only be rated as less important (1-4) or more important (6 or 7). Interviewers would then clarify the true intent of this scale – further exploration of the supervisors' experience with ROC principles. Interviewers relayed that all principles could be rated 1, all could be rated 7, or there could be great variability, according to the supervisors' assessment. Asking supervisors to rate each principle after they have answered its corresponding question(s) in section two of the interview guide may be an important addition in a future study.

During the interviews, probing questions were added to assist participants in considering other areas related to the principles or to increase clarification for the interviewer. An example of a probe used to clarify supervisors' understanding of the word 'consumer' (question 1) was, "Do you see any difference between the word 'consumer' and the word 'client'?" Probes that emerged during interviews were discussed by the research team and were included in subsequent interviews. Interviews were audio recorded. All interview audio files were de-identified and assigned a number, stored on a secure server and then transcribed. Paper transcripts maintained previously assigned identification numbers and were stored within a locked filing cabinet.

Analytic Strategy

The present study used grounded theory analysis as discussed by Corbin and Strauss (1998). Themes and overlapping categories of supervisors' experiences were identified using line-by-line coding, followed by axial coding. Analytic memo writing was employed in addition to coding, with the goal of returning to the memos at a later point in the research process. Throughout the coding process, these memos and the interview data were continually referenced in an effort to ensure soundness between the identified themes and the supervisors' experiences.

Results

A total of twenty-eight supervisors were interviewed, representing six counties in California - Tulare, Fresno, San Bernardino, Riverside, Los Angeles, and Orange. The majority of the participants (96%) had a master's degree, and 4% had a doctoral degree. Sixty-nine percent were Licensed Marital and Family Therapists and 31% were Licensed Clinical Social Workers. The greater portion of supervisors were BBS-approved (16) while five were designated as California Association of Marriage and Family Therapists-approved supervisors and four were designated as American Association for Marital and Family Therapy-approved supervisors. More than one-half of participants provided both individual and group clinical supervision (56%), followed by those who provided individual supervision only (32%) and those who provided group supervision only (8%). The study population mostly identified as Caucasian (50%), followed by Hispanics (15%), African American (4%), and the remaining identified as Other. Participants were between the ages of 31 and 70, divided into the following age groups: 31-40 years (30%), 41-50 years (30%), 51-60 years (26%), 20-30 years (4%), and 61-70 years (8%). There were 6 male supervisors and 22 female supervisors who participated in the study.

Future Directions

The implementation of the MHSA in California has prompted public mental health agencies and MFT graduate programs to change their approach to student training and consumer treatment, incorporating the principles of ROC. As such, agency clinical supervisors have been tasked with helping student trainees and interns to bring these principles to life. The empirical study shared in this paper employed a qualitative design to shed light on the methods used by clinical supervisors in recovery-oriented care settings as they incorporate the principles of recovery into their work with supervisees. The use of a qualitative methodology for this study appeared to be significant in a number of ways. It fashioned a means for this first empirical exploration of ROC within the state of California since the passing of the MHSA. In addition, the qualitative design was instrumental in exposing the rich experiences of clinical supervisors working with ROC principles.

Interview

As supervisors had not yet embraced the language of the new model in mental health care. As such, they were not very familiar with the essence of some of the questions. Often, they asked questions for clarification as the interview progressed. It may be concluded, therefore, that greater efforts have to be put forth to train a new generation of providers of mental health care in the new modus for clinical care.

Thus, there are implications here for training programs and academic institutions in the adopting of new and deliberate curricula to continue the positive transformation of the face of mental health services. Participants also expressed great interest in learning how others in similar positions are incorporating ROC principles. Given that supervisors appear to be rather open to the sharing of ideas with their counterparts, this may be a beneficial medium for public mental health agencies to utilize in training programs.

As mentioned earlier, this present work is the first of some empirical effort to explore how clinical supervisors are utilizing ROC principles in the California public mental health system. Thus far, preliminary analyses have yielded very interesting findings. However, there is a lot that remains to be studied and we would suggest the following future research inquiries as well as the application of the findings in clinical practice and supervision.

Incorporation of Supervisees and Consumers

While data from clinical supervisors are noteworthy and informative, data from supervisees and customers would prove to be invaluable for future implementation of ROC. It would also be important to know how practitioners are receiving the values and standards of the new model in the next generation of mental health service providers. Also, the voices of consumers with regard to the impact of ROC-infused treatment on their lives would be of great interest. Future research efforts should consider this addition. Such data would serve to close the supervisor-supervisee-consumer treatment loop and possibly provide answers to important questions such as, “How are supervisees translating recovery-oriented care information received from supervisors into practice with their consumers?” and “What are the key interventions that seem to make a difference in (a) the training of supervisees as well as (b) the recovery of consumers?”

Effects of Supervisor Collaboration/Research

In this present investigation, supervisor availability was a factor that played a large part in data collection. Supervisors’ time was limited and posed a significant problem for those who desired more education and collaboration with other supervisors as they learn to incorporate ROC principles. As such, study of the effects of collaboration with colleagues and supervisors’ exposure to ROC education on the development of supervisee learning may be helpful in two ways. One, such a study can shed some light on the appropriateness of agencies in delegating a portion of supervisor work time for education and collaboration. Two, such a study can offer suggestions about the best use of supervisors’ time for education and collaboration, including the types of activities that may be most supportive of these efforts.

Revisiting Recovery-oriented Care Principles

Recently, SAMHSA revised the ten principles of ROC, maintaining 7 of the 10 mentioned above with minimal changes in language. Two of the remaining three principles were incorporated into other existing principles and three other principles were introduced, bringing the final number back to ten (SAMHSA, 2012). Future research may choose to investigate the impact of these changes for clinical supervisors, supervisees, and consumers.

Utilizing Quantitative Analysis

In each of the future direction areas mentioned above, qualitative inquiry would be useful. As the information gathered from qualitative research studies focused on the use of ROC in California’s public mental health system increases, the incorporation of quantitative methodology may be appropriate. Along with documenting changes in supervisors’ work with supervisees, quantitative methodology can address some issues related to the amount of time needed to collect data from supervisors. Also, as quantitative studies tend to be less time-consuming for the participant, such studies may also increase the number of supervisors participating in these crucial studies and increase generalizability of findings with the use of more randomized designs.

Conclusion

Empirical studies of clinical supervision practices have long been useful in helping supervisors to better recognize their strengths, and to target areas in need of refining. This process benefits supervisees in the development of key clinical skills and, in turn, positively affects the recovery of consumers. Given the significant impact of ROC services in the state of California, empirical studies of supervisory practices within the state is necessary for continued learning and growth in this area. The study described above was an initial empirical attempt to meet this need. The responses of supervisors along with the continued emphasis on incorporating ROC principles in mental health treatment intimate a need for further study of the workings of these concepts in clinical supervision.

This paper has presented one methodology for investigating the recovery-oriented care supervision process and has offered suggestions for future study.

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Appendix A

Interview Guide

General

1. As a supervisor, what is your understanding of the word ‘consumer’?
2. What is your understanding of recovery-oriented care?

Self-Direction

3. There may be many ways to communicate to your supervisee that the consumer determines her/his own recovery. In what ways do you encourage or support your supervisees to allow consumers to determine their own path of recovery?

Individualized and Self-Centered

4. How do you work with your supervisees to promote the individual strengths and uniqueness of each consumer?

Empowerment

5. When working with supervisees, what are the ways that you support consumers participating in the decisions that affect their own lives?

Responsibility

6. Please share with me your thoughts about who is responsible for change in the therapist-consumer relationship?
7. How do these thoughts come to life in your supervisory relationships?

Holistic

8. To the extent that persons with severe mental illness often present with needs in multiple areas, e.g. housing and employment, how do you help your supervisee to be a resource for consumers in all areas of need?

Non-linear

9. Clinicians who work with the severely mentally ill tend to develop an understanding that there may be ups and downs in the process of change. As a supervisor, how do you communicate that growth is a continuing experience that is often accompanied by setbacks and apparent failures?

Strengths-Based

10. During supervision, how do you assist your supervisees in developing and maintaining an outlook of the consumer as being resilient, that is, having multiple capacities, talents and coping skills?

Peer-Support

11. Participating in the recovery of others may go a long way in helping to solidify consumers’ own recovery. How might you say you are able to help your supervisees to explore these possibilities with their consumers?

Respect for the consumer

12. As a supervisor, what does the term “respect for the consumer” mean to you?

13. How does this meaning show itself in conversations with your supervisees?

Hope

14. What is your belief about the ability of consumers to live with severe mental illness?

15. Please share the ways in which you help your supervisees to understand and communicate the message that people can and do overcome their obstacles?

General

How would you rate the importance of each of the following principles in treating severely mentally-ill persons?

	Not important	Low Importance	Slightly Important	Neutral	Moderately Important	Very Important	Extremely Important
Self Direction	1	2	3	4	5	6	7
Individualized and Person- Centered	1	2	3	4	5	6	7
Empowerment	1	2	3	4	5	6	7
Responsibility	1	2	3	4	5	6	7
Holistic Care	1	2	3	4	5	6	7
Non-linear Care	1	2	3	4	5	6	7
Strengths- Based	1	2	3	4	5	6	7
Peer-Support	1	2	3	4	5	6	7
Respect for Consumer	1	2	3	4	5	6	7
Hope	1	2	3	4	5	6	7