

Professional Supervision: Common threads, different patterns.

Conference Presentation -

Consumers Supervising Consumers - The Authority of Experience

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The Act of Supervision

Kites began to explore the need for more consumer supervisors in response to requests from consumer workers looking for peer supervisors.

Supervision is seen as a core component of professional and personal development and Kites decided to sponsor a supervision training course that would provide consumer workers with an equivalent qualification to other health professionals and to ensure sufficient supervisors were available to meet the needs of the growing consumer workforce.

A small number of consumer workers had undertaken 'clinical' supervision training in the past and found many aspects were not relevant or suitable to their roles as consumer workers.

Participants

Eleven people, who identified as consumers attended the course, passed the assessment process and received a certificate in Supervision and Mentoring from UNITEC.

Six women and five men completed the course. Their working roles included;

- Consumer Advisor (3)
- Consumer advocate / networker (1)
- Consumer consultant (1)
- Manager or frontline worker in peer run service (6)

Five participants worked for consumer run organisations, three worked for District Health Boards and one participant was self employed.

The Course

The course was held over a six week period with the contact days comprising of an initial three days and then students returning for the final two days after they had the opportunity to practice their learning and complete assignments.

Purpose Focused Training

Specific areas were identified to ensure the course was tailored to consumer workers and a number of consumer leaders offered their assistance to do this.

Areas discussed specific to consumer supervisors were;

- Supervisor responsibilities – safety, disclosure, boundaries.
- Code of Ethics for consumer workers– no specific code of ethics currently exist for consumer workers in New Zealand

Evaluation

Participants found the course to be practicable and applicable to their work. They valued that the course was specially catered to the consumer workforce and that the qualification could be cross credited to the Diploma in not for Profit Management.

Participants found the facilitation and course content to be excellent and stimulating. The focus on strengths and the use of real examples was seen as positive facilitation of learning.

Areas for improvement related to the venues, ways of managing the written material and a support system for participants during the practical application phase.

The Position of Consumers

I would like, in the time available, to open the case for consumers supervising consumers --people diagnosed with mental illnesses and in the mental health workforce supervising people diagnosed with mental illnesses and in the mental health workforce --time only, I fear, for a series of statements giving the impression or illusion of the argument!

Some distinctions to begin with:

Firstly, and fundamentally, the centuries-old and still fraught distinction between the *authority of observation* and the *authority of experience*; between what can be known by looking at it (albeit in the right way) and what can be known only by the living of it.

Secondly, the distinction between the illness itself, as seen but not experienced, and the diagnosis of illness, as experienced but not seen. The clinician, so to speak, *has* the illness; the consumer bears the name and impact of its diagnosis.

Thirdly, and importantly for us here, the distinction between the *clinical relationship* and the *personal relationship*: the clinician addresses the illness, the consumer must accommodate the diagnosis. The clinician wants to engage the illness; chronicle its convulsions, its disguises and silences. The consumer must engage the mental health service, come to terms with it: establish a sense, a meaning, a new identity as client of the service. For that is what, decisively, the diagnosis calls for, brings into being.

The clinician sees *illness condition*. The consumer experiences *client status*. Given the current manner of psychiatric practice this tension is inevitable.

Now, when it comes to consumers not as clients, as patients, but as employees of the service, as colleagues, these distinctions remain intact, in play. The consumer employee is, first of all, still the consumer, the bearer of mental illness --at best not so much an expert as an example; their performance a measure of the effect or expression of their illness at any given moment. It is apparently only a matter of time before the illness, at its most destructive, will break out again, and demolish all before it!

The illness explains everything. And can be relied upon to justify keeping the consumer in a safe place; well away that is from the action, from the job they were employed to do, for the sake, of course, of their own well being. It's nothing personal.

Meanwhile, from the supposed safety of the sideline, the consumer, now as employee, is still searching for that relationship with the service, this time as their employer, a relationship which recognises and respects the expertise for which they were employed - an expertise grounded in and legitimised by their experience. Unfortunately, this experience has to do inextricably with illness; and therefore with perceptions of disability, of inability. Without such a relationship, no more than the usual employer-employee agreement, nothing can be achieved. The impact upon the consumer of this refusal of a tenable working relationship will be seen as the inevitable re-emergence of their illness. Luckily, or unluckily, dependent upon where you sit, the illness, thus empowered, will gratefully go on to confirm everything that has ever been said about it. Perhaps you knew all along it would.

Enter supervision.

A tiny space in which to ... what, the task is almost impossible. To find a way to negotiate, talk one's way past the illness, out of its way, its unflinching regard? To slip through its net perhaps; to stand without it, a proper human being, if only for a moment. But what would be left then of the authority of experience, upon which everything has been staked? And which, so to speak, *authorises* the participation of consumers in the mental health workforce.

Time and time again, in my experience, consumers bring to supervision this very dilemma, in one or other of its forms: credibility, personal and professional; reliability, personal; trustworthiness, personal; recognition of the understandings gained through the experience of mental illness and the impact of its diagnosis; the validity, the veracity, of this experience, its status as a body of knowledge, –and the challenge of gaining a hearing for it; acceptance as a colleague and not a curiosity; participation in decision-making processes --sometimes participation, period.

Too much to ask? Maybe. Yet it is the very cliff face the consumer workforce finds itself once again perilously on the edge of. Pulled up short.

Supervision inherits the impasse. There is, a formal matter, nowhere else to take it. The questions are of little interest to anyone but those up to their necks in them. So, what can supervision achieve?

Too soon perhaps to tell. We are asking a lot of it. We expect, sometimes, personal development; sometimes professional development; sometimes workforce development; sometimes community development. Sometimes, we see a network of cells of supervision, subversive cells perhaps, hopefully --fomenting the first steps of a very different future --and then we are awake again!

One thing is certain though. The consumer experience is the necessary mutual condition without which supervision cannot proceed. Because it is this experience which is the issue, at issue. Nothing else. How to negotiate a place for it from which it will not be immediately expelled. How to establish a standing for it, a status, which will confer respect. Perhaps this is the subject of supervision, at least at this time. And, whenever they occur, its achievements will be small, sometimes barely noticeable and always individual --each of us, one by one, each day a little stronger, until a critical mass is reached, and we may ask new questions, the really interesting ones, the questions we have been employed to ask, that could actually make a difference, questions that wait, clamouring impatiently, down the dark end of the tunnel.

The issues are the same whether the consumer is employed in a consumer specific role, for example advisor or advocate, or in generic service provision, for example social worker or nurse, or in management positions.

Of course not all consumers in generic roles are out of the closet. No doubt, their own experience can contribute much of value to their practice. However, the choice to not disclose can be a mixed blessing. It is, I think, instructive to note that what is gained on the one hand may well be lost on the other. Certainly they will not need to wrestle with the question of credibility, important for clinicians, amongst other clinicians.

However, the ever-present possibility of outing can be a nagging anxiety. Sadly, it is still not often advisable for a clinician, or a manager, to declare a mental illness. I think you have to be mad indeed to do it --and that might well have been the problem all along!

I'd like to mention, before I close, the possibility of consumers mentoring clinicians and managers --the non-consumer decision makers-- which is, I think, an exciting, potentially fruitful, prospect. An examination of or meditation upon the *context* in which therapeutic practice and service development programmes do or ought to take place; a reflection which could well shape and guide a more responsive, respectful, replenished sector. And that context, as I have already suggested, is the defining relationship which underpins the entire enterprise: that between the consumer and the service, a relationship born at the instant of diagnosis, one's very own big bang, and to be borne for the duration of its impact.

I would have liked to talk more about this. Alas, for me,

my time is up.

In Conclusion

Kites believes the consumer workforce is a professional group that should have access to the same professional practice and knowledge development as other health professional groups do.

The holding of this course provided a worthwhile opportunity to progress development of the consumer workforce to ensure both consumer and non-consumer workers in the mental health sector can have increased access to trained and qualified consumer supervisors.