

FEATURE ARTICLE

Implementing clinical supervision: Part 1: Laying the ground work

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ABSTRACT: *Australia, like other countries, is experiencing a crisis in the recruitment and retention of nurses. Clinical supervision has been suggested as a potential strategy to enhance retention. However, there is a paucity of literature regarding the successful implementation of clinical supervision. The aim of this study is to explore and evaluate ways of implementing clinical supervision as undertaken in a rural health-care organization in Victoria. Qualitative methodology was used including a documentation audit and individual interviews with the staff responsible for implementation. The findings demonstrate that the successful implementation had occurred in five interrelated stages. This paper, one in a series of three, focuses on the preimplementation phase leading up to initial implementation. The main themes identified during these stages were: organizational culture, exploring the possibilities, leadership and education and training which will be examined. These issues were essential in laying the foundation for the systematic introduction of clinical supervision.*

KEY WORDS: *clinical supervision, implementation, nurses, strategic plan.*

INTRODUCTION

Much attention has been drawn to the crisis in the recruitment and retention of nurses in Australia. This has been the subject of government inquiries (Commonwealth of Australia 2005; Australian Institute of Health & Welfare 2005; Commonwealth of Australia 2002; Department of Human Services 2001), and has featured prominently in the nursing literature in general (Daly *et al.* 2004) and specifically in relation to mental health nursing (Centre for Psychiatric Nursing Research & Practice 2005; Clinton & Hazelton 2000).

These reports identified that nursing is highly stressful and there is poor job satisfaction, linked to high staff turnover. These have been identified as major factors

contributing to nurses leaving the profession (Clinton & Hazelton 2000; Daly *et al.* 2004).

Clinical supervision has been put forward as one possible solution to the nursing crisis. It is considered to be an important strategy in recruiting and retaining high-quality staff (Akerjordet & Severinsson 2004; Ashmore & Carver 2000; Gagan 2002; Pritchard 2000; Teasdale *et al.* 2000; Willson *et al.* 2001; Winstanley 2000). Despite this recognition of the important role of clinical supervision, there is a surprising lack of policies, procedures, and organization-wide approaches to guide and support its successful implementation.

The absence of a clear policy direction from governments and the absence of leadership in relation to recommendations for education and training, models, and evaluation tools, have been identified as a barrier to the successful implementation of clinical supervision (Clifton 2002; Cutcliffe & Proctor 1998; Mullarkey & Playle 2001; Riordan 2002). Clear policy direction is noticeably lacking in the Victorian guidelines for mental health services (Department of Human Services, Victoria 2006). While

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they contain very general non-prescriptive suggestions about policy and procedure, essentially the responsibility for implementation is devolved as a responsibility of local services. In the absence of distinct guidelines, the implementation process varies from health setting to health setting.

The importance of implementation has been described in the scholarly literature (Clifton 2002; Cutcliffe & Proctor 1998; Gonsalvez *et al.* 2002; Mullarkey & Playle 2001; Riordan 2002; Spence *et al.* 2002). Clinical supervision texts have included chapters addressing the implementation process (Bond & Holland 1998; Butterworth & Faugier 1992; Driscoll 2000). A brief overview of the literature regarding implementation will now be presented.

Developing supervision as a clear separate process to managerial supervision is highlighted in the literature as an essential part of implementation. A clear definition of clinical supervision was viewed as essential in order that it not be confused with management supervision (Bond & Holland 1998; Driscoll 2000). Driscoll (2000) emphasized the importance of assessing and addressing the culture of the organization. Implementation is viewed as a gradual and continual process where the strengths and weaknesses of a culture must be systematically identified and addressed accordingly. Clifton (2002) describes a four-stage approach with the first stage about preparing the culture by raising awareness and addressing nurses' concerns through information sessions.

Bond and Holland (1998) provide a guide to implementation outlining six stages: defining clinical supervision, involving staff, education and training for supervisors and supervisees, supervision for the supervisors, and developing a framework for evaluation monitoring and support. Bond and Holland also identified specific roles to facilitate the implementation programme. The senior manager or business manager, the unit or team leader, and the coordinator, should each take responsibility for specific tasks and actions. These roles should be supported by working groups consisting of people with experience of and an interest in clinical supervision.

Driscoll (2000) posed a less prescriptive, yet nonetheless, guiding approach. His focus was on individual teams and units, rather than on the macro-organizational perspective. He emphasizes the importance of encouraging staff involvement and participation which is also acknowledged by other authors (Clifton 2002; Spence *et al.* 2002).

Driscoll (2000) asserted that the desire to implement clinical supervision was not itself a sufficient ingredient for success. Challenges are likely to arise which Driscoll termed as 'forces' at work within the culture of the orga-

nization that either support or resist the implementation process. Driscoll describes these as 'pushing or resisting forces' (p. 159). Pushing forces are the strengths within the culture that assist with implementation. Resisting forces are aspects of a negative culture or a weakness that can slow down or impede implementation. Driscoll recommended conducting a 'force field analysis' on the culture of nursing and the organization towards clinical supervision at the very beginning. The 'force field' approach will facilitate the identification of enablers and detractors crucial in the implementation process.

Many authors (Clifton 2002; Hancox *et al.* 2004; McKeown 2001) stress the importance of education and training for nurses. This is an essential ingredient for implementing clinical supervision. Clifton (2002) suggests that education is best provided by external consultants who are not aligned or seen to be aligned with the philosophies or structures of the organization concerned. The value of external consultants was also reinforced by Bond and Holland (1998).

METHOD

An exploratory research method was used to examine the process and journey of the clinical supervision implementation strategy. An exploratory approach is sensitive to the specific intricacies, complexities, and emerging issues involved (LoBiondo-Wood & Haber 1990). Further, the exploratory framework enabled simultaneous analysis of the organization itself and the culture of mental health nursing within. The exploratory approach was also helpful because it allowed staff to recall their thoughts and perceptions from 2 years prior at the beginning of implementation strategy.

Setting

This research was conducted in a rural mental health service in South-East Victoria. It is large mental health service providing a range of mental health services to over 3000 registered clients. The service covered more than 44 000 square kilometres and consisted of eight community centres and two inpatient units. The service employed approximately 200 mental health clinicians, 144 of which were nurses.

A rural service was chosen because the geographical setting added another dimension to this research. In particular, the challenges facing the rural organization such as: the distance required to travel for supervision, the dual relationships within the service, the closeness of rural communities, and the limited options for cross-service clinical supervision caused by distance. Challenges like

these are common in rural areas causing potential barriers and creating further complexities.

Sample

Purposive sampling was used to select nurses who were directly involved in implementing clinical supervision. Seven nurses agreed to participate and two declined due to illness and work commitments. Purposive sampling requires judgements to be made by the researcher in selecting participants able to inform the phenomena under study (Burns & Grove 2001). The researcher therefore selected members of the clinical supervision implementation committee to participate in an interview.

Data collection

The data for this research were collected first via a documentation audit and then by seven individual interviews as described. The documentation audit involved the review and analysis of all documentation relating to the implementation of clinical supervision, including minutes of meetings and the strategic plan.

The individual interviews were conducted on site and ranged from 60 to 90 min. An interview guide was developed from the main themes identified in the literature, and from the documentation audit. The researcher used an in-depth focused and semi-structured interview technique common to qualitative research (Minichiello *et al.* 1996). The interviews were audiotaped and transcribed as close to collection as possible to ensure recency.

Data analysis

The documentation was reviewed in chronological order from November 2001 (the beginning) to November 2003. This provided the researcher a structured and detailed timeline and a list of the key staff involved. The researcher read and re-read the information to become familiar with the initial journey (as documented), as outlined by Ritchie and Spencer (1994).

Driscoll's 'force field analysis' (Driscoll 2000) was used as a guide to the analysis. Here, the researcher searched for strengthening and resisting forces in the culture. Once identified, an action plan was formulated to determine how, and if, the organization strengthened and built on the pushing forces and weakened the resisting forces. This approach was utilized for data analysis as a broad framework, rather than a prescriptive manual.

Once significant data were identified in the transcripts, the researcher searched for similarities and differences as a way to begin to interpret the initial data. During the explanatory process, theoretical ideas from the research emerged as key themes (Burns & Grove 2001).

Ethical considerations

Ethics approval was obtained from the Human Research and Ethics Committee at the Health Care Organization and the University Scientific Committee. All participants received a copy of the participant information sheet and consent form before participation. All participants were advised that involvement was voluntary and they were free to decline participation or to withdraw from the study at any stage without penalty.

As stated on the participant information sheets, participants were assured that all care would be taken to ensure they would not be identifiable to others. The fact that this was a small rural organization, and nurses in the organization knew the members of the implementation team presented a significant challenge to confidentiality. Some participants expressed their concern about being able to be identified. Identifying participants by number 1, 2, or 3 would have increased the likelihood of exposure. For this reason, in the findings the researcher has only cited what interview the finding came from and has not referred to the gender of the participant or the position they hold within the organization.

FINDINGS

The analysis of the findings collected from the documentation and the interviews indicated that the organization's clinical supervision implementation strategy had a distinct structure: it occurred in five stages. These five stages articulated the timeline or sequence of implementation and provided a framework for their implementation process. Themes from the data emerged throughout these five stages and interestingly a number of themes were identified in more than one stage. For example, the theme organizational culture was identified throughout stages 1, 2, 4, and 5. Although this same theme was identified at different stages throughout the implementation strategy, it had a different meaning, understanding, or emphasis.

To clearly articulate the clinical supervision implementation process, the findings have been presented in a thematic linear framework following the five stages. Therefore, themes such as culture may be highlighted and discussed a number of times. Table 1 identifies the five stages and subsequent themes from each stage. The findings from stages 1 and 2 are presented in this paper. Stages 3–5 will be presented in Part 2. Part 3 will present the model developed as a direct outcome of this research, to guide the implementation of clinical supervision.

TABLE 1: *Implementation – clinical supervision stages and themes*

| Stages | Themes |
|--|--|
| 1. Exploration | Organizational culture Exploring the possibilities |
| 2. The initial strategy | Leadership Organizational culture Education and training The project/strategic plan |
| 3. The project/strategic plan | Reflection Clinical supervision implementation committee The project/strategic plan |
| 4. Implementing the strategic plan | Clinical supervision committee Education and training Organizational culture |
| 5. Reflecting on the past and moving forward | Organizational culture – culture change Sustainability On reflection |

Stage 1: Exploration

This first stage was a process of exploration for a number of senior nurses. This involved the participants' assessing the culture of the mental health service and exploring what was available to support or address some of the issues identified in the assessment.

Organizational culture

Knowing the culture of the organization emerged as a core theme. The findings from the documentation audit (Clinical Supervision Project November 2001) and the individual interviews identified that senior nursing staff had assessed the culture of the organization before the decision to implement clinical supervision. Senior management, which included a number of senior nurses in the mental health programme, was concerned about the serious human resource issues such as: an increase in work cover and sick leave, and difficulties with recruitment and retention. In addition to the above human resource data, they also conducted a needs analysis via qualitative surveys and focus groups in two teams; the results of which highlighted a sense of dissatisfaction with work loads, team dynamics, and management. The culture and environment in this organization were described by one participant as:

... angry, hostile ... demoralized and anti-management.

Another participant stated that in general staff felt:

... unsupported ... There weren't systems in place to keep them safe.

The findings from the needs analysis and staff experience and knowledge of the organization proposed a number of possible explanations for the negative culture. There had been a number of significant challenges in mental health over the past 10 years, such as deinstitutionalization and mainstreaming. Furthermore, this particular service had experienced changes in hospital ownership, from public to private, and then recently back to a public hospital. One senior nurse noted that throughout these changes there were a number of sensitive human resources issues such as demotions of staff, redundancies, and major changes in the management structure. She or he described the impact these internal changes had on the organization in the following way:

... there was evidence of horizontal violence and cannibalism in a number of the units/teams.

From early to mid-2001, senior management began to discuss this negativity openly and honestly, and began to explore what could be done to address these concerns.

Exploring the possibilities

The senior management team started to explore the possibilities, in particular what could be done to assist consumers, staff, and the mental health programme. This group was not formalized; however, they consisted of a number of senior managers, nurses, educators, and consultants within the programme. This group discussed strategies such as: educational support, staff support, structural and system changes, and the need to find a new solution as described in the following statement:

... the earlier discussions revolved around the fact that there were difficulties retaining nurses and staff in general within the service ... that some of the problems encountered by nurses was [sic] the lack of support within the practice setting.

A number of senior nurses and managers had experience with clinical supervision personally, and they felt quite strongly about the potential benefits for nurses based on their own experiences:

... I had sought out and received clinical supervision during the change process so I knew on a personal level how beneficial it was.

Senior staff without personal experience were also supportive as suggested:

... clinical supervision was something I had read about for a long, long time and I could see ... that clinical supervision was so important to the development of the learning needs as students, or participants ...

Once the group, led by a senior nurse, began to explore the possibilities of clinical supervision in more detail, review of the existing mechanisms or informal supervision processes that were already embedded into the organization was completed (Clinical Supervision Project November 2001). The identified processes and structures included meetings that focused on the operational and clinical functions of the organization. These existing structures were compared with clinical supervision, to tease out the similarities and differences, and to identify whether introducing clinical supervision would be adding value. All participants commented on the differences between the aforementioned structures and clinical supervision, as highlighted below:

... it doesn't matter how comfortable you feel with your peers, there are times when you ... have an issue and you don't know how to handle it, but there's no way on earth you would bring it up ... if you expose a vulnerability then ... people use that ... I think that that is the benefit that [clinical supervision] offers ...

After these initial discussions at a senior management level, there was an in-principle decision to explore the implementation of clinical supervision. There had been discussions with a senior nurse in another organization about the value of clinical supervision and the course offered by the Centre for Psychiatric Nursing Research and Practice (CPNRP). A decision was made to formally collaborate with this other organization.

Stage two: The initial implementation strategy

Leadership

The first consideration in the initial implementation discussions was the issue of leadership. The findings indicate that a considerable amount of thought and energy went into finding the 'right leader' and 'right leadership group' as evidenced in the following comment:

You need to find a good nurse in your organization that is frustrated and hungry because [they] need leadership and ownership ... Those nurses who do not seem to be fitting in anywhere but you know that they are great ... those people, there are always at least five of them sitting in service somewhere ... Step back and give them more time.

Organizational culture

Once the initial leadership group was established, the committee again focused on the organizational culture. The main issues that arose out of this exploration were the level of paranoia/suspiciousness towards management and

issues of proving that management and the organization could sustain the implementation of clinical supervision. The findings indicated that nurses in this organization were cynical and pessimistic about anything senior management tried to implement and they had little or no faith in their ability to sustain anything:

... we have a very paranoid workforce ... and the people at the time with the loudest voices were probably the most paranoid ... about 80% were really resistant to clinical supervision or to anything we have tried to implement.

The financial commitment shown by the organization and the early decision to collaborate with another organization and the CPNRP seemed to give the implementation more credibility and send the message to staff that this time it might just work as highlighted below:

... we could see the importance of collaboration and networking, we could see the importance of developing things [together].

Education and training

The CPNRP was contracted by the organization and the collaborating service to tailor an education and training package to their needs. This package consisted of the 4-day clinical supervision for health-care professionals course and a series of 1-day workshops (supervision for supervisees). The engagement of an external organization met with mixed responses from the leadership team. Some advantages were identified, for example:

I think people feel more relaxed to be honest about their fears and their concerns.

One participant identified some limitations to the use of external facilitators, as stated:

... people who are internal know what the goals and plans are of the organization versus people that you are contracting to do it.

One participant suggested a combination of an internal and external facilitator to secure the best of both models.

Overall, the participants in the first 4-day course stated clearly that it was a huge success. It clarified what clinical supervision was, the types and what it could offer. It also provided valuable information on the legal and ethical considerations, models, and overall information on how to implement clinical supervision for the individual/organization. The CPNRP were also contracted to provide 1-day introductory workshops for supervisees.

This training was seen as essential by many participants as evidenced in a number of the findings:

... I think with the process of having those one-day workshops, people would go to those and then actually take that information back and you'd notice that ... there was more positive talk. I think that really peppered through the whole project [and] really helped a lot.

As part of the formal assessment for the 4-day course, the participants completed a strategic plan as a group project. This was seen as a very useful start for the process:

... the project/strategic plan was a framework for getting things started.

The completion of the first 4-day training and commencement of the project/strategic plan moved the implementation of clinical supervision into stage 3. The findings for stages 3–5 are presented in Part 2 of this paper.

DISCUSSION

The research findings addressing the first two stages of implementation reinforce much of the existing literature. The decision to implement clinical supervision required a major change in practice and culture for the organization. The leadership of change requires 'vision, courage, creativity, effective communication, and a clear plan' as identified by Daly *et al.* (2004; p. 185).

Marquis and Houston (2002; p. 17) describe planned change as 'a well thought-out and deliberate effort to make something happen', consistent with the implementation of clinical supervision in this organization. The decision to implement clinical supervision was a coordinated one. Once the key staff chose clinical supervision, they then began discussing and planning for implementation.

Their first step involved assessing and addressing the culture of the organization. As supported in the literature, this initial assessment of the culture of the organization is an essential part the implementation process (Bond & Holland 1998; Clifton 2002; Driscoll 2000).

The force field analysis revealed that the culture in the organization was negative and extremely resistant to the implementation of clinical supervision. There was a high number of resisting forces and very few pushing or strengthening forces (Driscoll 2000). This presented the organization with a substantial challenge, given that one of the greatest factors contributing to resistance in change

is the 'lack of trust between the employee and manager or the employee and the organization' (Marquis & Houston 2000; p. 79).

However, there were some significant pushing forces identified in the findings. The senior mental health nurse believed that clinical supervision could assist with the negative culture that existed within the organization. This vision was supported by the organization and the senior nurse articulated the vision of what clinical supervision could offer their mental health service. Daly *et al.* (2004; p. 11) identified 'the ability to conceptualise a vision and communicate it to others is a crucial issue for nurse leaders and managers'. Other pre-implementation pushing forces included motivation and willingness to change the culture and an emphasis on leadership, culture carriers, and collaboration.

Following this initial phase, the senior mental health nurse and other key members of the implementation committee focused on strengthening some of the positive pushing forces such as: organizational support, leadership, collaboration, and focusing on staff that are considered culture carriers. This approach equates to the 'action plan' articulated by Driscoll (2000) and supported by Marquis and Houston (2000).

The issue of leadership was identified as pivotal in the findings. The terms manager and leader are often seen as synonymous and used interchangeably within nursing; however, the senior nurse of this organization was clear that there was a distinct difference between the two, and hence did not just choose senior managers or nurse managers to be involved in the implementation of clinical supervision, they chose nurse leaders. 'In the nursing context a leader is a visionary with a concentration of time and effort who looks outward to how the unit, organization or professions can go forward' (Daly *et al.* 2004; p. 14).

Other authors who focus specifically on the implementation of clinical supervision (Bond & Holland 1998; Clifton 2002; Driscoll 2000; Spence *et al.* 2002) also support the need for leaders or champions. The findings from this research, therefore, highlight the choice of nursing leaders rather than nurse managers to affect the major cultural change needed.

A weakening of resisting forces was evident. One of the major resisting forces was the lack of knowledge of clinical supervision. Staff members were also suspicious about clinical supervision being linked with line management. Weakening these resisting forces involved defining clinical supervision as a separate process from line management. The literature supports the view that line management supervision and clinical supervision need to

be separate entities in order for nurses to accept and agree to clinical supervision (Consedine 1994; Yegdich 1999). The subsequent education and training strategy chosen by the clinical supervision implementation committee also addressed the nurses' lack of knowledge about clinical supervision.

Although there is not a consensus in the literature about the type of education and training required, there is an overall view that clinical supervision education is essential (McKeown 2001). The findings from this research identify that this organization had a well-considered education and training strategy, the details of which were articulated in their strategic plan. Further, the organization supported and promoted education and training for both supervisors and supervisees in order to dispel the myths (Bond & Holland 1998).

The choice to use external facilitators can also be supported in the literature. It is highly recommended in organizations/teams where there is a negative culture or negative views towards management to use external facilitators (Bond & Holland 1998; Clifton 2002; Cutcliffe & Proctor 1998; McKeown 2001; Riordan 2002).

As with all research, this research presents its own limitations. The inclusion of only one rural service and only mental health nurses could have reduced the applicability for other metropolitan services and other specialities of nursing. It is not expected that the research findings are automatically generalizable to other settings, rather that this information provides new insights and a possible plan or framework for the implementation of clinical supervision.

CONCLUSIONS

The research findings provide a clear overview of the preimplementation phase in introducing clinical supervision into one rural mental health service in Victoria, Australia. Assessment of the culture is crucial in order to identify the factors likely to detract from or facilitate the implementation process. Furthermore, during the initial two stages, the need for a structured approach was emphasized. The need for leadership to champion the cause and for education and training to ensure both supervisors and supervisees are adequately prepared and able to fulfil their roles effectively. This information makes an important contribution to mental health nursing, particularly in the absence of clear and informative implementation guidelines. Part 2 of this paper presents the next three stages in the implementation process. Finally, Part 3 presents a new model to guide implementation.

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