

**CLINICAL SUPERVISION AND  
LEADERSHIP IN COMMUNITY HEALTH**

**LITERATURE REVIEW**

**Victorian Healthcare Association**

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## **Acknowledgements**

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## Executive Summary

### Background

This literature review forms part of the Victorian Healthcare Association (VHA) Community Health Clinical Supervision and Leadership Project (CS&L) funded by the Department of Human Services. The project grew out of work conducted by the Clinical Governance in Community Health Project in association with the Eastern Metropolitan Region's Scope of Practice and Credentialling Project.

The development of effective, comprehensive clinical supervision and clinical leadership mechanisms were identified as the key to enabling effective scope of practice and credentialling to occur within agencies. Further development of clinical supervision and clinical leadership in the community health sector will contribute to the quality and safety of services provided to the community through mechanisms to develop the knowledge and competence of clinicians, staff satisfaction and retention. The management of clinical risk through systems and processes to enhance staff competence, such as clinical supervision and leadership, are integral to effective clinical governance in the community health sector.

The aim of this literature review is to provide an overview of current evidence and thinking to inform the development of clinical supervision and clinical leadership models for the community health sector.

### Key themes

The limited literature on clinical leadership highlights the essential characteristics of a leader. These include appropriate professional knowledge, skills and experience and personal attributes such as honesty, ability to be forward looking and to inspire others, credibility among peers and energy to communicate with colleagues. The literature reports on only a few organisations that have developed clinical leadership programmes.

Within the clinical supervision literature there is considerable emphasis on the lack of agreement on definitions and aims. Related to this is the tension between control and autonomy in a process which enables professional support and learning as well as ensuring that standards for quality health care are met. While there is unanimous agreement that supervision by a line manager is problematic, in many workplaces and professions this appears to be the reality.

Differences in assumptions and perceptions exist between health care professions. Professions such as social work, counselling and mental health have traditionally established professional requirements related to clinical supervision. Some of these professions have an established body of literature. Other professions, in recognition of the importance of clinical supervision, have begun contributing to the topic.

There are numerous descriptive studies of small introductory clinical supervision programmes in the UK, Europe and Australia. Many of these come from Nursing or Mental Health with some from Allied Health and the Alcohol and Other Drugs field. These studies highlight key components of clinical supervision, identify important issues and make best practice recommendations.

The literature reveals the importance of a number of factors to support effective clinical supervision. These include: provisional standards; policy development; documentation (e.g. contracts with clear roles and responsibilities); the relationship in supervision; selection of supervisors (e.g. background and choice) and education, training and orientation for the supervisory process. Access, support and resources are key factors for clinical supervision and are critical to quality health care practice.



A number of studies use surveys to assess perceptions of supervisor and supervisee experience of supervision and the outcome of their involvement. The literature highlights the personal and organisational benefits of supervision, including self reporting of improved competence and confidence, reduction in stress and burnout, reduced isolation and improved retention. Many of the barriers identified in the literature can be overcome by having a structure in place to ensure effective clinical supervision. There is little research measuring direct client outcomes. However, there is a growing recognition of the importance of research to measure outcomes of both supervision preparation and supervision involvement.

Currently there is one internationally valid measure to evaluate supervisee satisfaction of clinical supervision and few large scale landmark studies.

This literature review has identified a growing recognition of the importance of clinical supervision and leadership in health care delivery and workforce development. There is now considerable interest in establishing an evidence base for practice.

### **Future directions**

In addition to the summary issues identified, the key themes highlighted in the literature review that warrant further research and discussion include the following:

- **Policy and procedures, documentation and reporting**

The importance of and need for a clear understanding of the supervision process was highlighted in the literature as well as the need for policies and contracts outlining the supervisor and supervisee roles and responsibilities. The development of proforma policy and procedures, documentation and contracts would address this issue.

- **Training**

The literature also highlighted the need for training and preparation for both the clinical supervisor and supervisee and indicates that without appropriate education, clinical supervision may not be effective. Further work is required to encourage greater use of training for the clinical supervision process and to identify learning objectives and competencies for clinical supervision training to assist agencies seeking training programmes for staff.

- **Line management and clinical supervision**

The literature clearly highlights that line management should be separate to clinical supervision. However, this is not always practical for the sector and thus alternative options need to be considered to manage this effectively.

- **Funding/resources**

Difficulty allocating time to the supervision process was reported due to demanding workloads and the cost of time away from direct care. Models that consider supervision options that reduce the financial costs and assist with resource issues need to be developed.

Given the lack of literature on clinical leadership in the health sector in general, further developmental work would be useful in order to assist in the formation of models for clinical leadership. Much of the literature, including the development of educational programmes has stemmed from the acute sector.



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## 1. CLINICAL LEADERSHIP

Clinical leadership is essential to clinical governance and requires clinicians visibly enacting espoused values and plans (The Victorian Quality Council, 2005). The Clinical Excellence Commission (2007:2) of New South Wales suggests that Clinical Leadership occurs at all levels of patient care and refers to the:

- process of leading a set of activities that improve the delivery of safe clinical care
- the set of attributes required to lead a team, unit stream or cluster

Davidson et al (2006) view clinical leadership as an extension of the definitions of leadership from the private sector. They explain that leadership is a multifaceted process of:

- identifying a goal or target
- organising services
- motivating other people to act
- providing support and motivation to achieve mutually negotiated goals

Added to these more generic features of leadership is the responsibility for:

- care and safety of patients
- monitoring of both service and individual outcomes

Hence effective clinical leaders need to be able to:

- focus on promoting health
- have the capacity to build effective teams
- articulate and demonstrate what others cannot see
- address immediate challenges
- demonstrate expert clinical skills
- have a patient focus
- show selflessness
- be assertive and able to collaborate with others
- have the vision to lead their team into a future which is often unknown

### 1.1 Leadership Effectiveness

Kouzes and Posner's (2002) research of exemplary leaders identified that effective leadership relates to the practices of the leader rather than individual personality. They define these practices as the leader's ability to:

- model the way
- inspire a shared vision
- challenge the process
- enable others to act
- encourage the heart

The UK Clinical Leadership Programme (Large et al 2005) has also utilised the five practices defined by Kouzes and Posner (2002) as part of its programme. These five practices provide a foundation for the specific literature related to clinical leadership. The beliefs and attitudes of clinical leaders are evident in what they do and say and enthusiasm for the task. Modelling their commitment and learning, encouraging collaboration and developing a trusting relationship with others are fundamental practices of good leadership.



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Kouzes and Posner (2002) also investigated the characteristics people looked for in their leaders. They report that the four most important characteristics of admired leaders are their:

- honesty
- competence
- ability to be forward looking
- ability to inspire others

The importance of credibility in the workplace is also stressed by Kouzes and Posner (2002). This is consistent with earlier work by Agryris and Schon (1976) cited in Large et al (2005) who identified the need for leaders to ensure that their espoused theories are consistent with their theories in use: that is that leaders reflect beliefs and policies in their activities and behaviour. This is clearly articulated in the statement from the Victorian Quality Council (2005) that clinical governance requires clinical leadership by highly visible clinicians who are able to enact espoused values and plans.

Davidson et al (2006), Jasper (2002), and Siriwardena (2006) make the distinction between leadership and management. Siriwardena (2006) states the inherent difference in clinical leadership is the vision and attitudes of the leader. He sees these factors as the essential catalyst for change and inspiration for others. Siriwardena's list of the key characteristics of clinical leaders is in agreement. This includes:

- credibility among peers
- expertise and skills
- an ability to galvanise and support their teams
- education, skills and motivation
- energy to communicate with colleagues (Siriwardena 2006)

Pintar et al (2007:116) as part of the development of a leadership programme for clinical services in the US, identified leadership characteristics as:

- dedication
- enthusiasm
- optimism
- flexibility
- professional behaviour
- openness to ideas
- visionary skills
- ability to prioritise
- ability to focus
- commitment to learning

Jasper (2002) questions whether managers can demonstrate clinical leadership competence without clinical practice. Davidson et al (2006) agree that clinical leaders need to be informed about clinical practice and in addition have skills in service redesign and health care improvement. Gifford et al (2004) state that there is emerging evidence that leadership influences the sustained use of evidence based practice guidelines in clinical decision making. However Jasper's (2002) editorial expresses some cautionary pessimism about how much can be achieved by clinical leaders. Balding (2005) argues that a clinical governance programme will only be successful when embedded in everyday processes with line managers taking responsibility to ensure workplace practice reflects organisational policies. Hence supporting and encouraging the leadership capacity of line managers is seen as critical.



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## 1.2 Leadership Styles

Leadership is influenced by the leader's behaviours and assumptions. These are referred to in the literature as leadership styles. Davidson et al (2006) acknowledge leadership styles vary from authoritative to participatory. They describe leadership as:

Transactional - centering on exchanges between leaders and others with self interest as the key inducement for alliances

Transformational - based on creating a culture of leadership for all team members in nurturing empowerment, promoting individualism, open communication and inclusive decision making

Burns (1978) in Large et al (2005:12) defines transformational leadership as, '*a process whereby an individual engages with others, creating a connection that raises the level of motivation and potential of the leader and others within the team*'.

Large et al (2005) state that transformational leadership instills faith and respect to all parties involved. This reciprocal process incorporates personal development with leadership attributes such as power, authority, influence and charisma.

## 1.3 Strategies for Promoting Clinical Leadership

Balding (2005) asserts that although senior management can provide the foundation framework for the clinical governance programme, it is the clinical managers who play a critical role in the day to day processes related to patient care. She advocates that attention be provided to develop the capacity of line managers to relate organisational policies into practice, with the provision of resources and supports to empower them. Hence a more systematic and structured delegation of accountability to all levels of the health service organisation is achieved.

Balding (2005) advises senior managers that clinical leadership is encouraged by:

- defining the organisation's vision and values for safety and quality care
- defining the strategic direction consistent with achieving the vision and values
- collaborating with staff to identify clear achievable goals, roles, resources and processes
- providing information, skills and resources to staff to enable them to fulfill responsibilities
- providing support to managers and all staff to enact processes contributing to high quality care
- facilitating and rewarding a collaborative approach to safety and quality improvement between clinical and non-clinical managers and their teams
- evaluating the status of quality and leadership in the organisation
- reviewing incentives by increasing those rewarding engagement and removing others not contributing to quality care
- modeling commitment to safety and quality
- embedding improvements in policy and practices

Davidson et al (2006) list the following factors as critical in the development of transformational clinical leadership:

- available effective role models
- mechanisms for mentoring and clinical supervision
- career pathways
- intentional succession planning
- other strategies e.g. clinical doctorates, collegiality of professional associations, collaborative initiatives with academic institutions or other professions



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The influence of leaders as positive role models is illustrated by a study by Palmer et al (1996). They conducted a randomised control trial across sixteen primary care practices in the US and established that the quality improvement behaviour of physician leaders influenced the performance of their colleagues. However, interestingly leaders only exerted this positive influence after they had received direction from an external quality improvement source.

## **1.4 Barriers for Clinicians Taking on Clinical Leadership Roles**

Ham (2003) in an editorial in the Lancet cites a number of obstacles to doctors taking up leadership roles. These include:

- the high value placed on autonomy of independent clinical practice. He believes that incentives for clinical leaders may not be as clear with varying levels of support available for clinicians who move to leadership positions and underdeveloped career structures.
- the impatience of politicians for radical reform. He suggests more enduring and long lasting change is likely to occur with small changes from the bottom up
- the need to focus on organisational development to support change as well as leadership development
- the need for research into leadership in health care to inform policy, systems and model development

## **1.5 Change Processes**

Ham (2003) states that a range of approaches are required to improve clinical performance. These include:

- educational initiatives
- use of opinion leaders
- peer review mechanisms
- financial and other incentives

### **1.5.1 Change Process: Bottom up**

Ham (2003) strongly states the importance of building capacity for change from bottom up rather than top down. Harnessing the energies of clinicians in the quest for innovation and improvements, where professionals felt they were leading the process in an inverted pyramid of power, is more effective than top down imposed change. He stresses the importance of collegiate relationships in affecting the level of change required to achieve the reform of health services. He believes that strategies that motivate professional education and development, which focus on high standards of service, in a timely and courteous manner, are more likely to be successful than those that focus on tighter control on service delivery. However he states it is essential to develop a new equilibrium between autonomy and accountability.

### **1.5.2 Change Process: Top down**

The rise of the quality movement and the government initiatives focused on health care reform in the last decade have imposed huge changes to service delivery and practice (Kadushin and Harkness 2002, Tinsley 2001). The debate between clinical outcomes and financial profitability underlies many of the changes (Siriwardena, 2006). In the UK there have been policy changes which have increased the contracting out of services and involvement of private companies increased the variety of health providers and employed new providers from nontraditional backgrounds (Siriwardena 2006).



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More recent literature advocates the involvement of all levels of the organisation in a planned partnership between clinical and non-clinical managers. It is suggested to be facilitated at the executive level, supported by organisational structures, resources and education (Victorian Quality Council 2005). Ovretveit (2005) following his evaluation of leadership and quality and safety improvement recommended that unified leadership is required from leaders at the top and middle, as well as teams and professional leaders, although he admits there is little available, conclusive research evidence available.

## **1.6 Models of Clinical Leadership in the Health Sector**

Siriwardena (2006:125) suggests that there are critical factors to the success of quality improvement programmes including leadership and communication at executive, managerial and clinical levels. These are:

- a strong organisational structure focused on improvement
- feedback which utilises measurement of expertise

However he acknowledges that a change in mindset may be required in order to be successful.

There are few models for clinical leadership in the literature and there is a recognition that research is needed (Ham 2003).

### **1.6.1 Reflective Practice Model/Collaborative Action Research Model**

Ham (2003) and Siriwardena (2006) advocate collaborative approaches linking clinicians at the coal face close to the patients and point of care with managers and organisational support. Siriwardena (2006) with his background in managing an ambulance service in the UK stresses the importance of peer to peer interaction based on a set of underlying beliefs and language that facilitates communication. An action research model which focuses on learning through doing and derived from reflection through real experience is suggested as a model.

### **1.6.2 Canadian Nursing Model**

Gifford et al (2004) report on the development of a conceptual framework for clinical leadership in Canada designed to influence shape and sustain evidence based nursing practice. This model includes:

- personal attributes
- defined skills
- knowledge of culture and clinical practice as well as knowledge of politics and organisations

### **1.6.3 The Royal College of Nursing Clinical Leadership Programme**

Cunningham and Kitson (2000 a, 2000b) and Large et al (2005) report on a clinical leadership programme undertaken in England by the Royal College of Nursing. This ambitious and complex project sets out to focus on the development of work based, problem focused ways of assisting ward sisters and senior nurses to become clinical leaders with the ability to increase the quality of patient care. This six year research project utilised a pre-test post-test design and incorporated action research. Phase one focused on identifying how clinical nurses in recognised leadership roles provide high quality patient care and identified the following five themes:

- managing self
- managing the team and building effective relationships



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- patient centred care
- networking
- becoming more politically aware

A pilot educational programme for 28 nurses was developed and implemented over an eighteen month period. This intervention was practical and experiential and relied on expert facilitation. It incorporated personal development, action learning, workshops, mentoring, patient narratives and feedback based on direct observation of care. The evaluation of the effectiveness of the project to improve the leadership capability utilised questionnaires for both multifactorial leadership and organisation of care, as well as qualitative data from patient narratives and observation of care. Preliminary results indicated that the leadership capability of the nurses as well as patient care had improved. Phase three of the project extended the educational programme to over a thousand health care workers. 90% of these were nurses and 10% were from allied health (Large et al 2005). This programme ran a day a week for a year. Facilitators for the leadership programme engaged in an eighteen month education programme. Extensive evaluation of both programmes utilised the 360-degree leadership practices inventory. Results indicated that over time, leadership capacity can be developed to significantly change practice. There is a clinical leadership programme in Australia based on the UK programme (Clinical Leadership Programme in Australia (2005)). In reference to Programme Outcomes, the Programmes website refers to a number of evaluations undertaken in each country and conclude that, *'these evaluation and research reports equate to international evidence, recognition and agreement that leadership development is fundamental to quality health care practice'*.

#### **1.6.4 The Lehigh Valley Hospital and Health Network Clinical Leadership Development Programme**

Pintar et al (2007) report on the Lehigh Valley Hospital and Health Network (LVHHN) in the US offering a small group of high potential leaders the opportunity for accelerated leadership learning and development over a period of two years.

Pintar et al (2007:115) reported:

*the program was created to address an emerging need to develop skilled leaders able to create and then sustain an organisational culture of excellence and development. The program was also created because it was expected that the recruitment and retention of high-caliber clinical and nursing leadership would be more difficult in the coming years as the demands of health care and opportunities for healthcare professionals increase.*

Key points identified by Pintar et al (2007:121) in relation to Clinical Leadership programmes included the following:

- Leadership development programmes must clearly identify the needs of the organisation and staff targeted for development.
- A development plan must include a contract with specific goals and timeframes to ensure that both the organisation and the program participants are aware of expectations and responsibilities.
- Small group learning sessions need to be established before and after major events to provide participants with an opportunity for immediate application or increased depth of understanding.

After defining key leadership characteristics (refer section 1.1) a gap analysis of current leadership abilities was undertaken to develop the focus of the programme. The components of the programme included formal training, informal subgroups, mentoring peer coaching and individual self-development and reflection.



## 2 CLINICAL SUPERVISION

### 2.1 Definitions

There is unanimous agreement in the literature of the absence of a universal definition for clinical supervision (Barribal et al 2004, Williams et al 2005, and Kelly et al 2001). However Barribal et al (2004) state that there is consensus that clinical supervision is a practice based process. There are however a number of common features of the multiple definitions. Williams et al (2005) provide a summary of the clinical supervision definitions. These include:

- a dedicated interaction between two or more practitioners
- a focus on reflective practice
- a means to generate learning
- practice enhancement through self evaluation and development

Winstanley & White (2003) agree that there are many differences in the definitions. Their summary features are:

- providing empathetic support to improve therapeutic skills
- the transmission of knowledge
- the facilitation of reflective practice

Hence one of the most contentious issues in the literature is the lack of agreement on a clear definition. In fact much of the current literature seeks to address this. Some of the reasons for this confusion relate to the very different historical development of clinical supervision in individual professions as well as differences between countries.

#### 2.1.1 Historical Development of Definitions within Different Professions

Early literature from the Counselling and Social Work professions identify very different views of supervision. Carroll (2007) reflects that the early definitions in counselling relate to the psychoanalytic origins of the profession in the 1920's and its inception as a process very similar to counselling itself. The social work profession began with the understanding that supervision was about control. In the early days, supervision was an administrative function about the control of educational programme and institutions. Later the focus moved to individual workers and added responsibilities for education and support (Kadushin and Harkness 2002). Supervision was seen as a way of providing efficient and effective social work service to clients.

Carroll (2007) suggests that in the 1970's, counselling supervision changed from a focus on the person doing the work to centre on the practice itself. This shift created a divide between counselling and supervision as a more educative process. Indeed much of the current literature is based on experiential learning theory and encouraging reflective practice in a variety of processes. This raises questions about the overlap with reflection and the subtle differences between reflection and supervision (Refer 2.1.4.1).

Winstanley & White (2003) describe the spread of supervision to other related professions such as psychotherapy, social work and occupational therapy where supervision was seen as an essential and fundamental aspect of preparation for practice and ongoing practice as, '*an exchange between practising professionals that enables them to develop professional skills*' (Barribal et al 2004).



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More recent definitions have broadened to include evaluative elements. Much of the nursing literature arises from the UK and reflects the formal introduction of clinical supervision in nursing as a result of the quality movement and the increased focus on consumer protection in Government policy in the UK in 1993 (Cerinus 2005).

The Department of Health Vision for the Future (1993) document states that clinical supervision is:

*A formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety in complex situations.* Doll (1993) in Winstanley & White (2003:8).

Skerrett (2004) explains that a tradition for formalised clinical supervision has been established for some time in professions such as psychology and social work but other allied health professions have experienced undergraduate clinical education/supervision or mentoring. Student supervision is a different process and although a workplace model is couched in a reporting process, clinical supervision must be supportive rather than reporting. Skerrett's definition derived for a group multidisciplinary team states that supervision is

*...a working alliance between two or more professional members where the primary intention is to enhance the knowledge skills and attitudes of at least one staff member... It focuses on clinical practice and the ongoing development of the skills knowledge and competencies to practice effectively at the highest level* (Skerrett 2004:151).

Skerrett (2004) goes on to clarify that this definition does not include career counseling assistance for personal problems or management of administrative requirements although she acknowledges these topics may arise during supervision. She also views clinical supervision as:

- intra professional i.e. focused on the members of the same discipline
- cross professional with a focus on the global objectives of the team or health service and effective functioning

### **2.1.2 Clinical Supervision as Enabling and Ensuring**

Morton-Cooper and Palmer (2000) provide a helpful framework to assist in clarifying different definitions and roles of supervision. Consideration of whether the process is about enabling supervisees to develop certain attributes, or ensuring that supervisees meet certain standards of practice helps to highlight similarities and differences. The early definitions in counselling and nursing focus on enabling learning and professional growth for practitioners with a much stronger emphasis on ensuring standards of practice in the social work literature. Additional confusion in definitions arise when a paper titled clinical supervision defines the process as practice support, a means of offering a formalised support programme linked with practice review and professional development that aims to enhance the delivery of patient care (Willson et al 2001).

### **2.1.3 Working Definitions**

The lack of agreement on a single definition for clinical supervision has resulted in the need for individual professions, areas of practice and workplaces to develop a working definition for their specific purpose. Some of these are in the published literature e.g. a recent summary paper of supervision for occupational therapists by Fone (2006:278) defines supervision as,



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*a formal process to ensure all staff are given equal and consistent opportunities for reflection and learning....It is a two-way relationship driven more by the needs of the supervisee than the supervisor.*

Fone's definition focuses on enablement: a supervisee led process of change and adaptation. The supervisor's role is to encourage supervisees to reflect on their own performance, relationships with colleagues, learning needs and career goals within a supportive environment. She makes clear distinctions that within the occupational therapy profession this is distinct from performance appraisal, interviewing, teaching and counselling, although the supervisor may advise counselling be sought. She states that although teaching may be requested by a supervisee, it is not part of the basic role. A supervisor may or may not have the appropriate skills and knowledge and may either teach or recommend someone to fill this role.

Kavanagh et al (2002:247) define supervision as:

*a working alliance between practitioners in which they aim to enhance clinical practice, fulfill the goals of the employing organization and the profession and meet ethical, professional and best practice standards of the organization and the profession, while providing personal support and encouragement in relation to the professional practice.*

Ferguson (1989) in Rose et al (2005:294) defines professional supervision as:

*a process between someone called a supervisor and another referred to as the supervisee. It is usually aimed at enhancing the helping effectiveness of the person being supervised. It may include acquisition of practical skills, mastery of theoretical or technical knowledge, personal development at the client/therapist interface and professional development.*

It is interesting to notice that the grey literature contains multiple definitions. A recent educational package (Ask & Roche, 2005) developed for the Alcohol and Other Drugs field contains six different definitions. All guidelines reviewed in the grey literature included working definitions appropriate to their purposes to ensure that staff were clear about expectations and roles.

#### **2.1.4 Similar Related Roles and Processes**

There are a number of related processes and roles which overlap with clinical supervision. This section sets out to define these. Morcom and Hughes (1996) in Malin (2000:550) states:

*Clinical supervision is a collaborative dynamic process which goes beyond the pastoral nurturing role and positively works towards enabling and affirming the supervisee. It will embrace aspects of preceptoring and mentoring depending on the developmental stage of the supervisee.*

Morton-Cooper and Palmer (2000:189) provide definitions for these distinctly different but overlapping processes and roles.

A preceptor is, 'an identified experienced practitioner who provides transitional learning and role support within a collegiate relationship'.



A mentor is:

*some one who provides an enabling relationship that facilitates another's personal growth and development. The relationship is dynamic, reciprocal and can be emotionally intense. Within such a relationship the mentor assists with career development and guides the mentee through the organisational, social and political networks.*

A definition for mentoring is also provided by Szirom and Stephens (2006)

*as a mutual and reciprocal relationship between a more experienced worker and one who is new to their position and/or a new graduate. The nature of the relationship is about inquiry, reflection on practice, learning from experience and building skills and knowledge.*

A coach is:

*a skilled practitioner who provides an understanding of the nature of professional practice through the provision of learning opportunities and supportive intervention. Coaching involves constructive monitoring and feedback of performance to aid learning and personal development allowing the student to practice effectively (Morton-Cooper and Palmer 2000:189).*

#### 2.1.4.1 Reflection

It is not surprising that there is considerable overlap and confusion reported in the literature between reflection and clinical supervision which is focused on educative and supportive functions. The importance of reflection in health science education and professional practice is well recognised and arises from the early work of Dewey in the 1930s and the seminal work of Schon in the 1980s. Reflective practice is fundamental to practice development since it encourages practitioners to critically appraise their work and strive to continually improve it (Williams et al 2005).

Boud et al (1985) define reflection in the context of learning as a generic term for intellectual and affective activities in which individuals engage to explore their experience in order to lead to new understandings. Boyd and Fayles (1993) in Kember et al (2001) define reflective learning as a process of internally examining and exploring an issue of concern triggered by an experience which creates and clarifies meaning in terms of self and which results in a changed conceptual perspective.

A reflective learning process is suggested as a theoretical framework for many supervision education programme. Williams et al (2005) suggest the Gibbs reflective practice model be applied in both one-to-one and group supervision. This model follows the following cycle:

- a description of what happened
- an exploration of feelings and thoughts
- evaluation of whether this was good or not
- analysis of what sense might be made of the situation
- the development of an action plan for future practice or situation

Similar models of reflection are described by Johns (1997) and Driscoll (2000) in van Ooijen (2003).

Reflective processes form the basis for critical incident analysis, reflective journals and diaries. This raises questions about the difference between processes such as peer review and peer group



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supervision. It is not surprising that one of the conclusions from the Williams et al (2005) study which introduced a team clinical supervision programme based on the Gibbs reflective cycle was that following the introduction of the supervision programme all staff reported being more reflective in their practice in both informal and formal processes. However staff reported there was little difference between processes of shared reflection and those defined as clinical supervision. The authors stress the importance of maintaining the flexibility of multiple systems and valuing and validating all processes.

Fowler and Chevannes (1998) explore the efficacy of reflective practice in clinical supervision and identify some potential limitations. They point out that there is an interplay between reflection and clinical supervision and view reflection as an enabling process for many activities of professional supervision. They explain that although reflective practice is part of clinical supervision, it is not universally applicable to all clinical supervision. In some instances reflection may actually hinder supervisory outcomes. Effective reflection must engage the self and if the supervisee is defensive or unable to disclose his or her inner feelings to others then there may be other processes more appropriate (Fowler and Chevannes, 1998). Supervision needs to be structured to meet the specific needs of the individual practitioner. Clouder and Sellars (2004) agree that reflective practice and clinical supervision are not synonymous. They view reflection as integral to both the process and purposes of supervision however they state that supervision as only one of a variety of ways of engaging in reflection. Paget (2001) in a study of the clinical outcomes of reflection identified the importance of an effective facilitator of reflection in achieving changes in practice. van Ooijen (2003) raises the important issue that whatever model is used, it is the skill and the experience of the supervisor as well as the willingness of the supervisee to engage with reflection that determine the efficacy of the process. Veeramah (2002) identified that 87% of the nurses surveyed in his UK study of mental health nurses perceived clinical supervision helped them to reflect (Refer section 2.4.3.1.1).

## 2.2 Aims of Clinical Supervision

The historical development of supervision has highlighted three different aspects of supervision. These are clearly defined in the literature (Kadushin and Harkness 2002) as a model of supervision and provide a framework for aims related to:

<i>Educational Supervision</i>	This is concerned with tailoring learning opportunities to meet supervisees' individual needs related to knowledge, maturity, and level of professional development
<i>Supportive Supervision</i>	This is concerned with helping the supervisee deal with job related stress and developing the attitudes and feelings required to ensure the best workplace performance
<i>Administrative Supervision</i>	This focuses on organising the workplace facilities and human resources. It includes the requirement to monitor, review and evaluate the supervisee's performance

van Oijen (2003:62) explains that each of the functions of supervision relates to specific supervisory tasks:

- the administrative or managerial with its focus on monitoring and evaluating ethical and practice issues requiring clear lines of accountability, appropriate challenges and regular honest feedback and constructive criticism
- the educative function highlights teaching and learning issues, the facilitation of reflection and development of self awareness
- the supportive function highlights the establishment of a good supervisory relationship and effective listening skills



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Bernard and Goodyear (2004) outline the purposes of clinical supervision are to:

- to foster the supervisees professional development
- to ensure client welfare

Morton-Cooper and Palmer (2000:144) expand these further in listing the aims of clinical supervision for nursing in the UK as:

- expanding the knowledge base of the supervisee
- assisting the development of clinical expertise (of the supervisee)
- developing self esteem and professional autonomy

Added to these are the managerial functions related to:

- safeguarding standards of practice
- delivering quality care

A number of studies used supervisee perceptions to identify the aims of clinical supervision.

Skerrett (2004) describes the development of a flexible working alliance between supervisees, staff supervisors and team leaders aimed at:

- increasing the quality and autonomy of professional practice with a client focus
- enhancing relationships of trust and mutual respect necessary to balance the competing demands of facilitating practice skills and knowledge
- meeting organisational objectives

### **2.2.1 Role Conflict**

The lack of clarity about a process which combines education and support with an administrative function creates confusion and suspicion around what it is (Walsh et al 2003). Walsh et al (2003) state that the name clinical supervision implies a hierarchical process rather than one that is nurse-centred and reflective. Kelly et al (2001) report that it is essential to make a clear distinction between managerial control and the provision of personal/professional development through clinical supervision although acknowledge that this may not easily be achieved. Others contend that the conflict between management and control versus personal professional development causes mistrust and may inhibit the benefits of clinical supervision (White & Winstanley 2006).

White et al (1998) identified in interviews that some nurses perceived clinical supervision as a punitive tool for disciplinary purposes. These authors view the complexity of the management quality issue versus the personal professional development interface as a challenge that may inhibit the full commitment of practitioners. Many of the authors raise concern about the role conflict arising from a process which is both enabling and ensuring. Veeramah (2000) reported that one third of the community mental health nurses in their UK study saw clinical supervision as another management tool and 39% stated that it was used as part of performance review. It is possible that such misconceptions may arise from a lack of supervisee preparation for their involvement in clinical supervision or that they represent the perceived reality of these nurses' workplaces. Clouder and Sellars (2004) writing from an allied health perspective report that there appeared to be no indication that physiotherapists in the UK felt threatened by the clinical supervision process or saw it as performing surveillance or a regulatory function. However Clouder and Sellars (2004) caution that seeking to fulfill both a professional development and regulation agenda within the clinical supervision process is problematic. They believe these processes should not coexist and '*where there is an attempt to address both neither will be adequately fulfilled*' (Clouder and Sellars 2004:268).



## 2.2.2 Balancing the Functions of Clinical Supervision

There is agreement in the literature that in order to successfully provide the supportive and educative functions, supervisees need to feel supported and safe, in a trusting supervisory relationship. Shaw (2004) in an eloquent opinion paper clearly argues that effective supervision is more than just a safe place to reflect on clinical practice. Whilst she acknowledges the importance of a positive relationship, she also sees that an essential task of supervision is to provide feedback which may challenge or confront should the need arise. An evaluation of a small pilot peer group supervision programme by Walsh et al (2003) highlighted this important point (Refer section 2.8.3). Williams et al (2005) in another evaluation of a group clinical supervisor programme identified that the group had successfully developed a supportive environment, but an independent observer reported there were minimal attempts by group members to challenge each other. Plans were made to maintain the supportive atmosphere and in future, peers agreed to find ways of critiquing and challenging each other.

Shaw (2004) suggests that using an adult learning framework and engaging supervisees in goal setting with an outcome focus is the first step in the negotiation of the contract. When this is a collaborative process, which also includes self evaluation, then monitoring is shared and part of the contract.

Shaw (2004:66) defines a mistake as an '*unintended slip in good practice or a common therapeutic blunder*'. These are inevitable in practice. She argues supervisees may hide such instances out of fear, embarrassment or feelings of vulnerability. The supervisor must be able to judge between a genuine mistake and poor practice, negligence and malpractice. When a good relationship has been established, with clearly negotiated guidelines about dealing with such instances, then the supervisor can be instrumental in assisting the supervisee to rectify and deal with the situation. Shaw maintains that the best defense against litigation is good practice. She suggests that clinical governance provides a sound framework for shared responsibility between three different levels in the organisation.

The first is that supervisees need to be prepared for supervision and participate constructively in the opportunities provided for them. Secondly, supervisors need to take a broad overview of their supervisory responsibilities and engage in activities such as orientating and preparing supervisees for supervision, developing a positive learning relationship with transparent guidelines for all processes, monitoring supervisees' performance, providing timely feedback and clear evaluation of practice and using the identified systems for any serious problem identified. Thirdly, management has the responsibility for the development and promotion of sound organisational policies and for the provision of a supportive environment with appropriate resources and support.

## 2.3 Key Components of Clinical Supervision

### 2.3.1 Provisional Standards

Rafferty et al (2003) in a rigorous qualitative study (using a modified Delphi technique) developed provisional standards for supervision for clinical nurses and health visitors (Refer section 2.7.3). It should be noted that this research set out to identify standards and did not address the detail of any of the standards. It is interesting to notice that the list of standards does not include any evaluation process.



These standards include:

- appropriate time
- appropriate environment
- appropriate contract
- appropriate relationship
- appropriate atmosphere
- interventions – listening and reflecting
- remembering and recording - brief personal notes
- organisational support - feedback via supervisee
- competency
- maintenance of good clinical standards
- enabling emotional competency
- enabling collaboration
- enabling transition and change
- affirmation of good practice
- prevention of harm - supervisee and client
- promotion of reflective practice
- suggested helpful stages include the eclectic use of models and approaches
- focus of clinical supervision as a professional activity that is not disciplinary or counseling

### **2.3.2 Policy**

#### **2.3.2.1 Policy Development Processes**

Williams et al (2005) suggest the opportunity to explore and experience supervision should precede the development of a formal policy. This study reported on the use of an audit to inform policy development. Malin (2000) used action research to supply feedback to managers on policy objectives for a clinical supervision programme for community health disabilities services. A number of studies stressed the importance of a collaborative approach in establishing clinical supervision programme (Spence et al 2002, Williams et al 2005, Skerrett 2003).

Hawkins and Shohet (2006:209) advocate that the following steps be taken in the development of policy.

- create an inquiry into what supervision is already available in the organisation
- awaken the interest in developing supervision practice and policy
- initiate some experiments
- deal with resistance to change
- develop supervision policies
- develop ongoing learning and development for supervisors, supervisees and the organisation
- ensure an ongoing audit and review process

#### **2.3.2.2 Components of a Policy**

Hawkins & Shohet (2006:214) continue to highlight the importance of policy for clinical supervision, including components such as:

- purpose and function
- how supervision will contribute to the agency's overall aims
- minimum standards for the content and conduct of supervision



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- minimum requirement for supervision contracts, to include frequency and agenda setting
- a statement of anti-discriminatory practice
- how supervision will be recorded and status of the notes
- explicit statement about the relationship between supervision and appraisal
- rights and responsibilities of both supervisee and supervisor
- methods for resolving disagreements and/or breakdown in the process
- the type of confidentiality expected and guaranteed with a clear statement of how “poor performance” will be dealt with and “good performance” acknowledged
- what supervision should focus on i.e. the priority for supervision in relation to other tasks

A review of the grey literature for Victorian and UK community centres reveals that local organisations have spent considerable effort reviewing the literature and developing comprehensive policy to address the topics listed above. Southern Health (2007) Guidelines for Allied Health Clinical Supervision provides a good example. These guidelines also contain templates of supervision contracts and recording sheets.

Roche et al (2007) suggest the following seven elements for the development of a clinical supervision policy for Drug and Alcohol supervision:

- Rationale for the importance of supervision in the workplace
- policy statement regarding the organisation commitment
- an aim
- outcome statements or standards
- evaluation protocols
- identification of the key players and their roles
- specific arrangements e.g. group or one-to-one model

### **2.3.3 The Relationship in Supervision**

McMahon and Patton (2002) suggest that due to the complexity of the supervision process it is helpful to link three discrete concepts: Supervision as a relationship, as a developmental process (Refer section 2.5.3) and as a learning environment. Certainly the supervisory relationship is critical to supervisory outcomes. Cutcliffe et al (1998) state that it is the supervisor's responsibility to create the unconditionally supportive learning environment required to facilitate optimum supervisee personal and professional development. The key feature of the Kavanagh et al (2002) definition of clinical supervision is the notion that it is a working alliance between supervisor and supervisee based on trust and mutual respect. However these authors explain that the relationship exists with at least four parties: the supervisee, the supervisor, the client group, the employer and in many cases the professional organisation and registration board. The importance of a working alliance or effective relationship is evident in many of the themes of the literature review e.g., the different functions of supervision, supervisor role conflict, supervisee autonomy and choice of supervisor and the ongoing discussion about line managers as supervisors discussed latter in this section.

Cerinus (2005) stresses that the quality of supervision rests on the quality of the relationship between supervisors and supervisee. Hence outcomes of supervision are related to the attitude of the supervisor as well as the supervisee: whether each is committed to the supervision process and whether engagement in supervision is mandatory or chosen (McMahon and Patton 2002).

Interview comments about the perceptions residential care staff have about the relationship with their supervisors are consistent with those of positive relationships in general (Rennie 2003). Trust and confidence, honesty, respect, understanding and not being too opinionated or



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judgmental were the qualities sought and appreciated by supervisees in this study. In their absence supervisees identified difficulties in self disclosure and confidentiality. In fact without a good relationship, supervision was seen to be a waste of time (Rennie 2003). Clouder & Sellars (2004) explain that in clinical supervision there is a potential for this to be a power relationship and it is important to recognise that resistance may be an antidote to power. Such resistance may occur if supervisees “sanitise” issues brought to supervision.

### **2.3.4 Selection of Supervisors**

Spence et al (2002:68) suggest the following guidelines for the selection of supervisors. These relate to:

- position in the organisation i.e. some seniority
- a minimum of 2 years clinical experience (Barriball et al, 2004 increased this to three years).
- commitment to act and train as a supervisor
- effective communication skills
- knowledge and skills appropriate to the work place

Powell & Brosky (2004) in Roche et al (2007) list the following Fours A’s as essential attributes of good supervisors. They state supervisors must be:

- available
- accessible
- able
- affable

#### **2.3.4.1 Background of Supervisor - Discipline Specific or Interprofessional**

There is some debate in the literature about whether a supervisor needs to have the same professional background as the supervisee. Results from the Kelly et al (2001) study were inconclusive on the question of whether supervisors needed to come from the same profession as the supervisee. Focus group participants from allied health and community nursing expressed concerns about supervising a clinician from a different profession (Skerrett 2004). However Fone (2006) suggests that supervisors may not always have content specific skills and knowledge and a supervisee can access these from others.

Perhaps the background of the supervisor may relate to the specific objectives of supervision. In instances where the supervision has a strong educative focus it may be essential that the supervisor has appropriate content knowledge and the associated skills base. Roche et al (2006) report on specific challenges related to the Australian Alcohol and Other Drugs workforce, where it is essential to develop the skill base when complex challenging poly drug presentations is increasing. They explain that in Australia one third of workers have no related formal education. In Victoria this workforce has a complex mix of backgrounds ranging from TAFE to post graduate academic qualifications but only 8% have any formal education related to drug and alcohol or addiction.

Similar recommendations are made for Mental Health in Australia. Edwards et al (2006) refer to a specific directive in the National Mental Health Education and Training Advisory Group (2002) that the disciplines of psychiatry, nursing, social work, psychology and occupational therapy be supervised by a supervisor of the individual’s discipline. Kavanagh et al (2002) identified differing theoretical and professional perspectives on clinical practice related to the Alcohol and other Drugs field between medical staff, allied health and nurses. Hence supervision by a supervisor from another discipline had the potential to create conflict and confusion. They identified that



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supervisees perceived there was a higher impact on their practice when supervision focused on time with specific profession skills with a supervisor from the same discipline and did not perceive this occurred when supervision focused on generic skills with a supervisor from another discipline.

If the supervisee and the supervisor are from the same profession then client outcomes may be better (Kavanagh et al 2002).

#### 2.3.4.2 Choice of Supervisor

Tinsley (2001) writing with a background of clinical psychology describes the impact restructuring changes have on the nature of practice itself, patterns of employment and traditional arrangements of clinical supervision. At a time when primary care counsellors need to adapt to new work structures, legislation, accountability, legal requirements and data safeguards they also require a more specialised supervisory role. Her concerns relate to a potential lack of autonomy and choice in a new workplace imposed clinical supervision process.

Cerinus (2005) stresses that the quality of supervision rests on the quality of the relationship between the supervisor and supervisee. This small study highlighted the central importance of supervisees having the opportunity to choose their supervisors. This was seen to be critical in establishing a learning environment of comfort, trust and confidence as pre requisites for challenge.

Teasdale et al (2001) reported that all staff and the steering group agreed that supervisors should be chosen by supervisees. Edwards et al (2005) state that supervision was perceived to be of higher quality when supervisees could choose their supervisors. Winstanley and White (2003) also report that choosing the supervisor enhanced the quality of the supervisory relationship and hence the development of trust and rapport and challenge. Williams et al (2005) advocate supervisees choose their supervisor. All of the nurses in the White et al (1998) study were allocated randomly to their clinical supervision partners. However permission to reject an allocation was given in advance.

There is an interesting mismatch in the data from supervisors and supervisees in the Kelly et al (2001) study of community mental health nurses in Northern Ireland related to choice or allocation of supervisor. The percentage of staff allocated and supervised by line managers varied between supervisor data and supervisee data. The data acknowledges that respondents may have ticked more than one box and it was possible for a supervisee to be allocated by management to their direct line manager. It illustrates different perceptions of the same process.

Edwardes et al (2005) used the Manchester Clinical Supervision scale with community health nurses in Wales. The survey was completed after six or more sessions of supervision where 73% of the respondents were receiving supervision. Clinical supervision was most positively evaluated by nurses who had chosen their supervisor and where sessions took place away from the workplace. The greatest increase in effectiveness was for sessions which extended over one hour and occurred at least once a month. Time, space and choice were identified as critical elements of effective supervision.

#### 2.3.4.3 Line Managers as Supervisors

Kelly et al (2001) reported all allied health staff in their study agreed that there should be clear boundaries between practice supervision and line management. Others voice concern about the difficulty in roles when the supervisor is also the supervisee's line manager (Walsh et al 2003,



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Edwards et al 2005). The Kelly et al (2001) multidisciplinary study conclusion that serious training and education deficits exist at the managerial and clinical supervision interface, highlighted the importance of keeping administrative/managerial supervision separate from clinical supervision and the importance of confidentiality. The authors also cautioned that any amalgamation between the two roles would dilute the effective support system.

Skerrett (2004) in her study of an allied health team in Queensland reported that all staff agreed that there be clear boundaries between practice supervision and line management and recommended that supervision be resourced and accessible i.e. paid for by Queensland Health.

Cutcliffe and Hyrkas (2006:624) quote the United Kingdom Central Council's position that states:  
*Clinical supervision is not a managerial control system. It is **not** therefore: the exercise of overt managerial responsibilities or managerial supervision a system of formal individual performance review or hierarchical in nature*

The majority of papers strongly recommended that there should not be an administrative hierarchy between supervisor and supervisee (Sirola-Karvinen & Hyrkas 2006). Kelly et al (2001) reported that there was strong agreement from all staff that managers were not the best supervisors.

Although there is general agreement that a line management model is not the best model it appears to be prevalent in many workplaces (Kelly et al 2001, Roche et al 2007) which results in difficulties related to confidentiality (Clough 2003) (Refer section 2.3.6). Cutcliffe and Hyrkas (2006) agree that it is important to link the two processes of clinical supervision and management in local policies for example involving management in evaluation processes and service benefits. Fone (2006) acknowledges that although supervisees should not be supervised by line managers it may not always be practical. In such cases she advises it is important to recognise the power gradient.

#### 2.3.4.4 Location of supervision

There is some ambiguity in the literature related to the location of supervision. Some papers are clearly referring to external supervision, others to internal supervisors from the workplace finding a location which is quiet and free of workplace distraction. Although Winstanley and White (2003) reported the location of supervision did not appear to affect the content of supervision, supervisees who received supervision away from the workplace showed higher scores on the Manchester Clinical Supervision Scale. Roche et al (2007) suggest that although supervision external to the workplace provides a way of separating clinical supervision from line management, it is important to ensure the supervisors understand the mission aims and protocols of the supervisee's workplace.

#### 2.3.5 Clinical Supervision Education and Training

Although there is considerable literature available related to the importance of preparing both supervisors and supervisees for their clinical supervision involvement and many descriptions of education programmes, there is little rigorous evaluation on the effect such efforts have on supervision outcomes. Kavanagh et al (2002) reported that trained supervisors were more likely to relinquish power by encouraging active involvement of their supervisees in supervision, than supervisors who had not participated in training. Hunter and Blair (1999) in OT Australia (2000:14) recommended that, 'to enable staff to make full use of supervision, training in



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supervision is essential for both supervisee and supervisor'. However preliminary studies on the effect of training on supervisory behaviours are inconclusive.

### 2.3.5.1 Supervisor Education Material

Fone (2006) identified the paucity of clinical supervision literature available and developed an information and assistive package for Occupational Therapists to assist in the development of purposeful and rewarding supervision. In this she explored concepts of reflective practice, adult learning, emotional intelligence and shifting skills. She also addressed the purpose, function and benefits of supervision, models of supervision, and vignettes of supervision, as well as suggesting articles and documentation protocols. An excellent comprehensive practical guide on clinical supervision has been developed for the Alcohol and Other Drugs field by Ask and Roche (2005).

### 2.3.5.2 Supervisee and Supervisor Education Programme

If supervision is to be effective, supervisors and supervisees need preparation and ongoing support for their roles (Draper et al 1999, Barribal 2004, Veeramah 2002, Hawkins & Shohet 2006). A summary of principles for developing supervision education by Hawkins and Shohet (2006:130) includes the advice to:

- begin with self awareness activities
- utilise a range of experiential learning techniques
- teach basic skills and techniques and provide opportunities for practice and feedback
- address the real life issues of participants
- introduce theory after experiential learning is established

A number of studies provide details of the number of supervisors and supervisees who had received preparation for the role. An example of one of these studies is provided by Veeramah (2002) in a study of mental health nurses in the UK. This established that only 59% of supervisees had received some form of induction to clinical supervision and 33% felt they needed more education to help them fully understand the process of clinical supervision. In addition 71% of supervisors stated they would require further education if they were to be more effective in meeting their role and responsibilities. Details of the education provided were not included in the study.

Kelly et al (2001) in a pilot study of Community Mental Health Nurses in Northern Ireland reported that 81% of the workforce was involved in clinical supervision. A large number (63%) had not received preparation for the process. In regards to preparation, 37% of the nurses had received preparation for clinical supervision. Of these 60% received supervision skills preparation, 19% in supervisee skills and 21% in both. Managers, supervisors and supervisees agreed that preparation for the role is essential and should be planned and that without appropriate education clinical supervision may not be effective.

#### 2.3.5.2.1 Supervisee Preparation

Hawkins and Shohet (2006:34) advocate that supervisees take responsibility for their supervision by:

- identifying practices they need help with
- identifying responses they would like
- becoming increasingly able to share, ask for help and be open to feedback
- becoming more aware of wide organisational issues that affect supervisors, clients and supervisees



- monitoring tendencies to justify, explain and defend
- evaluating supervision and clinical practice

### 2.3.5.3 Variety of Supervision Education Programmes

Details of a variety of different preparation programmes for clinical supervisors exist in the literature. These range from four hours (Willson et al 2001) to two day courses (Spence et al 2002) to extensive postgraduate qualifications (Rafferty et al 2003).

#### 2.3.5.3.1 Examples of Clinical Supervision Education Programmes

The next section provides details of education programmes for clinical supervision. Skerrett (2004) provides details of a programme with a problem based learning focus with experiential activities, role play and videos. Ethical issues (confidentiality, duty of care and standards of care especially related to dual responsibilities) were explored. This programme ran for two days. On the second day the challenges identified on the first day were analysed and work shopped. Personal knowledge regarding individual preferences for learning styles and personality types was highlighted and details of reflective practice were presented. An agreement covering the following topics was developed:

- aims of supervision
- specific objectives
- responsibilities
- structure (frequency, duration and location)
- evaluation of the relationship
- record keeping
- ethical issues
- proformas for agreements, evaluations and record keeping

Rafferty et al (2003) describes study days, workshops and Diploma level post registration courses. Such clinical supervision education programmes aim to enable practitioners to learn supervisory ideas and skills and develop competencies through and from clinical supervision practice (Rafferty et al 2003). He describes a two day course which presented roles, skills, models and delivery and used reflection and contracts. The second day of this course was scheduled after three months practice to focus on reflection and deal with management and ethical problems.

A variety of theoretical perspectives are suggested for supervisor education. Williams et al (2005) used Gibbs reflective practice model to apply to one-to-one or group supervision. Roche et al (2007) provide details of the processes and content required for supervisors working in the Alcohol and other Drugs workplace. They suggest programme including adult learning, self directed learning and highlight the importance of autonomy in learning. They report that a practical resource kit has been developed for the Alcohol and Other Drugs field.

Survey results from Skerrett (2008) were taken into account in the development of a clinical supervision programme model, training programme and guidelines. The following recommendations were made for future implementation:

- a contract should be utilised and developed at the outset of the relationship
- supervision should be supportive rather than reporting
- trust in the relationship is essential for success
- supervision should be closely linked to performance appraisal and development programme and advanced skills identified in this within a supportive relationship



- regular objective review of the supervisory process

Future initiatives were planned such as:

- establishing a Help desk model where phone access on supervisory issues is available
- extending the preparation to nurses and doctors
- evaluating the long term outcomes

### **2.3.6 Confidentiality**

Cutcliffe and Hyrkas (2006) investigated multidisciplinary attitudes to clinical supervision in the US. They surveyed 72 professionals from eight different professions (Mental Health, Hospital and Community based and Learning Disability Nurses, Chiropractors, Occupational Therapists, Health Visitors and Physiotherapists) in the US and asked them to rank order 17 statements in order of their perceived importance.

There was unanimous agreement from all professions except the health visitors that the most important element to clinical supervision was that confidentiality should be assured and agreed on. However, there is no further explanation of the confidentiality terms and when it would be appropriate for a clinical supervisor to discuss a clinician's work with a manager. There was also agreement from all eight professions that the clinical supervisory relationship must be separate to the administrative managerial relationship. Cutcliffe et al (1998) raised concerns about the ethical issues related to whether the clinical supervisor should keep material confidential or inform an appropriate authority. They used case scenario to highlight legal and ethical issues and present a strong argument for setting clear guidelines and boundaries between management and accountability and education and professional development.

### **2.3.7 Documentation**

Both informal and formal recording are suggested in the literature. However conflicting views relating to documentation exist. Those who focus on clinical supervision as enabling professional growth and education suggest a recording system that is supervisee driven with less formal documentation.

#### **2.3.7.1 Informal Documentation**

Rafferty et al (2003) suggested supervisors make brief notes to aid memory especially in complex cases which are likely to extend over several weeks. Supervisees are also encouraged to keep notes to encourage them to articulate their thought processes and increase their self awareness. Fone (2006) in her package for occupational therapy supervisors suggested that documentation include supervision protocols, session records, goal setting sheets and a supervision contract. Willson et al (2001) in their pilot study suggested supervisors and supervisees keep personally held records of dates and times of the meetings with signatures of both participants. Any additional documentation was seen as optional and there was agreement that documentation was confidential. Williams et al (2005) advocate the use of an audit form to document frequency and type of supervision to provide evidence that clinical supervision was taking place. Cutcliffe (2000) in Veeramah (2002) suggests the use of reflective diaries and learning journals. Survey results of community mental health nurses in the UK identified that only half of the respondents reported keeping records of their session. Veeramah noted that, 'a significant number of respondents



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stated that issues of confidentiality are not incorporated in the supervisor contracts, despite the strong claim made in the literature that it is crucial...' (Veeramah 2002:21).

### 2.3.7.2 Formal Contracts

Many authors advocate the use of a contract for one-to-one sessions to empower participants (Williams et al 2005, Skerrett 2004) and to negotiate session rules, expectations and clarify confidentiality issues (Rafferty et al 2003). Cutcliffe and Hyrkas (2006) in a multidisciplinary UK study identified that 74% of the respondents agreed that a written contract for supervision be completed and 77% agreed that the goals of supervision be explicitly formulated. Hunter and Blair (1999) indicate that supervision contracts clarify expectations and build trust in the relationship. They cite Pritchard (1995) suggesting that without a contract, supervision cannot be fully purposeful nor can it be evaluated. Hawkins and Shohet (2006) emphasise the importance of using a contract. This provides an opportunity for both parties to explore personal expectations of both the supervisory process and the responsibilities each has of the other.

Veeramah (2002) alludes to the debate regarding legal implications. Falvey and Cohen (2003) strongly argue that documentation is a standard of competent supervisory practice. They state that since supervisors are accountable for interventions and clinical decisions implemented by supervisees, formal documentation is an essential risk management strategy. In fact professional standards exist in many mental health disciplines which stipulate that a written record of the supervision contract, ongoing supervision sessions and periodic formal supervisee evaluations be maintained. This not only protects the supervisor but also assists with structuring the supervision session, oversees the supervisee's clinical work and promotes professional development. The failure to adequately supervise has been identified as an increasing legal risk in mental health service delivery in the USA. Examples of legal precedence in mental health service delivery where the written supervision record was central to court decisions are provided.

Interestingly, Falvey and Cohen (2003) raise the point that there are potentially ethical and legal pitfalls in over documenting as well as under documenting. Examples of over documenting include disparaging remarks about clients or supervisees, disclosing sensitive personal details and opinions not supported by objective data. Examples of recording templates are included in this article.

## 2.4 Outcomes of Clinical Supervision

Rennie's (2003) study of the experiences of residential care staff of supervision identified a range of different personal responses to supervision and highlighted the impact personal differences have on supervisory outcomes. Some supervisees viewed their supervision as a scary and daunting experience. They voiced highly emotional responses related to authority and intimidation. Others viewed supervision as a waste of time either because of a perception that it did not change anything, or that the supervision functions were met by other processes or a lack of competence or commitment by their supervisors. Another group identified supervision as a positive enjoyable experience. They attributed this to the relationship with their supervisor and the support available to them, the exposure to new and different ideas and strategies and the opportunity to be listened to. van Ooijen (2003) describes the effect past educational and workplace experience has on supervision. If the workplace environment is shame based or negative then supervision has the potential to be viewed as destructive (Refer section 2.6).



### 2.4.1 Importance of Supervision

Many authors stressed the importance of commitment to supervision from the organisation in the allocation of time and resources (Barribal et al 2004, Malin 2000:555) (Refer section 2.6). Kelly et al (2001) reported that all respondents (managers, supervisees and supervisors) in their study agreed that clinical supervision was valuable and that it should be available to staff at all levels. However there is a general agreement in the lack of evidence to support many of the educational and supportive benefits (Coleman & Lynch 2006, Kelly et al 2001, Teasdale et al 2001, Malin 2000, Willson et al 2001) and little evidence to support claims of improved patient outcomes and improved care (White et al 2006, Wolsey & Leach 1997, Malin 2000).

### 2.4.2 Perceived Benefits

Potential benefits for community health nursing (but unsubstantiated) are listed by Clough (2003) and Willson et al (2001). These include:

- support – especially for those working in isolation
- confidence to implement innovations within practice
- enables practitioners to focus on personal and professional development need
- identifies and disseminates best practice
- promotes a sharing learning culture
- offers a sounding board and professional safety net
- increases awareness of professional accountability
- encourages critical reflection
- encourages evidence based care
- promotes patient focused care

Veeramah (2002) sent a postal questionnaire to mental health nurses in two UK Trusts to investigate their use of clinical supervision and their perceived benefits. The results are presented in the table below.

Table 1. Perceived Benefits of Clinical Supervision

<b>Responses of perceived benefits</b>	<b>Percentage (n=100)</b>
It provides the opportunity for a more experienced practitioner to monitor, educate and support a less experienced one	64
It provides a means of protection to practitioners by helping to reduce stress and burnout	79
Specific clinical and ethical issues or problems can be brought to the attention of the supervisor and therefore addressed	79
It provides significant benefits in terms of improved delivery of care	83
It helps the practitioner to examine his or her practice in detail including strengths, weakness and learning needs	83
It helps practitioners to reflect on their dilemmas, difficulties and successes and how they reacted, solved or achieved them	87

Draper et al (1999) report on studies describing potential benefits for community based health workers engaged in supervision. These include increased confidence and openness; improved role



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clarity; collaboration in teams; and increased awareness of the impact of their emotions on practitioners. A pilot programme reported that clinical supervision improved clinical insight, increased confidence and improved working relations (Brooker and White 1997 in Kelly et al (2001). Teasdale et al (2001) reported clinical supervision enhanced nurses' self image and sense of professionalism.

Clouder and Sellars (2004) report on research with physiotherapists in the UK where there was universal agreement that clinical supervision was a necessary function of professional practice. Physiotherapists identified benefits as: having time to reflect on practice; gain support and advice; develop personally and professionally; and feel less isolated.

Jones and Partington (2007) documented details of an action study in the development of a community nursing clinical supervision programme. It reported on the development of a policy and an education package from the results of a satisfaction survey undertaken in 2004, and the subsequent implementation of a small clinical supervision programme for 48 nurses delivered by 10 clinical supervisors. A satisfaction survey of nurses receiving supervision (n=35) indicated that clinical supervision assisted the nurses to reflect on clinical practice (85%) provided peer support in a confidential environment (94%) and provided learning through sharing experiences (84%). Nearly half of the supervised nurses reported that clinical supervision had assisted in a practice change.

### **2.4.3 Evidence of Benefits**

There are methodological difficulties associated with what and how to measure outcomes (Coleman & Lynch 2006) methodological flaws in much of the research, no agreement in operational definitions of key constructs and no empirical verification of described models (Wolsey and Leach 1997). Kavanagh et al (2002) state that the literature on supervision is very light on good evidence since it has few randomised controlled trials and much of the evidence relies on rated preferences of supervisees.

#### **2.4.3.1 Personal Benefits for Supervisees**

It is important to acknowledge that overall studies reported that supervisees perceived they had benefited from their experience in clinical supervision. White et al (2006) and Kelly et al (2001) list improved clinical insight, personal confidence and stronger working relationships as principal positive outcomes. However Kelly et al (2001) reported no positive value for 13% of clinical nurses.

Butterworth (1997) describes a large scale (23 sites) national evaluation of nurses in UK using the Manchester Clinical Supervision Scale (Butterworth 1997, Malin 2000, Winstanley and White 2003, Willson et al 2001). This study reported overwhelming positive results from supervisees who reported supervision had been beneficial and improved clinical competence and confidence. A small qualitative study by Malin (2000) identified that clinical supervision improved team relations and helped nurses to reflect on the care they provided. Some nurses felt that clinical supervision helped them to increase knowledge about discharge policies, cope with change, improve service delivery, prioritise work load and be more focused with their care.

Willson et al (2001) identified that nurses who acted as supervisor supporters, as well as those who were supervised, reported added insight into the roles of others and improved team functioning. Confidence and knowledge were increased for the supervisees in this study. Nurses interviewed by White et al (1998) listed personal benefits as outcomes of the supervision



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sessions. These included the development of confidence and self esteem and increased awareness of their abilities to take responsibility for their own practice.

The lack of clarity and agreement about what clinical supervision is appears to be an issue for the workplace. Most studies reporting on pilot clinical supervision programme reported positively. However Draper et al (1999) stated that although overall participants recognised personal benefits and felt more supported, there was also an increase in negativity about clinical supervision and the claimed benefits. The authors interpreted this increase in uncertainty of the benefits as an illustration of the complexity of the process, challenges of clinical supervision and the difficulties associated with implementation.

#### 2.4.3.1.1 Reflective Practice

Butterworth (1997) states there is ample evidence that clinical supervision provides a much needed opportunity for reflection and advancement of skills and support. Willson et al (2001) reported that over half of the nurses in the study developed heightened awareness of the importance of reflection and increased skills in reflective practice. The participants in the Barribal et al (2004) study listed the opportunity to talk with others and time to reflect as benefits of supervision. Draper et al (1999) identified that clinical supervision had encouraged reflection on practice and made some nurses think before acting and allow more time for reflection. Magnusson et al (2002) viewed the opportunity to reflect with others and express tacit knowledge improved the development of professional identity, competence, skills and self esteem. Having time to reflect on practice was identified by more nurses interviewed by White et al (1998) in the UK study than any other content theme.

#### 2.4.3.2 Client Outcomes

There is a general lack of research to demonstrate client outcomes. Most studies reported on the supervisees' perception of supervision, and there is little research evidence to provide another perspective. Roche et al (2007) refer to a study reporting enhanced quality of care management of challenging behaviours and improved team effectiveness of nurses working with people with borderline personality disorders.

The one clear exception is provided by Bambling (2003) who investigated the impact clinical supervision had on psychotherapy practice and the outcomes of treatment for clients with depression. This study concluded that clients who were treated by a supervised therapist, irrespective of the type of supervision, showed greater reduction in their symptoms, were more satisfied with their treatment and were more likely to continue with treatment than those clients treated by an unsupervised therapist. In fact the study indicated that a single session of supervision had a major impact on the working alliance between the client and clinician.

##### 2.4.3.2.1 Ethical Decision Making

Magnusson et al (2002) identified a lack of research on the benefits of supervision relating to ethics as the impetus for the following study. This Scandinavian survey focused on the nurse patient relationship and ethical issues related to home visiting. The study of 660 nurses who were working as district and psychiatric nurses and mental health care workers, identified that 51% of staff received supervision but 48% did not (1% did not answer the question). Responses from those nurses receiving supervision reported changes in ethical decision making related to:



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Emotional awareness - Those receiving supervision showed increased awareness of the effect of their intrusion into the client's home and were more sensitive to client needs. They were also more aware of the balance between paternalism and self determination.

Autonomy - Those receiving supervision showed respect for patients to make decisions and waited for participation. They identified inner conflict between paternalism and autonomy and between beneficence and non-maleficence and respected the patient's need for privacy.

Integrity - Those receiving supervision showed respect for personal and social integrity.

Individual differences - Those receiving supervision were more aware that working in people's homes implied a more equal relationship between carer and patient and showed greater respect for individual differences.

Overall the staff receiving supervision felt more secure in relation to the patient as well as being more confident in their own decision making. Supervision appeared to strengthen the supervisees' abilities to wait for patients' participation in care or take over if necessary.

### 2.4.3.3 Organisational Benefits

A number of organisational benefits were reported in the literature. The key themes include: workforce; stress and burnout; reduced isolation; and retention.

#### 2.4.3.3.1 Workforce

Roche et al (2007:242) state that clinical supervision is a promising workforce development strategy. They define workforce development as a '*multifaceted approach to addressing the range of factors that impact on the ability of the Alcohol and Other Drugs workforce to function with maximum effectiveness*'. Hence some of the personal benefits listed above also impact on organisational benefits.

#### 2.4.3.3.2 Stress and Burnout

Burnout is defined as: '*a syndrome of emotional exhaustion and cynicism*' (Maslach & Jackson, 1981 in Teasdale et al, 2001:218). The 2006 study by Edwards et al used the Maslach Burnout Inventory and the Manchester Clinical Supervision Scale in a population of community mental health nurses and concluded that if clinical supervision is effective, then nurses report lower levels of burnout (Refer section 2.7.4.1.2 and 2.7.4.1.3). This study reported evidence of the stressful effect of the mental health workplace. It identified significant levels of emotional exhaustion (36%) high levels of depersonalisation (12%) and low levels of personal accomplishment (10%). Younger male nurses who had not experienced six or more sessions of supervision were more likely to report negative attitudes to clients. Roche et al (2007) reported on a study showing clinical supervision provided emotional support and protected nurses from stress and burnout in a mental health setting. Willson et al (2001) found that one of the benefits of the time allocated for supervision was that it helped to prevent stress and enhanced peace of mind for community nurses in the UK. However Teasdale et al (2001) reported no effect of supervision on burnout.

Teasdale et al (2001) investigated the contribution clinical supervision made in the management of critical incidents, burnout and workplace support using three instruments:

- Critical Incident Questionnaire
- Maslach Burnout Inventory
- Nursing in Context Questionnaire



This study found no significant differences on levels of burnout between supervised and unsupervised nurses. However the Nursing in Context Questionnaire results indicated that supervised nurses reported feeling more supported and demonstrated higher coping abilities than unsupervised nurses. This was more evident in the junior nurses. The authors suggested that if resources are limited then it may be appropriate to concentrate on providing supervision to more junior nurses.

#### 2.4.3.3.3 Reduced Isolation

Professional isolation may be considered to be related to:

- physical distance
- separation from the learning environment
- detachment from peers (Coleman & Lynch, 2006)

Coleman and Lynch (2006:36) state that there is agreement in the literature that supervision relieves isolation and cite a study by Kipping and Hickey (1998):

*the most widely mentioned disadvantage of working in the community was the isolation and the lack of available colleagues to talk to and exchange ideas and talk over sessions that had been held. This sense of isolation seemed to be worse if supervision was not available.*

Coleman and Lynch (2006) state that stress amongst district nurses arose from the following five categories:

- demands of the job
- lack of communication
- working environment
- career development
- problems with patients and work/home interface and social life

Kelly et al (2001) reported that 83% of all staff in their study of community mental health nurses believed that clinical supervision relieves isolation. Evaluation of a programme designed to increase clinical supervision (referred to in the text of the paper as practice support) for nurses working in remote locations of Scotland reported that interaction with peers provided support, improved confidence and reduced stress levels (Willson et al 2001). White et al (1998) identify improved staff morale, strengthened relationships with work colleagues and less feelings of isolation as organisational outcomes identified by the nurses interviewed in their UK study.

#### 2.4.3.3.4 Retention

Davey et al (2006) cited in Edwards et al (2006) confirmed the investment in good quality clinical supervision can be a key strategy in retaining nurses. Willson et al (2001) reported that after nine months of participation in peer group clinical supervision (practice support) nurses felt that an established system would enhance recruitment and retention. White et al (1998:189) identified that the nurses interviewed in their UK study identified supervision was a recruitment incentive and 'a brake on staff leaving'

Speech Pathology Australia (2007:2) noted that in 2002, The Western Australian Allied Health Taskforce on Workforce Issues reported that, a 'lack of management support or lack of supervision structures was the second most cited reason given by allied health professionals



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across the state for leaving their past positions in the last three years'. Findings also indicated that 'limited or ineffective support systems' impacted on a professional's perception that they could fulfil their job requirements. It was also found that rural retention of health professionals was enhanced by the presence of formal supervision and support structures.

## 2.5 Models of Clinical Supervision

van Ooijen (2003) argues that it is important for supervisors to have an understanding of their model of supervision. However a variety of clinical supervision models exists and some reflect the theoretical perspectives of individual professions. Bernard and Goodyear (2004) from a counselling perspective, identify three broad categories of supervision models. These are the models grounded in psychotherapy theory, developmental models and social role models. Other common models are Proctor and Kadushin's content models and practice models which are also detailed in this section. It is important to recognise that the clinical orientation of the supervisor will affect the theoretical model chosen for supervision. Certainly, the opportunity to experience a model related to practice provides additional learning opportunities. It is important to recognise that many supervisors utilise more than one supervision model. Veeramah (2002) reported that 98% of nurses used a particular counselling or psychotherapy model as a framework for supervision and over 50% utilised an eclectic mix.

Magnusson et al (2002) identified the following three different types of models and definitions used in their study:

- process orientated from psychiatric care - a holistic understanding of dynamic processes at individual, group and organisational levels even extending to the patient's social framework
- clinical nursing - professional and personal development of supervisee using a pedagogical approach
- psycho therapeutic analytic tradition - focuses on structure in factors such as regulated hours, continuity, clarity and confidence of the relationship between supervisor and supervisee

The respondents identified that in general, different models of supervision were used in different areas of practice, and some overlap (6%) between areas was identified (Magnusson et al, 2002).

Veeramah (2002) reported that 98% of community mental health nurses identified that a particular counselling or psychotherapy framework was evident in the supervision they received.

### 2.5.1 Clinical Supervision Models Derived from Psychotherapy Theory

Bernard and Goodyear (2004) identify models for clinical supervision derived from psychotherapy.

**Psychodynamic Supervision** - This model of supervision emphasises the relationship between and among patient, supervisee and supervisor and the dynamic processes between them.

**Person Centred Supervision** - Based on the work of Carl Rogers, the person centred approach relies on the importance of a trusting, empathetic and genuine relationship. It is based on the belief that the supervisee has an innate ability and motivation to grow, explore practice and continually strive for improvement.



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**Cognitive Behavioural Supervision** - Cognitive behavioral supervision defines the potential of the supervisee to learn and apply principles of operant conditioning in structuring and influencing learning outcomes.

**Constructivist Supervision** - This view of supervision is based on assumptions that humans construct meaning from their past experiences, social interaction and within specific contexts. This view focuses on the importance of language and assumes a less hierarchical and more collaborative relationship between supervisor and supervisee. The focus of supervision is on helping the supervisee to construct personal knowledge and meaning.

## **2.5.2 Developmental Models**

Supervision may be viewed as a developmental process (Hawkins and Shohet 2006, McMahon & Patton 2002, Bambling 2004, and van Ooijen 2003). These models highlight the importance of modifying the focus, structure and goal of supervision according to the experience and level of competency of the supervisor and supervisee. Hence effective supervision takes into account the individual characteristics of both parties.

### **2.5.2.1 Supervisor Developmental Models**

Hawkins & Shohet (2006) present a developmental model for supervisors. This suggests that novice supervisors exhibit different behaviours and attitudes to more experienced supervisors. In this model it is suggested that supervisors' practice can be divided into four developmental levels:

- new supervisors tend to focus on getting "it" right and supervision is overtly mechanistic with attempts to be expert
- after some experience supervisors recognise the complexity of the role but fail to confide in or seek support from others
- more experience and survival of the previous two stages results in a supervisors showing constant motivation for the role, honest self appraisal and a continual drive for self improvement
- integrated, flexible, effective supervisory performance and the ability to work across disciplines and cultures and educate others come after considerable experience and constant motivation to improve

### **2.5.2.2 Supervisee Developmental Models**

Kavanagh et al (2002) report that the types of supervision strategies preferred by supervisees appear to change as their confidence and skills improve. For example, direct problem focused or skills based supervision is appreciated by inexperienced clinicians and more experienced practitioners prefer to focus on conceptual issues raised in practice. van Ooijen (2003) describes a developmental model of supervision where the novice is enthusiastic but has to learn everything. With more experience advanced beginners may fluctuate between wanting to have their hands held and being over confident. The competent worker is able to cope with most situations and the expert with a breadth of experience has an awareness of the importance of ongoing professional development.

Hawkins & Shohet (2006) also offer a four stage model for supervisee development. It illustrates the change in focus and concern according to the supervisee's level of experience and expertise. Supervisees may exhibit the following stages with corresponding different needs:

- Self-centred focus with questions about how to do it



- client-focus with a shift to help the client more
- process-focus with questions about collaborative relationships
- process-in-context focus with a broader understanding of interrelated processes

A similar model is described by Bambling (2004) citing Stoltenberg & Delworth (1987) and further expanded to include the supervisee characteristics and related optimum supervisory structure and environment as the supervisee develops competency and maturity. It should be noted that there is more research evidence to support the differences between level 1 and level 4 supervisees than the intermediate stages.

### 2.5.3 Social Role Models

These models of clinical supervision identify processes and key players that interact together. Such models are classified as integrative by Winstanley and White (2003). The supervisor, supervisee, client and workplace form the basic components in these models. Holloway (1995) provides a systems approach to supervision. This focuses on the supervisory relationship developed over time within a structure, and takes into account the specific characteristics of the supervisor, the supervisee, the individual client and the clinical workplace. The interaction of these three stakeholders with the clinical environment determines both the tasks and functions of supervision. In this model the functions are similar to the Proctor model (Bernard and Goodyear 2004).

### 2.5.4 Content Models

Proctor's Model of clinical supervision is the most widely accepted and popular model in the counselling and nursing literature (Clough 2003, Teasdale et al 2001, Walsh et al, Edwards et al 2005, Edwards et al 2006, Winstanley & Edwards 2003, Fone 2006, Willson et al 2001, Cerinus 2005, Cutcliffe et al 1998). Proctor's model defines the purposes of supervision. It presents the three following functions:

*Formative Function* - Supervision aims to provide an educative framework for reflective learning that:

- recognises individual strengths and weaknesses
- encourages the development of strategies for gaining knowledge
- assists practitioners in relating theory to their practice

More recent authors clarify this further. Teasdale et al (2001) and Walsh et al (2003) suggest that supervision aims at helping practitioners in the development of skills and updating knowledge. Winstanley & Edwards (2003) expand this purpose further in stating that clinical supervision aims at developing evidence based nursing practice.

*Restorative Function* - The supportive function focuses on the humanistic aspect of a supportive relationship which would encourage practitioners to:

- explore feelings and emotional responses
- develop insights related to listening valuing and caring
- reduce stress
- listen, value and cope

*Normative Function* - The normative or managerial function is concerned with:

- promoting safe practice and reducing risk
- maintaining and developing standards
- ensuring practitioners adhere to local and national guidelines



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Malin (2000) acknowledges the wide use of the Proctor model in the literature but states that some nurses found the terminology unclear and linked more with mentorship.

A similar model is provided by Kadushin (1976) from the early social work literature (Hawkins and Shohet 2006, Kadushin and Harkness 2002) with alternative wording for the three different areas:

- educational
- supportive
- managerial

Bones (2000) in Fone (2006) adapted this model for Occupational Therapists and added a fourth function. In this model the functions are:

- clinical - treatment care evaluation and planning
- managerial - case load management administrative tasks liaison and communication
- personal - staff interpersonal issues, motivation, job pressure team issues
- professional - professional goals and leadership interpretation of the professional role

## 2.5.5 Practice Models

Practice models of supervision may be divided into those focusing on the practice of supervision and others with a focus on clinical practice.

### 2.5.5.1 Supervision Practice Models

Hawkins and Shohet (2006:61) present a five stage supervision model. The CLEAR model describes the tasks of supervision as:

- contract
- listen
- explore
- action
- review

A similar system model is described by van Ooijen (2003) and also by Hunter and Blair (1999) in Fone (2006). Fone (2006) identifies key components for effective supervision. She also suggests that the process is supervisee led with the supervisor ensuring that there is:

- a balance between support and challenge
- a supervision contract
- training in supervision for both supervisees and supervisors
- review and feedback

van Ooijen (2003) simplifies supervision to a 3-step model which encourages supervisees and supervisors to structure every individual session to their own need and situation. It requires openness and flexibility, encompasses a diversity of methods and may be incorporated with other models. This 3-step model asks the following questions:

- What does the supervisee need to know and what are the relevant facts?
- How will they find out?
- What will they do?



### 2.5.5.2 Practice Focused Supervision Model

A clinical problem solving model is suggested by Nicklin (1997) in Fone (2006). This model focuses on the structuring of the clinical supervision session with a problem orientated approach similar to clinical problem solving models. Hence the supervisory session moves from an analysis of practice, identifying a problem, setting goals, planning and implementing action and evaluation.

## 2.6 Barriers

A considerable number of barriers to clinical supervision are documented in the literature and are reported below. Research by Skerrett (2004) identifies a number of these through a survey of staff from five professions (Psychology, Social Worker, Occupational Therapy and Speech Pathology). All disciplines reported receiving a similar process of clinical supervision but this was less likely to be received by more experienced staff or those clinicians in regional areas. The survey identified problems with frequency of supervision, availability and resources, insufficient training for the role, high workloads and insufficient guidelines and preparation. It also determined that contracts were rarely used and there was little focus on observation and practice.

### 2.6.1 The Difficulty Achieving Protected Time

Williams et al (2005) and Willson et al (2001) report that almost all negative comments about clinical supervision relate to finding time to allocate to the process, or difficulties related to scheduling the group session. Finding time in a busy work place may increase levels of burnout for emotional exhaustion and depersonalisation (Edwards et al 2006). Barriball et al (2004) identified difficulties with workload and time constraints and Teasdale et al (2001) describes this as a cost of time away from direct care. White and Winstanley (2006) cited difficulty finding time for clinical supervision especially when its usefulness was doubted. White et al (1998) noted that nurses reported difficulty making time for the sessions.

### 2.6.2 Concern about Mixing a Work and Supervision Relationship in the Same Team

The challenge of providing supportive and educative supervision as well as managerial has already been discussed. However it is important to acknowledge that the literature contains considerable supervisee concerns related to mixing work and supervision within the same time. These are explicitly identified as a barrier to effective supervision. Williams et al (2005) in an evaluation of a UK supervision programme voice concern about mixing a work and supervision relationship in the same team. They state that this is often imposed from above, seen as a management strategy and viewed as a regulatory tool. Clouder and Sellars (2004) raise similar concerns.

### 2.6.3 The Lack of Resources

The lack of time and other resources were identified as barriers to supervision by Clough (2003) and Draper et al (1999). Malin (2000:555) reported that, '*clinical supervision was not supported properly within the workplace*' and Roche et al (2007) identified funding shortfalls and limitations.



#### **2.6.4 Access to Supervision**

Kavanagh et al (2002) state that access to clinical supervision in Australia is patchy with more senior and experienced practitioners least likely to receive it. They explain that this may be due to the difficulties associated with finding an appropriate and available supervisor and report similar difficulties arise for those practitioners working across sites or services and in isolated rural communities. The access difficulties are also related to the competing demands of high workloads.

A study of the Australian Alcohol and other Drug related workforce by Roche et al (2007) reported that 60% of respondents did not receive regular clinical supervision and 95% of those receiving supervision had a team leader or manager as their supervisor. Over 50% of the respondents believed their supervisor did not have the skills required to provide effective supervision. However, increased access (73%) to clinical supervision was reported by a telephone survey of allied health professionals in Queensland (Kavanagh et al 2003 in Roche et al 2007).

White and Roche (2006) in a scoping study of mental health nursing in New South Wales identified a discrepancy between access data provided by the Area Health Services who reported supervision was available for all or some staff and the responses from the individual mental health nurses. Two thirds of the study population identified they were not receiving clinical supervision and the remaining one third, suggested clinical supervision occurred for less than two years on a monthly or fortnightly basis, of between one and two hours. Nurses reported that the focus of supervision was on reflection of clinical work with a preoccupation on local management and organisational issues (White & Roche, 2006). Respondents also reported the lack of time and opportunity for clinical supervision as well as difficulties associated with work release for professional development education and a lack of workplace funding (White & Roche 2006, White & Winstanley 2006).

#### **2.6.5 Confusion and Uncertainty about the Role**

The complexity of the supervision process and difficulties with definitions, models, organisation and application of systems are identified as barriers by Coleman & Lynch (2006), Roche et al (2007), Draper et al (1999) and Rafferty et al (2003). White et al (1998) identified that lack of a clear definition created confusion and suspicion amongst the UK nurses interviewed in their study. They identified overlap with similar formal processes such as performance review, preceptorship and counselling and informal processes such as time out sessions to discuss burning issues. Walsh et al (2003) state that confusion about personal and professional development creates ambiguity regarding the purpose of supervision.

One of the key issues related to clinical supervision is the access health care workers have to supervision. Discussion about models, methods and processes appear irrelevant when such a large percentage of the workforce does not have the opportunity for clinical supervision. White and Winstanley (2006) refer to a study by Davey et al (2006) that suggested that clinical supervision was comparatively novel for most hospital based staff in Australia and some mistrust of the supervisory process existed.



## **2.6.6 Lack of Understanding of the Process**

A lack of understanding of the process and a perception that it is not part of the professional culture accounts for negative prejudices and misconceptions about how it might be used (Malin 2000, Draper et al 1999). Roche et al (2007) and White et al (1998) also report that there is confusion and suspicion around what it is.

## **2.6.7 Additional Barriers**

Studies also identified the following additional barriers as:

- the difficulty of balancing clinical supervision to provide supervisees with a supportive learning environment as well as challenging learning and ensuring standards are met (Walsh et al, 2003)
- poor leadership (Roche et al, 2007, Barriball et al, 2004)
- shortage or lack of adequately trained supervisors or qualified and available supervisors (Barriball et al 2004, Clough 2003, Draper et al 1999, Rafferty 2003, White et al 1998)
- the culture of some workplaces and how responsive staff are to change processes (Spence et al 2002, Draper et al 1999)
- a cultural belief of some health care practitioners that practical benefits of clinical supervision are limited (Roche et al 2007)
- geographical distance between supervisors and supervisees (Roche et al 2007)
- lack of adequate preparation for the role of supervisor (Draper et al 1999)
- lack of research evidence available on clinical supervision Wolsey & Leach (1997)
- lack of operational definitions, the flawed methodology in many of the studies, the absence of a systematic theory base and an overall lack of a science of supervision as reasons for this deficit (Wolsey & Leach 1997)

## **2.7 Evaluation Methods**

Winstanley and White (2003) discuss a range of evaluation methods for use in clinical supervision.

### **2.7.1 Focus Group Interviews**

Williams et al (2005) used focus group interviews (n=45) before and twelve months after the implementation of a pilot clinical supervision programme for community nurses in the UK. Invitations were sent to nurses who were not participating in clinical supervision. All focus groups were audiotaped and transcribed for thematic analysis by a second researcher to ensure trustworthiness of the data.

Analysis of the content of the taped interviews identified four emergent themes.

Theme 1: Practice - Clinical supervision provided nurses with the opportunity to reflect on practice especially following challenging and stressful situations such as breaking bad news to patients, dealing with dying patients, antagonist patients or aggressive relatives.

Theme 2: Organisation and management - Clustered in this theme were a series of issues related to managerial style and feelings of lack of support. Nurses reported a tension between clinical and managerial responsibilities e.g. adequate resources to provide quality health care.

Theme 3: Education, training and personal development - Issues reported in this category especially to newly qualified nurses related to managing time effectively, nursing staff morale,



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confidence and assertiveness. Coping with change, dealing with personal problems and discussing mistakes or instances where practice could have been improved were provided as illustrations. These are consistent with lower levels of the supervisee development model.

### **2.7.2 Semi-Structured Interviews**

Barribal et al (2004) used a phone interview with a developed schedule to collect data for an audit to determine the extent and use of clinical supervision and the attitudes of managers and staff from different professions in a primary care trust in the UK.

### **2.7.3 The Delphi Technique**

Delphi survey research is a way of eliciting and refining opinions of a group (Winstanley and White 2003) and a means of using the specialist knowledge of a group of experts to reach consensus on a specific set of topics (Rafferty et al 2003). Rafferty et al (2003) used a modified Delphi technique in the development of provisional standards for clinical education in Nursing. This experiential collaborative research collected narratives from practice and explored the subjective knowing of participants to develop the following indicators:

- professional support - includes time, environment and relationship support
- learning - focuses on knowledge and interventions
- accountability - includes organisational support, recording and competency

Butterworth & Bishop (1995) in Winstanley and White (2003) also used a Delphi technique to identify characteristics of optimum supervisory practice. Surveys were sent to 1221 nurses and results from five open ended questions were analysed into 77 sub categories. An expert panel further reduced these to 18 characteristics. One of the key conclusions from this research was that clinical supervision is a system which provides support and promotes good practice.

### **2.7.4 Self Completion Questionnaires**

There is a lack of validated assessment tools related to clinical supervision (Barribal et al 2004, White et al 1998, Winstanley and White 2003) and instead the literature contains many examples of self completion questionnaires which provide both qualitative and quantitative data. Often a Likert scale is utilised to allow statistical analysis to demonstrate reliability. Open ended questions are often included and these require time consuming thematic analysis. Winstanley and White (2003) describe two measures with established reliability but limited statistical rigour. That is measurement scales on samples of sufficient size:

*Experience of Supervision Questionnaire (ESQ)* developed by Nicklin (1997). This is designed to elicit the perceptions of effectiveness of the supervisory experience and has demonstrated reliability.

*The Nursing in Context Questionnaire* was developed by Brocklehurst (1999) to evaluate clinical supervision. It has 18 attitudinal statements which are divided into three factors which Teasdale et al (2001) describe. It seeks to identify the extent to which nurses:

- perceive their managers as listening and supportive
- cope with their work and workplace
- successfully access support at work and the workplace



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Magnusson et al (2002) investigated the use and characteristics of clinical supervision and the perceived influence of supervision on the ethical decision making of community nurses working with people with mental illness in home care in Sweden. Their descriptive correlational study used pre and post questionnaires and compared responses from those nurses receiving supervision and those who did not. A 20 item questionnaire was developed from the literature and used a six point Likert scale. District nurses, psychiatric nurses and mental health care workers were included in the study and had varying levels of experience in mental health. Spence et al (2002) in an evaluation of the implementation of a collaborative clinical supervision programme between a School of Nursing and Midwifery and two UK Trusts used a combined methodology. Pre and post test surveys as well as focus groups provided details about the use, knowledge and attitudes to clinical supervision.

The collaborative approach between the academic setting and the clinical workplace was the focus of this study and the authors reported considerable benefits for all.

#### 2.7.4.1 Existing Evaluation Instruments

##### 2.7.4.1.1 Minnesota Job Satisfaction Scale

Winstanley and White (2003) describe this US developed scale based on a theory of work motivation. It is a 20 item questionnaire with a five point scale which measures:

- intrinsic satisfaction composed of 12 factors e.g. achievement and recognition or responsibility
- extrinsic satisfaction factors composed of six items e.g. salary, status, job security and demonstrated value of supervision

Studies using the Minnesota Job scale are cited by Winstanley and White (2003) but no literature from this search refers to the use of this measure.

##### 2.7.4.1.2 Maslach Burnout Inventory

Winstanley and White (2003) describe the Maslach Burnout Inventory as a measure of occupational burnout syndrome. It consists of 22 items which are scored on a frequency of occurrence. The items relate to the following three subscales:

- emotional exhaustion
- depersonalisation
- personal accomplishment

This inventory is used widely in nursing stress management literature, however results are not conclusive.

##### 2.7.4.1.3 Manchester Clinical Supervision Scale

Winstanley & White (2003) and White & Roche (2006) state that the Manchester Clinical Supervisory Scale (MCSS) is the only measure of clinical supervision which has established world wide validation with high internal consistency of items within each category and between subscales. The MCSS measures the supervisees perceptions of the quality and effectiveness of the supervision received, the effect of supervision on professional development and skill



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improvement, time for reflection and quality of the relationship. This is a 36 item measure with seven sub scales based on Proctor's model:

- trust/rapport
- supervisor advice/support
- improved care/skills
- importance/value of supervision
- finding time
- personal issues
- reflection

Edwards et al (2005) used the MCSS with a large population of community health mental nurses in Wales.

Edwards et al (2006) also used the MCSS and the Maslach Burnout Inventory with a large population of community mental health nurses (Refer section 2.4.3.3.2).

## **2.7.5 Action Research**

Hawkins and Shohet (2006) state that action research is the most suited methodology for clinical supervision evaluation since it seeks to improve practice as well as sharing similarities in both process and philosophy. Fish & Twinn (1997:103) explain that action research is used to improve practice. They identify the following principles of action research. It:

- seeks improvement by intervention
- involves the researcher as a main focus of the research
- is participatory and involves co workers rather than participants/informants
- is a rigorous form of enquiry which leads to the generation of theory from practice
- needs constant validation by educated witnesses from the context it serves
- is a public form of inquiry

The following study provides examples of these principles in the development, implementation and review of a clinical supervision programme in Queensland.

Skerrett (2004) used focus groups in the initial stage of a clinical supervision programme for allied health and community nurses. The focus groups also included carers, consumers, team leaders, indigenous and transcultural groups. Groups reported that supervision was regarded as important for staff competency and best practice and that it supported staff (especially new graduates). The need for a clear policy, training process and model of clinical supervision was identified. Concerns were expressed regarding cross disciplinary supervision and difficulties with access for rural practitioners. All allied health staff agreed that there should be clear boundaries between line management and supervision and that resources should be made available to support clinical supervision.

Other examples are provided by Jones and Partington (2007), Malin (2000), Williams et al (2005), and Cerinus (2005).

## **2.7.6 Randomised Control Trial**

Bambling (2003) investigated the impact clinical supervision had on psychotherapy practice and the outcomes of treatment for clients with depression. This PhD thesis hypothesised that a stronger working alliance between therapist and client would result in better client outcomes. 33 supervisors provided supervision and 127 therapists provided a standardised therapy approach



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for 127 clients with depression. The therapists were randomly assigned to three groups, one supervised with a skills focus, one supervised with a process focus and the third group of therapists was unsupervised. Measures such as client symptoms scores, drop out completion rates, client satisfaction and psychosocial stress, working alliance inventory and Beck depression scores were utilised (refer Section 2.4.3.2 for results).

## **2.8 Forms of Clinical Supervision**

Ferguson (2005) in Rose et al (2005) offers a list of supervision formats. These are common forms used in the community health sector.

### **2.8.1 One-to-One Supervision**

Ferguson (2005) in Rose et al (2005) describes one-to-one supervision as revolving around an individual's account of work with the supervisor facilitating reflection, conceptualisation and planning for future practice. Walsh et al (2003) go on to explain that the supervisor may be an expert from an individual discipline, a supervisor from another discipline, a colleague from the same or similar discipline or a supervisor external to the workplace.

### **2.8.2 Group Supervision**

Ferguson (2005) in Rose et al (2005) describes this format as a collective or alternative basis where common issues may be discussed by all group members with a supervisor and Roche et al (2007) further clarifies groups where individuals take turns in leading the group.

Hawkins and Shohet (2006) identify a number of advantages for group supervision related to economies of time, money and expertise. In addition there are considerable benefits related to the support of the group and for feedback and input from colleagues as well as the supervisor. This broadens the opportunity for all members to be exposed to a wider range of life experiences, emotional responses and differing views than is possible in one-to-one supervision. The potential for dependence and over influence on the supervisor is also reduced. In addition, opportunities for learning may result from the experience of interacting in the group especially if clinical practice includes group work. However group supervision also may present difficulties related to finding a time and place convenient to all members. Effectively managing complex group dynamics may present challenges to the supervisor or leader and there is less time available for individual issues.

White and Winstanley (2006) suggest that group supervision may be a cost effective method of delivery as this method would encourage sharing and common identification and support among group members. Their estimated cost of giving one to one peer supervision represented a cost of 1% of the nurse's salary. They agreed this cost could be reduced in a group model since this would decrease annual costs in preparing supervisors and a smaller number of supervisors would be required. However they agreed that such reductions would need to be balanced with the logistical challenge of scheduling at a time all members of the group could attend.

Draper et al (1999) report an evaluation of a pilot clinical supervision programme for District and Clinic nurses and Health Visitors in the UK. They describe a group model developed collaboratively. Members agreed to meet for one and a half hours every six weeks. Group



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guidelines for new members and group ground rules, reflection on practice and recording of sessions were agreed on. In this case, six to eight people met with a supervisor in a private comfortable and distraction free space in discipline specific groups. Every session a different team member would present a case. Supervisors for each group in this programme met with an external supervisor every six weeks.

### 2.8.2.1 Balint Groups

The use of Balint groups is described within the medical literature to assist doctors with the psychological aspects of their practice. Lustig (2006) and Benson & Magraith (2005) describe the use of Balint groups in General Practice in Australia. These small discussion groups are primarily focused on the doctor patient relationship and are facilitated by a trained leader (Bernard and Goodyear 2004). Balint group leaders' special training traditionally involves some of the following areas: psychotherapy, psychoanalysis, psychodynamic, or leadership and group facilitation (Lustig 2006). However, a number of GPs in Australia are also undertaking training for the role as facilitator (Barton 2007).

A group meets regularly to discuss patients who are causing difficulties for the GP. One or two members present cases for discussion each session within a trusting and non judgmental environment (Lustig, 2006). Lustig (2006) reports that the type of issues raised include noncompliance, demanding patients, child abuse, dying patients and bereavement, drug seeking behaviours or multiple referrals.

Balint groups provide a small group active learning experience which:

- provides professional development and support, especially for mental health related issues
- increases the doctors' sense of wellbeing
- increases professional satisfaction
- decreases the potential for burnout (Lustig, 2006, Benson & Magraith 2005)

Benson and Magraith (2005) suggest that since general practitioners are exposed to emotionally difficult situations they are at risk of developing burnout and compassion fatigue. This may be further exacerbated by professional isolation, long hours with limited resources, working with difficult client populations, unreciprocated giving and failure to meet personal expectations. Peer interaction under the guidance of an experienced facilitator provides the opportunity for group members to provide each other with positive support and feedback, to challenge unrealistic and inappropriate expectations or beliefs, recognise personal reactions and hence develop a more balanced and realistic sense of purpose. Lustig (2006) reports that there has been no formal evaluation of Balint groups.

### 2.8.3 Peer Supervision

Peer supervision is defined by Ferguson (2005) in Rose et al (2005) as occasions when two or more health professionals take turns or elect a group member to supervise another's work informally. The group may be joined by a supervisor on some occasions. Definitions of clinical supervision from nursing in the UK explicitly included learning from peers (Winstanley and White 2003). Tinsley (2001) and Hawkins and Shohet (2006) suggest that peer supervision either as one-to-one supervision or in groups may be a good way to develop expertise. In both instances it is essential that a clear structure is agreed on prior to implementation (Hawkins and Shohet 2006). Many of the examples in the literature on peer supervision included members of the health care team as group members.



Walsh et al (2003) describe a peer model of clinical supervision to meet the needs of a small group of community mental health nurses in South Australia. In this example six nurses agreed to meet for one and a half hours every month when a group member would present a case review. The role of group facilitator, who would take responsibility for keeping the group focused on the task, rotated each session. The group agreed on the following group behaviours:

- supervision would be a commitment and a priority
- supervision would take place in a supportive atmosphere. Group members would act as critical friends to the person who presented
- group members agreed to be prepared to take risks in disclosing practice issues
- group members agreed to be receptive to the views of others
- group sessions would be confidential except when potentially dangerous conduct was identified
- meetings would start and finish on time
- all members would attend unless there was an unforeseen clinical issue
- the presenter would take responsibility to come prepared for the session

Guidelines were also developed to manage instances of unsafe/unprofessional practice. It was agreed to support individuals to manage change from within the group and only if unsuccessful would they resort to normal lines of authority.

An evaluation of this small peer group supervision after six months with a questionnaire determined the model was meeting the needs of the group. Evaluation focused on the following criteria:

- safe group environment
- critical evaluation of practice
- provision of a supportive environment
- increased understanding of professional issues
- identification of solutions to problems
- overall improvement of practice (Walsh et al 2003)

All criteria were rated highly but it is not surprising that those staff members who prepared and presented a case for review rated their learning higher. Independent observation of the group process suggested that the members were so concerned in developing a supportive environment that there were minimal attempts to challenge. Plans were made to maintain the supportive atmosphere and find ways of critiquing, challenging and reflecting more in the future.

McMahon and Patton (2002) describe a programme of peer reciprocal supervision developed in New Zealand. The Plunket Model encourages cooperative collegiate relationships, focuses on encouraging reflective practice and support and provides a means of providing supervision for every staff member. It is nonhierarchical and cost effective as participants both give and receive supervision within the same relationship. The process is independent of staff appraisal and open to choice of format and partners. Documentation was prepared that clearly identified the expected functions, contract guidelines, standards and rights and responsibilities of supervisors and supervisees. Educational workshops were provided for managers, educators and all participants across 24 areas of New Zealand.



#### **2.8.4 Distance Options**

Audio or video tape may be used for partial or complete recording of clinical supervision sessions. Roche et al (2007) advocated the use of video conferencing for rural areas and a combination of phone links with face to face meetings.

#### **2.8.5 Live Supervision**

Ferguson (2005) in Rose et al (2005) explains this method may involve the use of a one way mirror for observation or the opportunity to consult during client interaction. There were few references to this type of supervision in the literature and Kavanagh et al (2002) report that most clinical supervision sessions involve talking about cases or solving clinical problems and that direct observation of practice is rare. A later study by Kavanagh et al (2003) reported in Roche et al (2007) of allied health practitioners in Queensland indicated that typically supervision sessions involved discussion on clinical issues rather than direct observation of practice. Magnusson et al (2002) identified that some district nurses in their UK study received on-the spot supervision.

#### **2.8.6 Use of Multiple Methods**

There was general agreement in the literature that no one model or method would suit the needs of all (Williams et al 2005). Many of the studies identified a variety of different methods being used in workplaces. In the White et al (2006) study 51% of supervisees were supervised by a peer and 43% by more senior clinical staff. However of the 75 nurses in this study only 43 (57%) were supervised by another nurse. Veeramah (2002) reported that one-to-one supervision was the most frequently used method with three variations; one to one with an expert supervisor (60%) one to one with a supervisor from another discipline (11%) one to one with a colleague from the same expertise and grade (peer, 9%) group (6%) and a mixture of one to one and group formats (12%).

Kelly et al (2001) study of community nurses in Northern Ireland found that there was no standardised delivery method. In this study the most common method was the one-to-one method (74%) with only 7% using small groups and 19% reporting they experienced both methods. Edwards et al (2005) reported that a one-to one method was the most commonly reported method in their study but there was no difference in quality between the different modes. This study identified greater benefits when supervision was carried out away from the workplace rather than within. The White et al (2006) study of supervision in Nursing in acute care and community settings identified that two thirds of all sessions were individual and the remainder conducted as a group, triad or other unspecified model.

Some studies attempted to investigate efficacy of the method but results are inconclusive. Williams et al (2005) reported that group supervision improved quality of care and Winstanley and White (2003) agreed that group sessions were more effective than one to one but suggest that although most people preferred group sessions they appreciated the opportunity to have one to one confidential clinical supervision if required. However other authors such as Cerinus (2005) and Titchen and Binnie (1995) in Williams et al (2005) cite benefits of individual sessions.



### 2.8.7 Timing and Scheduling of Clinical Supervision

Clinical supervision was more positively evaluated when sessions lasted over an hour and took place at least once a month (Edwards et al 2005). Winstanley and White (2003) reported that supervisees reported higher evaluation scores when sessions ran between 46-60 minutes in acute care and over one hour in community practice and supervisees with monthly or bimonthly sessions achieved the highest evaluation scores. Skerrett (2004) developed the following recommendations or minimum standards:

Table 2. Minimum Standards for Clinical Supervision

Frequency of supervision	Schedule and type of supervision	Level of staff
High	1 hour every week from a supervisor from the same profession	New graduates (3 months to 6 months after graduation)
Medium	1 hour every 2 weeks from a supervisor from the same profession	Recent graduates Experienced professionals returning to work or starting work in a new area of practice. Those with identified skills deficits
Low	At least 1 hour every two months from a supervisor of the same profession	All staff with over 2 years clinical practice and advanced skills in areas relevant to the workplace requirements

### 2.8.8 Association Practice Standards, Policies and Guidelines

The Nursing and Allied Health Associations have developed a range of documentation in relation to clinical supervision. These have varied according to each discipline. The Nurses Board of Victoria (2007:5) guidelines identify that the 'level of supervision should be appropriate to the degree of risk of the nursing activity'

The Australian Psychological Society (APS) Guidelines on Supervision (2003) refer to registered psychologists. It highlighted the importance of having a supervision contract, allocating sufficient time and providing adequate resources for the supervision process and the importance of distinguishing between line management and professional development supervision. The APS policy position on supervision notes that it expects that all psychologists will continue to enhance their professional expertise. The APS acknowledged that dependent on the experience of psychologists, some will require 1-1 supervision, group sessions or more experienced psychologists may utilise supervision on a "need to know" basis.

The National Practice Standards of the Australian Association of Social Workers (AASW): Supervision (2000) also states there should be a written supervision agreement and specify the qualifications and experience of supervisors. In relation to Table 2 above the AASW recommend one hour per week of supervision for recent graduates or for social workers with less than three



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years experience. For social workers with three or more years experience it is recommended that they receive one hour per fortnight as a minimum.

Speech Pathology Australia (SPA) (2007) supports a minimum of two hours per month of professional and/or clinical practice supervision for all speech pathologists. SPA identifies that for new graduates, rural/remote positions and sole practitioners a minimum of one hour per week of supervision is recommended.

The Australian Association of Occupational Therapists National Policy Paper on Mentoring/Supervision (2000) presents elements of best practice for supervision. OT Australia suggests weekly supervision for the first 3 months for a new graduate, then fortnightly ongoing for other practitioners.

### **2.8.9 Accreditation Standards**

A number of accreditation standards relating to community health services were examined as part of the literature review. There were very few standards relating specifically to supervision, whilst it was implicit in other standards.



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