Clinical Supervision Background Paper

Clinical Supervision [CS] is a formally structured arrangement to support staff in human service agencies, that has a long and established history in many health care professions, including social work and psychology/psychotherapy [Kadushin 1976; Watkins 1997]. Mental health nursing was also an early adopter of CS, particularly in northern European countries [Bodley 1991; Severinsson 1995]. Clinical Supervision is now commonly referenced in Australian mental health policy frameworks [National Mental Health Education and Training Advisory Group 2002] and considered by employers to be central to the role of mental health nurses in particular [NSWHealth 2007; Queensland Health 2009]. Considerable additional impetus has been provided by HealthWorkforce Australia [2011] with the adoption of emerging evidence that a formally defined alliance between practitioners, in which the roles of Supervisor [an experienced practitioner] and Supervisee[s] which is focused on professional support through facilitated reflection, is likely to develop increased sense of Supervisee well-being and therapeutic awareness. Although robust, outcomes-related CS research is difficult to design, conduct, interpret and fund [White and Winstanley 2011], there are growing indications that Clinical Supervision may be associated with an improvement in the quality of clinical care and, where this can be demonstrated, this may improve outcomes for mental health consumers [Bambling et al 2006; Bradshaw et al 2007; Winstanley and White 2010].

Operational definitions of Clinical Supervision, together with the preferred models of practice, frameworks for implementation and the strategies for systematic evaluation, vary within and between professional groups and practice settings [Sloan and Watson 2002; Milne 2007; Milne et al 2008], although the essential parameters have been
established. Clinical Supervision is usually conceptually distinguished from case review, personal performance review and therapy, although there is little doubt that when Clinical Supervision is provided to an efficacious standard it is likely to be therapeutic [Spence 2001]

Modes of Clinical Supervision provision:

Clinical Supervision is usually conducted either in dyads [one-to-one], or in small groups of 6-8 Supervisees. Over 25 years, the Proctor Model of Clinical Supervision [Proctor 1986] has become one of the most influential and widely adopted model to be adopted in nursing contexts [White and Winstanley 2011]. It comprises three domains:

- Normative: to address the promotion of standards and clinical audit issues
- Restorative: to develop the personal wellbeing of the Supervisee
- Formative: to develop knowledge and clinical skills

Recently reported evidence [White and Winstanley 2010] shows that effects of Clinical Supervision appear to act on these three Proctor domains at different speeds; changes in the Normative and Restorative are likely to precede measurable changes in the Formative. Importantly, therefore, this implies that the benefits to mental health consumers may be demonstrated _subsequent_ to the successful establishment of an organizational culture, in which staff well-being and attention to continuous clinical audit have been promoted through sound Clinical Supervision. Good Supervisors are as unlikely to have a desired effect in unhealthy cultures, as are poor Supervisors in healthy cultures [White and Winstanley 2010].
Evidence for Clinical Supervision:

Concerted effort is still required to ensure that Clinical Supervision is better understood, accepted and practiced in Australia [Taylor and Harrison 2010] and convincing programs of CS education [White and Winstanley 2009a] and outcomes-related research remain necessary to further substantiate the claims made for Clinical Supervision [White and Winstanley 2011]. These have variously related to personal matters [improved wellbeing, confidence and self awareness, reduced emotional strain and burnout], workforce concerns [staff morale, job satisfaction, sick leave, retention] and professional growth [greater reflection on practice, increased knowledge and awareness of possible solutions to clinical issues]. Due parsimony should be exercised in relation to the effects which it is prudent to attribute to the provision of Clinical Supervision, some of which have been previously extravagant and now rest at the level of folklore.

Benefits to both Supervisors and Supervisees have been convincingly established, as has a link between effective CS and reduced burnout [White and Winstanley 2010]. It has also been shown that any effect CS may have is likely mediated by the training that Supervisors receive, the quality of the supervision they provide, the culture in which the CS endeavour is located and, in particular, the attitude of managerial staff. However, in settings where each of these mediating factors was not an impediment, White and Winstanley [2010] also found incremental evidence toward a positive causal relationship with quality of care and patient outcomes. Further small and large scale outcomes-related studies are necessary, therefore, in a variety of settings, to test emerging theoretical propositions using relevant instruments that have well established and publicly reported psychometric properties [see The MCSS-26©; Winstanley and White 2011b].
Effective implementation of Clinical Supervision:

Whilst Clinical Supervision may help to achieve the best level of care possible, Bishop [1994] asserted that it cannot compensate for inadequate facilities, for poor management, or for unmotivated staff; challenges persist [White and Winstanley 2009b]. Given these caveats, in order that CS may be successfully implemented and sustained, the best and clearest directions currently available [White and Winstanley 2010] suggests that a number of environmental conditions should be met:

1. Clinical Supervision should be universally considered part of the core business of contemporary professional mental health nursing practice.
2. Positive support for Clinical Supervision should be evident at all levels of service management and accepted as a dominant feature of the organisational culture.
3. The mainstream status of Clinical Supervision should be written into all workforce policies, as a positive expectation for all staff to engage.
4. Explicit protocols should be in place to confirm the arrangements necessary for the sustainable implementation across all services [size, 1:1 or 6-8 in groups; frequency, not less than monthly; duration, not less than 60 minutes; ground rules about confidentiality and so on], together with a dedicated information management system to continuously monitor these are given full effect.
5. Supervisees should retain the option to choose their own Clinical Supervisor. This should be an appropriately trained and experienced practitioner, who does not hold operational or managerial responsibility for the Supervisee.
6. Individuals identified by local criteria to become Supervisors should be appropriately educationally prepared for their role, to an efficacious standard.
7. Upon appointment, all staff should be assisted to become fully orientated to local Clinical Supervision arrangements, including new graduates and others transferring into the mental health workforce.

8. Service managers who hold individual responsibility for the staff roster and budget should to be provided with the support necessary to ensure a smooth CS operation, without deleterious effect on clinical contact time [akin to exiting arrangements for staff handover meetings].

9. Programs of continuous evaluation in discrete clinical locations should be in place to ensure that the quality and efficacy of local Clinical Supervision arrangements are able to be demonstrated and regularly reported.

10. Suitable administrative records should be maintained [a suggested Clinical Supervision Agreement template is available from the ACMHN website].

References:
Australian College of Mental Health Nurses [2010] *Standards of Practice for Australian Mental Health Nurses 2010*. ACMHN, Canberra


Queensland Health [2009] *Clinical Supervision Guidelines for Mental Health Services*. Mental Health Branch, Queensland Health, Brisbane


