

Clinical supervision for mental health nurses

A framework for Victoria



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Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

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ISBN/ISSN ISBN 978-1-76069-283-4 (Print)

ISBN 978-1-76069-284-1 (pdf/online)

Available at <https://www2.health.vic.gov.au/mental-health/chief-mental-health-nurse>

Printed by Metro Printing, Airport West (1709044)

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Acknowledgements

This framework has been developed with the support of the following people:

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Foreword

Mental health nurses make up approximately two-thirds of the clinical workforce in Victorian mental health services. The nursing profession continues to evolve, particularly in relation to the clinical role and responsibilities, to provide responsive care and to adapt to policy, practice and service model changes.

Over the past decade, a range of initiatives have been prioritised within Victoria mental health services that have affected the nursing profession. Some of the key initiatives focus on:

- delivering care that is consumer-centred, family-inclusive, trauma-informed, recovery-focused, quality-focused and, above all, safe for all
- delivering gender-safe and -sensitive practices
- reducing restrictive practices
- providing holistic care in response to consumer needs (for example, dual diagnosis, family violence, disability).

It is important to acknowledge that safety and wellbeing continue to be a priority for the government and mental health service providers. Nurses need to be empowered to expect a safe workplace that is free from violence and aggression. They must be leaders in promoting and managing safe working environments, as well as creating and maintaining safe clinical and therapeutic spaces for the mental health consumers in their care. This is particularly challenging in mental healthcare settings where consumers' rights and freedoms are overridden under mental health law.

This framework has been developed under the guidance of experts in clinical supervision to help you – the nurse – to deal with issues that arise for you in your work; it will support and enable you to grow as an individual and as a professional.

It also provides an essential standardised structure to support mental health services to integrate clinical supervision as part of every nurse's professional role and provides a foundation upon which clinical supervision can be integrated into continuous professional development.

Whether you are a recently graduated enrolled or registered nurse, an experienced nurse unit manager or the manager of a mental health service, this document outlines the roles and responsibilities for providing and receiving clinical supervision that incorporates best practice principles and recognises the need for flexibility in delivering clinical supervision.

It is important to acknowledge that this document is consistent with and complementary to clinical supervision directions set by the:

- Supervision guidelines for nursing and midwifery – Nursing and Midwifery Board of Australia
- Joint clinical supervision position statement – Australian College of Nursing and Australian College of Mental Health Nursing.

Clinical supervision should be universally considered part of the core business of contemporary professional nursing practice.

**Anna Love – Chief Mental Health Nurse
Department of Health and Human Services**





Part 1: Introduction

This framework outlines the Department of Health and Human Services' commitment to supporting mental health nurses in Victoria in accessing consistent, appropriate and effective clinical supervision and support mechanisms. It is underpinned by an integrative literature review, which looked at literature from 2010 onwards, including several organisational policies and position statements. The framework development was steered by a group of experienced mental health nurses and nurse academics who hold specialist knowledge in providing clinical supervision.

A framework is a structured presentation of ideas that enables the observer to identify and retain information and to communicate that information to others. Additionally, a framework such as this should support ongoing assessment and reframing of the most recent developments in a given field or profession and include all interrelated information and knowledge. A framework that has been carefully chosen or developed will identify objectives and purposeful activities, help to determine which are the most important ones to implement and when, and support the implementation of identified project strategies.

Mental health consumers have a right to expect safe, competent, strengths- and evidence-based nursing care at all times. As the scope of practice for mental health nurses continues to develop and expand in relation to care and clinical interventions, clinical supervision is increasingly considered an essential aspect of professional practice.

Clinical supervision is considered by many to be part of the core business of contemporary professional nursing practice. It has emerged as a means of using reflective practice and shared experiences to support continuous professional development. Proponents of clinical supervision suggest it provides a structured approach to deeper reflection on clinical practice that may lead to improvements in practice and consumer care, and contribute to clinical risk management and service quality improvements.

Clinical supervision provides an opportunity for mental health nurses to further develop enhanced reflective skills that are essential to continued advancing practice and contribute to improvements in the safety of their nursing interventions.

This framework is designed to support individual nurses to meet their clinical supervision needs and to contribute positively to evolving mental health services.

Using this framework as a foundation, local services can further develop relevant, service-specific guidelines.

Why a framework for mental health nurses?

In general, international literature typically supports the idea that mental health nursing is a highly specialised field of nursing that focuses on working with consumers to meet their recovery goals. Mental health nurses consider the person's physical, psychological, social and spiritual needs, within the context of the person's lived experience and in partnership with their family, significant others and the broader community. While most professional disciplines working in mental health appear to have seamlessly adopted clinical supervision, written it into their curricula and included it as an essential component of professional development, there appears to be longstanding resistance to its inclusion in nursing. The literature strongly supports the contention that there

has been prolonged debate and many publications that focus on the challenges and barriers to providing clinical supervision (Butterworth et al. 2008; Long et al. 2014). Additionally, clinical supervision is not easy to investigate scientifically (Gonge & Buus 2015), yet these debates and analyses appear to have done little to improve the quality and efficacy of clinical supervision being provided. The explanation for this dichotomy is multifactorial but includes such issues as the barriers to access for shiftworkers, the paucity of accredited, regulated training in clinical supervision and a serious shortage of rigorous evaluation of outcome methods. The literature also strongly suggests that one of the key facilitating factors is a clear, detailed, specific mandate (Falendar 2014) at all levels of management within organisations that provide mental health services that supports the delivery and uptake of clinical supervision by all nursing staff. Ironically, there is little evidence to support the claim that clinical supervision is an essential part of best practice for consumer care (White 2016).

Increases in professional responsibility and accountability and increases in the complexity of modern clinical practice, when combined with a lack of clinical support, can potentially lead to greater numbers of clinical errors and higher staff turnover than would otherwise be expected (Caine & Jackson 2011). Good-quality clinical supervision can minimise the negative effects of these stressors and complexities by supporting nurses to access

increased learning opportunities, which in turn will help them develop new skills while increasing their connectivity with other team members. Supporters of clinical supervision have suggested that these positive outcomes can lead to an enhanced sense of professional wellbeing and may ultimately lead to a reduction in the number of people leaving nursing and looking for either new careers or focusing their nursing career development in non-clinical areas. Additional and more rigorous research is needed to verify these claims.

The content and approach to clinical supervision may need to evolve to match advances in nursing practice and the increasing experience of a mental health nurse over a career.

Purpose

The purpose of this document is to provide a formal framework for individuals and organisations to develop, implement and evaluate clinical supervision for nurses in Victorian mental health services.

Scope

The framework is intended to support all nurses working in Victorian public mental health services and is a guide for private mental health services and external clinical supervision providers.

Aims

- To outline key considerations for the establishment and sustainability of clinical supervision for nurses in Victorian mental health services.
- To delineate the essential roles and responsibilities of all stakeholders in clinical supervision.
- To support nurses and services to build capacity, skills and competency within the mental health nursing workforce in respect of clinical supervision. Ultimately this is expected to meet the needs of the individual nurses and contribute positively to evolving mental health services.
- To identify barriers and opportunities to implementing clinical supervision for mental health nurses across Victoria.

About the framework

The information provided in this framework is intended as general information and not as legal advice. Senior mental health nurses, nurse unit managers and mental health service managers should ensure that clinical supervision practices are developed and implemented consistently with the purpose and intent of the framework.

Australian College of Mental Health Nurses

As anyone who knows me will attest, I am passionate about strengthening the nursing profession and, in particular, mental health nurses. Clinical supervision is a cornerstone of professional development, individually and collectively. I have been providing and receiving clinical supervision for many years with both mental health and other nurses. My personal growth through working and learning with others has been enormous. Clinical supervision benefits both the giver and the receiver. Importantly, as each individual grows, so does the strength of the profession, because robust, resilient nurses are able to invest more of themselves without feeling overwhelmed and exhausted, leading to better outcomes for people who receive mental health nursing care. Research has clearly shown the positive outcomes of supervision in validating personal and professional concerns – in re-establishing confidence and efficacy and in learning new and innovative ways of delivering care through reflection of self and our role.

Clinical supervision is an active process and requires active engagement from individuals, the profession itself and organisations. However, getting started is sometimes difficult. This framework offers theoretical input as well as guidance to achieve a systematic and solid approach to delivering clinical supervision. It sets out clear standards and outcomes for clinical supervision to enable and empower mental health nurses to be the best they possibly can be.

Importantly though, it identifies the elements that go together to make clinical supervision possible from an organisational point of view. Leaders in organisations may have good intentions regarding clinical supervision but are often hampered because they are uncertain of the requirements that need to be applied and the policies and processes that inform and guide its implementation.

The Department of Health and Human Services is to be congratulated for compiling this framework. It sets the standard for, and the expectations of, mental health nurses and their leaders to commit to embedding and sustaining clinical supervision in everyday practice as a core feature of the professional mental health nursing role.

Wendy Cross – Former president, Australian College of Mental Health Nurses

What is clinical supervision?

Clinical supervision is a process of professional support and learning in which nurses are assisted to develop their practice through regular time spent in reflective discussion with experienced and knowledgeable colleagues who are adequately trained in providing clinical supervision. This is done by way of a voluntary working alliance between two or more staff members, where the primary intention of the interaction is to enhance the knowledge, skills and attitudes of at least one staff member.

Other definitions of clinical supervision include:

- Clinical supervision is a facilitated exchange between practising professionals to enable the development of professional skills (Faugier & Butterworth 1994).
- Clinical supervision is a structured process to reflect on clinical practice in order to more fully appreciate the meaning of the experience, to develop abilities, maintain standards of practice and provide a more therapeutic service to the client (Consedine 1995).
- Lynch and colleagues (2008) suggest that common concepts of clinical supervision include (but are not limited to) it being a supportive space for the individual clinician to reflect on their professional practice in such a way that growth, development and learning are promoted; that the essential ingredient in the process of establishing clinical supervision is the relationship between the supervisor and the supervisee, and it is this relationship that will influence the outcome of clinical supervision; and that clinical supervision is participated in on a voluntary basis and that all parties involved in supervision need to be fully committed to an open, honest process.
- On its website, 'Clinical Supervision in the Alcohol and Other Drugs and Community Managed Mental Health Sector', The Bouverie Centre (2013) makes the following statement:

Though definitions of clinical supervision vary, the principal aims described in the literature are fairly consistent and can be summarised as follows: to enhance supervisees' skills, competence and confidence; to provide a reflective space and emotional support; to provide assistance with professional development; to ensure that services to clients is safe, ethical and competent; to ensure compliance with professional and organisational treatment standards & practice.

Clinical supervision in relation to clinical governance

Clinical supervision is one component of a wider framework of clinical governance activities that are designed to support staff and to manage and monitor the delivery of high-quality services and effective outcomes for mental health service consumers. Other components include administration, line management, performance appraisal, development processes, mentoring, clinical education/training and participation in structures such as clinical reviews, team meetings, mentoring, clinical handovers and grand rounds.

Figure 1: A model of clinical governance and professional development

Source: Adapted from Queensland Health 2009, Clinical Supervision Guidelines for Mental Health Services



Clinical supervision: what it is and is not

The literature and the findings of consultations with clinicians experienced in receiving and providing supervision highlighted that clinical supervision is not a management activity and should not be confused with performance appraisal or administrative supervision with line managers. Elements associated with clinical supervision include consumer-focused, clinician-led, practice-focused, intraprofessional or cross-professional work that is delivered in a variety of modes. Clinical supervision is distinct from a line management tool, a method of surveillance, a formal performance review, a form of preceptorship, a form of therapy, a form of training, a form of mentoring or a compulsory element of employment and is neither counselling nor hierarchical (see Figure 2).

As described in the New South Wales Health Education and Training Institute (HETI) document *A supervision continuum for nurses and midwives*, there are a range of supervision types that can be used throughout the professional development of nurses and midwives, depending on individual professional development needs. The topics covered in the HETI supervision continuum include (see also Table 1):

- point of care – clinical teaching, clinical facilitation, preceptorship, buddying
- facilitated professional development – peer review, coaching, mentoring
- clinical supervision (reflective).

Figure 2: Clinical supervision: what it is and what it is not

WHAT IT IS

- Consumer-focused – reflect on issues relating to, or affecting, clinical practice and the delivery of consumer care
- Clinician-led – the clinician chooses the supervisor and determines the frequency, the purpose and the focus for each session and their own learning goals
- Practice-focused – focus on clinical practice issues associated with service delivery
- Intra-professional (conducted by members of the same profession) or cross-professional (conducted by a member of another profession)
- Delivered in a variety of modes including face-to-face, telephone and videoconferencing, and in either individual or group format

WHAT IT IS NOT

- A line management tool
- A method of surveillance
- A formal performance review
- A form of preceptorship
- Counselling
- Hierarchical
- Criticism of the individual as a nurse or a person
- A form of therapy
- A form of training
- Mentoring
- Compulsory for employment



Table 1: Types of supervision for nurses and midwives

Clinical supervision	Point-of-care supervision				
	Clinical facilitation	Buddying	Preceptoring	Clinical teaching	
Method of provision	Supervision and support of nursing and midwifery students during clinical placement Informal/formal Individual or group	Welcome and orientation to the new work environment Informal Individual	Clinical support for new staff during the transition to a new work environment Informal/formal Individual	Education on specific clinical and non-clinical skills Opportunistic Informal/formal Individual or group	
Duration	Short–medium term	Short term (approximately first three months)	Short term (approximately three–six months)	Short term Episodic/planned	
Feedback process	Feedback to student May include feedback to an education provider	Feedback to new staff member and NUM/MUM	Feedback to the preceptee and NUM/MUM	Feedback to the learner and NUM/MUM as required	

	Facilitated professional development			Clinical supervision (reflective)
	Peer review	Coaching	Mentoring	Clinical supervision
	Evaluation of care by a colleague of a similar level of experience and position Informal/formal Individual or group	Development of specific skills and knowledge to attain identified goal Informal/formal Individual or group	Senior professional shares knowledge and expertise to nurture professional growth Informal/formal Individual – instigated by the mentoree	Reflection on work and professional issues Formal/structured Individual or group
	Short–medium term (at regular intervals or in response to need)	Short term	Long term (frequency flexible according to need/availability)	Long term (monthly)
	Feedback to peer(s) NUM/MUM awareness of peer review process	Feedback to coachee May include feedback to manager	Feedback to mentee Manager may be informed by mentee	Feedback to supervisee(s)

Table 1: Types of supervision for nurses and midwives (continued)

Clinical supervision	Point-of-care supervision			
	Clinical facilitation	Buddying	Preceptoring	Clinical teaching
Intended outcomes	<p>Safe patient care during student learning</p> <p>Application of skills and knowledge to practice</p> <p>Feedback, guidance and encouragement to continue development</p> <p>Working towards competency attainment</p>	<p>Quicker integration into the work environment</p> <p>Interactions with NUM/MUM are more focused on key areas</p> <p>Increased opportunity for connection with other staff</p>	<p>Increased knowledge, clinical skills and application of theory to practice</p> <p>Safe clinical practice and supported transition to work environment</p> <p>Competency attainment</p>	<p>Increased knowledge, clinical skills and application of theory to practice</p> <p>Safe clinical practice</p> <p>Competency attainment</p>
Examples	<p>Observation of direct patient care and indirect care by RN/RM in accordance with student's level of training and experience</p> <p>Case discussion/ review</p> <p>Debriefing</p>	<p>Orientation to physical work environment</p> <p>New staff member able to ask questions freely</p>	<p>Orientation to clinical procedures and processes</p> <p>Support to achieve learning goals</p> <p>Observation of competency and transition</p>	<p>Teaching opportunities:</p> <ul style="list-style-type: none"> • direct patient care • at clinical handover • during ward rounds • education sessions

Source: Health Education and Training Institute 2013, The Superguide: a supervision continuum for nurses and midwives

	Facilitated professional development			Clinical supervision (reflective)
	Peer review	Coaching	Mentoring	Clinical supervision
	<ul style="list-style-type: none"> Quality and safe care Performance accountability and enhancement Professional development Measuring practice against professional standards of practice 	<ul style="list-style-type: none"> Focused support in the attainment of goals Empowering and enabling Improved performance and wellbeing Development of future leaders 	<ul style="list-style-type: none"> Extended support in the attainment of goals Further development of capacity and skills Sustained development of leaders 	<ul style="list-style-type: none"> Improved clinical practice and professional development Exploring new ways of working or dealing with difficult situations More reflective, vibrant professional staff members
	<ul style="list-style-type: none"> Review of medication errors and falls Auditing of files to improve documentation Case review Root cause analysis 	<ul style="list-style-type: none"> Action Learning Sets Leadership development Clinical leadership programs including 'Take the Lead' (for managers) 	<ul style="list-style-type: none"> Mentoring programs Development of managers and clinical leaders 	<ul style="list-style-type: none"> Individual or group supervision with a trained supervisor Peer supervision

The clinical supervision relationship

The effectiveness of clinical supervision is a direct result of the quality of the clinical supervision relationship (Bond & Holland 2010). Achieving a quality relationship is predominantly reliant on the skill and expertise of the supervisor. For this reason, it is imperative that supervisors receive appropriate theoretical and practical preparation (Lynch et al. 2008). The role of the supervisee is also important in order to build the relationship and to gain the most out of the experience. It is important, therefore, that all participants have a good understanding of the supervision process and that the clinical supervision relationship develops into an effective working alliance (Bond & Holland 2010).







Part 2: Clinical supervision for mental health nurses in Victoria

Mental health nursing professional practice in Victoria

A number of defined and variable factors affect the professional practice of mental health nurses working in Victoria (see Figure 3). Defined requirements include legislation, professional requirements, policy and procedures, among others. Variable requirements can range from clinical and service settings (bed-based services and community teams), to location (metropolitan, regional and rural), client groups (child and youth, adult and aged), acuity of illness and workplace settings (clinical, management and academic).

For these reasons, it is essential to develop a framework that accommodates the complex requirements for mental health nurses.

The framework

This framework is intended to help guide individual Victorian mental health nurses to engage in clinical supervision and to guide mental health service organisations to identify factors that could support increased uptake and more effective implementation of clinical supervision across the state. The framework also clarifies the key practice principles that should underpin the implementation and

delivery of clinical supervision to ensure that the highest quality of mental health nursing can be delivered to consumers. The framework should be considered as complementary to existing professional standards, organisational policies and associated legislation.

The elements of this framework are derived from an integrative literature review and a nationwide consultative process with an expert reference group, the combination of which led to a set of overarching principles and philosophy for clinical supervision. The consultation process resulted in the specification of various practice parameters pertaining to three domains:

- the supervisee – any mental health nurse working in a clinical area or non-direct clinical care such as coordinators, managers, educators and researchers
- the supervisor – a person with experience and training as a supervisor of clinical supervision
- the organisation – any employer of mental health nurses.

Australian Nursing and Midwifery Federation (Victorian Branch)

ANMF (Vic Branch) members who are engaged in agreed and effective clinical supervision regularly report professional development benefits arising from having time to reflect on their practice, particularly when employed in what is often a challenging environment. ANMF (Vic Branch) advocates for upholding the underpinning principles of clinical supervision including accessible, safe, confidential and voluntary arrangements with appropriately trained clinical supervisors. An equally important principle – and one that is emphasised in the mental health nurses' industrial instrument – is that the clinical supervision offered to nurses is provided by a supervisor of the nurse's choice.

Nurses employed in Victorian public mental health services have a workplace right to access professional (clinical) supervision up to two hours per month, with provisions that enable employers to offer additional time. Clinical supervision is also a critical element of the RPN 2 community training provisions with the framework for clinical supervision requiring organisations to collaborate on the development of effective implementation plans.

As an industrial entitlement, all parties – including employers, the Department of Health and Human Services and ANMF (Vic Branch) – have a role to play in supporting the workforce and ensuring improved access to clinical supervision for mental health nurses.

As indicated in the *Joint clinical supervision position statement*, employers must positively support and actively promote demonstrable and effective clinical supervision through organisational policies, procedures and workplace culture.

Lisa Fitzpatrick – Secretary, ANMF (Vic Branch)

Figure 3: Factors affecting mental health nurse professional practice in Victoria



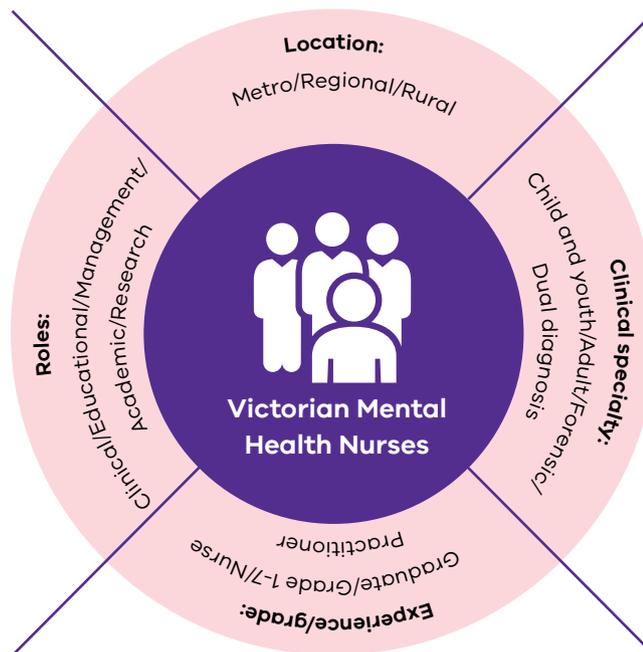
Organisation

- Service model policies and procedures
- Quality and safety clinical standards
- Occupational Health Safety
- Human Resources policies
- Records management and reporting



Legislation and policy

- Victoria's Mental Health Act 2014
- Reducing Restrictive Practices
- Health Records Act
- Human Rights Charter
- Vic. Chief Psychiatrist Guidelines and Directives



Consumer centred care

- Recovery oriented practice
- Trauma informed care
- Cultural safety
- Family inclusive practice
- Supported decision making
- Gender safety and sensitive practices



Professional

- Qualification
- Registration standards
- National Mental Health Standards
- Industrial Agreement
- Continuous professional development

Models of clinical supervision

Several models of clinical supervision have evolved over the past 10 years, during which time it is likely that clinical supervision has become an established part of the working practice of many nurses. Individual programs of clinical supervision have been developed and implemented by many healthcare providers and, for the purpose of this framework, concepts from four frequently recognised models have been taken into consideration.

Model 1: Growth and support model (Faugier 1992)

In this model the role of the supervisor is to facilitate growth both educationally and personally in the supervisee while providing essential support to developing their clinical autonomy. The supervisee experiences personal growth through a trust-based relationship with their supervisor. Key features of the growth and support model of clinical supervision include:

- generosity
- satisfaction (and that it is rewarding)
- openness and willingness to learn
- thoughtfulness (and that it is thought-provoking)
- humanity
- uncompromising sensitivity
- individualism
- practicality
- orientation
- trust.

Each of these aspects is offered as a framework on which to base the supervisory relationship (Faugier 1992) and to provide one possible structure to the supervisory process. Using this as a guide, supervisors can ensure that all the essential elements of the relationship are given adequate emphasis.

Model 2: Integrative approach (Hawkins & Shohet 1989)

This model looks more closely at the process of the supervisory relationship and divides supervision into four main components:

- supervisor
- supervisee
- client
- work context.

Hawkins and Shohet (1989) separate the process into two interlocking systems: the therapy system, which connects the client and supervisee, and the supervision system, which involves the supervisee and supervisor. Both systems are based on a similar type of agreed contract of time spent together through negotiated shared tasks and goals.

Model 3: The three-function interactive framework of supervision (Proctor 1987)

This model consists of three components:

- normative (managerial) – promoting and complying with policies and procedures, developing standards and contributing to clinical audit
- formative (educative) – skills development, developing evidence-based nursing practice
- restorative (pastoral support) – enabling practitioners to understand and manage the emotional stress of nursing practice.

Elements of these three components must be considered integral parts of an evaluation system for clinical supervision.

Model 4: The role development model (Consedine 1980s)

This is a person-centred model where the supervisor focuses on exploring the supervisee's question when they are ready to, rather than solving the problem. It is reflective, restorative and enabling, and the supervisor facilitates the supervisee's journey as they consider new ways of viewing a situation. In the role development model it is not considered necessary for the supervisor to be an expert in the supervisee's field of practice. However, it is considered necessary to be trained in the art and skill of clinical supervision.

Of the four examples mentioned above, the most widely adopted model in nursing has been Brigid Proctor's three-function interactive framework. An effective implementation and evaluation strategy should address elements of all four aforementioned models. The presence, or absence, of these elements will govern the relative success of the supervisory process, and each contributing factor will form a vital part of an integrated system.

Modes of clinical supervision

Clinical supervision creates a supportive environment that encourages reflective practice that is intended to improve therapeutic skills. The supervisor can be from your own discipline or from a different discipline and can be internal to the organisation or from an external source. There are three common forms of clinical supervision that nurses practice:

- **individual** – a single supervisor and supervisee meet regularly for clinical supervision
- **group supervision** – clinical supervision is facilitated by a supervisor for two or more supervisees
- **peer supervision** – two or more peers meet for supervision and share responsibility for the supervisor and supervisee roles.

Individual supervision

- This involves a regular, structured meeting/discussion between the supervisor and supervisee. Irrespective of the mode, clinical supervision is regular, protected time away from the immediate work environment (Bond & Holland 2010).
- The supervisor should have knowledge and skills in supervision practice (have undertaken some preparation for the role), be respected by their peers and demonstrate leadership qualities. Feedback is a critical component of supervision to ensure there is a two-way interaction between the supervisor and supervisee.
- The frequency and location of these sessions is agreed in the supervision plan and is prioritised and protected by both the supervisor and supervisee.
- This should occur in an appropriate, confidential environment and may include face-to-face, telephone, videoconference or online discussion.

- The risks or limitations associated with this method are:
 - individual supervisors potentially charging a fee, making this type of clinical supervision unaffordable for some nurses
 - lack of consistent support for the supervisee from their organisation
 - a poor relational fit between the supervisor and supervisee
 - routinisation or lack of challenge in the supervision over time
 - drift of focus over time
 - supervisees becoming dependent on the 'expert' supervisor
 - potential for the supervisee to feel intimidated, with no-one to break up the intensity
 - limited opportunities for group learning activities such as reflective role-play
 - awkwardness with terminating an agreement, particularly if the people involved usually work in close proximity.

Invited personal testimony 1

Clinical supervision in action – one on one (the supervisee)

I work in the acute mental health setting and have been engaged in clinical supervision (CS) for more than a year. Initially my sessions were sporadic. But the more I engage in CS, the more helpful it becomes. I now attend individual CS on a monthly basis. The value in having a space that is reserved solely for me is incredible. Each time I finish a session with my supervisor, I feel refreshed and invigorated. It has strengthened my resilience in the clinical setting, improved my understanding of myself and others, and allows me to discuss practice areas I feel I need to improve on. I also deliver CS in a group setting for our graduate and postgraduate nurses. They find it very beneficial and place value in the supportive and productive nature of the sessions. Of all the people I know who are engaged in CS, I have been hard-pressed to find anyone who finds no benefit from it or dislikes it.

I am a big believer in self-care through CS. The mental health setting can be a challenging and traumatic field of practice, so we need to look after ourselves to be truly present to care for others. CS helps me during times when I feel drained of compassion and in times when I might question the longevity of my career in mental health. CS helps me grow more resilient and passionate about the wonderful work we all do as mental health nurses.

Elyse Smith – Clinical Nurse Educator, Melbourne Health

Group supervision

- This is facilitated by a supervisor with knowledge and skills in working with groups and can take many forms and be effective for a range of outcomes and clinical groups. It is expected the supervisor has undertaken education/training in group processes and experience in leading groups
- It is an effective way of delivering supervision to larger numbers of practitioners (ideally four to six) and can be delivered in a variety of formats. Some bed-based services in Victoria use terminology such as 'reflective practice' and titles such as 'Hypothetically speaking...' and 'strengths brainstorming'.
- It provides an opportunity for supervisees to experience mutual support, share common experiences, solve complex tasks, learn new behaviours, and participate in informal training, increase communication, confidence and insight.
- It enables participants to discuss clinical issues or approaches that they would otherwise not have been exposed to and feel comfortable to ask questions and express concerns.
- It provides a forum for facilitated open discussion, sharing and learning between a group of clinicians and may include case discussion, topics of interest, inter-professional collaboration, conflict, organisational issues and team work activities.
- It may occur face-to-face or via phone, online or videoconference.
- The risks or limitations associated with group supervision are:
 - superficiality or lack of depth of sharing due to concerns about confidentiality, competitiveness in the group or inconsistency of relationships
 - lack of commitment by participants due to changing group membership
 - group dependency on the facilitator
 - lack of challenge of poor practice or potential for overload of ideas and confusion about which to use due to silence or minimal participation among the least competent member(s).

The strengths model of group supervision – brainstorming

1. This model includes a structured approach to supervision. The strengths model is optimistic and focuses on the consumer's preferences, strengths and goals.
2. The facilitator must be well versed in the strengths model of case management – their role in the sessions is important for keeping the process and focus.
3. The group is open and can include anyone who might work with that consumer and team.
4. Each session involves facilitation of discussion and brainstorming about the work of a clinician with a specific client.
5. The strengths assessment is the foundation for the work, so the clinician shares the strengths assessment with every participant.
6. The clinician puts a question to the group. For example: How can I engage better with this person? or What community resources might match this stated goal?
7. The clinician explains what they have tried that didn't work.
8. The team asks clarifying questions.
9. The team brainstorms as many ideas as possible about ideas that might be tried by the clinician.
10. The clinician does not refute any ideas but identifies the top three ideas and arranges to discuss at least these and potentially all suggestions with the consumer at the next session.
11. The sessions are intended to be affirming and supportive.

Bridget Hamilton – Associate Professor, The University of Melbourne

Invited personal testimony 2

Clinical supervision in action – bed-based settings

Implementing and sustaining group clinical supervision for inpatient mental health nurses comes with a unique set of challenges and requirements.

Inpatient mental health nurses are at the frontline of delivering mental health care 24/7 to consumers and their families when they are at their most vulnerable and unwell. Inpatient unit environments are highly pressured and can be relentlessly demanding of nurses needing to reprioritise their consumers' dynamic needs in a timely and safe manner.

Inpatient nurses can feel intensely pressured during a shift, and being able to prioritise their needs for professional development and, in effect, reflective practice or clinical supervision can feel like another thing they need to do. However, this is not the experience of all inpatient nurses.

Organisational and systemic support across all levels of management that aligns with the nurses' ability to prioritise this important professional development opportunity is vital to the program's success.

Having an appointed portfolio holder for the clinical supervision program serves as a central point to coordinate training in the area and as a resource for those seeking a supervisor. Nurses can feel at a loss, not knowing where to begin in finding a suitable supervisor without a central point.

Services may also establish a clinical supervision special interest group as a way of supporting supervisors in their role development and progression. Ideally supervisors should have refresher training every three to five years.

Mary Gilbert – former clinical nurse consultant, Alfred Health

Peer supervision

- This mode of clinical supervision occurs between two or more (usually experienced) mental health nurses who are experienced in participating in clinical supervision. It is a variation of the individual or group modes.
- It requires facilitation in the initial/formative stage, which may be shared/rotated among participants.
- It is a reciprocal learning relationship that uses the skill, experience and knowledge available within the group of peers.
- It may include consultation, problem solving, reflective practice and clinical decision making.
- It does not require a supervisor to have more experience or knowledge than the supervisee.
- It is more cost-effective (as is group supervision) for both individuals and organisations.
- It fosters and encourages mutual benefits, self-directed learning and the giving and receiving of feedback (as for group supervision).
- It may be conducted among internal colleagues or with external peers from different organisations.
- It may be supplemented with individual clinical supervision for mental health nurses.
- It might be unsuitable for novice nurses because there may be instances when unsafe practice is discussed and there is not an awareness that this requires action of some description.
- In this mode, the participants take up the role of both supervisee and supervisor.
- The risks associated with peer supervision include:
 - sustainability
 - maintaining the quality and effectiveness of the process
 - understanding the boundaries and limitations of the relationship
 - lack of leadership causing tension in the relationship
 - focusing on solutions and advice rather than mutual learning and reflection.

Invited personal testimony 3

Peer group supervision among experienced practitioners

I have belonged to a peer supervision group for more than two decades. We were all clinicians with considerable clinical supervision experience before this group formed; we had all also carried leadership roles in this and other services, by that time. The group began meeting monthly, for two hours per meeting, when we all worked together in a community mental health workplace. While we eventually all moved on from that team, the group continued to meet in each other's homes.

The focus of supervision is broad – covering any issues that we confront in our diverse roles in mental health care. Sometimes those issues are interpersonal in our teams, sometimes management and organisational, sometimes clinical in nature. We maintain confidences within the group but advise each other about ways to take accountability issues back into our workplaces. We annually review the fit of the process for our changing needs. As multidisciplinary group members we continue to gain mutual support through these monthly in-depth discussions of work dilemmas.

Bridget Hamilton – Associate Professor, The University of Melbourne

Invited personal testimony 4

Action Learning Sets

I participated in Action Learning Sets (ALS) while completing the postgraduate nurse program with North Western Mental Health and found this style of clinical supervision to be the perfect fit.

ALS are well suited to postgraduate nursing because postgraduates are expected to consolidate their learning and clinical reasoning. Being able to have supervision led by your peers, who are going through the same types of work problems and issues, is highly beneficial.

The action plans we formulated were relevant and we left sessions feeling as though we learned a lot about how to handle different scenarios from various different perspectives.

I also found learning how to use Socratic questioning fascinating and an incredibly valuable skill for mental health nursing, as I am now able to support consumers who are making very important decisions without feeling the pressure to provide them with an answer or offering them advice.

I highly recommend ALS as both a form of clinical supervision and as a learning tool.

Musashi Fujihara – postgraduate nurse, The University of Melbourne

Principles for effective clinical supervision

The literature identifies three separate and distinct agents involved in successfully integrating clinical supervision; these are the supervisee, the supervisor and the organisation providing the mental health service (Gonge & Buus 2010).

The concepts and definitions of clinical supervision at the local level require a purposeful and definitive statement plus a clear commitment from the organisation to support clinical supervision at all levels of management. Clinical supervision should be accessible, inclusive, adhere to principles for choice, support all levels of experience and expertise and be culturally sensitive.

Each service should provide the practical tools and resources necessary while remaining mindful of different environmental factors and ensure that every staff member identified as providing clinical supervision has the appropriate training and workplace supports. A culture of respectful reflection and learning that is strengths-based and part of a continuum of professional growth is essential to the careers of all mental health nurses, from students to advanced practice nurses. Clinical supervision accentuates the nursing focus on consumer rights and recovery-oriented practice and optimises consumer-centred practice. High-quality, professional clinical supervision is always intended to improve the quality of nursing interventions and result in a higher standard of consumer care.

This framework is underpinned by the following five principles for clinical supervision:

Figure 4: Clinical supervision development for organisations, supervisors and supervisees (mental health nurses)



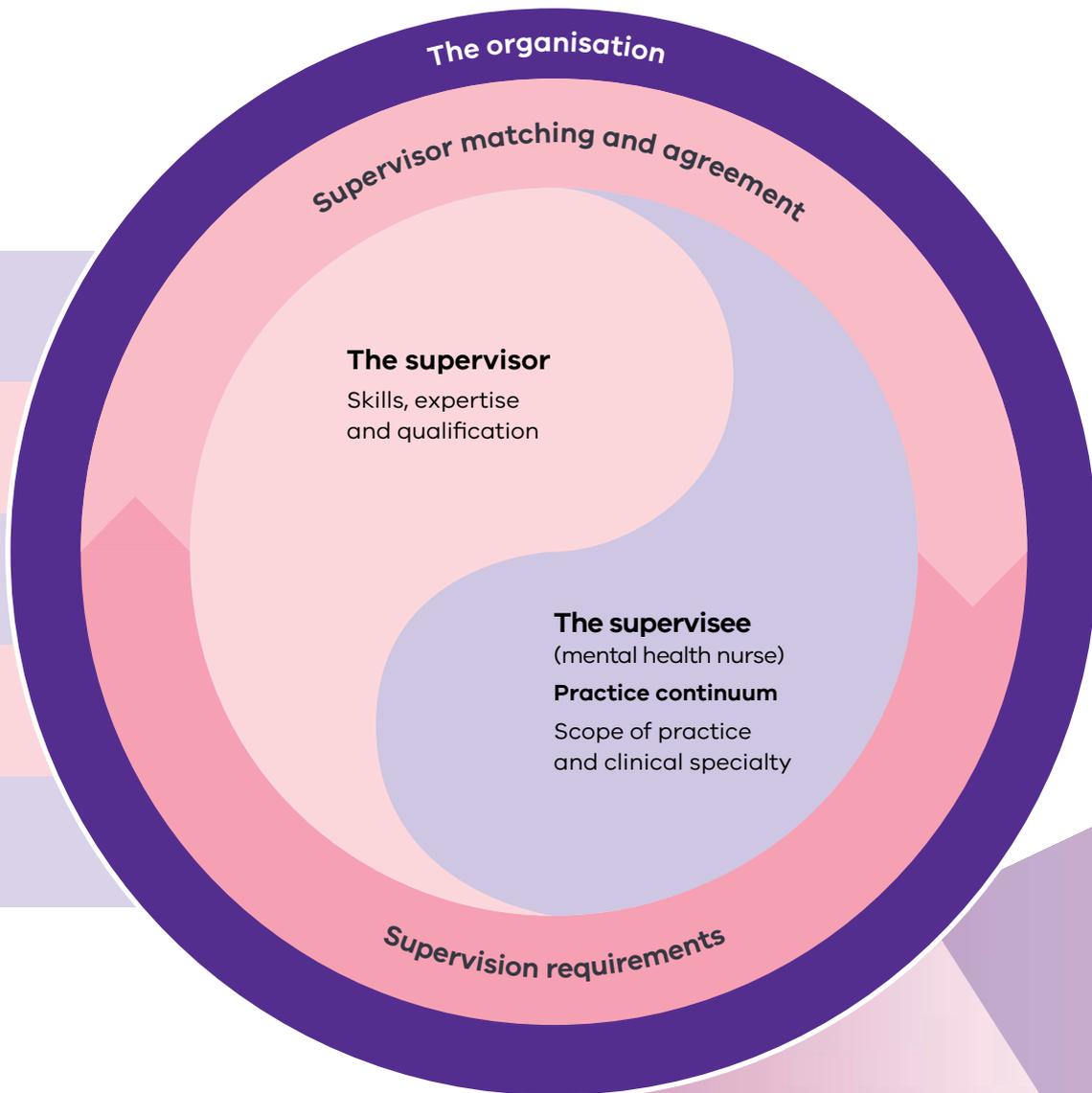


Table 2 and Figure 4 provide more information about clinical supervision development for mental health organisations, supervisors and supervisees.

Table 2: The principles of clinical supervision for mental health supervisors, supervisees and organisations

Principle	Supervisee	
<p>Principle 1: Clinical supervision focuses on strengths and is a positive nurturing experience</p>	<ul style="list-style-type: none"> • The supervisee is aware of the principles and practice of CS • The supervisee is able to identify strengths and opportunities to improve practice with the support and challenge of the supervisory relationship • The supervisee is able to apply the knowledge and skills learnt from the CS relationship into their practice • The supervisee experiences the relationship as supportive • The supervisee experiences the CS relationship as informative and educational 	
<p>Principle 2: Clinical supervision is accessible and inclusive; it is available to nurses in all areas of practice and expertise and is culturally appropriate</p>	<ul style="list-style-type: none"> • The supervisee engages in CS in a professional manner • The supervisor’s diversity of cultural beliefs and gender are respected and supported within the CS arrangement 	

	Supervisor	Organisation
	<ul style="list-style-type: none"> • The supervisor can articulate an understanding of the principles and practice of clinical supervision • The supervisor works within a model that is supported by the evidence • The supervisor facilitates an environment that is safe, confidential and based on an ethical and mutual agreement • The supervisor maintains current with their knowledge and skills and shares new practice developments as part of the CS experience • The supervisor is engaged in their own CS 	<ul style="list-style-type: none"> • The organisation develops an agreed implementation plan for CS, releasing staff regularly and supporting rostering arrangements to allow recipients of CS to do so in work time
	<ul style="list-style-type: none"> • The supervisor is an individual who has participated in recent education and has received some form of training in CS • The supervisee's diversity of cultural beliefs and gender are respected and supported within the CS agreement 	<ul style="list-style-type: none"> • There is support within the organisation from CEO and executive levels to the service delivery level • The focus of support is actively endorsing CS as a valued activity, that all mental health nurses have a choice and will be facilitated to engage in CS • The organisation develops and maintains a database of supervisors who are educationally prepared to provide CS, have completed training in relation to the organisation's CS policies and practice is regularly audited via surveys and feedback • The organisation provides workforce training or funds employees to attend recognised CS training and develops guidelines to implement CS • The organisation is responsible for education and ongoing support of supervisors • The organisation is responsible for developing guidelines for CS practice and implementation

Table 2: The principles of clinical supervision for mental health supervisors, supervisees and organisations

Principle	Supervisee	
<p>Principle 3: Clinical supervision supports professional development and promotes quality improvement in clinical care and professional practice</p>	<ul style="list-style-type: none"> • The supervisee engages according to the CS agreement that has been established • The supervisee uses CS to develop their ability to use reflective practice to enhance their ability to focus on clinical practices and their effect on self • The supervisee agrees that complex issues may require clarification by engaging with outside organisational or professional bodies • The supervisee investment in CS enhances quality outcomes 	
<p>Principle 4: Clinical supervision enhances the health and wellbeing of employees by providing a regular, continuous development platform for nurses to explore and reflect on their practice in a safe space and identifies future learning opportunities</p>	<ul style="list-style-type: none"> • The supervisee is encouraged to reflect on their practice, on how to reduce coercive practices and explore consumer-driven concepts, such as recovery and supported decision making, to influence their practice development • The supervisee uses CS to identify and establish healthy boundaries in their practice with the consumer group, their colleagues and within the organisation 	
<p>Principle 5: Clinical supervision optimises consumer-centred practice and improves the focus on consumer rights and recovery-oriented nursing practices</p>	<ul style="list-style-type: none"> • The supervisee uses CS to enhance their understanding of recovery-focused care and to test and evaluate their practice in relation to therapeutic engagement 	

(continued)

	Supervisor	Organisation
	<ul style="list-style-type: none">• The supervisor establishes agreed goals and timeframes within their CS agreement• The supervisor deals with any concerns related to OH&S, issues pertaining to harm to self or others and any legal issues within the session including agreed referral to external organisations• The supervisor investment in CS enhances quality outcomes	<ul style="list-style-type: none">• The provision of CS promotes a nurturing, developmental learning culture within the nursing workforce• The organisation articulates a vision for CS and develops an implementation plan and its own internal guideline to support the uptake of CS throughout its mental health services without coercion• At all times, the organisational investment in CS is intended to enhance quality outcomes for consumers, their carers and families and staff
	<ul style="list-style-type: none">• The supervisor uses ethical and professional strategies for CS practice to ensure each session is confidential, unless otherwise discussed and agreed with the supervisee• The supervisor will make all attempts to address the learning and reflective practice needs of the mental health nurses to whom they are providing CS	<ul style="list-style-type: none">• The organisation sets out and promotes its agreed implementation plan to support the uptake and continuous rollout of CS across the nursing workforce• The organisation implicitly states its support for implementing CS as part of its ongoing workforce development and retention strategy• The organisation addresses the CS learning, training and reflective practice needs of all mental health nurses working in the service
	<ul style="list-style-type: none">• The supervisor is aware of the expectations regarding CS for novices and all nurses, contributes to and informs nursing curricula when possible and actively promotes ownership of clinical supervision by all nurses to enhance consumer outcomes	<ul style="list-style-type: none">• The organisation values and regards the role of CS as essential to the development of the nursing workforce without coercion• The organisation and executive support the focus on CS to provide a nurturing, supportive environment adjunct to a learning culture that enhances consumer-centred practice by providing time and support for reflective practice

Invited personal testimony 5

Clinical supervision in action – being passionate about clinical supervision

I have been providing and receiving clinical supervision since the early 1990s. I feel passionate about supervision because it has kept me in the best shape to provide care to those I provide service to. People have often asked me how I do the work I do and I know, without doubt, that a key component of my survival in health care is good clinical supervision. My passion also extends to providing supervision. I love those joyful moments when the supervisee discovers something about their work that they didn't know previously.

As a clinical supervisor I believe it is important to have a framework for both providing supervision and for understanding people. For example, the theoretical and clinical framework that underpins my supervisory practice is nursing using a biopsychosocial model of care. Gestalt psychotherapy supports this nicely because it is a holistic and relationally based approach that is the cornerstone of my psychotherapy practice and provides the lens through which I understand the human experience. This is supported by psychodynamic theory, particularly developmental and relational concepts. Organisational psychodynamics and role theory have more recently informed my clinical supervision, particularly for nurses in advancing practice.

My framework for clinical supervision is in keeping with Brigid Proctor's model, which addresses the formative (educative), normative (standards) and restorative (supportive) domains of clinical supervision. Adult and reflective learning theories are also integral to my practice.

Combining these theoretical approaches provides a solid framework for understanding humans, therapeutic relationships, the helping process and clinical supervision.

Julie Sharrock – RN, Credentialed Mental Health Nurse







Part 3: Implementation and sustainability

Clinical supervision implementation

This section provides information about the implementation and sustainability of clinical supervision for mental health nurses in Victoria. Area mental health services are responsible for developing local clinical supervision policy and procedures/guidelines. Therefore, it should be recognised that it may be monitored by the same legal parameters as all other clinical documentation in the event of a serious incident.

Clinical supervision is a professional entitlement for mental health nurses in Victoria. Information about entitlements are available within the education and professional development section of the *Victorian Public Mental Health Services Enterprise Agreement*.

The supervision can be provided by a supervisor of the supervisee's choice, either from within the service or from an external source as determined by agreement between the supervisee, the proposed supervisor and, where appropriate, the employer. Senior psychiatric nurse positions (RPN 6 and RPN 7) also play an important part in implementing clinical supervision.

The content of clinical supervision sessions is confidential and is tailored to meet the needs of individual clinicians. However, clinical supervision in the public health setting is not implicitly a private arrangement; rather, it is conducted as part of the core business of workplaces. Therefore it should be delivered in line with the goals, organisational approaches and therapeutic modalities of Victorian mental health services.

Most area mental health services have a dedicated full-time senior psychiatric nurse. The clinical duties of these positions include the overall responsibility for, and coordination of, the professional development, education and training program within an area mental health service. This includes roles such as clinical supervision, planning and professional development opportunities and organising student and graduate nurse placements.

Health and Community Services Union

HACSU represents the industrial and professional interests of mental health clinicians in Victoria. I am delighted to be invited to write a foreword for this clinical supervision framework for mental health nurses in Victoria.

Since the early 2000s HACSU has worked with senior mental health nurses, nurse academics and clinician members to establish clinical supervision in mental health services through the successful inclusion of clinical supervision as an industrial entitlement in the *Victorian Public Mental Health Services Enterprise Agreement*. Some mental health services, senior mental health nurses and clinical educators have successfully introduced a framework of clinical supervision, and HACSU members have been participating in clinical supervision.

Although the benefits of clinical supervision have been articulated, it has been poorly understood. It has not been embraced or successfully rolled out across the state, and some senior managers and mental health clinicians have not fully embraced the concept.

Managers have expressed scepticism regarding the benefits of clinical supervision, including the effect on continual improvement in the skills and knowledge of clinicians and consumer/client outcomes and also the budgetary bottom line. Mental health nurses have also expressed scepticism, including seeing it as 'another task to be undertaken', or fearing that clinical supervision is a performance management process.

The barriers and challenges to the statewide introduction of a clinical supervision framework have been many and varied and are honestly and openly described in Part 1 of this framework. Part 2 describes clinical supervision as an integral part of mental health professional practice, outlining the principles for effective clinical supervision and the models of clinical supervision. Part 3 covers implementation and sustainability. Part 2 and Part 3 provide a concise description of accessible strategies and solutions to meet the barriers and challenges articulated by service managers, senior mental health nurses and clinicians. The framework outlines five principles underpinning clinical supervision that address myths, and the historical and current objections to clinical supervision. Importantly, the principles outline the responsibilities and obligations of the parties: the organisation, the supervisor and the supervisee, highlighting the importance of choice and trust in a supportive, non-punitive, non-threatening, learning environment.

The benefits of clinical supervision to services, clinicians and consumers and the great work being done are outlined in the testimonials. They provide examples of the what is done, how it is done and how clinical supervision has transformed their work with clients and peers, and how it has helped individuals to deal with the inevitable challenges of working with people experiencing mental health issues. The testimonials describe the value of reflective practice, the importance of the therapeutic relationship and use of self, outlining the specialist and unique nature of mental health nursing skills.

HACSU commends the department, Anna Love as the executive sponsor of this project and Wendy Cross for her career-long advocacy of the benefits of clinical supervision.

The members of the expert reference group are leaders in aspects of mental health nursing and have been long-time advocates for the benefits of clinical supervision in their areas of work, academia, teaching, service management and direct clinical practice. All members are leaders in the area of clinical supervision and have supported mental health nurses to participate in clinical supervision. The result of this collaboration is an informative and instructive document.

This framework will guide the statewide implementation of clinical supervision across all mental health services in Victoria and be evidence of a true and real investment in the people who are the mental health workforce.

Paul Healey – Assistant Branch Secretary, HACSU

Invited personal testimony 6

Clinical supervision in action – the organisation (management)

In my role as a director of nursing, I tend to have clinical supervision with my peers, who happen to be nurses (luckily enough!). This allows me to reflect on and review professional and practice matters as well as considering changes or modifications to approaches, often leading to me identifying training and continuing professional development needs.

It is important for the mental health nursing profession to commit to clinical supervision to provide the opportunity to review professional standards, keep up to date with developments in their profession, identify professional training and continuing development needs and, most importantly, to ensure they are working within professional codes of conduct and boundaries.

Also very importantly, clinical supervision is about maintaining the professionalism of mental health nursing in caring for people who have a serious mental illness. It supports mental health nurses to maintain their fitness for practice and instils a level of consciousness before planning and implementing their nursing care. Further, it can allow an individual nurse to reflect on and challenge their own practice in a safe and confidential environment. They can also receive feedback on their skills that is separate from managerial considerations.

In my opinion, clinical supervision should be valued within the context of the culture of the organisation, which is crucial in setting the tone, values and behaviours expected of individuals, especially within the nursing discipline. It should be regarded as a good practice approach to ensure that nurses have the right skills, attitudes and support to provide high-quality services. Ownership of clinical supervision is paramount, complemented by a structure and process for sustainable implementation.

Brian Jackson – Director of Nursing, Melbourne Health

Steps to building a clinical supervision implementation plan

1. Understand the organisational factors that support good clinical supervision practice.
2. Assess organisational readiness.
3. Develop a clinical supervision implementation plan. Mental health service executives, including the director of nursing (where appointed), should be invited to participate along with the senior psychiatric nurse and clinical nurse educators. A clinical supervision implementation plan should consider:
 - how supervisors should be chosen or assigned
 - what models and methods of supervision should be used
 - how evaluation processes should be carried out
 - how problems should be resolved.
4. Address challenges to effective implementation (such as rural isolation, access for shiftworkers, lack of trained supervisors).
5. Discuss common challenges to effective implementation within the organisation and provide suggestions for how to overcome these barriers.
6. Decide whether there will be clinical supervision champions recruited to support sustainability.
7. Review internal policy and procedures that address the organisation's context and culture, which will help establish the aims, structures and processes of supervision aligned to this framework and the industrial provisions. Organisational policy will articulate how serious problems within the clinical supervision relationship may be dealt with.
8. Obtain endorsement of the clinical supervision agreement template.
9. Give priority to clinical supervision in the organisation's budget or seek additional funding.
(Supervision has an immediate cost implication but remains a cost-saving measure overall, once the benefits to client care, worker satisfaction, professionalism, retention and quality assurance are taken into account.)

10. Plan the launch and associated promotional events.
11. Recruit or select effective supervisors (including contracting external supervisors).
12. Provide opportunities for ongoing training and consistent support for supervisors, as well as for evaluating and providing feedback on their work with supervisees.
13. Launch the program at an event.
14. Monitor and evaluate the selected framework, including the supervisees' satisfaction with their supervision.
15. To assist with monitoring and evaluation, the organisation should prepare a set of agreed tools as part of the implementation plan.

Key roles and responsibilities of the supervisor, the supervisee and the organisation

Clinical supervision must have sponsorship at all levels in mental health services if it is going to succeed. The organisation and all senior management must support and enable the process of formalised reflection on practice; organisational culture is a critical determinant of implementation (see Table 3).





Table 3: Success factors for implementing clinical supervision

Success factors	Supervisee	Supervisor	
Readiness	<ul style="list-style-type: none"> Supervisee is personally willing and professionally prepared to actively participate in clinical supervision (CS) and demonstrates a clear understanding of the difference between CS and other types of supervision 	<ul style="list-style-type: none"> Supervisor has engaged in identified specialist CS training and updates (suggested within a three- to five-year period) Supervisor is able to provide evidence of specialist training and/or experience in a particular modality of practice when relevant to a specialist counselling or psychotherapeutic approach 	
Database	<ul style="list-style-type: none"> Supervisee is aware of and has access to a current database of organisationally supported supervisors or via other networks (or is prepared to pursue a supervisor using their professional networks, has some knowledge of their training and area of clinical specialty and is free to make personal choices about with whom they engage in the CS relationship) 	<ul style="list-style-type: none"> Experienced supervisors with relevant training register in a database, indicating any areas of specific expertise, specialist training and most recent qualifications 	
Support	<ul style="list-style-type: none"> Supervisee has the full support of their immediate line manager because they initiate access to clinical supervision, and for ongoing support to engage in regular supervision 	<ul style="list-style-type: none"> Supervisor is personally and professionally prepared to provide CS and has the support of their line manager to fulfil the supervisor role, including access to their own supervision 	

Organisation

- The organisation or area mental health service (AMHS) agrees an explicit, unified, positive position on clinical supervision that includes training and education and an implementation strategy shared and supported by all levels of management (especially line managers of staff expected to participate in CS)
- AMHS allocates a coordinator (or champions) with the specific responsibility for establishing and maintaining a current (possibly voluntary) database of relevant information (staff being supervised, staff providing supervision, currency of training, areas of clinical specialties, etc.) and also for encouraging mental health nurses to access CS
- AMHS ensures that bed-based services are being provided with and participating in CS, taking into account different levels of practice, individual nurses' varying readiness to make active use of CS, differing service settings, best practice and organisational functioning
- AMHS consider the possibility that the nurse's preference is for individual CS
- If group CS is being provided it is recommended that the supervisor has additional training to be able to effectively manage a group process
- There will be a clear delineation between CS and line management
- AMHS will identify and prepare supervisors using 'in-house' or external education and/or training programs
- AMHS provide guidance regarding the maximum number of supervisees per supervisor while concurrently demonstrating flexibility in the context of making allowances for supervisors' other responsibilities
- Supervisors participate in their own regular support/supervision sessions

Table 3: Success factors for implementing clinical supervision (continued)

Success factors	Supervisee	Supervisor	
Agreement	<ul style="list-style-type: none"> Supervisee commits to the mutual agreement and prioritises attendance for the agreed frequency and duration 	<ul style="list-style-type: none"> Supervisor is free to make personal choices about with whom they engage in the CS relationship Supervisor ensures that the CS relationships are clearly documented with a supervision agreement in a mutually agreed and, where relevant, organisation-wide format including confidentiality provisions and what may be referred to outside organisations with the agreement of the supervisee Supervisor identifies and clearly states their boundaries for terminating the agreement 	
Evaluation	<ul style="list-style-type: none"> Supervisee participates in regular evaluations of CS as determined by the AMHS and is encouraged to provide informal feedback to the supervisor on an ad hoc basis 	<ul style="list-style-type: none"> Supervisor participates in regular evaluations of CS as determined by the AMHS 	
Boundaries	<ul style="list-style-type: none"> Supervisee demonstrates that they understand the boundaries and expectations pertaining to confidentiality and negotiates with the supervisor about mandatory processes related to any suspected breaches of ethics or codes of practice 	<ul style="list-style-type: none"> Supervisor negotiates with supervisee about the limits of confidentiality and comes to some written, formal agreement pertaining to any potential breaches of codes of ethics or practice and any mediatory interventions 	

Organisation

- AMHS provides a suitable venue and protected time for CS away from the immediate working environment

- AMHS takes responsibility for ensuring that CS is delivered sustainably and in such a way that it meets the changing needs of both the supervisees and supervisors
- The organisation provides a formal assessment tool at regular intervals to evaluate the usefulness of CS for supervisees (for example, the Manchester Clinical Supervision Scale – Winstanley 2000)
- An evaluation tool for supervisors and the organisation is also recommended

- AMHS acknowledges and respects the expectation of confidentiality inherent in the CS relationship but is also confident that all parties have a shared understanding that any breaches of codes of ethics or practice will be addressed according to organisational policies and codes of conduct, respectfully and in a timely manner

The way forward

The evidence provided in the integrative literature review, which formed the basis for this framework, highlights that, even without a substantial amount of rigorous research or an increase in the number of formal evaluation processes, mental health nurses are talking about clinical supervision and will continue to do so. Complications such as the projected shortage of nurses and the ageing nursing workforce provide further motivation for nursing staff to be as well supported as possible.

The investment of expertise, energy and time shown by professional bodies such as the Australian College of Mental Health Nurses and the Australian Clinical Supervision Association strongly support the notion that clinical supervision is an essential component to the health and wellbeing of mental health nurses and their practice. As the Chief Mental Health Nurse of Victoria commented in the foreword to this framework, nursing as a profession must view clinical supervision as 'part of the core business of contemporary professional nursing practice'. The intended outcome of this clinical supervision framework for mental health nurses in Victoria is that both individual nurses and their employing organisations fully commit to and participate in implementing clinical supervision to help ensure the best and safest care for consumers.

The next step for mental health nurses in Victoria is an implementation of clinical supervision that benefits from and aligns with this framework. With the support of the department and policymakers, area mental health services are now responsible for developing implementation plans that enable all the roles of organisational leaders, supervisors and supervisees.

Invited personal testimony 7

Clinical supervision – the future (a research perspective)

Our research team was fortunate to have the opportunity recently to implement and evaluate a pilot resilience program for mental health nurses. The program was strengths-based and interactive and was delivered in a peer group setting. Personal and interpersonal skills-building was a key focus, drawing on cognitive behavioural therapy and interpersonal therapy evidence bases.

Nurses were very positive about the program. We asked them what they thought would be helpful in supporting and sustaining their resilience at work after the program. A number of nurses recommended incorporating resilience strategies in clinical supervision, particularly group supervision where they could engage with other clinicians. They thought it would be useful to apply the skills they'd learnt – such as challenging negative self-talk, focusing on self-care, affirming strengths and building collegial relationships – to debrief challenging work situations and interactions. These strategies are well aligned with clinical supervision principles and models. Nurses considered that reinforcing these and other resilience strategies in clinical supervision would help support their personal wellbeing and improve their practice.

Resilience is a process of drawing on personal and external resources to overcome adversity and maintain personal wellbeing. Sustaining resilience for the mental health nursing workforce through clinical supervision may be one resource health services can offer to staff to support their wellbeing, strengthen their practice and improve the care of consumers and families. We look forward to building further collaborative evidence on resilient practice through clinical supervision in the future.

Professor Kim Foster – Professor of Mental Health Nursing, Melbourne

Health and Australian Catholic University



Invited personal testimony 8

The core of clinical supervision – the supervisor

Anecdotally, one thing that most supporters of clinical supervision appear to agree on is that, regardless of the training method or delivery model of the supervisor and irrespective of the level of experience of the supervisee, a key ingredient to successful clinical supervision is the authenticity and integrity of the relationships between the participants.

Katherine Fairest – Mental Health Training and Development Unit, Melbourne Health



Appendix 1: Background and methodology

Initial step

A discussion group facilitated by the Centre of Psychiatric Nursing highlighted that nurses need support to develop a culture that values clinical supervision and the various processes involved in accessing it.

Policy analysis

A policy analysis examined a number of Victorian and national policies, projects and legislation relevant to the successful promotion and implementation of clinical supervision in mental health services, with a particular focus on the nursing profession.

Literature review

A literature review was undertaken of Australian and international peer-reviewed and grey literature pertaining to clinical supervision for mental health nurses. The primary objective of the literature review was to provide an overview of relevant literature that defines good practice, identifies barriers and, whenever possible, offers solutions to these challenges. A copy of the integrative review of the literature document is available at <https://www2.health.vic.gov.au/mental-health/chief-mental-health-nurse>

Consultation and gap analysis

A gap analysis of the sector had previously been conducted via the Victorian nurse educators network, coordinated by the Centre for Psychiatric Nursing in Melbourne. The results indicated that there had been poor uptake of clinical supervision across all networks and that, despite strong policy and service commitment to support mental health nurses taking up clinical supervision as part of their clinical practice development, a majority of nurses in general did not view clinical supervision positively.

Method

This project involved an integrative review of international published and grey literature pertaining to clinical supervision for mental health nurses. The integrative literature review was designed to: evaluate the strength of scientific evidence, identify gaps in current research, and identify the need for future research (Russell 2005). The five-stage integrative review process included (1) problem formulation, (2) data collection or literature search, (3) evaluation of data, (4) data analysis, and (5) interpretation and presentation of results.

Following the integrative literature review an advisory committee comprising leaders in clinical supervision was formed. The group further identified several barriers and challenges to successfully implementing clinical supervision across the networks.

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