Clinical supervision for mental health nurses

An integrative review of the literature

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Contents

Background

Following a discussion group facilitated by the Centre for Psychiatric Nursing (CPN) with Victorian mental health nurse educators in March 2015 it was found that nurses need support to develop a culture of accessing and valuing clinical supervision (CS). Industry policies enabling mental health nursing staff to take time away from their work units to attend CS have largely not been adhered to. Anecdotally, some nurses report that they are unable to access appropriate supervision within worktime, therefore they have to make provisions for CS in their own time, either after work or on their days off. If their area mental health service (AMHS) does not have an appointed staff member who is responsible for the CS portfolio, there is no stewardship of CS. It ceases to be on the radar, is not valued and subsequently withers. Misunderstanding the goals and purpose of CS is also anecdotally identified as an issue, with some managers using CS as a performance management tool for staff. These findings suggest that although the CPN has delivered the CS train-the-trainer package to many mental health services, there are cultural and systemic issues that stymie a fully integrated program of CS in every mental health service in Victoria.

The overarching aim of this project was to produce a revised framework for Victorian mental health nurses and services as they seek to further embed CS.

The project involved an integrative review of international published and grey literature pertaining to CS, especially as relates it to mental health nurses. An integrative literature review is 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 includes (1) problem formulation, (2) data collection or literature search, (3) evaluation of data, (4) data analysis and (5) interpretation and presentation of results.

The findings of the integrative literature review will be synthesised and will inform the first draft of the revised *Clinical supervision for mental health nurses - A framework for Victoria*. The draft framework will be circulated to some stakeholders for comment and feedback. Stakeholders will include senior Victorian mental health nurses, the Australian College of Mental Health Nurses, the Australian Clinical Supervisors Association and the Department of Health and Human Services.

Framework used

Whittemore and Knafl (2005) describe an integrative review as a five-stage process by which the past empirical and theoretical literature pertaining to a specific topic can be summarised with a view to providing a more comprehensive and current understanding of the subject. Typically, integrative reviews consist of more wide-ranging goals such as defining concepts, reviewing theories and evidence and analysing methodological issues.

Due to the broad scope of an integrative review, clarity about the problem statement is essential. The authors of this framework also recommend that the literature search process, the search strategies and the inclusion and exclusion criteria are identified in the body of the review.

Method and search strategy

The integrative review method includes both empirical and theoretical literature and aims to synthesise findings to facilitate a greater understanding of a given topic. Using the terms 'clinical supervision', 'nurs*', 'psych*' and 'mental health', the databases CINAHL, MEDLINE and PUBMED were searched. The literature has been limited to the past 15 years (2000–2015). Much of the literature included made reference to seminal earlier works, but it was felt that literature prior to 2000 added no new information to the issue being investigated in this integrative review, which is primarily concerned with recent developments that may be of use in updating current CS guidelines for mental health nurses (published in 2009).

Table 1 provides a snapshot of the literature reviewed.

Inclusion and exclusion criteria

Quantitative/qualitative, mixed-method and peer-reviewed research or discussion papers focusing on CS (especially those focusing on mental health nurses) published in English between 2000 and 2015 were included. Grey literature, various other documents and organisational websites were also included, providing further references that informed this review. Literature that had a primary focus of overcoming barriers was prioritised, as were any articles that included a strong research base with a focus on the efficacy of CS. Foreign language documents, those written prior to 2000 and articles that didn't incorporate some reference to improving the implementation, regulation or provision of CS were excluded.

Eighty-six journal articles and websites were further reviewed for their contribution to the current state of knowledge or recommendations for improvements in the context of the three guiding questions (see below). This information was then analysed and led to formulating three domains that then formed the final framework for the guideline recommendations.

Problem formulation

Anecdotal reports provided by most Victorian mental health services indicate that the implementation of CS across the state has been only partially achieved, at best. There would seem to be various factors involved in these low success rates. Much of the available literature comments on the barriers and challenges to successfully implementing a CS process, but there is very little rigorous, evidence-based research recorded identifying possible solutions. This is complicated by the fact that the area doesn't easily lend itself to scientific evaluation (Gonge & Buus 2015), and most authors comment on the importance of organisational support. The development of a set of guidelines that are recognised and supported by all stakeholders may serve to eliminate some or reduce other barriers, which will further enable the implementation of an effective CS framework for all mental health nurses across Victoria.

Guiding questions

1. What progress has been made towards establishing a culture of valuing and accessing CS by nurses, including barriers and enablers?
2. What impacts have recent investigations and published literature had on the implementation of CS?
3. How could current guidelines for the implementation of CS be improved upon?

Table 1: A snapshot of the literature reviewed

Author(s), publishing date and location	Purpose	Sample size/source	Design	Findings
White 2016 Australia	Editorial: *Journal of Advanced Nursing*	N/A	N/A	CS has entered the realms of nursing and midwifery 'folklore' and is exalted in many public policy statements. However, the author believes there are many facets of CS that are inconsistent, anecdotal rather than evidence-based and that without further rigorous research the status quo will remain – namely that CS will continue to be subject to wilful blindness. The efficacy of any CS being undertaken and the contemporary national CS landscape will remain wholly uncertain.
Tomlinson 2015 United Kingdom	A response to a National Patient Safety Advisory Group report discussing challenges to implementing CS with junior health professionals, especially medical officers	N/A	N/A	CS, especially when it is professionally led, learner-centred, educational and supportive, has great potential. It fosters a culture that is educational, self-critical, outward-looking and patient-focused, centred on patient safety and quality care. The challenges include how to separate its educational and supportive functions while improving access and acceptability. The evidence strongly supports this goal.
Pack 2015 New Zealand	Investigates the CS of early career mental health professionals as social workers and occupational therapists	(*n* = 12)	Telephone or face-to-face interviews, thematic analysis	Importance of ongoing peer review and critique; importance of addressing transferences; importance of identifying gaps in training and education; importance of exploring self-care and referral to other services as required.
Nelson et al. 2015 Australia	Identifies issues affecting the CS of the Aboriginal and Torres Strait Islander mental healthcare workforce and proposes alternative supervision models	(*n* = 5)	Participative action research extending over a 15-month period	Recommends implementing alternative supervision models including the use of cultural supervisors and dual supervisors, and accessibility to consultation, supervision and communities of practice for remote workers through modern technologies.

Author(s), publishing date and location	Purpose	Sample size/source	Design	Findings
Gonge & Buus 2015 Denmark	Tests the effects of a meta-supervision intervention in terms of participation, effectiveness and benefits of CS on psychiatric nursing staff	(n = 43)	Randomised controlled trial, self-reported questionnaires at baseline and completion of project	The intervention had a positive effect on individuals or wards already actively engaged in CS, which suggested that individuals and wards without well-established supervision practices may require more comprehensive interventions targeting individual and organisational barriers to CS.
Temane et al. 2014 South Africa	Explores and describes advanced psychiatric nurses' ideas and needs regarding supervision in advanced nursing in private practice	(n = 8)	Qualitative, descriptive, exploratory and contextual design using a phenomenological approach	The data analysis generated the following themes, which the supervisor should have or possess: (a) professional competencies, (b) personal competencies and (c) specific facilitative communication skills. The findings indicate a need for supervision of advanced psychiatric nurse practitioners in private practice in South Africa.
Taylor 2014 United Kingdom/ Ireland	Identifies the effects of group CS on the practice of biofeedback nurse therapists	(n = 9)	Qualitative, in-depth interviews, semi-structured interviews and non-participant observation; phenomenological reduction	Identified five important categories of CS: having an outlet, simplifying complexity, feeling secure, developing self, and endorsing service, plus three functions of CS: managing the emotions of participants, extending knowledge and skills, and recognising and responding to boundary issues.
Martin, Copley & Tyack 2014 Australia	Outlines the elements required to establish and sustain an effective CS arrangement for health professionals, based on current evidence and the author's expert opinion	N/A	Narrative literature review and expert opinion	CS has been adopted by various disciplines as a means to support health practitioners as well as to uphold the quality of patient care. Based on research findings to date, this article outlines 12 practical guidelines to assist practitioners to set up an ongoing effective CS arrangement.

Author(s), publishing date and location	Purpose	Sample size/source	Design	Findings
Long et al. 2014 United Kingdom	Evaluates effective of CS for register nurses and health care assistants in medium-secure psychiatric services for women	(*n* = 128) 67 per cent response rate	Secure Unit Supervision Questionnaire (SUSQ) Partnership Questionnaire for Supervision Bradford Clinical Supervision Scale	That nurses who engage in supervision are self-confident, committed and competent professionals who feel supported by empowering and fair leadership when there is analysis of nursing culture, secure organisational and management support, a well-developed and operationalised strategic plan for implementation and ongoing monitoring and evaluation of the integrity of CS.
Falendar 2014 South Africa	Explores the components of competency-based supervision and makes recommendations for implementation	N/A	N/A	As supervision guidelines and standards adopted internationally, goals include enhancing the appreciation of CS as a distinct professional activity that requires specific training and competence. CS is the key to transmitting the profession to future generations.
Falendar et al. 2014 South Africa	Explores the current state of research pertaining to competent CS and emerging effective practices	N/A	N/A	Practising competency-based CS that provides a structure for evidence-based enquiry requires training in supervision and competence in current standards for supervision guided by evidence. A challenge is that many supervisors have received minimal education, training and supervision in providing supervision and that there is high variability among the training offered to those advancing towards professional practice.
Soheilian et al. 2014 United States	Examines supervisees' perceived experiences of supervisor multicultural competence in supervision and its impact on supervisees' clinical work	(*n* = 102)	Online survey, questionnaire, participants recruited through electronic contacts	Findings emphasise the importance of the ability of the supervisor to facilitate exploration of supervisee values and to educate, guide and attend to multicultural processes in supervision, with special attention being paid to the supervisor's multicultural awareness, knowledge and skills.

Author(s), publishing date and location	Purpose	Sample size/source	Design	Findings
Cookson et al. 2014 United Kingdom	Investigates the provision of and adherence to recommendations of CS for nurses and allied health professionals in mental health settings	(*n* = 205)	22-item questionnaire, online access (SurveyMonkey)	Most of the staff reported receiving regular, formalised CS that met their needs. However, significant differences between the experiences of allied health professionals and nurses and between community nurses and inpatient nurses may indicate a cultural difference between these groups regarding the uptake of CS.
American Psychological Association 2014 United States	Taken from website: *Guidelines for CS in health service psychology*	N/A	N/A	Outlines guidelines for supervising students in health service psychology education and training programs. The goal was to capture optimal performance expectations for psychologists who supervise. It is based on the premises that supervisors (a) strive to achieve competence in providing supervision and (b) employ a competency-based, meta-theoretical approach to the supervision process.
Australian College of Mental Health Nurses 2013 Australia	Taken from website: *ACMHN clinical supervision: position statement*	N/A	N/A	It is the position of the Australian College of Mental Health Nurses Inc, that CS is a core component of contemporary professional mental health nursing practice and central to practising within the ACMHN *Standards of Practice for Australian Mental Health Nurses* (2010). Mental health service employers positively support and actively promote demonstrably efficacious CS through organisational policies, procedures and workplace culture.

Author(s), publishing date and location	Purpose	Sample size/source	Design	Findings
Care Quality Commission 2013 United Kingdom	Taken from website: *Supporting information and guidance: supporting effective CS*	N/A	N/A	The Care Quality Commission produced this supporting information and guidance in response to recommendations from the Winterbourne View Serious Case Review and in line with the commitments that were made in the Winterbourne View Review Concordat: Programme of Action. It sets out what effective CS should look like and is of particular relevance within care settings for people with a learning disability. However, it has broader application for registered providers, registered managers and staff across *all* care sectors and settings.
Koivu, Saarinen & Hyrkas 2012 Finland	Reports the results of a quasi-experimental study exploring the effects of CS on medical/surgical nurses' wellbeing at work over a four-year period	(*n* = 166)	Questionnaire survey provided to nurses in all medical surgical units of the hospital	The findings of this quasi-experimental study provide robust evidence for the positive effects of CS on the wellbeing of medical–surgical nurses at work. The benefits of CS were outcomes (increased professional autonomy and self-efficacy) obtainable by critical reflection and transformative learning. Although CS seemed to have no impact on the strain experienced by nurses, their job resources increased and psychological distress decreased.
Health Education and Training Institute 2012 Australia	Taken from website: *Superguide: handbook for supervising AHPs*	N/A	N/A	CS was found to be a useful tool, with recommendations provided for its implementation.

Author(s), publishing date and location	Purpose	Sample size/source	Design	Findings
Australian College of Mental Health Nurses 2011	Taken from website: *Clinical supervision: background paper*	N/A	N/A	While CS may help to achieve the best level of care possible, one author asserted that it cannot compensate for inadequate facilities, for poor management, or for unmotivated staff and so challenges persist. Given these caveats, in order that CS may be successfully implemented and sustained, the ACMHN proposes that services follow the authors' suggestions for the best and clearest directions currently available (White & Winstanley 2010).
Turner & Hill 2011 United Kingdom	Implementing CS (parts 1, 2 and 3) review of the literature	(n = 25) (n = 17)	An untracked postal questionnaire based on a Likert scale and qualitative opinions, suggestions or concerns	As this literature review illustrates, CS is a complex process and therefore no one should be surprised that implementation across the workforce remains patchy and remains a challenge. The studies that follow in this series offer insights into some of the difficulties and possible solutions when implementing this initiative, both for practitioners at the beginning of the journey who are considering implementing it for the first time (part 2) and for those who have embraced CS within their practice (part 3).
The Bouverie Centre 2011 Victoria, Australia	Taken from website: *Clinical supervision in the alcohol and other drugs and community managed mental health services*	N/A	N/A	Resources for CS including a definition of the purpose of CS, supervision models, modalities, CS competencies, creating the context for effective CS, ethical and legal considerations, guidelines for supervisees, organisational support for CS, useful resources and publications.
Caine & Jackson 2011 United Kingdom	Explores CS and the theory–practice gap, with a view from a student mental health nurse	N/A	N/A	The mental health students of today are tomorrow's mental health practitioners and among them will be our profession's future leaders, educators and innovators. CS can offer so much to enhance those pathways, but ultimately it will affect the standard of care received by the service user. The consequences of poor or no CS will probably continue to be reflected on in future government inquiries.

Author(s), publishing date and location	Purpose	Sample size/source	Design	Findings
White & Winstanley 2010 Australia	Profiles Australian attempts to establish an evidence base for causal relationships with quality of care and patient outcomes		Randomised controlled trial	This RCT has made incremental headway towards establishing an evidence base for some of the claims made about CS. It has made a telling methodological contribution to the design of future attempts to research this challenging substantive area. It has confirmed the importance of the prevailing service/managerial culture in the outcome of implementation attempts. It has generated corroborating evidence that supervisees value, and gain benefit from, CS. The effect this may have on the quality of care and patient outcomes was able to be demonstrated in a controlled setting within this RCT but remains elusive to demonstrate across a broad front.
Taylor & Harrison 2010 Western Australia	Explores and evaluates the introduction of CS across WA public mental health services	(*n* = 155)	Random distribution, voluntary participation, quantitative study with initial info-gathering survey followed by evaluation survey	The progression of CS in WA may benefit from a change in institutional culture and this is something that occurs over time. Further energy is required for CS to continue as a key strategy in supporting the mental health nursing workforce to maintain their own mental wellbeing through providing professional and emotional support, and attracting people into the mental health workforce. It is essential that there is a commitment to providing CS education workshops in the long term and regular marketing of the CS database to attract qualified clinicians to WA and to maintain the momentum already gathered.

Author(s), publishing date and location	Purpose	Sample size/source	Design	Findings
Gonsalvez & Milne 2010 Australia	Provides a review of the current problems and possible solutions to CS training in Australia	Discussion paper	N/A	Supervision appears to play a significant role in developing clinical competence in supervisees and in promoting clinical outcomes, whether assessed empirically, judged in terms of its influence by the participants, or considered by experts. Paradoxically, the development of supervisors' competencies has been sorely neglected. The paper uses the available scientific literature and expert consensus in the United States and the United Kingdom to clarify for the Australian psychologist and supervisor some key questions and promising answers about the development of systematic training in CS, supported by better regulation.
Gonge & Buus 2010 Denmark	Examines individual and workplace factors that influence psychiatric nursing staff's participation in CS	(*n* = 239)	Questionnaire survey	A relatively large amount of research on CS in psychiatric nursing has been conducted without proper attention to actual participation in CS. This study emphasises the importance of examining participation, as participation varies considerably. Attention must be paid to nominal participation but also to the rate of participation in the available supervision, as provision of supervision would not be likely to be homogenous across organisational units. The study specifically highlights participation in CS as being much more common in community mental health centres than in general psychiatric wards, where more than half of the staff did not participate at all during a period of three months.
Cleary, Horsfall & Happell 2010 Australia	Explores and acknowledges the challenges of establishing CS in acute mental health inpatient units	Discussion paper	N/A	Interesting conclusions, especially pertaining to bed-based services. Despite well-intentioned efforts, successful and sustainable models of CS are by no means assured. The issue may speak to exactly how CS is introduced, operationalised and managed and the level and extent of training provided. The introduction of CS in acute inpatient units takes time and needs to be tailored to specific settings.

Author(s), publishing date and location	Purpose	Sample size/source	Design	Findings
Australian Psychological Society 2009 Australia	Taken from website: *APS code of ethics*	N/A	N/A	These guidelines have been developed primarily to address supervision of psychological practice, rather than psychological research. They address key issues to be covered prior to starting any supervision arrangements, and then focus on the considerations of the different roles involved within the process of supervision. The guidelines are designed to enhance the process of supervision and to assist supervisors and supervisees to develop a rewarding supervisory relationship.
Cummins 2009 Ireland	Asks the question: Is CS the way forward?	Literature review	N/A	Essential to the successful practice of CS is the need to ascertain whether it is simply a system to ensure an effective workforce or one that will empower nurses to realise their vision of nursing.
Buus & Gonge 2009 Denmark	Looks at empirical studies of CS in psychiatric nursing	Literature review	N/A	Empirical research of CS in psychiatric nursing is characterised by a basic lack of agreement about which models and instruments to use. Challenges and recommendations for future research are discussed. CS in psychiatric nursing was commonly perceived as a good thing, but there was limited empirical evidence supporting this claim.
Townend 2008 United Kingdom	Uses grounded theory to develop a model for mental health nursing through CS in cognitive behavioural psychotherapy	Unstated	Qualitative: in-depth interviews using grounded theory	This study, through a process of inductive reasoning using grounded theory, has identified eight core categories that together have been related into a broad framework of cognitive behavioural psychotherapy supervision. The ideas presented make important links between moderating inputs, supervision relationships, beliefs and values, learning processes, cognitive processes, mechanisms, outputs and monitoring and assessment.

Author(s), publishing date and location	Purpose	Sample size/source	Design	Findings
Butterworth et al. 2008 United Kingdom	Reviews the CS literature from 2001 to 2007	N/A	N/A	CS has become an established part of nursing. Implemented in various different ways, it has attracted attention from the research, educator and practice communities. The literature reported and analysed in this paper describes work that may benefit professional practice, but there continue to be questions about application and method. Two new messages arise from the literature. The first underscores the responsibility of healthcare organisations to sustain and develop CS and the second points to the potential benefit that CS may have on patient outcomes.
Sloan 2008 Scotland	Looks at accreditation in mental health nursing CS	Discussion paper		This paper has made a case for introducing accreditation of clinical supervisors in mental health nursing. It is suggested that this level of accreditation would have significant ramifications. In particular, it would provide increased legitimacy to CS as a core activity in mental health nursing practice.
Rice et al. 2007 Northern Ireland	Examines CS for mental health nurses in Northern Ireland	Unstated	Questionnaire, survey of all stakeholders, 12 Mental Health Trust Directors and all heads of education providers	Recommends 12 strategies for implementing effective CS that appears to still be relevant to current practice.

Data analysis

While there is a lot of support for implementing CS throughout the literature, researchers and writers often appear to arrive at very similar conclusions about the barriers and challenges that seem to consistently block more generalised uptake of CS. This analysis of the literature and websites reviewed considers these conclusions in the context of developing a set of guidelines that could facilitate more mental health nurses in Victoria consistently accessing CS.

The invisibility of clinical supervision

White (2016) proposes that, most recently, CS has become invisible on the contemporary nursing and midwifery policy agenda. He contends that, while CS has remained a topical issue for nurses and midwives for some time and is mentioned repeatedly in many public policy statements, rather than improving the quality and efficacy of CS, this prolonged focus has simply channelled attention to the volume of CS being accessed and provided. Particular attention appears to be being paid to frequency, duration and whether or not certain key performance indicators are being met. More important questions – such as what are the measurable effects of CS and at what cost, whether or not CS actually improves the quality of care or the patient-reported outcomes and whether or not CS has any positive effect on staff retention – remain hypothetical questions that are receiving very little attention. Following a review of 1,460 abstracts presented at seven purposively selected national and international conferences held in 2015 in the United Kingdom, Australia and the United States, White could only draw the conclusion that CS is no longer holding a prominent position on the national and international nursing agendas. White argues that when the level of pressure and stress nurses are described as being under and the continuing number of reports of tragic care failings are taken into account, this is a very disturbing possibility. He concludes that, while some would argue that the invisibility of CS on the nursing agenda is because it is sufficiently well-established in professional practice and no longer needs to be on the research and policy development agenda, he would contend that this lack of visibility reflects underdevelopment, poor efficacy of whatever CS is being practised and a wholly uncertain national landscape. This is a situation that he feels is unacceptable and must be addressed.

The dichotomy of clinical supervision

Tomlinson (2015) spoke of the dichotomy in which CS is clearly perceived to be necessary by health professionals but, in fact, is insufficient for guaranteed patient safety, quality of care and staff wellbeing. While there is much evidence of its benefits, there is a lack of clarity to what extent this evidence can be applied across disciplines. He also comments on the lack of consistency and regulation in the various forms of supervision and the paucity of rigorous outcome measurement. Tomlinson also believes there are inherent difficulties in separating the educational functions of CS from those that are intentionally supportive, which in turn continue to aggravate the rate at which CS is being taken up.

Translating clinical supervision to practice

In her study, Pack (2015) spoke of the differences in the use and translation of CS between social workers and occupational therapists, although she seemed more inclined to see this as being related to the more systemic training experienced by social workers versus the apprenticeship model used in occupational therapy training, rather than as a complication of CS implementation. However, she did comment that both sets of supervisees clearly preferred the use of an established mutually trusting and respectful relationship with their supervisor over more formal, organisational critical incident stress management programs. Pack goes on to highlight the importance of allowing the supervisee to choose their own clinical supervisor and stresses the importance of providing adequate time and resources for the formal training of clinical supervisors. Pack believes that CS must include the awareness and resolution of any vicarious traumatisation of the supervisee and that supervisors need specialist training in this area of work. The formal and ongoing nature of the training of those clinicians providing supervision is commented on repeatedly throughout the literature. Pack (2015) also comments on the complexity and frequently neglected situation wherein a supervisor is also the supervisee's line manager. She concurs with other literature that this is fraught with potential for role confusion and tension.

Cultural awareness in clinical supervision

When considering the importance of cultural awareness and sensitivity in CS, Nelson et al. (2015) investigated the current state of indigenous mental health and looked at ways of addressing supervisory needs. They concluded that, for any form of CS to be relevant and effective, it must provide the clinical expertise for the supervisees to acquire and develop new skills, must provide personal support that recognises the culturally specific issues faced by Aboriginal and Torres Strait Islander practitioners (which they refer to as 'the blur'), and that the supervisor must have cultural and community understanding that informs both the professional and personal support of the clinician.

They proposed five different types of CS. 'Dual supervision' is when one supervisor has demonstrated competencies in professional development and skill acquisition and the second has capacity to meet the community/cultural obligations. 'Culture and community education' is when supervisors and supervisees are provided with education and training that addresses the shortfalls in the cultural and community skills together. The 'Consultation model for skill development' is when clinical staff make extended use of internet-based technologies to facilitate both didactic and experiential training opportunities by a perceived expert in the field. Topics for training are frequently generated by the group so that the expert can prepare sessions tailored specifically to the group's needs. 'Development of communities of practice' is described as 'one of the oldest forms of human skill-learning activities'. It refers to a group of people who use web-based communication (for example, WebEx or Adobe Connect) to meet and for sharing tips and best practices, asking questions of each other and providing support with the expressed intention of developing and enhancing a specific set of skills. Finally the 'supervisor training model' focuses on developing a high level of supervisory expertise and maintaining it through high-level accreditation, supervision and ongoing skill development and assessment. This meant that the supervisor had to be assessed and accredited by Aboriginal and Torres Strait Islander peoples.

Nelson et al. concluded that using any of these forms of CS in organisations servicing regional and remote Aboriginal and Torres Strait Islanders could be considered more of an investment than a cost. They also suggested that a health economics study of the value of supervision for Aboriginal health practitioners would be very valuable.

Scientific investigation of clinical supervision

In one of the rarer nurse-specific randomised controlled trials (RCTs), Gonge and Buus (2015) concluded that the area of CS does not easily lend itself to scientific investigation. This particular study focused on strengthening the supervisees' active engagement by reflecting on how they could overcome both individual and organisational constraints that limited the effectiveness of their own CS, as opposed to a focus on the method of delivery of CS per se. In what they considered a robustly designed study, there were serious methodological challenges that they feel potentially contributed to the lack of well-conducted intervention studies that have been investigated. Ultimately their study strongly suggests that individual and organisational barriers to involvement in CS must be addressed and, in so doing, it is recommended that attention is paid to both the individual and, most especially, the organisational attitudes towards CS.

The needs of advanced psychiatric nurses

In another qualitative, nurse-specific study, Temane, Poggenpoel and Myburgh (2014) looked at advanced psychiatric nurses' ideas and needs regarding CS. They found that good CS is provided when the supervisors have:

- advanced professional competencies, which include experience and expertise in supervision, psychotherapy and involvement in research
- advanced personal competencies, which include an authoritative and assertive personality, high emotional intelligence, flexibility and an holistic and broad worldview
- specific facilitative communication skills that include highly developed techniques of questioning, effectiveness in receiving and offering feedback and advanced listening skills.

They were also very clear that a culture of support must be fostered in mental health settings in order to enhance nurses' professional practice.

Group-based clinical supervision

In another qualitative study looking at the effects of group CS for a small group of nurses practising as biofeedback therapists, Taylor (2014) found that when the feedback regarding the group supervision was formulated using Proctor's model of CS, clinicians commented that it offered them an opportunity for analytical reflection and sharing of experiences that led to greater personal insight and professional understanding, concluding in meaningful changes in practice. Group supervision was deemed to encourage critical thinking as well as confirming the scope of advanced nursing practice. One might also consider that the use and overt identification of a specific CS framework may have enhanced the participant's engagement with the supervision. There is an opportunity for further research to investigate the efficacy of identifying a specific model of CS.

Tips for establishing effective clinical supervision

One of the journal articles that appears to provide some very specific and strategic information pertaining to guidelines was an Australian piece published by Martin, Copley and Tyack (2014). Based on a narrative literature review and 'expert opinion', they documented 12 specific 'tips' that they consider enable the clinician to establish the most effective CS partnership. These tips state that:

- the clinician must identify and choose their own supervisor, deemed by them as suitable according to their own personal criteria
- the clinician should be able to choose whether they receive individual, group/peer supervision or a mixture of both
- together the supervisor and supervisee(s) should agree on and establish an agreement/contract as well as identifying a formal supervision agenda
- a venue is decided that is ideally away from the clinician's workplace (which negates any possibility of the supervision being interrupted)
- prior to any meetings, agreement should be reached on the optimal meeting length and frequency
- agreement is reached about the method by which both parties will provide and receive feedback and whatever style of feedback and communication will be used.

Furthermore, they state that:

- effective CS is best provided using facilitative reflective practice, which may include the use of logs, diaries, dialogue and discussion
- consideration should be given to experiencing more than one form of CS, face-to-face and distance supervision (which also honours the commitment to respecting the CS as an important part of the clinical function of any practitioner)
- both parties should commit to building a positive supervisory relationship
- there is a clear separation of CS from line management and that, whenever possible, the two forms of professional support are not provided by the same person
- the clinicians providing the CS should receive both basic training and ongoing advanced practice training so their CS skills remain current and relevant
- there is a regular and effective evaluation of the efficacy and outcomes of the CS.

This latter strategy relates well to the anecdotal reports that CS is often provided by more advanced or more senior nurses who lack any formal CS training and without any formal structure or method of regular evaluation. This ultimately may lead to a form of disillusionment and dissatisfaction on the part of the supervisee. Their vocalised experience of CS may then end up being less than positive.

The importance of innovative managerial initiatives

Speaking to the ongoing importance of the organisational commitment to implementing and delivering CS, Long et al. (2014) assert that their study highlighted the need for innovative managerial initiatives that will remove the obstacles to CS engagement by frontline staff. They suggest that the significant credibility that has historically been assigned by management to handovers and staff meetings is misguided and misplaced. Their primary reason for this assertion is that these long-established forms of clinical feedback and support do not allow for consideration of the relationship between nurses and patients, most especially regarding the psychological and systemic organisational processes that can interfere with it. By assessing and delivering their findings using Proctor's three-function model and concluding that this goes some way to addressing this shortfall, they appear to lend kudos to the belief that identifying a specific form of CS structure is important to the perceived value of the supervision.

The need for specific supervisor training

Falender (2014) - p. 6 considers the view that CS is increasingly being recognised as 'a distinct professional competency that requires specific training and competence apart from general clinical competencies'. She asserts that at least part of this competency-based supervision is achieved by formulating and implementing regulatory guidelines. By considering supervisor competence as such an integral part of providing effective CS, she lends weight to the argument that one of the imperatives for effectively implementing CS is formalising, and then providing, consistent supervisor training. This training would be important both before commencing as a supervisor and in an ongoing manner, and should be provided in such a way that it can also be regularly evaluated. Falender also notes the ethical and legal challenges to supervision brought about by using the internet and strongly supports the development of guidelines that are specific to these forms of media.

In a further work, Falender, Shafranske and Ofek (2014) go on to be more specific about the apparent lack of regularity and consistency in the training of providers of CS and even more specifically identify the lack of 'supervision of supervision' as one of the barriers to effectively implementing good CS. Their protest is that many supervisors have received minimal education, training and supervision in providing supervision and that there is high variability among the training offered to those wishing to provide CS. They comment that the recent identification of specific guidelines for providing supervision by the American Psychological Association is a very important step in addressing this inconsistency. They also conclude that it is the responsibility of 'the field' (by which one might fairly safely assume they refer to the field of mental health service delivery) to address the challenge of the severely limited resources available to ensure the provision of high-quality care and the safety of people using mental health services.

The essentials of effective clinical supervision

Another recent study that surveyed nurses and allied health professionals' attitudes to CS and ultimately identified local CS guidelines was completed in Scotland by Cookson et al. (2014). They postulate the following essentials of effective CS:

- The supervisee and supervisor are given free choice about with whom they engage.
- There will be a supervision agreement mutually formulated by the supervisee and supervisor.
- All staff engaged in providing CS will receive training.
- There will be regular evaluation and/or audits of the CS.
- Staff will experiment with and identify a range of formats for CS.
- The duration and frequency will be specifically stated in the agreement and meet best practice guidelines.
- There will be distinct separation of CS and line management.

There were other findings from this study that may be deemed significant. Notably, they identified that community nurses are more likely to engage in and maintain their CS than inpatient nurses. They suggest that this may indicate either the more severe lack of time and resources experienced in the inpatient setting or the relatively recent emphasis on community-based treatment, potentially resulting in more isolated practice. They identified the many CS models being employed in the various healthcare settings and suggest there could be useful work done in determining whether CS is more effective with or without the use of a specified model of CS practice, and in particular whether or not this had any effect on the clinician's satisfaction with their CS. This study also highlighted the importance of choosing your own supervisor and the essential separation of the clinical supervisor role from the line manager role (62 per cent of clinicians who were unhappy with their CS stated that (a) they had been allocated a supervisor and that (b) the supervisor was their line manager).

The Australian College of Mental Health Nurses delivered the background paper to their position statement in 2011 and reviewed and further clarified their position statement in 2013. In these two documents they maintained their support for the environmental conditions proposed by White and Winstanley (2010) and further clarified their organisational commitment to the stated parameters for effective practice when utilising CS (Australian College of Mental Health Nurses 2011; 2013).

Developing guidelines for mental health nurses

Several key professional body and government documents were uncovered in the literature searches that appear to have strong currency and relevance to developing guidelines for mental health nurses. These documents have provided guidelines for the American Psychological Association, the Care Quality Commission (UK), the Health Education & Training Institute (NSW), The Bouverie Centre (Vic.), the Australian Psychological Society and Queensland Health and they have all been referred to and considered in this integrative literature review (American Psychology Association 2014; Australian Psychological Society 2009; Care Quality Commission 2013; Health Education & Training Institute 2012; Queensland Health 2009; The Bouverie Centre 2011).

The impact of stress and burnout

In the medical-surgical paradigm of nursing, stress and burnout are considered relatively commonplace. Attempts to manage the shortage of qualified nurses, to maintain the quality of patient care and, at the same time, to promote the wellbeing of nurses can become frustrating for nurse managers. In their four-year Finnish study, Koivu, Saarinen and Hyrkas (2012) surveyed a large group of nurses (n = 328) and found that there were two very definite and clear outcomes of providing CS to these nurses. They split the experimental group into a further two distinct subgroups: nurses who rated the support they experienced from CS highly and those that rated it less positively. The nurses who considered CS effective also experienced significant positive shifts in their overall sense of being valued by the organisation. Additionally, they identified an increased sense of professional efficacy. The nurses who experienced CS as less effective and the control group, on the other hand, all experienced significant deterioration across the suite of assessment tools. In concluding that this study provided robust evidence for the positive effects of CS, they recommend that more research is undertaken with particular emphasis on developing more detailed theoretical models and constructive mechanisms that may be more easily empirically tested. Koivu et al. (2012) also concluded that nurse managers should pay particular attention to ongoing efforts to integrate CS into the routines of nursing work.

Common barriers to clinical supervision

Turner and Hill (2011) published a very informative article that began to elaborate on several commonplace barriers to implementing CS. They comment that while there is a great deal of literature regarding the efficacy of CS, there is much less available about the training of supervisors. They further conclude that the problems with CS include:

- the inadequate and inconsistent training of supervisors, with no standardised program or agreement about what supervisor training should consist of
- the paucity of time and resources experienced in most nursing environments, commenting that group supervision may alleviate some of this difficulty but isn't supported in the literature as being the most efficacious
- the lack of empirical evidence supporting the anecdotal claims that it works, mixed results and small study numbers, which they also link to the lack of funding available to support rigorous research
- the plethora of models and approaches for providing CS
- the very important need for nurses to differentiate CS from line and performance management.

This article was part 1 of 3 but all attempts to locate parts 2 and 3 were unsuccessful.

The benefits of co-production in clinical supervision training packages

Training packages for clinicians are becoming increasingly committed to the model of co-production, wherein the service user's input is equally valued and established from the outset, including and specifically targeting the identification of need rather than the more historically common post-production consultative role. Caine and Jackson (2011) identify a model of CS that includes input from service users in the clinical development of mental health nursing students. They see starting this inclusive process with students as more empowering and essential to an overarching holistic approach to clinical development. Very few other studies included in the search considered including service users' input in the context of CS. They conclude that CS using a collaborative education-practice model is a positive step forwards and benefits all concerned.

The relationship between clinical supervision, quality of care and patient outcomes

Many articles referenced the work of White and Winstanley (2010), who completed an RCT looking for a causal relationship between CS, quality of care and patient outcomes. Having considered literature that identified low overall job satisfaction, dissatisfaction with perceived quality of decision making by managers, dissatisfaction with lack of in-service training, dissatisfaction with physical working conditions and burnout as frequently identified reasons for leaving mental health nursing, White and Winstanley believed there was a correlation between these factors and the remedial claims made for CS. Their study revealed that the barriers and challenges that impede the implementation of CS across health networks are many and multifaceted. Both their quantitative and qualitative data support the notion that participation in CS research can, in itself, precipitate sustainable beneficial effects. But investigators and managers must not discount the fact that the very successful individual performance of the clinical supervisors, as judged by the supervisees, can easily be mediated by the organisational culture in which they operate. Good CS in an inhospitable organisational environment can be as unlikely to achieve its desired outcomes as poor CS in a more hospitable organisation. Ultimately they identified five challenges that must be addressed before CS can be successfully implemented in any organisation-wide approach.

1. The need to redress the misconception that having and being seen to have CS will automatically provide 'magic' cures for any and all clinical difficulties. They determined that if CS is poorly understood and delivered superficially, it wastes public money and resources and, at worst, proves to be ineffectual and/or inadvertently detrimental to both the supervisee and health consumer.
2. CS, no matter how competently provided, cannot compensate for inadequate facilities, poor managerial practices or unmotivated staff.
3. Their data confirmed the anecdotal belief that the staff who need CS the most are those who are least likely to be receiving it or facilitating it for others. Furthermore, there was clear evidence that the busier and more time-poor staff become, the stronger the argument to allocate and protect time for CS becomes.
4. There is an absolute need for nurses (clinicians and managers alike) to conceptualise CS as an integral part of nursing work and not to consider it an additional burden on finances and resources. Included in this new attitude is the need to impress upon middle managers that implementing CS will not automatically add burden to already constrained finances and that,
in fact, *not* implementing CS may actually create otherwise avoidable costs.
5. There is a dichotomy in the need to establish CS as an explicit National Competency Standard for professional nursing practice while simultaneously respecting the confidential nature of the work.

The Western Australian framework

In Western Australia the Office of Mental Health commissioned a project to develop and implement a framework for Western Australian public mental health services to provide education in CS for mental health clinicians and to establish a web-based CS database to facilitate supervisees accessing clinical supervisors (Taylor & Harrison 2010). The results of this study support the identified barriers to accessing CS as high acuity, high staff turnover and other generalised demands on nursing time interfering with the commitment to attending CS. They also confirmed that commonly held attitudes such as suspicion, resistance and mistrust of CS can be ameliorated by providing nurses with specific CS education that, in turn, provides the nurses with new levels of knowledge and skills, which then results in increased engagement with CS. The web-based database was described as having only limited success, which Taylor and Harrison (2010) assert related to inadequate support and commitment from the various mental health services.

The lack of attention to supervisor training

Although describing the state of CS in the field of psychology, comments made by Gonsalvez and Milne (2010) resonate equally in the nursing paradigm. There is increasingly widespread acceptance and acknowledgement that CS appears to play a significant role in the development of clinical competence in supervisees and promotes positive clinical outcomes. And yet it would seem apparent from the research and the literature that there has been insufficient attention paid to supervisor training. They cite Whitman, Ryan and Rubenstein (2001) as claiming this to be 'the persistent paradox'. They conclude that for the impetus towards improved regulation of CS to be successful, it is necessary to develop parallel, proactive processes that will facilitate and support supervisory practice with improved resources such as approved CS training manuals, workbooks, assessment tools and the all-important but mostly neglected framework for CS evaluation. From the evidence of this integrative review it could be considered to go without saying that this would be equally applicable to mental health nursing.

Psychiatric nursing participation in clinical supervision

In one of their earlier works, Gonge and Buus (2010) considered the factors that influence psychiatric nursing staff to participate in CS. This study was performed in acknowledgement of the view that earlier research had failed to substantiate any evidence that CS actually provided any positive effects and that this reflected the need for a more thorough approach to any investigations of the topic. Their findings revealed that:

- service location/setting was a significant factor (community mental health service nurses were more likely to attend regularly than their inpatient nurse counterparts)
- shift work was also an influence (those on day shift were more likely to participate than nurses on afternoon or night shifts)
- the amount of informal social support from peers and colleagues for participating in CS was an influence, especially in the inpatient setting.

This study appears to lend support to the concept that it is erroneous for services to try to adopt a 'one-size-fits-all' approach to implementing CS.

Why nurses are reluctant to engage in clinical supervision

Cleary, Horsfall and Happell (2010) contend that, for some time, CS has been poorly understood – there are significant differences between the proposed benefits of CS and the reality of it in practice. They go on to suggest that too much is being expected of one process and that these are the factors that have led to the marked reluctance of nurses to engage with it, most notably in the inpatient setting. They concur with other authors that unless and until there exists a shared understanding, expectation and rationale between clinicians and managers as to what CS is and does, an effective framework for its implementation will remain elusive. They also believe that CS should be defined by the nurses participating in it. This further promotes the rationale that a 'one-size-fits-all' approach is detrimental to progress.

The relationship with recruitment and retention

In her review of the literature related to the relationship between CS and staff recruitment and retention, Cummins (2009) purported that one of the key tasks for the nursing profession is the necessity to determine whether CS is a system to ensure an effective nursing workforce or an opportunity to empower nurses to realise their own vision of nursing. Her findings support the ideas that time away from the clinical environment, erratic and sporadic CS, the financial costs involved in implementation and uncertainty about the efficacy of outcomes from the patient perspective all add to the prolonged reluctance on the part of organisations and nurse management to conclusively and unreservedly commit to ensuring that CS is mandated for all nursing staff. Anecdotally, and with reference to other CS guidelines, the use of the term 'mandatory' in the context of CS proves to be something of an oxymoron.

A systematic review of the literature

Buus and Gonge (2009) completed a systematic review and critical evaluation of the literature pertaining to CS in psychiatric nursing. They found that studies were typically small-scale, used relatively new and basic methods for data collection and analysis and rarely included strategies for identifying complicating factors or how the researcher's preconceptions influenced the analyses. They identified four categories of study of CS, namely effect studies, survey studies, interview studies and case studies. The effect studies were alleged to be designed to measure the effect of CS on outcomes – but they concluded that these did not provide adequate empirical evidence to support the claim that CS has an effect on the nurses and/or the patient in their care. The survey studies were believed to have inconclusive evidence regarding the causal relationships between CS and other variables. However, the assumptions were found to be invalid because the cross-sectional data did not allow interpretations to be drawn regarding causality. The interview studies were also difficult to evaluate because two of the five studies concerned themselves with developing an understanding of the meaning of concepts related to CS, while the other three concerned themselves with description and evaluation of practices related to CS.

In summing up, there was insufficient clarification about how the analysis of the studies was performed and could not be evaluated by the readers. The case studies also used an interpretive approach, but the social dynamics occurring during the sessions were disregarded as part of the data making the interpretation of any outcomes difficult to generalise. Their ultimate conclusion was that a lot more empirical research needs to be completed before any serious consensus regarding which definitions and models should guide the implementation of CS can be reached.

The efficacy of cognitive behavioural psychotherapy

In his interview-based study, Townend (2008) considered the efficacy of using cognitive behavioural psychotherapy to produce a model or framework by which to consider the success or otherwise of CS. He found that the interviewees reported in areas of moderating inputs, relationships and roles, values and beliefs, cognitive and learning processes, monitoring and assessments and the ultimate outputs from supervision. Townend further reported that this model was particularly useful when applied to the process by which supervisors made sense of the complexities of the supervisory task and process, particularly in relation to the organisational cultures and the implications of these in the triadic relationship (supervisee, supervisor and organisation).

The criticality of the employer environment

Butterworth et al. (2008) also reviewed the literature and concluded that there is an inherent responsibility among healthcare organisations to develop and sustain the practice of CS. This work paid particular attention to the increasingly prominent view that employer organisations are critical to the successful uptake of CS by nurses. They further commented on the implications for clinicians of time-poor environments in which the opportunities for nurses to discuss their practice and especially their patient safety were increasingly being considered unproductive and removed from the working week by employers. Complicating factors in the search for evidence of the usefulness of CS include tokenism, badly practiced CS and the fact that it continues to make some clinicians uncomfortable, viewing it as sinister (and anecdotally not uncommonly referred to as 'snoopervision'), whereas others consider it almost a 'magic bullet'.

Accrediting clinical supervisors

One paper discusses the introduction of accreditation of clinical supervisors in mental health nursing and suggests that accreditation would increase the legitimacy of CS as a core activity in mental health nursing practice. It would also provide recognition for an individual's supervisory practice, lead to improvements in supervisor training, contribute to the development of its effectiveness and support mental health nurses' key leadership role in supervising other professions (Sloan 2008).

Recommendations for formulating guidelines

When considering formulating best practice guidelines for implementing effective CS, Rice et al. (2007) concluded that there were 12 recommendations that should be included.

1. An organisational definition of CS should be agreed upon and accepted by all nurses and their managers and be included in all operational, policy and procedural documents.
2. Managers should facilitate nurses accessing CS.
3. Managers should ensure robust operational policies supporting the provision of CS are implemented.
4. Contracting agreements should be included in organisational policies.
5. Accessing CS in work time should be a documented part of the agreement.
6. Supervisors must have sound clinical skills and a strong knowledge base.
7. Supervisors must demonstrate a clear commitment to the role of supervisor and be available and have the ability to act effectively when needed in clinical situations.
8. Supervisors should be inspirational.
9. Supervisors should have completed recognised training as well as be able to provide first- and second-level therapeutic care to patients.
10. There should be process by which monitoring and evaluation of CS will occur.
11. Supervisors and supervisees should be comfortable providing data to inform evaluations.
12. Patient feedback should be considered as a means of assessing efficacy
    (acknowledging that this could prove to be problematic in certain environments
    such as bed-based, acute services).

Results

Following this review of the literature, it would appear reasonable to present the solution to the reportedly poor implementation of CS across Victorian AMHS as a framework of three distinct yet equally essential domains.

The first domain is that of the supervisee's personal and professional readiness, which includes such factors as having access to information about a suitable supervisor, freedom to choose their supervisor, specific involvement in the formulation of the CS agreement and participation in regular evaluation of the process.

The second domain is that of the personal and professional readiness of the supervisor. This include such factors as the currency and relevance of their training and the fit of their chosen 'model(s)' for delivering CS – again, some form of evaluation of the supervision process and their own engagement with CS.

The third and equally essential factor is the readiness of the AMHS to support both the supervisee and the supervisor in the process. Key issues in this domain include:

- an explicit, unified, positive position on the implementation of CS
- organisation-wide managerial support for this position
- flexibility of implementation, recognising that a 'one size fits all approach' will not succeed, especially with reference to bed-based services
- commitment to a regular evaluation process
- ensuring that supervisors receive and commit to their own CS.

While considering the three domains of equal significance for effectively implementing CS, it should be noted that without the AMHS's commitment to the engagement, education and organisation-wide approach to CS for all staff, the likelihood of any sustained improvement in the understanding and the uptake of CS, and, as a consequence in the clinical outcomes for the consumers of services, is low.

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