Clinical Supervision Background Paper

Clinical Supervision (CS) is a formally structured arrangement between a supervisor and one or more supervisees purposely constructed to provide a space for critical reflection on the work issues brought to that space by the supervisee(s). The broad aim of CS is to facilitate the professional development of the supervisee(s) through increased awareness and understanding of the complex human issues within their workplace.


CS for all professions is now commonly referenced in Australian mental health policy frameworks (Commonwealth of Australia 2009, South Australia Health 2010, Department of Human Services 2014) with a number of jurisdictions producing their own guidelines (New South Wales Health 2006, Queensland Health 2009, Bouverie Centre 2011, Health Education & Training Institute 2013), and the establishment of interest groups and associations (Australasian Association of Supervision 2016, Australian Clinical Supervision Association 2016, Australian College of Mental Health Nurses Clinical Supervision Special Interest Group 2016).

CS is usually conducted either in dyads (one-to-one), or in small groups of 6-8 supervisees. Because CS originated in psychotherapy and counselling training, the focus of CS has
traditionally been on the clinician consumer relationship. Material from that relationship is brought to the formal CS meeting and discussed in a retrospective and reflective way. Through the development of a trusting professional alliance, the supervisee can explore the helping role and all the uncertainty it carries. Within this framework, the aim of CS is to maximise the supervisee’s ability to provide therapeutic support to the consumer through:

- understanding the consumer;
- understanding the emotional, cognitive and behavioural reactions of the consumer as well as the supervisee;
- understanding the relationship between the supervisee and consumer;
- maximising the psychotherapeutic potential with the consumer and;
- learning from linking theory and practice.

In addition, the supervisee may explore professional issues that require deeper reflection to understand. Through reflection on practice, CS provides the supervisee with the opportunity to develop reflective skills more generally, which Benner (1984) proposed as essential to advanced practice. The supervisee learns not only to reflect on practice but also to reflect in practice (Freshwater 2008) and before practice (Heath & Freshwater, 2000). It has been argued that the ability to reflect can result in ‘more carefully chosen interventions in the moment and decrease the risk of being reactive or impulsive’ (Sharrock et al. 2013), to practice mindfully (Rolfe 1997), or with intentionality (Freshwater 2008), which all increase the likelihood of helpful interventions.

**Models of Clinical Supervision provision**

Operational definitions of CS, preferred models of practice, frameworks for implementation and strategies for systematic evaluation vary within and between professional groups and practice settings (Buus & Gonge 2009, Wright 2012, Sloan & Grant 2012). Dilworth et al. (2013) suggest that “…the complexity and confusion within the literature is generated by the diverse expectations and outcomes of clinical supervision”.

However, the Proctor Model (1986) of CS has become one of the most influential and widely adopted models in nursing contexts (White & Winstanley 2011). It comprises three domains:
• Normative: to address the promotion of standards and professional accountability
• Restorative: to support the wellbeing of the supervisee
• Formative: the educative component that develop knowledge and clinical skills

In the literature review undertaken by Bunero and Stein-Parbury (2008), the reported outcomes from 22 studies into the effectiveness of CS were categorised according to Proctor’s domains. This paper provides a useful summary of the proposed benefits of CS. The authors concluded that in the studies that they reviewed, the restorative function was reported more frequently. White and Winstanley (2010) demonstrated that effects of CS appear to act on the three domains at different speeds; changes in the normative and restorative are likely to precede measurable changes in the formative. Importantly, therefore, this implies that the benefits to consumers/patients may be demonstrated subsequent to the successful establishment of an organisational culture, in which staff well-being and attention to continuous clinical audit have been promoted through sound CS.

CS is conceptually distinguished from case review, performance review and management and managerial line reporting. Although, CS is a helping relationship and therefore has similarities to psychotherapy and counselling, it is also distinguished from personal therapies in that it is not directed toward the personal growth and development of an individual but on professional skill development. Personal growth occurs as a by-product of CS (Sharrock et al. 2013) as opposed to being the goal of CS. It is important to note that it is the responsibility of the supervisor to maintain the structure, boundaries and focus of CS as the supervisory relationship develops (Lynch et al. 2008).

Evidence for Clinical Supervision:
There is growing evidence that a formally established alliance between practitioners, in which the roles of supervisor and supervisee(s) are clearly defined and that is focused on professional support through facilitated reflection, is likely to have positive outcomes for
the supervisees (Brunero & Stein-Parbury 2008). These have variously related to the restorative functions (e.g. personal development, improved coping and wellbeing, confidence, reduced emotional strain and burnout, staff morale, sick leave and retention), normative functions (e.g. professional identity and satisfaction, critiquing practice, moral sensitivity and confirmation of actions and role) and formative functions (e.g. increased knowledge and awareness of possible solutions to clinical issues, greater reflection on practice, professional growth, self-awareness of thoughts and feelings, improved communication skills and confirmation of consumer uniqueness). Supervisees report a perceived improvement in their ability to provide clinical care to consumers (Brunero & Stein-Parbury 2008) which is supported by more recent studies (Bambling et al. 2006, Bradshaw et al. 2007, Buus & Gonge 2009, Winstanley & White 2010).

While the positive impact of CS is repeatedly reported and there is an overall commitment to CS for those working in the helping professions, there are cautions and concerns about the promotion of CS. Whilst CS may help to achieve the best level of care possible, Bishop (1994) asserted that it cannot compensate for inadequate facilities, for poor management, or for unmotivated staff (White & Winstanley 2009b). In addition, good supervisors are as unlikely to have a desired effect in unhealthy cultures, as are poor supervisors in healthy cultures (White & Winstanley 2010). Risks that have been associated with CS and reflective learning include unintended disclosure of personal information, breaches of confidentiality and bullying (Yip 2006, Butterworth et al 2008,).

Limitations regarding the strength of the evidence have been identified and ‘...there is a need to address methodological limitations in order to improve the strength of the evidence’ (Dilworth et al. 2013). This is a challenge given robust, outcome-related CS research is difficult to design, conduct, interpret and fund (White & Winstanley 2011). Further small and large scale outcomes-related studies in a variety of settings are necessary to test emerging theoretical propositions using relevant instruments that have well established and publicly reported psychometric properties.

**Implementation of Clinical Supervision:**
Despite the interest in CS within nursing, there have been significant challenges for the implementation of integrated systems for CS (Lynch & Happell 2008a, Lynch & Happell 2008b, Lynch & Happell 2008c). Concerted effort is still required to ensure that CS is better understood, accepted and practiced in Australia (Taylor & Harrison 2010) and convincing programs of CS education (White & Winstanley 2009a) and outcomes-related research remain necessary to further substantiate the claims made for CS (White & Winstanley 2011).

It has also been shown that any effect CS may have is likely mediated by the training that supervisors receive, the quality of the supervision they provide, the culture in which the CS endeavour is located and, in particular, the attitude of managerial staff. However, in settings where each of these mediating factors was not an impediment, White & Winstanley (2010) also found incremental evidence toward a positive causal relationship with quality of care and patient outcomes.

In order that CS may be successfully implemented and sustained, the best and clearest directions currently available White & Winstanley (2010) suggests that a number of environmental conditions should be met:

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

7. Upon appointment, all staff should be assisted to become fully orientated to local CS 
arrangements, including new graduates and others transferring into the health 
workforce.

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

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

10. Suitable administrative records should be maintained (a suggested CS Agreement 
template is available from the ACMHN website).
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