



# Claims to the benefits of clinical supervision: A critique of the policy development process and outcomes in New South Wales, Australia

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# **Claims to the benefits of Clinical Supervision: a critique of the policy development process and outcomes in New South Wales, Australia**

## **Abstract**

The historical development of Clinical Supervision has been variously interpreted in the international literature. Creditable evidence has accumulated, particularly over the past two decades, to show that Clinical Supervision has a positive demonstrable effect on Supervisees. However, comparatively little research evidence has entered the public domain on any effect that Clinical Supervision may have on other nominated outcomes.

In Australia, developments in Clinical Supervision were recently prompted by initiatives at national and State levels. Since 2010, lead agencies for these have sought feedback from professional bodies and organisations on a number of inter-related draft policy documents. The present article tracked changes over time, between the draft and final versions of these documents in New South Wales and reviewed the original sources of literature cited within them. The strength of evidence upon which the final published versions were reportedly predicated was scrutinised.

Upon examination, claims to the wider benefits of Clinical Supervision were found to be unconvincingly supported, not least because the examples selected by the agencies from the international literature and cited in their respective documents were either silent, parsimonious or contradictory. Many claims remain at the level of folklore/hypothetical propositions, therefore, and stay worthy of rigorous empirical testing and faithful public reporting. Such investigations have been acknowledged as notoriously difficult to conduct. The present article identified noteworthy examples in the contemporary literature that signpost robust ways forward for empirical outcomes-orientated research, the findings from which may strengthen the evidence base of future policy documents.

## **Introduction**

Australian national backdrop:

Whilst the international origins of Clinical Supervision (CS) are much longer established (White and Winstanley 2014), an impetus for the latter-day development of CS policy in Australia came in July 2010. Health Workforce Australia (HWA; an independent statutory body, established to implement the Council of Australian Governments; -COAG- health workforce

initiatives, agreed to in November 2008) published the Clinical Supervision Support Program (CSSP) 'Discussion Paper' (HWA 2010). The document was based on consultation feedback from 61 named stakeholder organisations. Within a year, following submissions from 134 stakeholders, HWA published the Clinical Supervision Support Program (CSSP) 'Directions Paper' (HWA 2011a) which referred to the terms 'clinical supervisor' and 'clinical supervision' as the '*educational context of student and trainee learners and not clinical supervision in the broader sense*'. HWA reported that '*the clinical supervision of medical students had traditionally been on an apprenticeship 1:1 model*'; the Chief Executive Officer also confirmed that it was '*important to note that some of the comments in the stakeholder submissions were not necessarily supported by evidence*' (Cormack, M. Personal correspondence. 6 April 2011).

New South Wales:

At State level, the Clinical Education and Training Institute (CETI; a multidisciplinary education and training agency) was also established in July 2010 by the New South Wales (NSW) Government, under the Health Services Act 1997, as recommended by the Garling Inquiry (2008). By November, CETI (2010) had published the first of two so-called '*Superguides*', subtitled *a handbook for supervising doctors in training*. Clinical Supervision was explicitly identified as having three key elements:

- Clinical oversight to lead, guide and support the trainee at the point of care to ensure patient safety.
- Clinical teaching to enable trainees to develop the competence and knowledge required for responsible practice.
- Trainee management to ensure that trainees are safe and well in their work

The following year, a second *Superguide* was published *for supervising Allied Health professionals* (CETI 2011). Within a few months, CETI was restructured to become the present Health Education and Training Institute (HETI), which began operations in NSW in April 2012, in conjunction with the Interdisciplinary Clinical Training Networks (ICTN) Program. Eight networks were established across NSW in mid-to-late 2012. Almost immediately, HETI commissioned a so-called CSSP Mapping Study, from Zest Health Strategies, North Sydney, funded by HWA. Upon release of the report (Zest Health Strategies 2012) conceded 14 substantive and methodological caveats and considerations. In its response to the 235-page document, HETI (2012) lamented that it was not possible to identify the number of Clinical

Supervisors who worked in in the NSW health system. Moreover, HETI reported that the Zest study had *'one significant failing; the limited participation from nursing'*. Although 48% of health professionals in NSW public hospitals were nurses, only 26% were study respondents. The HETI response also foreshadowed the development and publication of further *Superguides* for other health care disciplines. One such was to become *The Superguide: a handbook for supervising nurses and midwives*, which began development in February 2012. It was scheduled for release in November 2012, when HETI anticipated *'quite a song and dance'* (a phrase admitted to have been *'rather flippant'* and later retracted). By way of possible coincidence, the Zest mapping report was published in November 2012. It had been written-up ~4 months earlier, in August 2012, but was beset with *'unforeseen delays'*, caused by *'being reviewed by management and awaiting sign-off'*, and *'a communication strategy for the document'*. In the event, and without public explanation, the *Superguide* itself was then delayed for release by a further ~10 months, until the end of August 2013, during which time the document was re-titled and published as *The Superguide: A Supervision Continuum for Nurses and Midwives* (HETI 2013) -hereafter, *Superguide*.

### **The Superguide: A Supervision Continuum for Nurses and Midwives**

The *Superguide* publicly acknowledged individual members of a Reference Group (n=17), which included 10 service and education managers drawn from the NSW Local Health Districts and Speciality Networks. As if to adhere to the HWA portend, the document discriminated eight different types of 'supervision', in a manner designed as if to appear mutually exclusive and exhaustive [viz; preceptorship, mentoring, clinical teaching, reflective clinical supervision, clinical facilitation, peer review, buddying and coaching]. HETI conceded that *'there may be some overlap'* and that reflection was considered as a *'central component of all types of supervision'*, undertaken in a range of clinical settings. Even so, one of the eight types of supervision was designated *'reflective clinical supervision'* which, in the *Superguide*, was also interchangeably referred to as *'clinical supervision'*.

Earlier (between 12 March and 18 April 2013), HETI had gathered feedback on the draft version of *Superguide*, via an *'extensive pre-launch evaluation'*, assisted by an external consultant. Findings from the so-called 'focus testing' were not conveyed back to members of the Reference Group, prior to publication. Subsequently, HETI also resisted multiple

informal requests for such feedback to enter the public domain, upon which the draft *Superguide* had apparently been validated. Indeed, HETI went on to reject a formal request for access, submitted under the Government Information (Public Access) Act 2009 (the so-called *GIPA Act*). However, upon appeal to, and review by, the NSW Information and Privacy Commission, IPC recommended that HETI '*make new decisions*'. Almost two years after publication of the *Superguide*, HETI relented and eventually released information into the public domain on 3 July 2015 (<http://www.heti.nsw.gov.au/Global/Corporate/HETI-GIPA-Request-Item-2-Full-and-Final-Report.pdf>).

### **HETI Strategic Plan 2015-2017**

Then, within a tight time window during the festive holiday period (1 December 2014 and 31 January 2015), HETI also sought feedback on its draft Strategic Plan 2015-2017. In a subsequent and summarised website report, HETI conceded the '*concerns of a number of internal and external stakeholders had with The HETI Way and the negative way it could be interpreted*' (<http://www.heti.nsw.gov.au/Global/Consultation/HETI-Strategic-Plan-2015-2017-consultation-response.pdf>). Although HETI had reported the Key Performance Indicators (KPIs) were '*to be developed*', they remained missing from the final version of the strategic plan; indeed, the KPI column was deleted from the document. In specific relation to Clinical Supervision, HETI invited feedback on the intended *Action* to '*further development and integration of clinical supervision support to empower all clinicians*'. In the final version, *Action* had been replaced by an *Initiative* to '*develop a clinical supervision framework and continue training support to build the skills and confidence of clinical supervisors*'.

### **NSW Clinical Supervision Framework**

Accordingly, in May 2015, HETI invited comments on another draft document; the so-called '*NSW Health Clinical Supervision Framework*' (CSF), which had been developed in partnership with a third party (again, Zest Health Strategies), the purpose of which was to '*set out an overarching framework that provides a strategic, aligned and informed approach to clinical supervision across NSW Health*'. Thirty-three submissions were received (Merrick, J. Personal correspondence. 1 February 2016), either in writing or by way of transcriptions of telephone conversations with purposively-selected interviewees. A summary document of the key

findings from the consultation was produced, dated August 2015. Upon written request, HETI released the anonymised document in February 2016.

Upon review, the non-attributed contents of the feedback document were reported in the form of bullet points, next to each of which were three columns, respectively headed 'Change', 'Noted' and 'HETIs input on suggested approach made'. However, the information contained in all three columns had been blacked-out. Every page was watermarked 'Confidential'. HETI subsequently heeded a further written request to reveal the comments hidden beneath the blackened areas, to remove the confidential watermark and to release the information *'in its entirety'* (<http://www.heti.nsw.gov.au/About/public-access/HETI-Disclosure-Log>). Such eventual transparency provided the opportunity to identify changes between the draft and final published versions and, for each author/organisation who had submitted comments to HETI, to track the impact of their respective contributions to the consultation/policy development process. Osman Consulting Pty Ltd (hereafter, Osman), a consulting company with a long-established track record in Clinical Supervision research, was one such and did so.

### **Draft and final versions of the NSW Health Clinical Supervision Framework**

In relation to observed differences between the draft and final version (HETI 2015) of the CSF, Osman found much of the content remained essentially unchanged. However, a number of subtle but noteworthy alterations were identified. Examples of these included, but were not limited to;

- Zest Health Strategies was no longer credited for the development of CSF in the final published version. Eight *'contributing organisations and groups'* were publicly credited, five of which were medical colleges. None were nursing.
- Clinical Supervision was publicly spun as a *'continuum of activities, extending from point of care to reflective clinical supervision and facilitated professional development'*. A discourse about such a conceptualisation has not been without contest, but this was not mentioned in the draft version and ignored in the final versions of the CSF, despite being raised in independent written submissions from Osman and the Australian Clinical Supervision Association (<http://clinicalsupervision.org.au/wp-content/uploads/2015/08/ACSA-Response-to->

HETI-July-2015.pdf). Neither submissions were listed for acknowledgement in the final CCF document.

- *'Reporting, measuring and monitoring'* subtitle (which contained the text *'mechanisms for accurately describing and monitoring clinical supervision practices and evaluating the effectiveness'*) was changed to *'clear and structured mechanisms for accurately describing and monitoring supervision practices'*. *'Evaluating the effectiveness'* no longer appeared in the final version of the CSF. *'Patients expectations of safe and high quality care'*, accompanied by the text *'both a mechanism and an outcome for achieving change in clinical supervision'*, which was listed in the draft version, no longer appeared in the final version.
- Subheading of *Principle 1* was changed from *'All professionals have clinical supervision to optimise patient care and outcomes'* to *'Clinical supervision is available to all professionals have clinical supervision to optimise patient care and outcomes'*.
- In Principle 3 (Element, Health Professional), *'Supervisors are offered training and education addressing core knowledge and skills to provide clinical supervision'* was changed to *'Clinical supervisors access education and training addressing the core knowledge and skills required to provide effective clinical supervision'*.
- In Principle 5 (Element, Health Service), *'Health services collect data on the extent of delivery and form of clinical supervision'* changed to *'Health services collect data on programs of clinical supervision and the models of clinical supervision in place'*.

### **Contribution by Osman Consulting Pty Ltd to the CSF feedback document**

In relation to specific content, the CSF feedback document comprised 76 bullet points. Osman had submitted 36 of them; six of these highlighted the repeated (and contested) use of *'successful'* as a prefix of *'outcomes'*, found on different pages of the draft CSF. In the event, *'outcomes of success'* remained in the final version; the Osman contention (that outcomes deemed *unsuccessful* were equally important to report) was not mentioned. Of the 30 unduplicated Osman bullet points, 22 had been cut and paste into the CSF feedback document, *verbatim*. Three other bullet points submitted by Osman were deemed by HETI to be *'outside the scope of Framework'*; these were listed on the last page of the feedback document, under the heading *Items for discussion*, viz;

- What are the predicted costs associated with the implementation of the CSF and how will they be funded?
- How will the *'effectiveness'* of clinical supervision be measured? Internationally recognised rateable scales, with established psychometric properties, should be cited.
- Does *'Principle 1'* mean that clinical supervision will be mandatory in New South Wales, for all health professions? If so, why? If not, why not? What will be the repercussion(s) for an individual/group of staff who choose not to access clinical supervision?

The final version of the CSF did not reveal whether such 'discussions' had taken place or, if so, between whom and when, nor with what outcome(s). The non-Osman feedback bullet points (n=40) were apparently culled from the 32 other anonymous submissions.

#### **HETI use of cited literature in the CSF**

The list of references remained unchanged between the two versions of the CSF document, save *'Mason, J. Review of Australian Workforce programs, 2013'* (partially cited in the draft), which was deleted from the final version. Two references, which were not listed in the draft, appeared in the final version; viz; Health Workforce Australia 2014a; Smith and Pilling 2008. The HWA reference reinforced the conceptualisation of Clinical Supervision as *'...oversight – either direct or indirect – by a clinical supervisor(s) of professional procedures and/or processes performed by a learner or group of learners within a clinical placement for the purpose of guiding, providing feedback on, and assessing personal, professional and educational development in the context of each learner's experience of providing safe, appropriate and high quality patient-client care'*. Close inspection of the Smith and Pilling (2008) article revealed that it was concerned with a structured program to supplement routine induction, professional development and supervision activities for new graduate Allied Health staff. It concluded that although *'subjective evaluation'* suggested the program had contributed to improved retention rates, it *'acknowledged that many factors influence staff recruitment and retention and changes are not attributable to participation in the program'*.

The final version of the CSF claimed that *'research has shown that clinical supervision is essential for the provision of safe and high quality patient care'*; four references were cited



(Milne *et al* 2008; Kilminster *et al* 2007; Farnan *et al* 2012; Kilminster *et al* 2000). Similarly, close inspection of these references revealed that, in order to better define clinical supervision, Milne *et al* (2008) had reviewed 24 studies from the literature that satisfied eight criteria. One such criterium was that the studies were *'focused on clinical supervision and not training or mentoring'*. Farnan *et al* (2012) also reviewed 24 published articles across a variety of medical specialties that met inclusion criteria and conceded that these were *'limited by small sample sizes, non-randomized designs and a lack of objective measures of clinical supervision'*. The Kilminster *et al* (2000) review of the literature, ~¾ of which is now 20+ years old, was concerned with clinical teaching *'from a medical education perspective'*.

Insofar as the claim that Clinical Supervision was essential for the reduction of errors, HETI (again) cited Farnan *et al* 2012 and Kilminster *et al* 2000. The former article actually referred to other publications, in which residents in graduate medical training in the USA mentioned *'inadequate supervision as one of the most common causes of the medical errors that occur during a patient's hospitalization'*. The latter article noted (16 years ago) only that *'trainees (aka, junior doctors in surgery, anaesthesia, trauma and emergencies, obstetrics and paediatrics) need clear feedback about their errors, corrections must be conveyed unambiguously so that trainees are aware of mistakes and any weaknesses they may have'*. Kilminster *et al* (2000) concluded that there was *'a need to establish ways of assessing the effect of supervision on patient/client outcomes'*. Neither publication provided primary empirical evidence that a reduction in errors was causally related to CS.

In relation to claims to the benefits of CS, the final CSF document cited three references (Kilminster and Jolly 2000; Smith and Pilling 2008; Driscoll 2007). Upon inspection, the Kilminster and Jolly (2000) article actually concluded that *'current supervisory practice in medicine has very little empirical or theoretical basis'*. In a later article, Kilminster (misspelt in the HETI document) *et al* 2007 asserted that *'clinical supervision must have patient safety and the quality of patient care as its primary purposes'*. She conceptualised CS as the *'direct supervision'* of medical students and junior doctors (aka, oversight at the point-of-care) and cited an elderly McKee and Black (1992) article which, in general terms, questioned whether the use of junior doctors in the United Kingdom affected the quality of medical care? As was

noted previously, the second reference (Smith and Pilling 2008) could not solely attribute the change in retention rates to staff participation in the Allied Health graduate program.

The third reference (Driscoll 2007) listed *'some of the broad benefits cited for engaging in regular clinical supervision in nursing'* (increased feelings of support, reduction in professional isolation, reductions in levels of stress, reduction in emotional exhaustion and burnout, increased job satisfaction and morale). This list was an abbreviated form of that earlier found in the *Superguide*, which was also referenced to Driscoll (2007) and, on that occasion, also included *'the promotion of work-based learning and the development of new skills'*, *'increased professional identity'* and *'improved recruitment and retention of staff'*. Direct contact with the author (Driscoll, J. Personal correspondence. 15 March 2016) and close inspection of his textbook, confirmed that he did not provide his own primary evidence; rather, he cited articles drawn from four fledgling studies (Butterworth *et al* 1997; Cheater and Hale 2001, Hyrkas 2005, Severinsson and Borgenhammer 1997 and Teasdale *et al* 2001). Each of these identified modest claims to benefits that specifically accrued to Supervisees. A second list in the Driscoll textbook, claimed to *'also highlight a similar range of positive outcomes for Allied Health professions'*. Here, too, Driscoll's discourse was sufficiently parsimonious to fit findings from these elderly citations (Grover 2002; Sellars 2000, 2004; Strong *et al* 2003; Tate *et al* 2003, Weaver 2001) into younger and stronger accounts of creditable primary evidence (see for example, Watkins' 2011 review).

However, wider claims (and/or vicarious inferences) made by HETI in the CSF, for Clinical Supervision to be causally related to *'the development of new skills'* and *'support for organisational issues, such as recruitment and retention'*, were (and have remained) far less well defended in the international literature. For example, no such mention of either benefit was claimed in the Tate (2003) report, which was concerned with Complementary Therapy Clinical Tutors. It concluded that *'the relationship of clinical supervision to the experience of the student and the patient is difficult to assess. Some of the findings seem to suggest that involvement in clinical supervision enhances teaching, and that this ultimately impacts on the patient. However, it was not possible to measure that in the context of this study'*. The Butterworth *et al* (1997) evaluation, explicitly aimed *'to give an informed view on assessment tools that can be used to report on the impact of clinical supervision'*. *Inter alia*, it reported

that *'many employers have invested significantly in clinical supervision and mentorship. This investment has been largely an act of faith, as employees have responded with enthusiasm to the felt advantages which it offers. Where resources are finite and competing demands are made on the valuable time of expert practitioners, evidence is needed to support investment'*. The measurable transfer effect that CS had on the retention of staff/turnover rates, the development of new skills, quality of service provision and patient outcomes, all fell outside the terms of the evaluation. The Strong (2004) article (not 2003, as cited) found that the development of new skills was least frequently reported when respondents were asked what they saw as the benefits of supervision (rather than what researchers actually found the case to be) and then, discretely, this was in relation to *'the preservation of discipline-specific skills'*, which *'helped affirm the professional identity of that allied health professional group'*. The article was silent on recruitment and retention.

Teasdale (2001) actually found that *'statistical analysis of the data from the MBI (Maslach Burnout Inventory) failed to detect any protective effects against burnout from Clinical Supervision'*. In a small study of physiotherapists, Sellars 2004 concluded that although some self-reported benefits accrued to Supervisees, *'fewer benefits were identified for patients'* and that *'some respondents could not identify any positive outcomes for the organization'*. Furthermore, *'if the implementation of clinical supervision is to be effective across the professions, it is clear that there is a need for the ongoing evaluation of systems already in place, so that the results can be made public and provide a measure against which the impact of clinical supervision can be judged. These results must highlight not only the impact on individuals engaged in the process, but also the impact on practice, on patient care and on service delivery'*. In her earlier *'short piece [less than one page] for a physiotherapy magazine -not academic journal'* (Sellars, J. Personal correspondence. 20 April 2016), she reported only that *'at least one member commented that the support received through clinical supervision had been a factor in her remaining at the hospital'* (Sellars 2000). Based on feedback from 18 podiatrists in a project commissioned in 1999, Weaver (2001) concluded that *'there is currently a lack of information on the benefits and outcomes and of clinical supervision'*. Driscoll 2007, himself, asserted that *'while self-reported practitioner outcomes may not be that difficult to evaluate, improvements in patient/client outcomes remain the holy grail for Clinical Supervision and will continue to be a major challenge'* (akin to 'the acid test'; Ellis and

Ladany 1997, p485). He also observed that *'unfortunately, Clinical Supervision has already many (interchangeable) names'* and added the warning of Power (1999) that *'...the real problem is that the more words we use to avoid the one that we have -and should be using (Clinical Supervision)- the more we dig a bigger hole for ourselves...'*. Ryan [2015] echoed this sentiment, thus: *'Every attempt I am aware of over time to redefine clinical supervision with the intent of fixing the historical confusion over the term has resulted in even more confusion.... the pervasive use of the term (Reflective Clinical Supervision) should revert to the term clinical supervision and then explain to those who are confused...what it means, leading hopefully to a conversation about the confusion and the confused (or usurpers)'*. White (1993) had previously foreshadowed such a *'tautological maelstrom'*; quod erat demonstrandum.

## **Discussion**

In January 2010, HWA invited 61 stakeholder organisations, that covered 24 different Health professions, to submit feedback on the Clinical Supervision Support Program Discussion Paper (HWA 2010). Only 3 were nursing organisations. Even then, the peak national body for *mental health* nurses (Australian and New Zealand College of Mental Health Nurses Inc; ANZCMHN) was not one of the three, despite having published a Clinical Supervision research monograph (Winstanley and White 2002) eight years before HWA became operational. MHNs comprised the majority of the national mental health workforce, and the most common mental health professional found in rural and remote areas, and were early adopters of CS (White and Winstanley 2014), with telling experience to account. That their national representative organisation [established, then, ~33 years before HWA] was not immediately on the radar, sent an ominous signal of the future and set a tone that, as White (2014) later observed, was immediately apparent in the way in which 'Clinical Supervision' had been conceptualised. Upon being alerted to the omission by a Fellow of the College, the ACMHN subsequently made a *post-hoc* submission to HWA. Equally prophetic, in relation to the tenor of this article, HWA conceded at the outset that some of the comments submitted during the consultation process *'were not necessarily supported by evidence'* (Cormack 2011). The strategy adopted by HWA to deal with such non-attributable commentaries was not reported.

Insofar as was possible, this article has chronicled the recent development of Clinical Supervision policy in New South Wales. It has tracked the behaviour and public outputs of the

former and current lead agency charged with the responsibility for so doing; CETI and HETI respectively. The NSW Clinical Supervision Framework was claimed as an *'overarching framework that provides a strategic, aligned and informed approach to clinical supervision across NSW Health'*. However, it was developed after publication of the so-called 'Superguides', which had already drawn operational distinctions between different health care professionals. It can be reasoned, therefore, that both adopted an unusual temporal order by which to develop such policy. Arguably, the policy development process may have been more convincingly established if the *'overarching framework'* to *'outline principles and outcomes of success'* had been agreed and published before the development and publication of the operational Superguides (at least one of which -nursing and midwifery- has not been without contest; White 2014). The HETI assertion that the *'framework has been designed to complement the HETI Superguides'*, therefore, rang hollow. An alternative and accessible agenda, to help frame conceptual and practical considerations, can be found at Appendix 1.

The present article has also shown that, unlike HWA which published fulsome feedback information, including a list of named organisations that made submissions (HWA 2011b), the HETI claim of *'openness and collaboration'* has been belied by the adoption of opaque mechanisms, which have tightly controlled the dissemination of information; witness the need for the application lodged under the Government Information (Public Access) Act 2009. Upon release, the international research community readily saw that the premise for publication of the *Superguide* arose from a methodologically unsophisticated review of the draft version. The online survey link (<https://www.surveymonkey.com/r/ClinicalSupervisionGuideFeedback?sm=tpnluy99h54r5Qmhpu%2b4dYNbRn7IWCDdhOrwKSegiRpcp%2frmWWycgmEN74GBstS2D%2fWkLx1cS6MyplyF7MpFFA%3d%3d>) was sent to *'selected'* Deputy Directors of Nursing in 7 Local Health Districts, for circulation. Seventeen responses were received. Seven 'focus tests' were also conducted; the respondent selection procedure and method(s) of qualitative analysis were not reported. The information obtained via a *GIPA Act* application also showed that the HETI spend on 'nursing and midwifery focus testing' was A\$23,478. Summary quantitative findings from the 'tests' were shown to have been essentially contained to variables concerned with matters of style (*'user friendly'*, *'formatted appropriately'*, *'easily understood'*, *'professionally presented'*), rather than matters of substance. The feedback report also revealed that *'the*

*idea of focus-testing*’ subsumed an intentional secondary purpose; viz, *‘the parallel promotion of HETI during the exercise’*. It was reported as a *‘known fact’* that the original draft document ran to 144 pages, which *‘independent writers/editors were engaged to edit and enhance’*, before *‘HETI staff reviewed and shortened it to 80 pages’*. Whilst the individual external consultant was self-reportedly *‘stirred’*, individuals who had been recruited to assist HETI with the development of the *Superguide* were blinded to feedback findings from the *‘tests’*. HWA confirmed that it *‘did not have a copy of the testing report’*. Never the less, HETI published the (by then) 90-page *The Superguide; A Supervision Continuum for Nurses and Midwives*, in August 2013. The overall cost was reportedly A\$97,805. It was originally intended for commercial marketing, as an adjunct to *‘the possible commercialisation of training in clinical supervision’*. Ever since, the *Superguide* has remained unchanged; indeed, *‘any [feedback] pertaining to the current resource will not result in changes in the near future’*.

Further information released under the *GIPA Act*, showed that the only *pre-publication* report had been prepared by the external consultant and was submitted to HETI in April 2013. The pre and post-test evaluation of the *Superguide* had reportedly adopted *‘important & relatively innovative approaches to resources development & evaluation’* and that *‘this process has been written up’*. At the time of writing (June 2016), however, HETI’s intention *‘to publish a peer-reviewed research paper, based on the results of the focus group testing’*, had not eventuated. Moreover, again upon formal request, HETI (2013) had also revealed that *Part B* of the CSSP Mapping Study, which was to have been the evaluation of implementation of a training strategy based on the findings in *Part A* (Zest 2012), *‘was not completed’*.

Without hawkish observation of the policy development process, it would not have been possible to notice that subtle, but significant, movements in the posture HETI adopted over time. For example, between the draft and final (published) versions of the NSW CSF, the emphasis changed from an expectation of staff *‘having’* clinical supervision, to CS *‘being available’* to all professionals. The import of that change showed that HETI had retreated from a starting position to make CS a requirement for all health professions in NSW and had disassociated itself/employers from the former commitment to ensure universal *‘uptake’*. The repercussion(s) for an individual/group of staff who chose not to access clinical supervision

was not publicly addressed prior to publication of the CSF; rather, it was listed as an *'item for discussion'*. Similarly, a change was observed between the two versions in which Supervisors would be *'offered'* training and education to address core knowledge and skills to provide clinical supervision (found in the draft), to Clinical Supervisors *'having access'* to education and training (found in the final version). This, too, moved the intention and expectation of organisations to *'offer'* training and education, to staff having individual responsibility to *'access'* it. Such a shift raised the spectre of the possible corollary; personal blame. Moreover, in the final version of the CSF, organisations were unhooked from a requirement to collect data on the *'extent of delivery'* of CS (a measurable KPI), in favour of descriptions of *'programs and models of clinical supervision in place'*.

In both versions of the framework, the HETI assertion that health professionals should receive clinical supervision at *'appropriate times, to ensure high quality and safe patient care'* was, at best, ambiguous. This, because a lack of available time for clinical supervision has frequently been a clarion call in the literature, as a major obstacle to CS engagement. Perversely, therefore, the first of 12 *'Outcomes of success'* listed in the CSF [p20] provided a catch-all defence for *non*-engagement, if it was argued that *'appropriate time'* could never be found without compromise the quality and safety of patient care. Even on occasions when this was actually so, a paradox appeared to have been missed; viz, the busier and time-poorer staff become, in ever more demanding and stressful clinical settings, the stronger an argument becomes to quarantine regular time for Clinical Supervision, *not* the weaker [see Appendix 1]. Insofar as the CSF is concerned, in settings where *no* time would ever be considered *'appropriate'*, all other 11 *'Outcomes of success'* have been rendered irrelevant. Moreover, that the CSF did not acknowledge the relationship between the enactment of CS arrangements and local whistleblowing policies (and whether or not they were trusted by staff; a proxy indicator of organisational culture), gave a wayward impression of Clinical Supervision as an unconnected panacea.

An early apprehension that one health care discipline would eventually imperialise the conceptualisation of Clinical Supervision, such that it would become the dominant and irrevocable construction of reality for all other helping professions (White 2014), has been realised. Self-evidently, despite the theatre of public consultation, the recent development of

Clinical Supervision policy in NSW has been driven by medical and managerial sub-textual agendas and has become instrumental in the realignment between and within professional health disciplines. White (2016) has argued that without concerted effort, the nursing and midwifery professions may eventually lose control of their own CS narrative. Arguably, shrewd readers of the NSW CSF may remain unconvinced by the impression, no matter how many times the message has been spun, that Clinical Supervision would be universally supported in health service organisations and that the oft-cited benefits would automatically accrue. As has been revealed earlier in this article, both assumptions can be reasonably doubted. Furthermore, systematic reviews of the CS literature by professorial scholars who were *not* cited in the CSF have frequently published openly cautious accounts. For example, Carpenter *et al* (2013) reported that *'supervision has a long way to go to prove itself as an evidence based practice'*, whilst Wheeler and Richards (2007) found that the outcome of their review *'does not provide the robust evidence that would ideally be required to make bold statements about the efficacy of supervision practice'*. Furthermore, by way of redress, both reviews also found that there was *'very little research on supervision'* and that a strategic supervision research agenda was urgently required. White (2016) recently concurred and lamented the *'continuing under-development of CS research and education'*. In an attempt to encourage dialogue across disciplines and countries it was timely, therefore, that an American-led initiative recently invited a group of eight active CS scholars to join a forum held in New York, USA [prior to the 11th International Interdisciplinary Conference on Clinical Supervision, in June 2015], to prioritise questions and methods for an international and interdisciplinary supervision research agenda (Goodyear *et al* 2016).

In operational terms, follow-on research studies have been afforded credible contemporary advice, informed by the conclusions of a review of the international CS literature published over the last 30 years. Whilst acknowledged as notoriously difficult to conduct, Watkins (2011) identified three studies (ironically, two of which were conducted in Australia, the other in England; indeed, 2 were led by mental health nurses) *'that provide the best and clearest directions for further thought about conducting future successful research in the supervision-patient outcome area'* (Bambling *et al* 2006; Bradshaw *et al* 2007; White and Winstanley 2010). Furthermore, novel empirical research methods have recently been developed which allow the efficacy of CS provided to staff to be tested and to identify the local service



conditions which were likely to achieve best possible outcomes (Winstanley and White 2014). Each of these studies and others (see, for example, Reiser and Milne 2014) have sign-posted directions for investigators and policy makers to respond, in the development of Clinical Supervision at local, State and national levels.

To date, however, despite unsuccessful external attempts to caution otherwise, the CS policy development process and outcomes in Australia *per se*, and in NSW in particular, has been characterised by an apparent cavalier [dis]regard for the international literature, which appears to have been cherry-picked to keep *on-message*. However, as the present article has revealed, the examples selected by lead agencies were either silent, parsimonious or contradictory about claims to the benefits of Clinical Supervision (beyond the measurable impact on Supervisees). Many of these claims, therefore, remain at the level of folklore/hypothetical propositions; *ergo*, they remain worthy of rigorous empirical testing and faithful public reporting. The proper use of findings arising from any and all such future empirical outcomes-orientated research activity may strengthen the evidence base of subsequent policy documents and moderate claims made within them which, in turn, may encourage clinicians and their employing organisations to manage expectations.

### **Note Bene**

Health Workforce Australia was closed in the 2014 Australian Federal Budget and all existing grants and programs were transferred to the Department of Health [HWA 2014b]. In June 2016, the Interdisciplinary Clinical Training Networks Program was also closed, due to the end of the Multi Schedule Funding Agreement with the Department of Health. No further funds will be forthcoming.

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## Appendix 1

### Clinical Supervision: conceptual and practical challenges

- How to realign a common misconception that merely ‘having’ Clinical Supervision (and being counted as ‘having’ it, for personal/managerial key performance indicator {KPI} purposes) will automatically reap a raft of benefits, many of which are themselves often exaggerated and unsubstantiated. Only demonstrably efficacious Clinical Supervision (CS) may have a desired effect on some nominated outcomes. The corollary is; if CS is poorly understood at the conceptual level and is delivered

superficially, at best, it may waste public money and other scarce resources or, at worst, prove ineffectual and/or inadvertently detrimental to Supervisee and human service consumer alike.

- How to comprehend that, whilst Clinical Supervision may help staff to achieve the best level of care possible, it cannot compensate for inadequate facilities, or for poor management, or for unmotivated staff. This is akin to 'the operation was a great success, but the patient died'. Good Supervisors are as unlikely to have a desired effect in unhealthy cultures, as are poor Supervisors in healthy cultures.
- How to address two ironies: (1) staff who need Clinical Supervision most, may be those (including middle managers) who are least likely to receive it themselves and/or facilitate it for others and (2) the busier and time-poorer staff become, in ever more demanding and stressful clinical settings, the stronger an argument becomes to quarantine regular time for Clinical Supervision, *not* the weaker.
- How to establish a contemporary professional mindset that recognises Clinical Supervision as an integrated part of work in human service agencies, *not* an activity which is separate from work. This is akin to 'the right to wash off the grime, in the boss' time': 1920's British Miners slogan (so-called 'pit-head time').
- How to manage the enthusiasts of Clinical Supervision, who may be innocent of the prevailing evidence and socio/political drivers, and the detractors of CS who may be fully informed.
- How *not* to perceive Clinical Supervision as an additional burden on costs, but as a vanishingly small cap on the level of direct service provision. This akin to the universal acceptance of (say) the need for a clinical handover between staff shifts on hospital wards, often away from direct patient contact.
- How to resolve the likelihood that revenue costs may accrue when Clinical Supervision is *not* an integrated part of contemporary professional practice and may not accrue when it is.
- How to establish a conduit that allows for the content of CS sessions (as agreed by participants as appropriate) to transfer to those who hold responsibility for the local governance agendas, assuming that such individuals are not *the issue* and that an organisational whistle-blowing policy is in place and is trusted by staff.
- How to develop CS implementation strategies which acknowledge that any demonstrable success may be a function of, and directly proportional to, the size of

the enterprise. Initial niche CS developments, linked across an organisation, may be more likely to succeed than those attempted simultaneously across a broad front.

- How to frame a convincing argument for Clinical Supervision to be an explicit National Competency Standard for professional practice, with the implied corollary that the absence of engagement with demonstrably efficacious CS may be tantamount to negligent practice.
- Finally, to consider whether the implementation of Clinical Supervision policies in human service agencies, should assume that helping professionals adopt new practices because they see the light, or because they feel the heat?

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