Day One Program

Wednesday 23rd May 2018

Acknowledgment of Country
Lisa Fitzpatrick Victorian branch (ANMF)

Keynote Speaker  Paul Bailey
Honoring our Talent for Seeing Blind Spots

Kate Thwaites | Randolfo Obregon
Looking after the Mental Health Nursing Workforce: A Collaborative Approach to Producing Victoria’s Clinical Supervision Framework – Our Story so Far…

Jo Cole | Alison Lancaster
Implementing a Clinical Supervision Guideline for Allied Health Professionals in a Public Health Setting

Natalie Jack
Supervision Online: Reflections on a Web Based Supervision Practice

Valda Dorries
Bringing the Body into Reflective Supervision: Essential for Trauma Informed Care and Practice

Kerry Mawson
Clinical Supervision: People, Passion and Purpose – My Lived Experience

Margaret Thomas | Sophie Isobel
Facilitated Reflective Practice Groups for Nurses: A Potential Bridge Across Barriers to Clinical Supervision

Keynote Speaker  Elisabeth Shaw
Mentoring VS Monitoring – An Argument for Integration
Matt Rankine
How Critical are We? Revitalising Critical Reflection in Supervision

Paul Kelman | Cathy Boyle
Looking Back – Moving Forward

Carolyn Cousins
The Third Contract: Issues of Employer Expectations and Confidentiality in Funded External Supervision

Bradley Roser
Engaging Team Supervision to Foster Dialogue and Healing After a Traumatic Event

Kate Thwaites
Reflections and Kindness

Deborah Burke
Finishing Well: Stories of Parallel Process in Clinical Supervision

Sonia Hoffman
Using Narrative Practices in Supervision: Some Stories and Reflections on what These Practices Make Possible

Shirley Hamilton
Mandatory Clinical Supervision for Nurses – Fantasy or Reality?

Jennifer Fenwick | Bev Love
Unscrambling what’s in Your Head: A Mixed Method Evaluation of Clinical Supervision for Midwives

Kobie Hatch
Quality or Quantity? The Challenges of Supporting Access to Nursing Clinical Supervision Within a Large Metropolitan Mental Health Service in Queensland Australia

Fiona Howard
Being Valued, and Connected: How Psychologists Maintain their Resilience in Adversity

Joy Forster | Julie Sharrock
Témoin à Deux: An Experience of Paired Reciprocal Peer Clinical Supervision
Please note:
For a variety of reasons, not all speakers and presenters wished to share their papers in the ACSA Conference 2018 Book of Proceedings, while some provided both a PowerPoint presentation and a paper. We hope you enjoy the format.

Acknowledgment
ACSA formally thanks all speakers, presenters and delegates for making our inaugural Conference 2018 the success it was. Let’s Meet in Melbourne again!
Honing our Talent for Seeing Blind Spots

Paul Bailey

Private Practice, Bardon Counselling Centre, 151 Boundary Road, Bardon, Brisbane, 4065, QLD

Abstract

If clinical supervisors really do have ‘powers of observation heightened beyond the normal’, what is it that we look for or see?

Certainly, we do look for the blind spots in those we supervise so that these can be brought into the light for the benefit of others. And we also hone our talent for ‘seeing’, ‘hearing’ and ‘feeling with’ the client/patient/consumer, who is not in the room, in order that the supervisee might work more effectively with her.

What do we see, though, when we shine these same observational powers on ourselves and on the emerging profession of clinical supervision in this country?

In this talk I’ll explore this theme, aware, though, that shining a light on blind spots brings us so close to shaming and being shamed and that we live in a wider culture in which there is such a close link between shining and shaming. Yet, I believe we must, for doing so allows our particular talent to shine and frees our work from the ordinary.

Invocation

I invoke the dreaming of this ancient land, the life of stones and streams, the in and out of the sea, the way trees sway and flowers burst with colour and the way rain excites the soil.

I honour the Wurundjeri people, who have woven their Songlines into the very fabric of this country for thousands of years.

In their language, the Woiwurrung language, this land is Birrarung.

Wurun is what we call the Manna Gum, a eucalyptus which grows easily in the Birrarung. And djeri is a witchetty grub found in this tree.

In a Welcome to country ceremony, visitors pass through the smoke of a fire smothered in young Manna Gum leaves. These represent cleansing and respect for Wurundjeri people.

I acknowledge the Wurundjeri people as the Traditional Custodians of the Birrarung. I honour their elders, past, present and emerging.
Honing our Talent for Seeing Blind Spots
Paul Bailey
Private Practice, Bardon Counselling Centre, 151 Boundary Road, Bardon, Brisbane, 4065, QLD.

My introduction to the conference theme

What a rare experience this is to be in a room full of so many people involved in this field of clinical supervision and, in particular, with so many elders of this emerging profession. Thank you for inviting me here to discuss themes that are close to my heart; themes that I’ve been working with for the past forty years.

I look forward to the opportunity to hear from you, Wanda and Cathy, as you give voice to how you see clinical supervision from your vantage points. And Matthew, I wonder what you have gleaned for us from recent research on our collective endeavor. And great to have you here, Elisabeth, offering your particular perspective on clinical supervision in this country. And I look forward to hearing what others of you in the room will share with us, both formally and informally, of discoveries you, too, are making.

I want to dedicate this talk to my colleague and friend, Neville Vines. He was a gifted clinical supervisor, who died recently at the age of 82. He worked up until a few months before he died and he and I often explored the themes that I want to share with you today. How brief and fleeting a life is!

How rapidly, too, we enter these early decades of the 21st century. New technologies arise daily. Digital communication abounds. Globalisation rules. These accelerating processes are having a huge impact on the ways we each live and work; on what home means and how we relate to each other. Our thinking speeds up. How strenuously our collective politics, economics and ethics struggle to stay in touch with the impacts of such fast thinking.

In this rush to keep up, we can so easily lose sight of ourselves and of what is important and of what we value. I see clinical supervision and practices like clinical supervision being and becoming crucial counter-points to the rise of fast thinking; safe vantage-points from which to step out of the pace in order to slowly and deeply reflect on what is happening. A space where we might pause to consider what effective practice means and as a way to move from mere knowledge to embodied wisdom.

As I understand it, the purpose of a keynote address is to attune us each to the underlying message of the gathering. So, I have been reflecting deeply on what the ancestors of clinical supervision might want to say to you through me. With them and you in mind, I want to weave together three themes:

- firstly, I want to describe what I believe the particular talent is that is at the core of our collective endeavor and to ask why is it so hard to do this well?
- to attempt to answer this, I will draw on and draw out some of the paradoxes inherent in the practice of clinical supervision.
- and, then, I want to finish by shining a light on some of the blind spots that have developed as the practice of clinical supervision has been emerging in this country and how we, as individuals and collectively, are addressing these.

Talent

I believe that we all arrive into the world with a talent.

I believe that our talent is a gift we did not earn.
It was given to us.
It is innate, inborn, natural.
It lives in our neurophysiology and in our implicit memory.
It is through our talent that we shine.
And it is through our talent that we allow others to shine.
As Picasso is purported to have said: ‘*The meaning of life is to find our gift. The purpose of life is to give it away*’ (1). Between the finding of our gift and the giving of it away, that’s where the hard work happens. For it isn’t the talent alone that makes a person shine, it is the effort that attends the work that frees it from the ordinary.

I believe that the work of clinical supervision rests on a particular talent: effective clinical supervisors have powers ‘of observation heightened beyond the ordinary’ (2). And, more specifically, I believe that such people have a talent for being aware of and working with blind spots, of being able to hold skillfully the tension between shining and shaming.

What do I mean by blind spots? You probably are aware of the Johari window. In 1955, Joseph Luft and Harrington Ingham (3) devised this simple image of a rectangle divided into four quadrants based on what we know and don’t know about ourselves. The top left quadrant they called the Known, what I know about myself and what others also know about me. The bottom left is the Private or the Personal, what I know about myself and what others also know about me. The bottom right, the Unknown, includes what I don’t know about myself and what others don’t know about me. And, the top right is the blind spot, that which I don’t know about myself yet other people do. This is where clinical supervision primarily lives.

Siri Hustvedt, the writer, said: ‘*It is a particular truth that I see far less of myself than other people do… instead of actually seeing ourselves, we walk around with an idea about ourselves*’ (4).

Our work, whether we are the one seeking clinical supervision or the one facilitating the process, is to discover blind spots in the work and to risk doing so for the benefit of others. The clinical supervisor assists us to see what we don’t yet see in how we work. She does this patiently, respectfully, skillfully, so that we can gradually transform our blind spots and our unknowns into the ‘a-ha’s’. These are the hallmark of clinical supervision. For the ‘a-ha’ is when the light inside goes on and we begin to see what we weren’t able to see or what we didn’t want to see.

Jonathan Swift said that ‘vision is the art of seeing things invisible’ (5). A competent clinical supervisor has also developed the capacity to see who is not in the room – the person who is the patient, the client, the consumer. Seeing them, she is aware that they are, inevitably, the beneficiaries of the aha.

And, of course, she does much more than seeing. She listens, too. As the character in one of Ben Okri’s recent novels said: ‘*It’s easier to be clever than to listen*’ (6).

It is so difficult to still the ego to allow the other to be fully present.

As clinical supervisors, we are imbued with and endeavor to practice within the 80/20 rule, in which 80% of the time our job is to listen, with what Carl Rogers describes as ‘*this kind of sensitive, active listening (which) is exceedingly rare in our lives. We think we listen but very rarely do we listen with real understanding, true empathy. Yet listening, of this very special kind, is one of the most potent forces of change that I know*’ (7).

And, more than listening only to the content of the words, she does what Chaim Potok said about listening to the silence between the words:

> We can listen to silence.
> We can listen to silence and learn from it.
> It has a quality and dimension all its own.
> It has a strange and beautiful texture.
> It doesn’t always talk. Sometimes – sometimes it cries and we can hear the pain of the world
in it. It hurts to listen to it then.
Yet we must, for being heard is so close to being loved' (8).

Paradox 1
We are likely drawn here together to this conference because we each have a natural talent for this work; powers of observation and of listening heightened beyond the ordinary. Yet why is it that only a relatively few really develop great mastery of their talent? Why is it so hard to find who the really talented clinical supervisors are in this country? Where do I find the talented clinical supervisors in an age that privileges information and knowledge over wisdom and compassion? And, in particular, why honing our talent is so challenging in our fast-paced dominant culture? Bruce Wampold, Barry Duncan, Scott Miller, Michael Lambert and so many others have considered this paradox.

Daniel Kahneman
The recent Nobel prize winner, who wrote 'Thinking, fast and slow' as well as 'Attention and effort', highlights this paradox at the heart of talent. He explains that we have two major brain systems for ways of thinking – system 1 is fast, intuitive, implicit, (automatic) and subconscious, whereas system 2 is slower, deliberative, explicit, (controlled) and is conscious.

The operations of system 2 are effortful and one of its main characteristics is laziness – a reluctance to invest more effort than is strictly necessary. He says: 'superficial or lazy thinking is a flaw in the reflective mind'.

He calls this the Lazy Controller. He says our thinking tends towards cognitive ease and quickly away from effort. The quickness of system 1 makes it easy to generate quick answers to difficult questions, without imposing much hard work on our lazy system 2. The laziness of system 2, he says, is an important fact of life. ‘It makes it easy to talk about reflecting without necessarily doing much reflecting’ (9).

If what Daniel Kahneman says is so, and I think it is so, how likely it is that we, too, easily defer to cognitive ease and fool ourselves with the myriad ways we keep effortful system 2 thinking at bay. We may simply say to ourselves, we don’t have time. Or that we’ll reflect on this later and later never arrives. And, in so doing, how those we work with at the frontline, miss out on a higher quality service simply because of our collective tendency towards cognitive ease.

Daniel Goleman
In his book 'Focus: the hidden driver of excellence', debunks the myth of the 10,000 hour rule. He writes that ‘hours and hours of practice are necessary for great achievement, but not sufficient. There are two factors, he says, that make a difference in any field between who is O.K. and who is great: firstly, how we pay attention makes a crucial difference, what he calls ‘deliberate practice’; secondly, we require feedback from someone with an expert eye’ (10).

So, getting regular feedback matters and so too does the deliberate practicing of what we learned from the feedback. At least at first. But, as we master how to execute the new learning, practice makes it more and more effortless.

He says: ‘After about 50 hours of training – whether in skiing or driving (or clinical supervision) – people get to that ‘good-enough’ stage, where they can go through the
motions more or less effortlessly. They no longer feel the need for concentrated practice but are content to coast on what they've learned. No matter how much they practice in this mode (system 1), their improvement will be negligible'.

At that point, we don't need to think about it – we can act well enough on automatic. And this is where the O.K. and the brilliant diverge. If we do too much on automatic, we cease to improve.

Jeffrey Kottler says: ‘It may very well be that it isn’t what superlative (practitioners) do that is as important as all the reflective time and energy they spend between (tasks) thinking creatively about their cases’ (11).

It may be that those who have been clinical supervisors longer need even more reflective time than those new who carry the greater humility of the beginner’s mind. The risk of elders falling into cognitive ease is a reality and, in my view, one of the great challenges facing this Association. How do we each, as colleagues, collectively assist each other to stay engaged in honing our talent for the benefit of others?

**Paradox 2: The creative tension between shining and shaming**

This particular theme of developing talent collectively, of honing our capacity to see blind spots, of navigating our way through shining and shaming, seems to me the most pressing theme that I can offer. For I believe our contemporary civilisation is facing a crisis of empathy. I believe that, as a species, we are persisting in blindly overheating the vulnerable planet upon which we live. That, as a civilisation, we increasingly live with the fear of chilling terror, in which Donald Trump's childish tantrums are seen by many as leadership and in which Pauline Hanson's racist views are popularised. Our world needs, as much as ever, the refined talent that lives here in this room. Good people who understand the value of respect, who can skillfully develop their talent for holding and challenging the nuances of human complexity for the benefit of others.

We each choose a clinical supervisor to assist to develop our talent in the work we do. Yet, we soon become aware that by allowing a clinical supervisor to shine a light on our own blind spots, our areas of vulnerability and of our not knowing, in the very doing of this, we come so close to shaming ourselves or being shamed. It requires skill and a particular sort of person to do this well when we live in a wider culture in which there is such a close link between shining and shaming. It requires a person who is willing to hone her talent in order to allow others to shine. The opposite is properly called narcissism. Narcissists feel their gifts come from themselves and they work simply to display themselves not for the benefit of others. An age in which few do so for others is an age of narcissism’ (12).

If our collective work is to shine and we are to avoid narcissistic cul-de-sacs, how crucial it is, therefore, for us, individually and collectively, to be willing to be open to be guided towards seeing our own blind spots. Such ‘feedback is and always has been at the centre of clinical supervision’ (13). And it is for this reason that the alliance needs to be safe and trusting and confidential and why practitioners need to choose who is to be their clinical supervisor.

**A little about me**

I want you to know that I am not someone who seeks out opportunities such as this. Rather, my lifetime’s work is and has been more one-to-one and in small groups. I am at home in the less public space; in the more intense intimacy of psychotherapeutic and supervisory relationships. I step out of my comfort zone, though, because these themes have emerged out of my own hard-won experience and because Deb asked me to share with you.
I found my love for psychotherapy and for clinical supervision early. Whilst attending a psychotherapy workshop in the early 1970s, I was blown away by the talent of the psychotherapist; how he held the group and, in particular, how he worked with one woman in the group; and how, while they worked together, time seemed to stop, ordinary time and something timeless happened. At that moment, I knew I wanted to be a psychotherapist. Despite my many self-doubts, I have pursued this call ever since. My stubborn aspiration to do the work really well was coupled with a deep sense of shame, of mistrust in my own capacity to ever do so. This led me to clinical supervision. I realised that shame derives its power from being unspeakable. And, somehow, I began to trust that shame is always easier to handle if we have someone to share it with; that shame cannot exist where a good listener is. I deliberately sought out people to guide me in my clumsy stumbling. This paradox drove my work and still does.

Such longing to do well in the work led me out of Aotearoa New Zealand, my homeland, to London. There, in the late 1970s/early 1980s, I was more fully introduced to the art and craft of clinical supervision. I worked with remarkable people, who were, dare I say, wise and compassionate. And ‘since the power of example speaks more forcefully than any other communication’, they showed me what is possible to accomplish and how. I understood that when clinical supervision is practiced well it has the power to quieten and humble us and to allow our work with others to shine. I have worked intently as a psychotherapist and as a clinical supervisor for over 25,000 sessions over these past forty years.

I think, though, that the main reason I’ve been invited to speak to you today arises from what I learned about clinical supervision in this country during my five years within Queensland Health. So, in this last part of my presentation, I will tell you now of this experience for I believe that this is more than my own story: I think that what I witnessed was more typical than it was exceptional.

My Queensland Health experience

In September 2009, I was invited by Queensland Health to assist in educating its mental health staff into clinical supervision. I agreed and, in so doing, I became part of an already existing network of senior colleagues from around the state (some of whom are here in this room today) who had, for years, been embedding generic clinical supervision in the organisation.

I began work at the very moment that Queensland Health was launching a document entitled ‘Clinical Supervision Guidelines for Mental Health Services’. What a great document! Surely a set of guidelines that would allow clinical supervision to shine as a beacon within the public sector. I was both pleased and proud to be associated with the aspirations articulated in this vision. It was a document that acknowledged clinical supervision as generic, as having a common-factors foundation and it acknowledged that all front-line disciplines would benefit from having access to this invaluable opportunity for ‘thinking slow’ in a fast-paced workplace. And, most powerfully, it acknowledged that: ‘staff are more likely to participate actively in, and benefit from, clinical supervision if they choose their supervisor’ (14).

I was, though, more than a little disappointed that it was only called a Guideline and was not ratified as Policy. For, right from the start, I saw that a Guideline is only a guideline – it has no teeth. Whereas a policy does have teeth, attracts more money and there would be consequences if a policy was not enacted.

Within a very short time, I became acutely aware of the cluster of ethical dilemmas that I had landed myself in. And this is what makes my story more typical than exceptional.
I was perturbed to discover that:

- many of those offering clinical supervision were not being supervised.
- those supervising other clinical supervisors had not been educated into this complex role and, in the main, were winging it.
- many supervisees had little or no idea how to make use of clinical supervision and had no say in choosing who their clinical supervisor was.
- the organisation often, blurred the gate-keeping role of professional supervision with clinical supervision’s critical reflection.
- there was no formal assessment of who were the safe and competent clinical supervisors.
- there was no transparent accreditation process for clinical supervisors.
- and, as I was soon to discover, there was no national body holding the governance responsibility for this emerging profession of generic clinical supervisors. Instead, there was a proliferation of other professional bodies, the Psychologists Board, The College of Mental Health nurses, the Royal College of Psychiatrists, the Psychotherapy and Counselling Federation of Australia, and many others claiming to govern clinical supervision. Yet, they were each only spelling out the protocol for their own members’ accountability not for the profession of clinical supervision itself. There was no national body responsible for holding the national governance of clinical supervision.

I quickly realised from my wider reading on these matters that this ethical blind spot was not Queensland Health’s alone. In fact, it seems that Queensland Health was at least addressing the embedding of clinical supervision better than most. Internationally, the history of this profession is and has not been exemplary about this matter. Janine Bernard and Rodney Goodyear, in their book ‘Fundamentals of Clinical Supervision’, referenced Ludmila Hoffman’s research in which she may have been the first to point out the traditional lack of clinical supervision training as the mental health profession’s ‘dirty little secret’ (15).

I reflected deeply, in my own clinical supervision, on these ethical enigmas. I did so knowing, as we all know so well, the gift of seeing can be a profound burden: for once we see blind spots, we cannot un-see them. And once we see, we must act in some way on what we see. There is a Japanese saying: ‘Vision without action is a daydream. Action without vision is a nightmare’ (16).

So, I want to turn now to acknowledge and to celebrate some of the actions that we undertook together to begin to address these ethical concerns.

I want to say that we did so not alone. We felt, in the small of our backs, the collective hand of the ancestors of clinical supervision supporting us: Sigmund Freud, Max Eitingon, Brigid Proctor, Michael Carroll, Carol Falender and Edward Shafranske, Janine Bernard and Rodney Goodyear, Peter Hawkins and Robin Shohet and all the other women and men, including Matthew Bambling, who stayed up late at night, burning the midnight oil, devising the foundational theory, undertaking the research and creating the practice that is now our work.

**Blind spot 1: the lack of adequate education for clinical supervisors**

I believe that if we ensure that the elders of clinical supervision are well cared for, educated thoroughly and are part of a supervising supervisors’ network, this would have a powerful
benign parallel process impact on the organisation.

So, our focus, primarily though not only, was on working with the elders. We looked for senior clinical supervisors, who were not only very experienced but who were also open and honest and curious enough to risk shame in order for their work to shine; who were willing, as Socrates said, to let ‘wisdom begin in wonder’ (17).

Queensland Health invited selected staff to a series of these pioneering two-day workshops. We kept these workshops deliberately small, each made up of no more than nine participants, three groups of three or, even better, two groups of three. Not only did we do live supervision of supervision with each other, we also videoed each one-hour session. As Daniel Goleman says: ‘we require feedback from someone with an expert eye. If we practice without such feedback, we aren’t as effective as we could be. So, getting regular feedback matters and so too does the deliberate practicing of what we learned from the feedback’ (18).

To achieve this, we used Interpersonal Process Recall (19), a technique that was first developed by Norman Kagan and his colleagues in 1960. Using this method with a video camera is a particularly effective way to access system 2 thinking. There are two things that a video camera does not do that we humans tend to do much of the time. The video camera does not evaluate and it does not interpret. It simply records and then plays us back to ourselves. It becomes the expert eye that Daniel Goleman indicated is necessary for honing our talent. So, video recording our clinical supervision sessions and watching them alone or with our own supervising supervisor using Interpersonal Process Recall is a powerful way of honing our talent. It takes courage to look. It takes time to see.

Peter Hawkins and Robin Shohet, who were my colleagues in London, were staunch advocates of this method. They write of Interpersonal Process Recall that it ‘is based on the idea that at any moment in time we are receiving and experiencing hundreds of feelings, thoughts, sensations, images and bodily reactions, of which we are not normally aware and which we do not have time to process in the moment but which subtly behave, react and interact. If we can find a safe way to bring this into conscious awareness, name it and examine it in a spirit of non-judgmental inquiry, then it can provide us with useful information about our own interactions, our mode of behaving in certain situations, the way we perceive others and the way they may perceive us’ (20).

Through live sessions and, then, watching the videos, we found ways to encourage each other to be curious rather than clever. We did so aware that we cannot really begin to see and work well with the blind spots in others unless we are willing to explore those hidden within ourselves. The use of video recording is both liberating and humbling. As Antonio Machado, the Spanish poet wrote:

"El ojo que ves no es
Un ojo porque lo ves.
Es ojo porque te ve".

"The eye you see is not
An eye because you see it.
It is eye because it sees you" (21).

Through senior clinical supervisors being humble enough and curious enough to meet together regularly to watch videos of one another’s work, using Interpersonal Process Recall, and to deliberately practice what is learnt from such feedback, how extraordinary this would be for the growth of this collective talent!
Blind spot 2 – the lack of a generic assessment tool

In clinical supervision, as in any field of human talent, ‘what we see depends mainly on what we look for’ (22).

So, what are we looking for?

What were the specific competencies, the capabilities and the capacities that Queensland Health wanted its clinical supervision staff to have? For, if I was designing and facilitating these ‘common-factors’ workshops for staff from the range of mental health disciplines, I needed to know this and how these skills were to be assessed. I asked around and no one seemed to know where this information might be. So, I went looking in the Queensland Health archives for the generic assessment tool that was the basis for the clinical supervision program. I did not find one. I soon learned that there was no such thing. Some disciplines had created assessment tools, however these were discipline specific. I searched the national and, then, the international literature for a common-factors assessment template and still I could not find one.

And, even more alarming, I was also told by the organisational-powers-that-be that they had no funding nor apparent willingness to do what was required to assess clinical supervisors. As I was told, ‘if you assess a senior consultant, who has been clinically supervising others for decades, as not being a safe nor competent clinical supervisor, where does this leave the organisation?’

So, despite my aversion to the smell of burning martyr, I devoted time and effort to designing such a tool. I began by asking what is the talent I look for in a clinical supervisor. How do we even begin to operationalise the characteristics of self-awareness, courage and respect needed to do this work well?

Having come up with a draft design, I invited input and feedback from a few trusted colleagues: Annalise O’Donovan and Matthew Bambling, who were both already very active in national and international research and education in clinical supervision. And I asked Valda Dorries, who is here today and with whom I was working on the clinical supervision project. We later also sought input from Carol Falender in Los Angeles. Carol has been central to the development of clinical supervision in the United States. With their encouragement, I and others, including Tania Yegdich, further refined the tool. Then, we waited and waited for someone to arrive who would be willing to do the enormous work of further refining the tool, testing it and offering it for use to the clinical supervision world. In the end, Sarah Hamilton, who also worked closely with me in Queensland Health and who is here today, took on this task and is now moving toward completing the assessment of the assessment tool. After so many years of addressing this particular blind spot, I look forward to the publication of Sarah’s findings. If we know what we are looking for, in ourselves and in others, we are so much more likely to see whether it is present or not and we will begin to see more clearly where we might need to focus our attention and effort for the benefit of others.

Blind spot 3 – the lack of a national association

Here is the final story: while having a beer at the Mount Isa pub with a colleague at the end of a clinical supervision workshop, that we had been facilitating together, Tom asked me a simple question. He asked: ‘if you had a wish list of what you would like for the clinical supervision project in Queensland Health, what would it be?’ I said, ‘we urgently need a strong national multidisciplinary network to govern this emerging profession: to guide educators; to assess and to accredit and welcome in new clinical supervisors; to foster research and to offer regular conferences. Without this, each discipline, each organisation,
each team is left to ‘re-invent the wheel themselves’ at such unnecessary cost of time and energy and confusion’.

Tom simply said: ‘Let’s do it’.

Michelangelo once said: ‘The greatest danger lies not in setting our aim too high and falling short, but in setting our aim too low and achieving our mark’ (23).

Tom, to his credit, immediately began gathering together a group of senior practitioners, from around the various States and Territories. We met in South Bank, Brisbane in July 2011. Many flew in. Others connected by phone or video. This group was particularly perturbed by Health Workforce Australia’s attempts to re-define clinical supervision in ways that were contrary to internationally accepted understandings. That, if no immediate action was taken, then, by default, the field of clinical supervision was likely to be further confused and divided. Together, the group agreed that the time was right; that there was enough momentum to begin to create a coherent and unified voice for clinical supervision in this country.

Thanks primarily to the work of Tania Yegdich, the Australian Clinical Supervision Association was incorporated on 4 July 2014 and a website was formed. I, also, acknowledge and honour Deb Burke, Tom Ryan, Paul Spurr and the rest of the Association’s management committee who are now hosting this inaugural conference. Thank you, on behalf of us all, for your years of behind-the-scenes work to make the Association a reality and to make this conference happen.

What makes clinical supervision as a profession and the Association as a political collective so dangerous to the status quo is that the blind spots are usually not ours alone. They tend, also, to be systemic. And when we see how these once-were-blind spots and how they impact on clients/patients/consumers, we feel called to change the wider system. And this requires moral courage as much as it requires clear awareness. For shining a light on systemic blind spots can so easily lead to shaming and to silencing. We live in a fast-moving society that does not honour disciplines that think slow. It suits a dominant culture that thinks fast, to keep clinical supervision in the blind spot, well out of the line of vision of the dominant culture.

Yet, for those of us who value thinking slow and the benefits that accrue to thinking so, then we need to pay the price. For thinking slow does have a price. It is a labour. Clearly, clinical supervision done well costs. It suits a dominant culture that thinks fast to keep clinical supervision impoverished on the periphery. Sadly, I witness many organisations, deliberately or unintentionally, blur the ethical boundaries of what clinical supervision is. Maybe they do so to save money. They might deprive practitioners from making an informed choice as to whom they want as their clinical supervisors. Such lack of choice is most obvious in organisations in which group clinical supervision is deemed the most cost-effective solution. Yet, to do clinical supervision on the cheap is unwise. I believe that it is better to have no clinical supervision than poor quality clinical supervision.

This Association has a responsibility to reflect deeply on who will pay the cost for clinical supervision to be done well rather than as lip service. For me, this means that we together find ways to ensure that everyone offering clinical supervision:

- is appropriately educated for this complex task.
- is assessed as being safe, competent and effective, using an agreed upon generic assessment tool.
is accredited for this complex task by an appropriate accrediting body.

- is aware of how important it is for people to choose who will clinically supervise them.

- has regular supervision of how they are supervising others.

- belongs to a clinical supervision association.

- keeps their practice alive and relevant through being an active member of a local clinical supervisors’ network.

There is a final paradox that I want to add as a way of finishing. And this paradox is to do with happiness.

Paradox 3

Mihalyi Csikszentmihalyi devoted much of his life to the study of what he called flow. He concluded that being accomplished at whatever we want to do is among the deepest sources of fulfilment we will ever know in our fleeting lives.

‘Contrary to what we usually believe, moments of flow, these best moments in our lives, are not often the passive, receptive, relaxing times – the best moments usually occur when our body and mind are stretched to the limits in a voluntary effort to accomplish something difficult and worthwhile’ (24).

Think of a child. She might be placing, with trembling fingers, the last block on a tower she has built, higher than any she has built so far. What joy!

Optimal experience is, thus, something that we make happen. We work at it.

So, it seems, that paradoxically and, fortunately for the profession, our efforts to improve our work through deliberate practice and feedback lead to much joy.

Mihalyi found that some people enter the state of flow more easily than others. Such people generally have ‘curiosity and interest in life, persistence and low self-centredness, which results in the ability to be motivated by intrinsic reward’ (25).

Conclusion

So, maybe in the end, this is why we do our work: as all people of talent do, because we are most alive when we give back the talent that we have laboured so hard over back to the world. I want a clinical supervisor who has honed her talent and freed it from the ordinary for the benefit of others; who is willing to reassure me that I can ‘forget my perfect offering; that there is a crack in everything; that’s how the light gets in’ (26). And I want a clinical supervisor who finds joy in her work. Thank you.
References

1. Picasso, P. www.goodreads.com/picasso
7. Rogers, C. www.goodreads.com/carlrogers
17. Socrates www.goodreads.com/socrates
18. Goleman, D. ibid.
25. Csikszentmihalyi, M. ibid.
Clinical Supervision Framework for Victorian Mental Health Nurses

ACSA conference Melbourne 2018
Kate Thwaites & Randolfo Obregon
Welcome to Melbourne
Looking after the Mental Health Nursing Workforce: A Collaborative Approach to Producing Victoria’s Clinical Supervision Framework – Our Story so Far…
People

Over 4000 mental health nurses
In rural & metro
Prevention and Recovery Care, Secure Extended Care, Inpatient, Community, residential, forensic
Child & Youth, Adult, Aged

Academic, management, research, member organisations
The Office of the Chief Mental Health Nurse – who we are

Anna Love
CMHN

Kate Thwaites
Mental Health Nurse Advisor

Randolfo Obregon
Senior Project Officer

Nicole Edwards
MHN Adviser

Reanna Clarke
Project Officer

Julie Anderson
Senior Consumer Advisor

Frances Sanders
Senior Carer Advisor

Doreen Wibawa
Project Officer

Safewards Implementation Team

Helen Lowy
Medicine Quality and Safety

Steve Penne
Case Load Management Project Manager

Anna Love
Chief Mental Health Nurse
Passion

• Chief mental health nurse
• Senior Nurse Group across all mental health services
• Member organisations
Purpose

1. Common understanding across Victoria
2. Support nurses to negotiate with employers
3. Policy drivers
   - Occupational violence
   - Quality and safety
   - Workforce retention
Approach

Expert reference group
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?
Literature Review – Results

Domains

1. Supervisee
2. Supervisor
3. Organisation
Expert reference group recommendations

- Apply literature review to mental health nurse practice
- Identify universal and Victorian specific elements
- Provide a frame with modes and models of clinical supervision
- Practical
The framework – content

Part 1: Introduction to clinical supervision and Why a framework for mental health nurses?

Part 2: Clinical supervision for mental health nurses in Victoria

Part 3: Implementation and sustainability
The framework – Victorian mental health service context

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

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

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

- **Location**
  - Metro/Regional/Rural

- **Clinical speciality**
  - Child and youth/Adult/Forensic

- **Roles**
  - Clinical Educator/Manager
  - Academic/Research

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

- **Professional**
  - Qualification
  - Registration standards
  - National Mental Health Standards
  - Industrial Agreement
  - Continuous professional development
The framework – Organisational context

Figure 1: A model of clinical governance and professional development
Source: Adapted from Queensland Health 2009, Clinical Supervision Guidelines for Mental Health Services

- Administration, line management, supervision
- Clinical review, team meetings, handovers, grand rounds
- Clinical governance, professional development
- Performance appraisal, development plans
- Clinical education and training
- Mentoring
The framework – Principles

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

Principle 1: Clinical supervision focuses on strengths and is a positive nurturing experience.

Principle 2: Clinical supervision is accessible and inclusive; it is available to nurses in all areas of practice and expertise and is culturally appropriate.

Principle 3: Clinical supervision supports professional development and promotes quality improvement in clinical care and professional practice.

Principle 4: Clinical supervision enhances the health and wellbeing of employees by providing a regular, continuous development platform for nurses to explore and reflect on their practice in a safe space and identifies future learning opportunities.

Principle 5: Clinical supervision optimises consumer-centred practice and improves the focus on consumer rights and recovery-oriented nursing practices.
The framework – Modes and models

Modes of clinical supervision
• Individual supervision
• Group supervision
• Peer supervision

Models of clinical supervision
• Growth and support model (Faugier)
• Integrative approach (Hawkins & Shohet)
• The three-function interactive framework of supervision (Proctor)
• The role development model (Consedine)
Invited personal testimony 8

The core of clinical supervision – the supervisor

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

*Katherine Farest – Mental Health Training and Development Unit, Melbourne Health*
• Clinical supervision implementation
• Steps to building a clinical supervision implementation plan
• Key roles and responsibilities of the supervisor, the supervisee and the organisation
• The way forward
### Implementation – Partners in action

<table>
<thead>
<tr>
<th>Role</th>
<th>Chief Mental Health Nurse</th>
<th>Centre for Psychiatric Nursing</th>
<th>Organisation Senior Mental Health Nurses</th>
<th>Member organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Resources</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Entitlements</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Recruitment</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Retention</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>
Implementation and sustainability

Victoria’s SUPERvision
A conversation about making it a reality
Thank you
IMPLEMENTING A CLINICAL SUPERVISION GUIDELINE FOR ALLIED HEALTH PROFESSIONALS IN A PUBLIC HEALTH SETTING

Jo Cole and Alison Lancaster, ACT Health
I wish to acknowledge the traditional custodians of the land we are meeting on, the Wurundjeri people of the Kulin nation.

I wish to acknowledge and respect their continuing culture and connections to the land. I would also like to acknowledge and welcome other Aboriginal and Torres Strait Islander peoples who may be attending today’s event.
CANBERRA

• Population 2018 - @448,000
• 71.4% of residents born in Australia, slightly higher than the national average of 70.3%
• English (3.7%), Chinese (1.8%).
• 6508 Aboriginal and Torres Strait Islander people identified in the 2016 census (1.64%)
ACT Health context

- Two public hospitals
- 4 community health centres
- 2 walk-in centres
- Approximately 1200 Allied Health staff
- Includes Mental Health, Justice Health, Alcohol and Drug Services
- Tertiary referral for Southern NSW (pop @200,000)
Chief Allied Health Office

- Clinical Education
- Governance including regulation and scope of practice— including credentialing, clinical supervision
- Inter-professional learning and collaboration
- Policy development
- Professional development
- Recruitment and retention
- Research
- Workforce planning
- Workforce reform and innovation
Allied Health

Nutrition
Occupational Therapy
Physiotherapy
Psychology
Social Work
Speech Pathology
Allied Health Assistants
Aboriginal Liaison Officers
Art Therapy
Audiology
Biomedical Engineering
Cardiac Scientists

Clinical Neurophysiology Scientists
Counsellors
Dental Practitioners
Exercise Physiologists
Environmental Health Science
Genetic Counselling
Medical Laboratory Science
Medical Physicists
Nuclear Medicine
Orthoptists
Cardiac Perfusionists

Pharmacy
Podiatry
Prosthetics and Orthotics
Radiation Therapy
Radiography
Respiratory Science
Sleep Science
Sonography
Forensic Chemistry, Toxicology, Environmental Chemistry and Microbiology Analysis
Project History

- Literature review (ACT Health 2015)
  - Structured and standardised approach
  - Organisational and management support
  - Policies and guidelines
  - Sufficient time allocation
  - Education and training provided
  - Templates and evaluation tools to guide implementation
Project History

• Extensive consultation about existing practices and the draft Guideline from Project Officers
• Development of *Operational Guideline for ACT Health Allied Health Clinicians*
• Approval by CHHS Policy Committee
KEY OBJECTIVES

- Formal CS to be provided
- Formal CS training, resources and support
- Supervisors will be qualified, trained and supported
- CS will comply with CPD requirements
- CS and training will be monitored and evaluated
Learning from Phase 1

• 3 groups in terms of how they interact with CS (‘Tiers’)
• Inconsistent provision of CS for senior clinicians
• Barriers and enablers were consistent across three tiers
THREE TIERS

1. Technical and scientific
2. Therapeutic
3. Psychosocial
TIER ONE

Clinical measurement sciences, dental practitioners, medical imaging, orthoptics, pharmacy, radiation therapy

- Not usually required by registration board or professional association
- Students and new graduates well supported but more senior staff without access to CS
- Often not distinguished from line management
- Training for formal CS of staff is limited.
TIER TWO

Audiology, dietetics, exercise physiology, occupational therapy (except in Mental Health), physiotherapy, podiatry, prosthetics and orthotics and speech pathology.

- CS is managed hierarchically and is frequently combined with line management.
  CS occurs regularly and utilises individual, peer review and group models.
  Most disciplines use informal or formalised documents to capture CS.
  Senior clinicians may not have access to CS, unless working in large teams.
  Training for formal CS of staff is limited.
TIER THREE

Occupational therapy (in Mental Health), psychology, social work, genetic counselling, counsellors, art therapy.

- Usually required by registration board or professional association.
- Line management & CS are separated.
- Established positions for clinical supervisors.
- Policies, procedures and guidelines exist
- Templates are used to capture the supervision process.
- Some senior clinicians do not receive CS.
- Formal CS training is provided, although the frequency and number of places are limited.
Learning from Phase 1

Barriers
- Workload pressures
- Diversity in allied health a barrier to a consistent approach

Enablers
- Supportive workplace culture that values and prioritises CS
- Policy and structures to support CS
- Adequate training and resources
Phase 2 of the project

• Focus on getting the Operational Guideline endorsed by the organisation (April 2016).
• Begin implementation of the Guideline for each Tier
• Chose to engage Tier one first - identified as needing the most support.
• Modified version of a model implemented in CYW Health of a group supervision model.
Phase 2 of the project

• Development of a small group clinical supervision training program and resources for Tier one, and roll out of a trial of the model.

• Access to SA Health’s Women’s and Children’s Health Network Centre for Education and Training CS online courses for all Allied Health staff

• Individual, group and peer clinical supervision templates developed and made available
Feedback from participants: Barriers

- Level of knowledge and experience of CS
- Difficulty with consistent attendance
- Amount of time spent in the group too low (monthly 1 hour sessions over 6 months – total of 6 hours)
- Group members working in the same area
Feedback from participants: Benefits

• A good chance to discuss and debrief, provide support
• An opportunity for reflection
• Meeting other professionals at same level
• Finding out there are common themes across workplaces
• Talking with people from outside your profession makes it easier to discuss issues
• Good learning experience
• Well facilitated
Trial of Group CS
Reflections

- Reluctance and resistance
- Discussion of reactions and feelings related to work
- High need for structure
- Effect of distress
What now? Phase 3

- Education
- Face to face workshop to complement the e-learning
- Collect data about level of implementation
- Formal evaluation of quality of supervision
WHAT IS WORKING WELL?

• Ongoing group supervision for Tier one senior managers
• Creative implementation solutions
• Growing interest in interprofessional supervision
What else is needed?

• Education about reflective practice
• Genuine support from management for attendance at sessions
• Support for interprofessional group supervision
• More implementation support for Tier one?
• Discussion and questions
• Contact details:
  - Jo Cole
  Allied Health Clinical Education Unit
  Jo.Cole@act.gov.au
Implementing a Clinical Supervision Guideline for Allied Health Professionals in a Public Health Setting

Jo Cole and Alison Lancaster

ACT Health

Abstract

The aim of this paper is to share the learning from a project within ACT Health to develop a Clinical Supervision (CS) Guideline for allied health professionals (AHPs).

The Chief Allied Health Office (CAHO) in ACT Health has funded a project to support the development and implementation of a guideline to ensure best practice CS across 25 allied health professions.

In 3 Phases the project has consulted widely with AHPs about their current understanding of and uptake of CS; developed a guideline for all AHPs; and begun support of implementation of these guidelines across each profession, tailored to specific needs and limitations.

This paper describes the process of development of the guideline, the implementation so far of the guideline, including staff and supervisor education; resources developed; and the trial of an interprofessional group CS model for staff using experienced supervisors as volunteers to support new and inexperienced supervisees. It will also outline the current and future plans for evaluation, and the insight gained from implementation so far including the barriers and enablers identified by participants in CS.

ACT Health has been innovative in keeping all of the AHPs in scope, rather than excluding those traditionally not considered part of implementation of CS; as well as trialling an interprofessional model of CS not often used outside of mental health services. The project undertaken in the ACT is of interest to clinical supervisors, educators and policy makers within the public health setting, looking to learn more about how to promote and support the implementation of universal CS for AHPs.

Introduction

In 2014, ACT Health began scoping a project to support clinical supervision (CS) for allied health professionals (AHPs). The project was divided into two phases:

1. **Phase One** (2015): the creation of a policy and governance structure for allied health CS in consultation ACT AHPs and departments
2. **Phase Two** (2016): the implementation of the “Operational Guideline for ACT Health Allied Health clinicians”.
3. **Phase Three** (2017 onwards): Development of CS education and data collection about CS in ACT Health
Phase One: Policy and Governance Structure for Allied Health Clinical Supervision

During Phase One, the Chief Allied Health Office wrote:

*Clinical supervision is a critical component of a comprehensive quality and clinical governance framework and access to appropriate clinical supervision is now a requirement for all Canberra Hospital and Health Service Clinicians. The ultimate goal of clinical supervision is to ensure safety and quality in patient care, however there are additional benefits for clinicians and organisations. The Chief Allied Health Office has supported this initiative to lead the implementation of formal clinical supervision for ACT Health Allied Health Clinicians.*

(ACT Health, 2015b, p 4).

A review was undertaken of the literature along with the CS frameworks implemented in other jurisdictions in Australia. This review concluded, that despite the limited research evidence base, to improve the quality of CS in organisations there should be:

- A structured and standardised approach
- Organisational and management support
- Policies and guidelines
- Sufficient time allocated
- Education and training provided
- Templates and evaluation tools devised to guide implementation

Consultation occurred across 27 allied health professions to determine current supervision practices, barriers and enablers to participation in CS, as well as existing and anticipated training and resources needed for the implementation of formal CS. This consultation was also extended to external stakeholders (i.e. unions, Universities, AHPRA and profession boards/associations).

Information obtained during the literature and consultation informed the development of the “Operational Guideline for ACT Health Allied Health clinicians”. The Canberra Hospital and Health Services Policy Committee approved the Guideline at the April 2016 meeting, for a period of five years. This Operational Guideline covers:

- Professional board and association requirements;
- Minimum standards of the amount and type of CS each level of AHP should receive;
- A discussion of the distinction between the role of CS and line management;
- Roles and responsibilities of ACT Health, Profession Leads, Managers, Supervisors and Supervisees; and
- Evaluation, monitoring and implementation processes.

The document is publicly available at the ACT Health website (see Reference Section).

Phase Two: Implementation of the “Operational Guideline for ACT Health Allied Health Clinicians”

The “Operational Guideline for ACT Health Allied Health Clinicians” divided the professions into three different groups (i.e. Tier One, Tier Two and Tier Three) based on their historic level and type of engagement with CS (see Table 1).
This differentiation was useful for identifying that the implementation of the Guideline would require different support and planning for each Tier of professions:

1. Tier one: the priority was to engage senior clinicians in group CS, as staff from these professions had the least knowledge and experience with the model of CS outlined in the Guideline

2. Tier two: the priority was to support the professions to increase their adherence to best practice in CS, such as making it a formal process, having a written agreement and scheduling regular times

3. Tier three: the priorities were increasing the level of best practice CS and the provision of resources to support the development and regulation of external supervisory relationships in specialty areas (where practical).

### Table 1

<table>
<thead>
<tr>
<th>Tier</th>
<th>Included professions</th>
<th>Description of engagement in CS</th>
</tr>
</thead>
</table>
| One  | Cardiac scientists, clinical neurophysiology scientists, dental practitioners, nuclear medicine scientists, orthoptists, pharmacists, radiation therapists, radiographers, respiratory scientists, sleep scientists and sonographers. | • Not usually required by registration board or professional association  
• Students and new graduates well supported but more senior staff without access to CS  
• Often not distinguished from line management  
• Training for formal CS of staff is limited. |
| Two  | Audiologists, dietitians, exercise physiologists, occupational therapists, (except in mental health, justice health, and alcohol and drug services), physiotherapists, podiatrists, prosthetics and orthotics and speech pathologists. | • Sometimes required by registration board or professional association  
• Students and new graduates well supported but more senior staff without access to CS  
• Currently engaging in individual and group CS  
• Sometimes not distinguished from line management  
• Needing support and education to ensure best practice CS is being implemented. |
| Three| Occupational therapists (in mental health, justice health, and alcohol and drug services), psychologists, social workers, genetic counsellors, counsellors, art therapists. | • Usually required by registration board or professional association  
• Strong part of training and encouraged throughout continuing professional development  
• Access to training and education still limited  
• Limited evaluation to ensure best practice  
• High level of current engagement in CS within ACT Health |

### Tier One Group CS Trial

Historically Tier One professions have supported their students and entry-level clinicians well, but after this initial period, CS was not implemented in a systematic way. Given the limited CS experience amongst the Tier One professions, the focus was on engaging senior clinicians in group CS.
Supporting these clinicians through the provision of group CS time would give them the opportunity to receive dedicated CS. These senior clinicians could then use the knowledge gained from this experience to determine how to implement CS within their discipline or team.

The project then focused on the development of a facilitated small group CS training package through engagement of senior AH managers and clinicians from Tier one disciplines. It was agreed to implement a group supervision model, which had been used successfully within Child, Youth and Women’s Health for nurses and supported by AHPs. The group model focused on structured reflective practice amongst colleagues, facilitated by an experienced clinical supervisor and a co-facilitator.

The CS groups consisted of five to six senior clinicians from the Tier One professions (see Table 1). Each participant in the group was provided with written information and a one hour education session. Group facilitators were selected through an Expression of Interest process available to Tier Two and Tier Three clinicians who were experienced in supervision, and had an interest in learning more about group supervision. Co-facilitators for the groups were selected from the Tier One clinical educators to assist with growing the CS knowledge and experience within this Tier. All facilitators and co-facilitators were provided with a three hour training session, received ongoing support from the project coordinator, and attended Tier One CS facilitator network meetings during the group CS trial.

The Tier One Group CS Trial was scheduled to run for one hour per month, for six months starting in late 2016, with the final group finishing in June 2017. There were 31 participants. During the final session, group members were asked to complete a formal evaluation. This evaluation was based on a Supervision Feedback Form resource from the HETI Superguide (HETI, 2012); containing primarily open-ended questions about the group experience. Evaluations were received from 11 participants (response rate 35%). There were no evaluations received from two of the groups as their last sessions were cancelled.

Overall participants reported a mixed experience, with positive and negative elements of the experience identified. See Table 2 for a summary of responses from group participants.

### Table 2

<table>
<thead>
<tr>
<th>Benefits of the groups</th>
<th>Concerns/issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>• A good chance to discuss and debrief, and receive support</td>
<td>• Not enough time in the group and group not long enough</td>
</tr>
<tr>
<td>• Meeting other professionals at same level</td>
<td>• Inconsistent attendance</td>
</tr>
<tr>
<td>• Finding out there are common themes across workplaces</td>
<td>• Workmates in same group made it hard to discuss some issues</td>
</tr>
<tr>
<td>• Talking with people from outside your profession makes it easier to discuss issues</td>
<td>• Difficult to juggle clinical responsibilities to attend</td>
</tr>
<tr>
<td>within your profession</td>
<td>• Participants having a different understanding about the meaning of CS from the model presented</td>
</tr>
<tr>
<td>• Good learning experience</td>
<td>• Participants not understanding what the group was for or why they had been asked to participate</td>
</tr>
<tr>
<td>• Well facilitated</td>
<td></td>
</tr>
</tbody>
</table>
Increased Adherence to Best Practice in Clinical Supervision

To support staff to be able to implement best practice CS, resources available online were reviewed and adapted for use in ACT Health. The resources that were identified as being required were:

- **Individual supervision templates**: to assist with developing a CS agreement for individuals and keeping a record of each session.
- **Group supervision templates**: to assist with developing a CS agreement for a group, for collecting attendance and keeping a record of sessions.
- **Peer supervision templates**: to assist with developing a CS agreement for peers and guidance for how to make the most of a peer supervision arrangement.
- **External supervisor agreement**: internal legal advice was sought to protect ACT Health where supervisors who aren’t ACT Health staff are engaged to provide CS to staff members. A brief agreement document that can be edited to suit individual circumstances and fact sheets to assist people to use these were developed.

All of the documents are available to all staff, editable and able to be modified to suit local circumstances. Currently they are being accessed regularly and modified for use with the support of the project coordinator where necessary.

Education and Training

Education for supervisors and supervisees was identified as an extremely important resource for the organisation that would support the implementation of high quality CS. There were some existing or newly emerging education resources within ACT Health. The Mental Health, Justice Health & Alcohol and Drug Services Division currently provides Psychology-Board approved CS training twice a year to any interested and qualified staff member, including allied health and nurses, although places can be limited. Staff Development Unit was providing a course across allied health and nursing covering basic supervision skills for working with students and new graduates. Some discipline-specific CS education has been organised by a professional group where a speaker is available, although this is not usually available in an ongoing way. Recently, ACT Health has begun teaching a new module within the Teaching on the Run program from the University of Western Australia’s TellCentre (tellcentre.org) about CS although this is more focused on support for students than for staff supervision.

Part of the project over time will be to coordinate our CS education efforts using a variety of methods. Nationally, quite a lot of training has already been developed to support allied health CS. Due to the limited resources available locally, a number of existing training packages were reviewed with the intent of purchasing access. South Australia Health’s CS eLearning package (made up of three modules) was considered one of the most useful and practical, and ACT Health purchased access to these modules for ACT Health staff. The feedback about this eLearning has been very positive and to date, 165 modules have been completed. We plan to augment this eLearning by offering a follow up face-to-face workshop where supervisors can discuss and reflect on their CS practice after completing the eLearning, and practise their skills together.

Face-to-face training provided so far has focused on the group supervision trial, with packages developed for group facilitator training and group participant training by the project coordinator. These sessions were provided for all of the group facilitators and participants prior to the attendance at the groups.
Implementing a Clinical Supervision Guideline for Allied Health Professionals in a Public Health Setting

Jo Cole & Alison Lancaster

ACT Health

The trial of group CS for Tier one, and the process of supporting Tier two implementation has identified further areas for ongoing education and this includes more in depth education about reflective practice, and making the most of CS as a supervisee.

Reflections on progress and plans for the future

Our experience has shown us that although there were differences between the professions in how they were currently engaging with CS, there were many similarities, including the perceived barriers and enablers to CS, and the gaps in CS being provided for more senior clinicians. This means that many of our plans into the future will benefit all AHPs, rather than having to design separate support for the different professions.

While the trial of group supervision for Tier one has not yet lead to implementation of similar groups across the Tier, we are continuing to offer support to a voluntary CS group for senior managers within the Tier facilitated by the project coordinator and another clinical educator. This provides support for a group that often receives limited CS, and continues to grow the understanding and engagement with the CS model in the Guideline.

This project has been different from others attempted in Australia, as we have kept all AHPs with a clinical role in scope for the Guideline. A pleasing development emerging is the positive response so far to interprofessional CS and the interest expressed by different professions in seeking more of these kinds of opportunities into the future. There is little research into this kind of interprofessional CS outside mental health clinical services. Tiers two and three have a lot to share with Tier one about the practice of CS. In the Group CS trial, senior staff found it useful to meet and discuss their issues with people from outside their own professions as it helped them to gain a new perspective on the topics discussed, and to understand that they faced common issues across different areas. There is the opportunity to grow this experience across the health service into the future and to research the outcomes, which would be a significant contribution to the CS field.

Overall we see our project as having been very successful so far, with the creation and approval of a governance structure and the Guideline, and support for implementation through education, resources and support for CS experiences made freely available. The commitment to CS in ACT Health is growing. Although our resources are limited, we plan to continue to develop the capacity of staff to participate in and provide best practice CS within and across professions. Into the future, the focus will be on the following areas:

- Education – we will explore options for using existing staff skills and expertise to develop more education packages as needs are identified. Initially, the priority will be on foundation skills for supervisees and supervisors. The first face-to-face workshop is in development and this will complement the eLearning that our newer supervisors have completed.

- Collecting data about implementation – to help us understand where there are strengths and gaps in implementation, each Profession Lead is now required to report once per year on the percentage of staff with a formal CS agreement that meets the Guideline. Part of the desired governance structure at the beginning of the project was to establish this single point of accountability for CS. Only preliminary data has been collected at this stage, with strong differences in the level of implementation between the Tiers being evident.

- To assist with measuring our progress and devising future strategies to support implementation, we plan to formally evaluate the quality of CS being provided under our Guideline using a validated tool such as the Manchester Clinical Supervision Scale (MCSS-26; Winstanley & White 2011). In its first part, this scale asks questions about barriers to participation, attitude towards CS, and level of satisfaction with CS. In the second part, questions about the structure and frequency of CS are asked.
Conclusion

Although the research evidence is limited for some of the expected and theorised outcomes of CS, there is promising support from some jurisdictions for the positive effects of best-practice CS. Over the last three years, ACT Health have developed and commenced the implementation of a CS Guideline for AHPs to provide a framework for best practice CS. The work so far has focused on supporting each profession to develop a more structured and standardised approach to CS, in line with best practice; and provide resources and education to assist with the implementation of the Guideline. Into the future we will look to provide more education and support for implementation, and collect data about the level of implementation and quality of CS in ACT Health.
References


Paper Aims

- describe reflective supervision and the supervisory working alliance in the context of trauma informed care and practice in mental health.
- discuss supervision of trauma work in reducing the risks of vicarious trauma, secondary trauma and compassion fatigue.
- describe the Neuroscience of Supervision and role of reflection on the body and somatic experience in supervision
A moment of reflection
Empathic Accuracy or Emotional Contagion?

• We are deeply affected by our clients through an emotional, psychological and somatic connection - this effect is both desirable and useful – or a threat to our professional competence and wellbeing.

• Contemporary neuroscience has been of the empathic process should be able to normalise this effect as part of the work, however it often goes unchecked
Trauma Informed Therapy

• Over the past decade there has been an exciting merging of trauma, mindfulness, positive psychology, and neuroscience research that is revolutionizing clinical practice.

• Neuroscience research provides profound insight into the brain changes therapeutic interventions are capable of producing.
Trauma Informed Care

• Is an organizational approach that strives to prevent re-traumatization while promoting healing.
• Requires a Paradigm shift: “What is wrong with you?” to “What has happened to you?”
• Is anchored in safety, trustworthiness, empowerment choice and collaboration (Harris & Fallot, 2001).
Complex traumatic stress creates sustained autonomic nervous system arousal, generating perceptions of physical and/or emotional risk which can limit the development of adaptive emotion regulatory skills and exacerbate pre-existing biological vulnerabilities toward dysregulation (Shore 2003).
Trauma held in the Body

From a neuroscientific and neurophysiological viewpoint individuals with complex trauma histories have been “wired” for either hyper-arousal (fight-flight responses) or hypo-arousal (freeze-dissociative responses) and sometimes a combination of both. Implicit trauma memories can re-traumatise a person in the present even if the person knows that the danger was in the past. This is because ‘the imprints of trauma are stored, not as narratives about bad things that happened…in the past, but as physical sensations that are experienced as immediate life threats – right now’.
Compassion Fatigue

• describes the set of symptoms experienced by caregivers who become so overwhelmed by the exposure to the feelings and experiences of their clients that they themselves experience feelings of fear, pain, and suffering including intrusive thoughts, nightmares, loss of energy, and hypervigilance.

• is conceptualized as a special form of countertransference stimulated by exposure to the client's traumatic material (Courtois, 1993).

• traumatizing for the helper - sometimes called “vicarious traumatization” or “secondary traumatization” (Figley, 1995).
Countertransference is an informer of the supervisory process and can provide important insights into not only the supervisee’s and supervisor’s intrapersonal and interpersonal worlds, but also give information about the therapist and the client relationship that the supervisee is supervising.
Clinical Supervision

It is a relationship based activity. “To promote a safe learning atmosphere (where supervisees) are able to think openly, express half formed ideas, raise questions….., and discuss inner experiences that arise in learning therapy,…without undue fear of criticism, humiliation or intimidation” (Jacobs et al 1995 in Watkins, 2013)
Research is unequivocal in declaring that nothing has more influence on the effectiveness of clinical supervision than the quality of the clinical supervision relationship.

(Bond & Holland, 2008; Bernard & Goodyear, 2004; Hess, 1987; Holloway, 1997; Watkins, 1995).
Strengthening the Alliance

An effective supervisor is sensitive to the alliance relationship and intervenes directly to manage alliance problems and to repair alliance ruptures as they occur in supervision.
Trauma Informed Supervision

• Individuals with complex trauma history often have a variety of learned and adaptive survival behaviours and characteristics which at times can be challenging for the workers and agencies that support and work with them.
A Place for Reflection

“Reflection refers to our capacity to reflect on the sensations, thoughts and emotions that are passing through our awareness as information about our inner and outer experience.

Neurologically, this capacity to reflect on our experience involves the frontal cortex and the hippocampus”

(Siegel, D., 2007).
More than Brain Based Supervision

Fear is born in the mind. It lives in the body and keeps us separated from ourselves – and so from each other.

Sheila Ryan quoted in Robin Shohet
“Fear and Love in and Beyond Supervision”
`The body remembers’: how traumatic memory is expressed

Neuropsychological models highlight:

- the role of mirror neurones, facial feedback, postural mirroring and respiration synchrony in empathy and in the therapeutic relationship, as a somatic communication of the other’s experience

- Somatic markers of body memory – navigational tool”
Neuropsychotherapeutic Safety

• Intense feelings can emerge ranging from empathy to anger. These must be understood to manage reactions/empathic strains such as: over identification, avoidance shutting down emotionally, terminating the case prematurely, or leaving the field when faced with overwhelming trauma and loss.

• To psychologically “hold” the trauma each clinician must find their own ways to cope with the overwhelming feelings aroused.
Countertransference

- Classical definition: feelings that the therapist transfers from his or her past and inappropriately applies them to the person they are seeing.
- Modern understanding: reactions set off in the therapist as a result of being receptive to the person’s transferred feelings. An indication of the therapist’s empathic connection with the client.
Parallel Process

Originating within the psychoanalytic literature, suggests that dynamics of the therapeutic relationship stimulate and are reflected within the supervisory relationship.
Containment

• Bion's theory of the mother as the container and modifier of the infant's projective identifications

• A capacity for managing life and life’s difficulties without continued avoidance or suppression. (Casement, 1985, p.133)
The Goodenough Supervisor

Term Good Enough developed by Winnicott “Good Enough Mother” – idea that a perfect parent is not helpful, inhibits development. That some frustration is necessary first to allow a child to learn.

Contain and hold the supervisee’s anxiety and emotional reactions within the safe setting of the supervisory relationship, where it can be experienced, survived, reflected on and learned from.
Difference Supervision and Therapy

• It is critical to maintain the boundary between supervision and psychotherapy when addressing countertransference reactions. Any exploration of supervisee personal factors must be specifically related to the supervision or the therapy they are offering others.

• How supervisees address and manage countertransference reactions is more important than the fact that such reactions occur.
Conclusion

• A clinical supervisor contains and holds the supervisee’s anxiety and emotional reactions within the safe setting of the supervisory relationship, where it can be experienced, survived, reflected on and learned from.

• The ethical imperative of Supervision when working with clients “Do no harm”
Clinical Supervision
People Passion Purpose
My Lived Experience

Kerry Mawson
Lecturer, School of Nursing, Midwifery and Para-medicine. Faculty of Health Sciences Australian Catholic University
Community Mental Health Drug & Alcohol Clinician/Clinical Supervisor, CNS, CDAN. Northern Sydney Local Health District, Mental Health Drug and Alcohol Service
Clinical Supervision
My Lived Experience

Risk
Experience
Skills

Psychoanalytical
Cognitive behavioral
Person Centered
Role Theory

Reflection
Hidden elements and not so hidden

- Barriers
- Policy 100%
- Rhetoric versus reality
- Activity based funding
People

“I’m not telling you it is going to be easy- I am telling you it is going to be worth it.” - Art Williams

- People make Community
- Community of practice
- Identity
- Exchange of experience
Passion

“I have no special talents. I am only passionately curious.” Albert Einstein

- Love / Suffering
- It is motivating
- It is transformative
- Shapes my purpose
- It is relational
“Living in a way that reflects one's values is not just about what you do, it is also about how you do things.” Deborah Day

- It isn't enough to talk about clinical supervision. One must believe in it. And it isn't enough to believe in it. One must work at it.

- The purpose of clinical supervision is to explore and experience which constructs meaning
Rising above barriers

“I am who I am today because of the choices I made yesterday.” Eleanor Roosevelt

- Knowing what CS means
- Identity, values and valuing myself
- Attitude
- Community of believers - empowering
- Risk of speaking up
- Reciprocity and growth

- Continued CS, refreshers, experiential workshops and education.
Acknowledgements

Owen Brannigan – Interested inquirer
Lisa Juckes – Generous companion
Tanya Alexander – Insightful explorer
Paul Spurr – Supportive leader
Julie Skinner – Thoughtful guide
Clinical Supervision: People, Passion and Purpose:

My Lived Experience

Kerry Mawson

Australian Catholic University Sydney, NSW

Northern Sydney Local Health District Mental Health Drug and Alcohol Services, NSW.

Abstract

My understanding of clinical supervision has been strongly shaped by my own lived experience as a supervisee and as a supervisor. These positive relationships, over many years, have contributed towards a passion and style of clinical supervision which supports a working relationship that is both empowering and reflective in action. However, the term “lived experience” has been mainly used in the mental health arena to describe the first-hand accounts and impressions of living as a member of a minority or oppressed group. I would like to suggest that my experience of clinical supervision as a supervisor has a hidden element, where the rhetoric and the reality can be very different, where an increased focus on throughput becomes the dominant influence rather than quality treatment and a skilled and valued workforce. Rising above what can seem like powerful influences requires passion, purpose and like-minded people to help navigate the yellow brick road of clinical supervision.

Starting a manuscript using terms to describe my own experience, and not acknowledge the historical meaning and power of these terms, especially in the context that gave life to them originally would be thoughtless. The popularity of the term ‘lived experience’ is increasing in use and with this a diminishing of meaning to what the term really represents. The lived experience movement of consumer/survivor presents a rich history of fighting for human rights, social justice and the ongoing change required of mental health systems. The experience of marginalisation, oppression and discrimination of people with mental health challenges and use of services requires an understanding that is much more than the illness itself. This understanding provides “insights into the lived experience of suffering, healing and recovery” (Byrne,2017a,b). The recognition of consumers’ lived experience as “experts by experience” and “experts in their own lives” has placed them for the first time in a position where their expertise is a requirement for service provision but more importantly “experts in the mental health system” (Epstein, 2013). It is for this reason, that acknowledgement needs to be given firstly, where it is deserved, with the many people who have a truly lived experience.

My lived experience of clinical supervision (CS) spans over twenty years and was not a struggle for survival or recognition. I did not have a day-to-day lived experience of CS, however I became experienced in clinical CS. This experience enriched my life professionally and gave me the understanding and significance of the narrative that is the lived experience. Clinicians also bring their own lived experience into the room, but they also bring the first-hand accounts of another’s lived experience. I am going to take you on part of my journey of CS that created a passion, a purpose and a circle of safety, which changed my future clinical experiences and relationships.

There is something intriguing when we speak about the word, ‘passion’. Mostly, the meaning is interpreted as “something we love to do” or “someone we love to be with” and has significant emotional intensity; however, the word also means ‘to suffer’.
Suffering can be life defining and presents a depth of meaning in our lives we would not have experienced without going through the suffering (Hall, 2009). When I find meaning in what I experience, passion motivates me to be better, whether this experience is about the passion of love or suffering. Clinicians can often bring their own suffering or the suffering of others to CS. Recognising the significance of these experiences when working as a clinician or clinical supervisor has a depth attached that brings purpose. Passion gets me thinking about what I don’t know and how I begin to know. Passion is about what I believe and how I share this with others. Passion is what shapes my purpose in life. It creates the emotional connection where people relate to me on a level that nurtures authenticity.

I started my nursing education in the late seventies. It was not until the mid nineteen nineties that I would encounter the culture of regular CS. There was an expectation that you would attend CS and so I reflected on what this might mean for me. This period of time was the only time I experienced this expectation to attend CS with passion. I spoke with colleagues, who were very passionate about the experience, along with the increased understandings of their practice and clinical development. I realised the difficulty these clinicians had explaining CS was also a difficulty found in the literature with definitions just as ambiguous. Although definitions are important, the actual experience of attending CS gave me the understanding of my own contribution to the therapeutic relationship that was insightful and empowering.

I initially had the luxury of attending CS weekly. My first supervisor was psychoanalytically-minded and this relationship lasted for six years. A psychoanalytic orientation to supervision is worth describing further as it is one of the oldest forms of psychotherapeutic supervision. The supervisee learns from the supervisor by the mirroring of therapy. The qualities of trusting the process, patience and respect for client resistance were encouraged. My experience of CS focused on working with my own anxieties, transference and countertransference, which involved a lot of reflective practice. Initially, the focus is on how the client presented in the therapy session; however, this could move towards the process of my experience of being the therapist with particular clients. This type of supervisee-centred supervision can stimulate growth internally as a result of gaining an understanding of my own psychological processes, although this needs to be entered into carefully as the boundary between clinical supervision and therapy is delicate and requires a very different skill set. Although I do not work from this perspective myself as a clinical supervisor I am grateful for the experience and lasting impressions, which has informed my clinical practice significantly.

My professional background has continued to be influenced by various counselling theories. Initially starting with psychoanalytical clinical supervision and further advancement with cognitive behavioural, person-centred and role theory models. The further development of the self as a therapeutic agent came through the form of reflective practice. One definition of reflective practice that sits nicely with clinical work is the experience of analysing complex interactions with clients, “to make meaning and gain a deeper understanding of the experience” (Sharrock, Javen & McDonald, 2013, p. 118). Reflecting on practice has been a natural ongoing development through clinical work, academia, self-awareness, my own supervisor and practice based courses. Reflection remains a strategy that influences my nursing practice and education. We all need time to reflect, not only in our personal life as a self-care strategy, but for our professional life. Honouring reflection as important as everything else we do should be our purpose, or it won’t happen.

Clinical supervision has taught me to value myself enough to know that I need clinical supervision to be the clinician I am. This benefits the lived experience of those I work with and my colleagues. The choice of supervisor is a very personal one and requires a commitment from the supervisor as well as the supervisee. I have had the experience of many different supervisors over the years, which have all contributed toward my experience and ongoing clinical practice. All these experiences have helped me to understand myself.
and the roles that I practice at a depth I would not have experienced without CS. My current supervisor is a Senior Clinical Psychologist who also works from a psychodynamic approach with reflections and skill development. This relationship is significant to CS.

Engaging in a positive, respectful and non-judgemental experience is a priority. I need to feel relaxed in this relationship so as to move forward in my own professional development. Discovering new ways of thinking about a situation that is clinically pertinent brings forth possibilities. I have learnt the importance of tolerating feelings of not knowing what to do until something more clinically relevant emerges. The supervision session always gives me the experience of where I am going therapeutically. This further develops the lived experience clinical relationship towards healing and recovery. My ongoing development as a clinician is important, but more importantly my lived experience makes me the nurse I am. This contributes to how I relate to some clients better than others, and by understanding my experiences, I am going to understand the clients I don’t relate to as well and find ways that I can professionally work with them. The experience of talking it through with my supervisor gives me a freedom to move to a different level, of understanding the lived experience and honouring this experience. This development of practice engages me reflectively, intellectually and emotionally. But, more importantly, CS supports me professionally through the experience of challenging and demanding work.

The professional development of self can move you in directions that can initially present as risky. I call this risky as I still was not sure what I was embarking on, but soon realised that this would be the start of something new and refreshing in my professional life. In 2008, I attended my first four-day training to become an “approved” clinical supervisor with Paul Spurr as the Facilitator. This workshop was Clinical Supervision for Role Development. “The Role Development Model” was originally developed by Michael Consedine of New Zealand in the mid 1980s. Mike created the ‘Role Development Model’ from the principles of Psychodrama and the Morenian concept of spontaneity to provide a framework of clinical supervision for health professionals (Consedine, 2003). This model contributed to an experience of CS that was empowering, reflective and personal for the supervisee. It has given me a confidence as a supervisor to facilitate the exploration of the issue, rather than trying to solve the problem for the supervisee.

My purpose of clinical supervision is to provide a confidential and safe place for nurses to engage in independent reflective thinking about their practice. This experience is an ongoing development of their knowledge and skills in the context of clinical practice. If you don’t know your purpose, you won’t be able to clearly communicate your passion. This purpose becomes a community where clinical supervision is the activity at the centre of the experience. Understanding “a shared purpose creates consequences that go beyond the individual” and is especially important in a world of individualism and disconnection (James, 2015, p.126). My experience with other nurses and what they bring to supervision teaches me about their experience, but more importantly, contributes to a reciprocity, where by giving I receive; maybe just as much as the nurse I supervise. Understanding my passion and purpose, gave me the confidence to move my ideas about CS into the university sector. I have been given the freedom to pursue what I am passionate about by introducing CS to undergraduate nurses working in mental health services as AINs. I have witnessed these students grow through reflecting on their own practice, assumptions and understanding of the lived experience by learning to listen and be present.

There are significant barriers that have continued to be presented and discussed in the literature when implementing CS (Cottrell, 2002; White & Winstanley, 2009). Current policy within one local health service states that 100% of staff should be engaged in CS, yet it is realistic to suggest clinical supervision is not currently a routine component of clinical nursing in many areas of health.
The shortage of clinical supervisors could be a contributing factor to this, with my own experience of twenty years showing how difficult it is finding experienced nurses who are clinical supervisors. My CS has mainly been with senior psychologists and consultant psychiatrists. The lack of options available in nursing has meant I attend and pay for CS through an external provider. With so many nurses still not attending clinical supervision, it remains one activity that is left unknown and unexplored with a mythology more powerful than the reality. Although these barriers have not affected my purpose, I have experienced a system barrier creeping into the CS world called Activity Based Funding (ABF). There are interesting insights given in the literature about ABF being a disastrous path for mental health services, which are worth reading, although outside the scope of this paper (de Jong, 2018; Rosen, McGorry, Hill & Rosenberg, 2012; Wand, 2014).

However, my concern has been the way ABF has been communicated to staff. This communication is a reminder that seeing clients is core business, which means a significant amount of time spent accounting for every interaction involved with each client, family member and other staff members. De Jong, in his paper, gives a figure of 30% of the healthcare budget being spent on “administrative burden”. The result of this burden on healthcare workers is experienced as a “demoralisation and growing job discontent” as clinicians are no longer solely focused on what was originally a desire to “help” and also what they were trained to do (p.28. 2018). This latest change in funding models increases the need for CS, yet due to increased work pressures decreases the likelihood of clinicians attending.

Lakeman and Malloy (2017) refer to ABF as a

   new world order” where “creative, reflexive practitioners are not required, and indeed anything that does not fit the model of care, as determined by the computer system is not seen to exist

   (p. 3.)

The true value of CS is overlooked with organisations preferring to focus on throughput rather than quality. An increase in financial focus and outcomes does not always take into account the quality of the treatment. Possibly, organisations do not see the value of CS as it does not generate money in an ABF environment. As a supervisee, I am fulfilling managerial key performance indicators by attending CS; however, as a clinical supervisor and educator I have experienced more barriers and ongoing struggles toward my expertise, what policy states and the funding model I work within.

Rising above what can seem like powerful influences can be almost “mission impossible”. However, I have learnt a lot about myself as a human being and as a clinician through CS. What I value is what I bring from the past, which is my past professional experience and knowledge and incorporate this into the day, to create the present. Clinical supervision has given me the ability to stand back from myself and look at my interactions with others through self-reflection. My values shape who I am personally and professionally, which helps me to be clear about my identity and what I stand for. My professional identity is inclusive of CS, which encompasses knowledge, skills and abilities to self-reflect that contribute to my passion and purpose. The cultural script of “I have made it on my own” is not satisfying or rewarding and does not fit the values of community. I require a community of practice around me who are also passionate about CS. This community gives me a sense of belonging, feeling understood and motivates me toward my purpose. The practice of gratitude for the people who have come into my life and what they have shared with me keeps me grounded in my purpose. I need a community who understands what I say and believes in what I say when I speak of CS.
This community shares something with me that not many others share. When you share a belief, this is motivating and provides a sense of belonging and an excitement that we are part of something that is bigger than we are; we are part of a movement.

It is not enough that we talk about supervision. We believe in it! The success of anything is the people who become our community and contribute to the professional development of that community. There is a depth when I practice what I preach. Taking personal responsibility and being consciously aware of my own practice knowledge and self-care, needs to be a priority. I am no good to anyone if I don’t do what I expect of others. I need to have balance in my life where what I do when I am not at work rejuvenates me for what I need to do at work. But also when working within my passion and purpose, rejuvenation can be experienced as part of my work. Accepting support from my community of practice strengthens those parts of me that need to rise above the forces that can disconnect me from my authentic self.

In conclusion, clinical supervision has been one professional activity that has given me more than I expected. It no longer represents an activity, but has become a part of my identity and a way of life that has contributed to who I am professionally. This passion has contributed to my confidence, creativity and spontaneity. I have invested in others and myself to be the best I can be in a world that is not always the best it can be. I have learnt how to rise above what can be barriers to practice and stayed focused on what my purpose is. What started as a supervisee, became a supervisor and has become a course of action where I know CS always leads to worthy pursuits professionally. CS is a community of practice that has provided a safe place to develop relationships and professional accountability. That is my lived experience of “The yellow brick road of clinical supervision”.
References


Mentoring or Monitoring - Impossible Bedfellows?

Elisabeth Shaw
CEO Relationships Australia NSW
ACSA Conference 2018
Supervision evolution

• Conceptualised between supervisor and supervisee.

• 3 Pillars:
  – Support
  – Development/education
  – Administrative/managerial
Supervision definition circa 1982

• “An intensive, interpersonally focused one-to-one relationship in which one person is designated to facilitate the development of the therapeutic competence in the other person” Loganbill, Hardy and Delworth.

• “An ongoing educational process in which one person in the role of supervisor helps another person in the role of the supervisee acquire appropriate professional behavior through an examination of the trainee’s professional activities” Hart.
Supervision Stakeholders

- Clients (Internal and external)
- Supervisees (Individuals and groups)
- Management and the board
- Third party payers & their organisations
- Community (people and organisations)
- Professional/industry groups
- Government
Workplace challenges

- Supervisors as appraisors.
- Supervisees who always want to talk about organisational functioning, or team dynamics, saying “supervision is the only safe place to do so”.
- Managing organisational or external intrusions into the supervision space
- Being asked to supervise someone who has been inappropriately recruited, or who displays “performance problems” (and who hasn’t been told!)
- Use of supervision for training
- Supervision or “snoopervision”
- Third party payers and information obligations
- Supervisees that are “clinically fine” but chronically late or behind in case notes
- Supervisees that are “clinically fine” but very disruptive in the team & justify behavior through “overwork”.
- Supervisors having more “line management” delegations
Leading to...

- Trying harder to distinguish clinical supervision from line management
- Splitting off the “unwanted” or uncomfortable tasks onto management, or letting them drift unaddressed
- Ambivalent messages to staff and management
- Increased experiences of splitting, triangulation or collusion
- Unwillingness to take on senior duties
- And more!
Organisational Supervision Context
Supervision Definition circa 2009

• The formal provision, by approved supervisors, of a relationship based education and training that is work focused and which manages, supports, develops and evaluates the work of colleague/s. The main methods that supervisors use are corrective feedback on the supervisee’s performance, teaching, and collaborative goal setting...Supervision’s objectives are “normative (e.g. quality control) “restorative” (e.g. encourage emotional processing) and “formative” (e.g. maintaining and facilitating supervisees’ competence, capability and general effectiveness) (Milne: 439).
Getting Ready to Supervise

• Supervisor’s primary focus must always be the client.
• Supervisors need to really own the authority about the service is delivered.
• Supervisors are the gatekeepers of the profession, and guardians of the public interest.
• Supervisees trust that the relationship will be in their best interests. Supervisors need to maintain an ethical & boundaried framework for supervisees to explore difficult issues without it being interpreted as an invitation for a role change. (Corey et al 2011)
• Supervisor’s have to manage the loss that comes with their role, and embrace different relationships.
The supervision relationship

- The supervision relationship is central to the success of supervision. It must be respectful reciprocal and safe.
- The relationship must be founded on *supportive collaboration*...
- However this does not exclude the possibilities of the supervisor being directive or challenging. In fact some research demonstrates that a combination of both care and challenge offer the best learning (e.g. Kadushin & Harkness 2002; Starr et al 2012)
- Common factors research suggests the supervisory experience is at its best when in balance...

Elisabeth Shaw 2015
Supervision activity

(Morgan & Sprenkle 2007)

Clinical emphasis Professional competence

Elisabeth Shaw 2015
Individual vs profession
(Morgan & Sprenkle 2007)

Idiosyncratic/ particular

specificity

General
Supervisory relationship

(Morgan & Sprenkle 2007)
Comfort AND challenge

- Support was strongly endorsed as a form of comfort, holding and ultimately empowerment.
- Necessary and desired tensions: comfort as well as challenge, the anxiety of knowing and not-knowing.
- “It is suggested that it is the supervisory relationship, which is perceived as ‘safe’ and the working alliance therein, that facilitates a supervisee to engage in these conflictual experiences” (Starr, Ciclitira, Brunswick and Costa 2012:12).
Supervision & Performance

• A supervisory style of ‘consideration’ (mutual trust, respect, warmth) is positively related to autonomy, responsibility, self initiative, participation & independent decision making. Supportive supervision is strongly related to morale & job satisfaction (Rauktis et al 1994).

• Levels of interaction & job satisfaction are higher when supervisor is seen to be authoritative through experience & practice skills rather than agency based sanctions (Munson 1981).

• Support generally is important, but instrumental & informative support most linked to decreased psychological stress (Himle et al 1989).

• Key predictor of performance is effective leadership (York et al 1990; Newsome et al 1991) (in Tsui 1997)
• “Many supervisors question the legitimacy of evaluation and lack a sense of entitlement. They don’t think they can or should judge the work of another”.

• Organisations lack effective tools to undertake a reliable evaluation, resulting in supervisors being “oppressed by conflicting, ambiguous evidence of performance and by imprecise, vague standards available to judge performance. Consequently they feel neither qualified to make such a judgment not confident they can make a valid evaluation” (Kadushin and Harkness 2002).
Evaluation & Direction

• Large scale studies about supervision satisfaction indicate that their major area of dissatisfaction is in the supervisor’s “hesitancy in confronting inadequacies in performance and their uneasiness in exercising positional authority” (Kadushin and Harkness 1992:15; London and Chester, 2000).

• Cherniss and Equatios (1977) noted that while insight oriented approaches utilising questions to elicit the supervisee’s own thinking were described as best, the didactic-consultative style was often preferred. This involved advice, suggestions, interpretations concerning client dynamics and clinical technique.
Emotional Intelligence

- Emotional Self-Awareness
- Emotional Self-Regulation
- Emotional Self-Motivation
- Empathy
- Social Influence, Nurturing Relationships
RANSW Organisational Supervision in a Cross Cultural Framework
Supervision Principles: Relationship Starting Blocks

• Transparency
• Principle of professional autonomy
• Importance of Contracting; establishment of a broad agenda (including emotional intelligence, ethical maturity, health & well-being)
• Modelling professional integration.
• Role Authority and Management of boundaries, roles and tasks.
• Routine engagement with performance and evaluation
References

How critical are we?
Revitalising critical reflection in supervision

Matt Rankine
The University of Auckland, New Zealand
Some definitions

- Reflective practice provides a professional process for developing self-awareness and considering alternative plans for action.

- Critical reflection assists practitioners to examine power relationships, challenge assumptions and critique existing social structures.
Supervision is…

• A professional relationship that provides opportunities to reflect on the organisational, administrative, professional, practical, and cultural contexts of practice (Beddoe & Egan, 2009).
Methodology

• **Key informants**
  – academic and practice experience with close affiliations to community-based child welfare social work.
  - definitions of reflective practice, critical reflection and knowledge of current practises in supervision.

• **Supervisory dyads**
  - social workers currently working in community-based child welfare context.
  - the practice realities of reflective practice and critical reflection.
The key informants

1. Thinking and self-awareness
2. Stepping back and changing perspectives
3. Going deeper, extending beyond the micro
Thinking and self-awareness

Initially, reflective practice was described as thinking:

“after something happens ... how you felt at the time and able to discuss it. That makes you more self-aware the next time you find yourself in that situation.” (Mary)
Stepping back and changing perspective

“by sitting back, exploration can begin...you get to pull it apart and putting the jigsaw puzzle back together so it fits.” (Bridget)

“when working with the client you look at it from their perspective, you dissect it, investigate it and how you might look at it differently.” (Alana)
Going deeper… beyond the micro

“critical reflection is … looking [more] at … the reasons behind the action and the outcome.” (Elizabeth)

“It’s moving beyond that micro level … to thinking more broadly.. identify the structural constraints on both yourself and your client’s lives.” (Mary)
How does supervision ‘fit in’?

Supervision was highlighted as the space to illuminate power issues, understand cultural factors and the associated implications on the work undertaken with service users.

“being able to identify [in supervision] the structural constraints on both yourself and your client’s lives in terms of race, class, gender, ability, and sexuality … the broader structural things like 99 per cent of my clients are solo mothers so what does that tell us about gender, poverty etc.” (Mary)

“[B]ringing in what’s happening for Māori and different views about a way forward. It’s that whole systems theory going out … how it relates to relationships, child protection, and how things might be “fixed” in our society?” (Bridget)
Supervisory dyads: the realities of critical reflection in supervision

“in the organisation it’s about the cases and how the cases are moving or going to move.” (Grace)

“people don’t come with [understanding of critical reflection]…. They’ve only had case management.” (Jessica)

“we’ve got external pressures coming from government [and social workers] are not actually looking at practice, they’re not looking at theory, they’re not looking at anything other than that whole emotional cycle that they are caught up in.” (Jane)
One example of critical reflection

“I started actively drawing on some Māori models of supervision, about trying to connect really deeply with whānau [family] because we’ve talked about whānau and leadership before … we’re both Māori and that’s important to us. That has to start being active and integrated into our supervision.” (Ohaki)
Discussion

• Reflective practice and critical reflection are terms that professionals struggle to articulate in education and practice.

• Key informants identified the need for critical reflection within supervision and the value this brought to practice.

• Supervisory dyads described the tension to fulfil organisational demands and managing risk at the expense of professional values and critical reflection of practice.
Discussion

Supervision needs to promote reflective practice and critical reflection.

• practitioners need to engage with critical conversations in supervision.

• supervisors have a central role in facilitating supervision with frameworks that promote critical reflection in practice.

• educators hold a valuable position towards the development of reflective practice and teaching critical reflection in professional programmes.

• managers need to support their practitioners to attend supervision programmes and to utilise supervision.
References


References

HOW CRITICAL ARE WE? REVITALISING CRITICAL REFLECTION IN SUPERVISION

Matt Rankine
University of Auckland, New Zealand

Abstract Text

Globally, professionals who work with people struggle to critically consider how dominant managerial discourses impact on practice. Additionally, reflective practice and critical reflection have become problematic terms in how they have been adopted and implied by educators and practitioners alike. In order to effectively support service users and improve practice, practitioners need to understand power relationships, navigate oppressive structures and support disadvantaged groups in society. Supervision provides the space for critical analysis of the wider professional environment. This article reports on a qualitative study examining critical reflection of practice in supervision within the current context of community-based child welfare services in Aotearoa New Zealand. Data was analysed from interviews with two participant groups: key informants with considerable academic and practice experience and supervisory dyads from different community-based child welfare social work agencies. Analysis of the key informant data identified reflective practice having different stages of criticality and critical reflection in supervision as a process that illuminated the impact of environmental factors on social work. Within practice, supervisory dyads utilised the supervision session for reflection on a superficial level but rarely critically explored the wider contextual issues impacting on practice. Greater examination of the wider socio-political, socio-cultural and structural factors that influence practice and engagement with service users is urgently required. Critical reflection within supervision is essential for all practitioners to develop professional practice and strengthen social justice strategies within their work.

Introduction

Reflective practice and critical reflection are valuable skills and essential for professionals working with disadvantaged groups. These terms are also subject to conjecture between educators and practitioners. Reflective practice is embedded in professional learning and provides a process of developing self-awareness, skills and the consideration of alternative actions. Literature related to reflective practice has gathered momentum in the last one hundred years and covers fields of education, professional and organisational learning in many different professions (Fook & Gardner, 2007). Models and concepts relating to reflective practice, such as Schön (1983) and Kolb (1984) have contributed to ongoing learning and development of professional practice. Reflective practice has also been described as being progressive over time with different layers of criticality in learning from challenging individual thoughts, forming alternative strategies to transformative approaches to living (Boyd, Keogh & Walker, 1985; Brookfield, 1995; Mezirow, 1981).

Reflective practice has also been argued as being superficial in how complex issues facing service users are examined by professionals (White, Fook & Gardner, 2006). The historical, social, cultural and political factors that discriminate between people also need acknowledging (Brookfield, 2009).
Critical reflection is the process for exploring the wider context of practice and analyses power dynamics, assumptions made on practice and provides strategies for action (Brookfield, 1995). Critical reflection requires the individual to deconstruct their values, attitudes, social, political, professional and theoretical influences in order to reconstruct meaning with changes in awareness and action (Fook & Gardner, 2007). In doing so, critical reflection provides a fresh perspective for professionals working with others and the ability to explore contemporary issues relating to oppression, power relations and domination in society (Gray & Webb, 2013). Moving forward, for professionals to be critical, wider systemic and contextual levels influencing practice require constant consideration and the professional space and time is needed to critically reflect on practice. This professional space for reflective practice and critical reflection can be found within supervision.

Supervision provides a balance by assisting practitioners to meet professional and organisational objectives associated with their work (Davys & Beddoe, 2010; Hawkins & Shohet, 2012). Being reflective in supervision provides a structure to the supervision session that emphasises learning and growth between the supervisor and supervisee. Supervision has been a growing area in literature in the last few decades and specific models have been developed to explore a holistic examination of practice (Rankine, 2017a), different contexts and perspectives (Noble, Gray & Johnston, 2016) and promote new learning and decision making (Davys & Beddoe, 2010).

However, the current climate of professional practice is heavily influenced by managerialism that favours caseload surveillance and strict organisational and procedural requirements of services administered to service users.

Such managerial agendas stifle reflective practice in supervision and notions of critical reflection appear aspirational. The supervisor’s role is influenced by these dominant discourses and, in turn, compromises the professional nature of supervision with the danger of a new generation now emerging with a lack of awareness of critical reflection on their work (Gibbs, 2009). The supervisor then has a crucial role in facilitating critical conversations related to social justice so that professional and anti-oppressive practice can be continually developed (Hair, 2015). Recognising the causal impact of social structures and the influence of socio-cultural and socio-political factors during supervision facilitates the development of culturally sensitive practice (Hair & O’Donoghue, 2009). Critical reflection in supervision requires an ongoing understanding in practice and research so it remains relevant with the current managerial environment (Beddoe, 2015; Ruch, West, Ross, Fook, & Collington, 2015).

Methodology

This paper has been developed from a research thesis with key informants and supervisory dyads working in community-based child welfare social work in Aotearoa New Zealand (Rankine, 2017a). Data from participants related to the current use of reflective supervision were collected via semi-structured interviews that were audio-recorded and transcribed. The findings have been developed from thematic analysis (Braun & Clarke, 2013) of the key informants’ and supervisory dyads’ feedback.

Nine key informants and eight supervisory dyads volunteered to participate in the study from across Auckland, Aotearoa New Zealand. Participants represented a range of diverse demographic profiles and had a range of professional experiences in social work. The key informants’ definitions of reflective practice, critical reflection and the current context of supervision in community-based child welfare were analysed alongside the contextual realities for supervisory dyads to critically reflect in practice.
Key informant definitions

Reflective practice was described by the informants as a layered process with three levels of criticality in depth and thinking. Key terms were associated with each layer from the data. Initially, reflective practice was described as the ‘development of thinking’ made by an individual and ‘self-awareness’. The second layer of reflective practice was articulated by the informants as ‘stepping back’ from direct practice to allow distance from the particular event or issue. This process then led to ‘changing perspectives’ through the consideration of alternative possibilities in the practitioner’s personal and professional development. This description has similarities with the cyclic models of reflection (Kolb, 1984) in that reflection has a change orientation and transformative potential. Finally, layer three of reflective practice was defined as ‘going deeper’. Some key informants identified critical reflection as being part of this deeper level of reflective practice, but could not clearly articulate this process. Others identified the differences between reflective practice and critical reflection as the consideration of wider ‘macro’ issues influencing practice and addressing these areas in day-to-day practice.

The importance of reflective practice and critical reflection occurring in supervision was central to the informants’ discussions around professional development and understanding the wider context of practice. Supervision was highlighted as the space to illuminate power issues, understand cultural factors and the associated implications of this on the work undertaken with service users. Specifically to social work within Aotearoa New Zealand is the commitment to the bi-cultural practice and ethics (ANZASW, 2008; SWRB, 2016) and informants described supervision as the place to critically examine the socio-political and socio-cultural factors that impact on Māori and other disadvantaged groups. However, informants also described the intrusion of managerial and bureaucratic practices that stifled critical reflection taking place for many practitioners in community-based child welfare.

The realities of practice: supervisory dyads

The analysis of the supervisory dyads discussion emphasised the significance of managerial practices within supervision that ensured organisational standards and expectations were met within community-based child welfare services. Core professional values related to promoting positive relationships, anti-oppressive practice and critical examination of wider structural and cultural factors were lacking. The realities of practice for the supervisory dyads were similar to the concerns voiced by the key informants regarding supervision and the community child welfare environment.

Regular conversations noted in supervision by the dyads were the accountabilities each practitioner had towards meeting specific performance criteria for the community-based organisation, crucial to receiving ongoing state funding. In addition, the impact and management of risk through case compliance dominated supervision discussions. The current community child welfare environment as described by the supervisory dyads emphasised a sense of busyness and urgency to meet targets associated with service delivery. Deficit-based thinking and distancing from decision making on practice was a common theme identified.

Evidence of critical reflection within the dyads’ supervision was lacking in the feedback discussions. Only two of the supervisors made connections to the socio-political and socio-cultural environment and the importance of doing so to improve ways of working and develop alternative discourses within supervision.
Discussion

Reflective practice and critical reflection are terms that practitioners struggle to articulate in education and how they can be utilised effectively within practice. An example used in this paper is from a study of social work practitioners and their use of supervision in Aotearoa New Zealand. Analysis of some key informant definitions in the study demonstrated both terms to be described at times as an indivisible whole and difficult to delineate. For some participants, critical reflection was distinct in meaning and held a clear inter-relationship between people, policy and structures.

Recent literature has reinforced the importance of critical reflection in supervision for practitioners (Davys & Beddoe, 2010; Hair, 2015; Hair & O'Donoghue, 2009; Noble et al., 2016). Key informants in the study also identified the need for critical reflection within supervision and the value this brought to practice. However, within the current technocratic realities of managerialism operating in community-based child welfare social work, the supervisory dyads described the tension to fulfil organisational demands and managing risk at the expense of professional values and critical reflection of practice. This level of preoccupation by practitioners within supervision provides an example of the context in which many professionals currently operate – disastrous for the future of professional work.

Supervision needs to promote reflective practice and critical reflection for the professional development of ‘big-picture’ practitioners (Noble et al., 2016) and the future of every profession operating in a complex and managerial environment. In order to maintain professional values related to human rights and social justice, practitioners across a range of professions need to engage with critical conversations in supervision that examine existing oppressive structures and ultimately advance practice with service users. Internationally, professional mandates in a range of helping professions provide the fulcrum for reflective practice and critical reflection to be part of the space for supervision. Supervisors have a central role in facilitating supervision with frameworks that promote critical reflection in practice (Noble et al., 2016; Rankine, 2017b). In doing so, the supervisee is able to articulate a deeper sense of self and understanding of cultural, social and political systems. Educators hold a valuable position towards the promotion of reflective practice and teaching critical reflection in professional programmes as well as supporting trainee supervisors in postgraduate training related to supervision. Equally, managers need to support their practitioners to attend supervision programmes as part of their professional development and understand the significance of critical conversations in supervision for the work completed with service users.
References


Rankine, M. (2017a). What are we thinking? Supervision as the vehicle for reflective practice in community-based child welfare services (Unpublished doctoral dissertation), University of Auckland, NZ.


LOOKING BACK: MOVING FORWARD

PAUL KELMAN & CATHY BOYLE

Mental Health Nurse Educators
Metro-North Mental Health Service, Queensland Health, Brisbane, Queensland.
Clinical ‘SUPER’vision – people • passion • purpose
Individual nursing supervision is an alliance between the nurse and the supervisor that is honest, supportive and non-judgmental. It provides the opportunity for reflection and education on the therapeutic consumer interactions and workplace commitments.
ACSA Conference
22–24 May 2018

Clinical ‘SUPER’vision – people • passion • purpose
ACSA Conference
22–24 May 2018

Clinical ‘SUPER’vision – people • passion • purpose
<table>
<thead>
<tr>
<th>YEAR</th>
<th>NUMBER</th>
<th>INCLUDED Q/HEALTH Central Zone *</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>33</td>
<td>*</td>
</tr>
<tr>
<td>2007</td>
<td>72</td>
<td>*</td>
</tr>
<tr>
<td>2008</td>
<td>49</td>
<td>*</td>
</tr>
<tr>
<td>2009</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>32</td>
<td>Restructure to HHSD</td>
</tr>
<tr>
<td>2013</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>306</td>
<td></td>
</tr>
</tbody>
</table>
ACSA Conference
22–24 May 2018

Clinical 'SUPER'vision – people • passion • purpose
ACSA Conference
22–24 May 2018

Clinical ‘SUPER’vision – people • passion • purpose
ACSA Conference
22–24 May 2018

Do You Bend or Break?

Clinical ‘SUPER’vision – people • passion • purpose
ACSA Conference
22–24 May 2018

Clinical ‘SUPER’vision – people • passion • purpose
ACSA Conference
22–24 May 2018

Clinical ‘SUPER’vision – people • passion • purpose
ACSA Conference
22–24 May 2018

Clinical ‘SUPER’vision – people • passion • purpose
ACSA Conference
22–24 May 2018

Clinical ‘SUPER’vision – people • passion • purpose
<table>
<thead>
<tr>
<th>Numbers of current clinical supervisors</th>
<th>Number of current clinical supervisees</th>
<th>Group Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>106</td>
<td>246</td>
<td>TPCH SMHRU, 2 Inpatient units, ACT.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Graduates (current and previous).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Red Cab NUMs.</td>
</tr>
</tbody>
</table>

Clinical ‘SUPER’vision – people • passion • purpose
Clinical ‘SUPER’vision – people • passion • purpose
<table>
<thead>
<tr>
<th>YEAR</th>
<th>NUMBER</th>
<th>INCLUDED Q/HEALTH Central Zone *</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>33</td>
<td>*</td>
</tr>
<tr>
<td>2007</td>
<td>72</td>
<td>*</td>
</tr>
<tr>
<td>2008</td>
<td>49</td>
<td>*</td>
</tr>
<tr>
<td>2009</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>32</td>
<td>Restructure to HHSD</td>
</tr>
<tr>
<td>2013</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>306</td>
<td></td>
</tr>
</tbody>
</table>
Clinical ‘SUPER’vision – people • passion • purpose
References


The Third Contract:
Issues of Employer Curiosity, Expectations and the Ethics of Confidentiality in Employer Funded External Clinical Supervision

Carolyn Cousins, Tuned In Consulting
BSW, MSW, MEd(Adult)(Hons), MACSW
carolyntunedin@gmail.com
Background

• Contexts and training for supervision.

• Types of individuals and teams.

• Approach – negotiated, but includes…
“accepting but not passive, thought-provoking without being directly challenging, inclusive without being seeming to make everyone say or think the same thing, if this is achieved – something transformative can happen.”

Bion.
• Seek External supervision for a variety of reasons.
• Individuals: Self or Organisation paying?; Past positive experiences; commitment to growth in practice and reflection; problematic experiences and vicarious trauma.
• Organisations: Commitment to staff professional development; protection from risk; obtain skill set not in organisation; support and keep staff;
• … all lead to differing expectations of the process.
Confidentiality

- Explicitly discussed and implicitly expected, but these boundaries can be perceived as ‘loose’ by managers if they are paying.

- Contracting – who may have an expectation of more than ‘serious risk and harm issues’ being discussed outside the supervisory relationship.
• Supervision literature.

• Experiences.

• The ‘Third Contract’ and triangulation.
Third Contract - Newman

- Organisation
- Supervisor
- Employees

Clinical ‘SUPER’vision – people • passion • purpose
Individual Supervision

- Ethics of career planning when the organisation is paying
- Supervisor awareness of agency context and policies?
- Reporting back concerns about the supervisee’s abilities, insight or practice ….
- Supervisee ‘games’ in supervision – are there any obligations to check the implications on clinical practice?
Group Supervision

- SAFETY
- Impact of the Manager or Team Leader being in the session
- Managing a range of professions in the room
- Containment / Control and Direction - the stance of the supervisor for the group
- Feedback into performance or structural issues?
Checking our Stance and Ethics

- Seen as the check and balance on clinical practice – parallel process around little checking
- Tracking and monitoring changing developments and expectations
- Revisiting expectations and staying true
- Ethics and Reflections
Discussion and Questions
Engaging team supervision to foster dialogue and healing after a traumatic event.
Engaging team supervision to foster dialogue and healing after a traumatic event.

Abstract

- Critical incidents where aggression and violence are directed at the team pose significant potential for destabilisation and trauma. The viability for future therapeutic engagement with the patient or perpetrator may also be severely compromised. While initial debriefing may occur, and individual team members can seek additional support, the health of the team can, literally, be left to “drinks at the pub”!

- This paper asks how do we engage teams and foster resilience? How do we help traumatised teams to regroup? From lived experience, this presentation explores role theory and play of life in team supervision to foster dialogue and healing after a traumatic event.
Critical Incident

- Pt X
- “Abandoned”
- Escalation in PT X aggression violence
- Nursing Forums to develop consistent care
- Post Christmas Incident
- Offer to provide supervision to the team using the Role Development Model and Play of life
Role theory for Role Development in Supervision Michael Consedine

- From Merino “The functioning form the individual assumes in the specific moment he/she reacts to a specific situation in which other persons or objects are involved”

- Role is fundamental to who we are and is often the immediate unconscious and spontaneous response to the individual or object

- “To make meaning of interactions between people”

- Supervision as a process to foster development from one role to another…. “The ideal scenario”
The Play of Life Dr Carlos Raimundo
The Play of Life
Structure of session

- Warm up
- Agreement to focus on Pt X
- Confidentiality
- Focus/Reflection - Exploration of Pt X’s World & Team Roles reflected on
- Sense and Meaning “empathic response”
- Action/ Outcomes
Focus of the session on Pt X

- What is Pt X’s world like?
- How does her world feel?
- What is it like to be Pt X?
- Team identified Pt X has 3 worlds
  - Inner world
  - Immediate World
  - Outside World
Pt X  Inner world

frightening  punitive
institutionalised  bored
sh*t  damaged
world  hopeless
against  lost
isolative  confused
Immediate world
Outside World
Outside World
Outcomes Fostering Resilience

- Supervision promoted new insights and ways of working for staff.
- Progression to new roles “the cautious advocate”, “the empathic risk taker”
- Designated PT X team with CNC to support and develop new ways of working
- Rotation of staff each shift
- Debriefing post engagement
To finish

We have an obligation to be leaders in promoting and providing clinical supervision for all.

It is our duty to challenge when money or time are seen as barriers to supervision

We patch up, we listen, we hold, we instill hope when all hope has been abandoned

We sit with our patients taking there last breath giving them permission to finally let go

We bring new life into the world

We support we educate

We are there 24 hours a day for our patients.. their partners and families, for our colleagues too

Our day to day work is never ordinary it is rather extra ordinary.
Reflections

As an enrolled nurse, registered nurse and mental health nurse I have been supervised in many different modes and models.

As my practice has advanced, I have also provided supervision in a number of different modes and models.

I have practiced over the last 3 years as a Clinical Supervisor with the model of Role Theory for Role Development (Paul Spurr/Mike Consedine).

More recently, I experienced the privilege of providing clinical supervision to general Nurse Unit Managers in a time limited quality improvement project which informs some of my discussion today.
“What you do makes a difference, and you have to decide what kind of difference you want to make.”

Jane Goodall
Principle 1 Victorian Clinical Supervision Framework for mental health nurses

**Principle 1** Clinical supervision focuses on strengths and is a positive nurturing experience.

**Principle 2** Clinical supervision is accessible and inclusive; it is available to nurses in all areas of practice and expertise and is culturally appropriate.

**Principle 3** Clinical supervision supports professional development and promotes quality improvement in clinical care and professional practice.

**Principle 4** Clinical supervision enhances the health and wellbeing of employees by providing a regular, continuous development platform for nurses to explore and reflect on their practice in a safe space and identifies future learning opportunities.

**Principle 5** Clinical supervision optimises consumer-centred practice and improves the focus on consumer rights and recovery-oriented nursing practices.
Without the mud, there would be no lotus flower
Small Towns

There is a little town called Me
Where things aren't what they used to be
And nearby is the town of You
Which is getting tired too.

But we can take the morning bus
And travel to the town of Us;
A larger, louder place with bells;
With parks and schools and wishing wells;
Churches, restaurants and shops;
Potatoes, pumpkin, peas and chops;
Some ginger sponge, a cup of tea,
Then back again to You and Me.
The Path isn’t a Straight Line; it’s a Spiral. You continually come back to things that you thought you understood and see deeper and deeper Truths.

~Journey on Earth~
The importance of the intangibles

This is my reflections about providing these wonderful nurses clinical supervision and the changes that I noticed in my role; what I noticed in my reflections of the work we had done together and what I have been left with - the lived experience of developing relationships and engagement with an intention of kindness and support; expectations and ambition; safe space making; the making of meaning.
To make a difference in someone’s life you don’t have to be brilliant, rich, beautiful, or perfect. You just have to care.

-Mandy Hale
Robin Youngston – co-founder of hearts in health care. The heart of healing, a compassionate approach to mental illness and different ways of relating to the people we are caring for.

Empathy is a human skill to understand someone’s feeling. Empathy alone is self related emotion, feeding with the other, empathetic distress, poor health and burnout, aversive experience, activation of brain circuits related to toxic pain.

Add underlying kindness and the motivation to address suffering

Adding compassion to practice

Empathise and validate their fears
Adding compassion to practice

Empathise and validate fears

Positive suggestions with warm empathic consultations

The science of interpersonal connection, mindfulness, calm passionate presence bring mirror neutrons intuit the feelings and expression of others. If we bring in compassion to patients we changes their biology immediately – causing cascading reactions in the health response.

Wellness genes are up regulated, protein synthesis for tissue healing – there have been Quality improvement projects related to high empathy with compassionated doctors.
“Be curious.”

Stephen Hawking
1942 - 2018
Healing powers of compassion

Compassion in mental health means honouring the whole person, emotional validation is life saving, health occurs in relationships in groups of people.

Compassion means sitting alongside a person in their darkest places.

Having compassion means being vulnerable.

Open hearted compassion with mindfulness.

Difference with Recovery oriented care: and the Fixing helping – Health professional control.

Serving – personal service that seeks to understand a person’s needs and wishes – the person served grows in their own capacity.

Taking the time to care.
Increased self awareness

The supportive statements about professional development, increased self awareness and emotional self expression was new for some people.

Validating and respecting the feelings which arise from nursing practice was also prominent in my reflections.
Among the other reflections were the validations of people who were feeling stressed, elated, vulnerable and tearful. The other areas of interest was acknowledging belief systems and bringing into awareness in relation to nursing care.

My reflections also include the work we did supporting the exploration of work role and functions which in turn enhanced the learning.
Respecting the feelings which arise from nursing practice

Being comfortable with emotions and feelings which arise from our work and being safe enough to explore the origins of the feelings
The making of safe spaces and the energy put into valuing the individual was also a highlight of my reflections.
Compassion in health care

Compassion is not just a feeling, but a
The gathering of kindness project

The unconference of 2016

Dr Catherine Crock AM and Mary Freer founders of the Gathering of Kindness, with the purpose to build a community of people interested in integrating kindness into every aspect of the healthcare system. To encourage a dialogue amongst participants and acknowledge that poor behaviour exists and move toward...the ways to promote kindness, respect and trust amongst patients, families and staff.

“We live in an age where health of the body can be quantified and maximised, but health of the spirit is completely ignored. It’s time to reframe healthcare – its time to make care the context. “Col Fink 2017 Gathering of Kindness Anthology)
Organisational support

The lack of organisational structural support and scaffolding for the nurses emotional selves was also a large part of the work reflections.
Autumn in Melbourne
What supervision means to me.....

When I visualise supervision - I see the nurse as a tree and clinical supervision as the nutrients and water - if watered when needed the roots grow strong and deep and give the tree strength against wind and weather. Providing and receiving reflective clinical supervision is like taking a deep breath of fresh air in, counting to 10 and then breathing slowly out. It is soul work.
We need to celebrate, the required fireworks...
Finishing Well: Stories of Parallel Process

Deborah Burke
Context

• Offered work by my colleague Paul Spurr with Western Sydney-based NGO

• November 2015 commenced 1 monthly group, 3-4 supervisees working with out of home youth refugees & asylum seekers

• Within 3 months offered 10 groups

• Took up 4 more, 2 colleagues facilitated 2 each (9 in total)

• 4 new groups were caseworkers for refugees and asylum seekers, many “boat people”.
Supervisee Background

- From various professional backgrounds, mainly new graduates
- Various ethnic backgrounds, including refugees themselves
- Mostly young with some mature participants
Supervisor Background

- Mature person
- RN (General & Mental Health)
- Degrees in Social Welfare, Public Health & Clinical Supervision
- Clinical Supervisor for over 25 years, trained supervisors since 2009
- Volunteer in Middle East 2 months of year, working with Gazan, Kurdish, Syrian, Assyrian & Yemenite children & their carers.

Clinical ‘SUPER’vision – people • passion • purpose
Supervision Framework

Predominantly use Proctor framework within which I use many techniques such as
Psychodrama
Play of Life
Gestalt
And tools such as Strength Cards, storycatching cards…
Issues

- Almost exactly 12 months ago murmurings of job loss
- Caseworkers losing clients
- Complaints of Management not being transparent
- Organisation lost tender for program; 11th May 2018: 70/1200 clients left, 15 people in the office, 4 caseworkers + 2 coordinators
Parallel Process

- Definition: “the unconscious replication of the therapeutic relationship in the supervisory relationship”.

Not popular with those who don’t view it as a valued way of learning or too close to a psychoanalytic model.

- Caseworkers, Management, Clients, Supervisors
Story 1: Caseworker-Client (PC)

Oct 2017 new to service,
1\textsuperscript{st} group November 2017, last February 2018
Member of ethnic minority Jummas in Chittagong Hill Tracts of Bangladesh
Sought asylum in Australia for political activism
Alone, family in Bangladesh
February Group: This Year, Next Year exercise Play of Life (revised/tailored)
This Year, Next Year (Revised)

2017

• Pick a figure to represent yourself and place it on the mat.
• What achievement are you most proud of? Choose something to represent that.
• Choose something to represent the activity that gave you the greatest joy.
• What was the greatest lesson that you learned? Choose something to represent that.
• Choose something to represent your biggest piece of unfinished business?
• What do you want to let go of from last year?
Reconstruction
This Year, Next Year (Revised)

2018

• Pick a figure to represent yourself and place it on the mat.
• What do you need to bring over from last year and represent it on the mat? (leave last year’s mat as it is)
• What would you like to happen that isn’t happening now?
• What is success for you in 2018?
• What support/s do you need to meet your goals?
Reconstruction
Major Themes

• Aloneness – separated from family, mistrust, isolation, fear
• Realised he and one of his “difficult” clients were no different
• Wept for 10 minutes in the session
• Supervisor support – contacts of people who could walk with him; parallel process of supervisor aloneness in loss
• Sent an email of apology for getting emotional
Finishing Well

• “Sorry that today I could not hold back my emotions which put you and … in an awkward situation.

• Please there is no need for an apology. With tears come neurological and emotional relief so I do hope that you felt some relief and support. Let me see if I can find some way to get you some support.

• Yeah, I really felt much relief after shedding tears. I felt embarrassed inside but now after reading your email I feel OK.

• Thank you so much for your time in arranging all these contact details. Surely, I will browse all these websites and will see who best suit my purpose.
Finishing Well

3 weeks later…

• Sorry for my late response. The entire day was hectic as this is my last week with ... I have completed all my week’s work today to smoothly transfer the rest of my clients to ...

Where he found a job. According to his peers the new organisation snapped him up. He is finishing the work he began with his clients from the previous organisation and starting with new ones.
Story 2: Caseworker-Management GN

- 1st group June 2017 – only attendee
- Refugee from Congo, torture victim/survivor/overcomer
- Spent 10 years without seeing his wife and children
- Regular attendee even via ZOOM when I was overseas
Caseworker 2

- December 2017 complained of issues with Mx not being transparent, not doing what they said to assist
- Feeling humiliated, challenged, panicked (about future)
- Some Mx feeling challenged and panicked (leaving service)
- Personal life impacting on work – panicking about how to support family, feeling humiliated about possible unemployment
- Explored parallel process between personal and professional relationships
Finishing Well

• How to leave well?
  Being courageous, humble and seeking support (EAP), focussing on clients and impact of service closing/ transferring
  Process – March 2018 still angry with Mx.
    April 2018 offered new job, feeling positive, acknowledged Mx being supportive and helpful. Focus on clients as 1st priority.
  Measured changes with LASS.
Caseworker 3

• July 2017 discussed flatness of group – redundancies in 12 months.
• November 2017 discussed preparation for leaving

Theme: peace vs anxiety
Casewoker 3

- February 2018 used Play of Life “This Year, Next Year” (revised)

Parallel process:
Family (wife) – Caseworker 3 – Client
Balance between being strong (saying No) and being soft (saying Yes). Finding it difficult to be strong with both wife and client.
Described himself as a “developing personality”.
Caseworker 3

- March 2018 Rs last group as it turns out
- Used Storycatching Cards

**Journey** – parallels with childhood

**Doorway** – second family, camaraderie, mixed emotions, wants to “finish well”

**Waiting** – for right job, high benchmark created in this organisation, 60% in this job, 40% thinking about next/future

Examined how to deal with it – “reshaping personality”.

Role of Clinical Supervisor

• Paraclete = Greek term for Holy Spirit
In Christian theology = comforter, counsellor, advocate, intercessor
In Jewish writings = good deed, advocate, intercessor
• Hebrew word for Holy Spirit = Ruach Hakodesh is feminine
Ruach = wind, breath, spirit
Ruach Hakodesh in Tanakh = the spirit of inspiration or indwelling revelation of the Divine Presence
Role of Clinical Supervisor

• By delving in to parallel processes we can be comforters, advocates, intercessors.

• With our breath (words) we can give comfort, hope and facilitate insights (Restorative and Formative functions)

• By listening we can
  “…give the highest form of hospitality” (Henri Nouwen)
  “(offer)...healing” (Gerard Hughes)

Who are we offering all of this to? The supervisee? The client?
Using **Narrative Practices** in Supervision:
Some Stories and Reflections on what this makes more possible...

Sonia Hoffmann, Clinical Supervisor and Social Worker, BaptistCare NSW
Narrative practices... explore how stories shape us
stories make us who we are
they are shaped by context
we are live many-storied lives
Ideas that shape narrative practice...

1. People are meaning makers
2. Meanings are influential
3. Stories provide a frame for meaning making
4. Life is multi-storied
Ideas that shape narrative practice...

5. Stories exist in a context

6. Some stories have more space to exist

7. Identity is social and relational
Exploring possibilities
For moving from
problem stories
to
preferred stories
Opportunities to explore *preferred identities* and rich descriptions of...

**Person** (‘client’ at centre of story)

**Therapist** (‘supervisee’)

**Relationship**

**Therapeutic Work itself**

**Therapist’s Team**

**Agency**

- Hugh Fox (2012)
Decentred
Influential
Curious
Interested
Co-researcher
Investigative journalist
Accountable
Word rescuer
Recognise & address
power & privilege
Further exploring...

Dulwich Centre website

Chimamanda Ngozi Adichie- *The Danger of a Single Story* (TED)

Michael White – *Narratives of Therapists Lives*

Hugh Fox – *Using Narrative Ideas in Supervision*

Vicki Reynolds- *Resisting Burnout with Justice Doing*
MANDATORY CLINICAL SUPERVISION - FANTASY OR REALITY?

Shirley Hamilton
Clinical Nurse Consultant Mental Health
Shirley.hamilton@health.nsw.gov.au
Introduction

- Recognition of difficulty in the practical application of clinical supervision (CS)
- “Mandatory” cs was implemented to a mental health hospital made up of 4 acute inpatient units.
- This Discussion paper will discuss the process, the barriers and the challenges of implementation.
Nursing staff were told that clinical supervision would be mandatory.

Communication workshop.

The CNC designed an informal system whereby every nurse (position, casual) was assigned a clinical supervision group.

Clinical supervisors were selected.

Logistics.

Involved 41 staff and 10 clinical supervisors.
Barriers

- Lack of resources – org support, time, finances & staff
- Lack of understanding of cs
- No development and enactment of a strategic plan
- Poor Leadership
- Poor attendance
- Supervisors confirming prior, chasing people up – merit of this
- Mistrust
Barriers continued

- Mandatory for some vs not others.
- Clinicians perceptions.
- Reluctance to engage.
- Poor self-awareness.
- Refusal to attend.
- Problems rostering.
- Evaluations.
Challenges

- Culture.
- Top-down approach.
- Poor implementation. Lack of structural support
- Lack of leadership, role identity.
- Not seen as a priority.
- Lack of education
- Inadequate resources.
- Cs training for supervisors and supervisees
Lack of establishing a system for evaluation monitoring and support

Unfamiliarity with existing literature and research.

Recognising that it takes time.
Discussion

- Pair up
- Share
- What’s happening, regarding clinical supervision, in your workplace
- What’s working
- What’s not
QUESTIONS
Mandatory clinical supervision for nurses in mental health –
Is it fantasy or Reality???????
THE END

THANK YOU
Quality or Quantity?

The challenges of supporting access to nursing clinical supervision within a large metropolitan Mental Health Service in Queensland, Australia

Kobie Hatch
Nurse Educator
Metro North Mental Health Service
Royal Brisbane and Women’s Hospital
Mental Health Services  
The Royal Brisbane and Women’s Hospital

- Part of Metro North Mental Health Hospital and Health Services
- 122 mental health and alcohol and other drug beds across 7 inpatient, community care and ED units
- 7 community mental health teams
- Approximately 240 nurses
Clinical Supervision prior to 2006

- Mental Health Transition Support Program Nurses
  - Small group supervision conducted monthly (commenced in 1994)
  - Individual clinical supervision available to program participants and their preceptors
- Individual Clinical Supervision - on request
- Team clinical supervision - on request
- All clinical supervision provided by the Nurse Educator
- No designated Nursing Clinical Supervision Coordinator
- No allocated resource for Nursing Clinical Supervision
Momentum for change

- Queensland Health Central Zone coordination support
- Queensland Health funding support for training
- Queensland Health Clinical Supervision Guidelines, 2009
- 2006 RBWH Submission Paper
- Access to 3 day Nursing Clinical Supervisor training
- Regular group supervision commenced on the inpatient mental health units.
- Appointment of Nursing Clinical Supervision Coordinator
## Group Supervision Transition Support Program Evaluation

### Mental Health Nursing Transition Support Program
**Group Clinical Supervision Evaluation**

<table>
<thead>
<tr>
<th>Question</th>
<th>2016 19 Responses</th>
<th>2017 14 Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>I felt the group clinical supervision sessions helped me reflect on my</td>
<td>4.63</td>
<td>4.21</td>
</tr>
<tr>
<td>nursing practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel my practice benefitted from participating in the group clinical</td>
<td>4.53</td>
<td>4.14</td>
</tr>
<tr>
<td>supervision sessions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I enjoyed the group clinical supervision sessions</td>
<td>4.74</td>
<td>4.14</td>
</tr>
<tr>
<td>I liked the structure of the group clinical supervision sessions</td>
<td>4.53</td>
<td>3.93</td>
</tr>
<tr>
<td>How would you rate your overall satisfaction with the group clinical</td>
<td>4.79</td>
<td>4.14</td>
</tr>
<tr>
<td>supervision?*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1= Strongly Disagree, 2=Disagree, 3=Unsure, 4=Agree, 5= Strongly Agree
Being able to discuss issues that had been bothering me all month with my fellow grads

Knowledgeable supervisors with strong skills in running supervision

Learning from others experiences, both from grads and the clinical supervisors

Getting to share when something was upsetting me and receiving helpful feedback. Feeling like I wasn’t alone with these problems

Being able to discuss issues in a confidential forum

Everyone was on the same learning level

Listening to others experiences and learning strategies to deal with the issues

Having time to reflect
Group Supervision in Clinical Areas

- Conducted across 8 clinical areas
- Well established
- External facilitators
- Good attendance
  - 5 staff/fortnight in 7 areas
  - 17 staff per month in 1 community team
Successes

• External supervisors
  • Decrease fears re ‘snoopervision’
  • Transition Support Program
    • Not an educator for past 3 years
• Well established in most clinical areas
• Attendance data
• Transition Support Program
  • attendance and evaluations

Challenges

• Time for inpatient nursing staff to attend supervision together
• Evaluation of open groups
• Staff training in group clinical supervision
• External supervisors
  • Possible future challenges cost and availability of external nursing clinical supervisors
• Establishing ‘supervision of supervision’ group
Individual Nursing Clinical Supervision

• Recommended by Queensland Health Clinical Supervision Guidelines for all Mental Health Staff
• Available to all nurses in Mental Health at RBWH
• Supported by the organisation
  • In work time
  • Q Health supervisors available (no cost)
  • MNMH 3 day workshops in training nursing clinical supervisors
  • Option of accessing own external supervisor (at own cost)
Accessing Individual Clinical Supervision

- Attend a ‘Nursing Clinical Supervision Awareness Session’
  - Overview of nursing clinical supervision
    - what it is & what it is not
    - supporting literature
    - local procedure and processes
  - Provided with a list of available nursing clinical supervisors to choose from
- Contact a clinical supervisor to arrange a preliminary session
- Complete a ‘Nursing Clinical Supervision Working Agreement’
Governance
Nursing clinical supervisor requirements

• Completion of Nursing Clinical Supervision training
• MNMHS 3 day training workshops requires applicants to:
  • Have participated in clinical supervision for a minimum of 12 months
  • Be recommended by their current clinical supervisor
  • Have application endorsed by line manager and Nursing Director
• Recertification process every 3 years
  • Ongoing professional development
  • Own supervision
  • Signed by Line Manager and Nursing Director
Application Form
3 day Training Workshop for Supervisors in Nursing Clinical Supervision

Applicant:
I have (please circle):
• Less than 2 years experience in mental health practice
• More than 2 but less than 5 years experience in mental health practice
• More than 5 years experience in mental health practice

I have demonstrated advanced skills in core competencies (Australian College of Mental Health Nurses, see below) in mental health and
I can attend all three days. Yes □

I can confirm that I am currently receiving clinical supervision and that I will commit to supervising a minimum of 2 supervisors, as well as maintaining my own supervision: Yes □

Line Manager
I support this training application and will complete actions necessary to support this individual to meet their obligations as clinical supervisor, as outlined above.
I agree with the above statement:
Approved: No □ Yes □ Signed □

From Clinical Supervisor:
[Signature] has had one preliminary and
[signature] has had one preliminary and
Clinical Supervision training in the role of supervisor.
Through experience working with [supervisor’s name], a Clinical Supervision Alliance, I have formed the opinion that they are suitable and ready to commence training to fulfill the role of Clinical Supervisor.
Signed: [Signature] [Supervisor name]

Clinical Supervisor’s Name: _____________________________
Course Name: __________________________________________
Date completed: _____________________________
Certificate of completion attached (if not previously submitted): Yes □ No □ N/A □

I have completed a Clinical Supervisor Refresher Course within the last 3 years (if applicable): Yes □ No □ N/A □
Course Name: __________________________________________
Date completed: _____________________________
Certificate of completion attached (if applicable): Yes □ No □ N/A □

I am currently receiving clinical supervision: Yes □ No □
Supervisor’s name: _____________________________
Supervisor’s Clinical Supervision qualification: _____________________________

I have read and understood the MNMH Nursing Clinical Supervision Procedure and am aware of my responsibilities: Yes □ No □

I am currently providing clinical supervision: Yes □ No □
Course Name: __________________________________________
Date completed: _____________________________
Certificate of completion attached (if applicable): Yes □ No □ N/A □

I am not aware of any issues that would prevent me from performing the role of a Nursing Clinical Supervisor: Yes □ No □

Signature: _____________________________ Designation: _____________________________ Date: _____________

Line Manager Certification
I am not aware of any issues that would prevent this staff member from performing the role of clinical supervisor: Yes □ No □
Signed: _____________________________ Name: _____________________________ Designation: _____________________________ Date: _____________

Nursing Director Certification
I am not aware of any issues that would prevent this staff member from performing the role of clinical supervisor: Yes □ No □
Signed: _____________________________ Name: _____________________________ Designation: _____________________________ Date: _____________

Please return completed form to your local Nursing Clinical Supervision Coordinator:
Alcohol and Drug Services - Rodney Jones@health.qld.gov.au
Redcliffe/Caboolture- Paul Kelman@health.qld.gov.au
Royal Brisbane and Women’s Hospital- Kobie Hatch@health.qld.gov.au
The Prince Charles Hospital- Gerard Mullan@health.qld.gov.au
Nursing Clinical Supervisor Training Attendees
Nurses accessing clinical supervision

- 2010
- 2011
- 2012
- 2013
- 2015
- 2017

nurses in supervision

ACSA Conference
22–24 May 2018
Successes

• Collaboration across MNMH
• MNMH Procedure
• Clinical supervisor training pre-requisites
• Recertification process
• Refresher workshops
• Supervisor choice

Challenges

• Building nursing interest in clinical supervision
  • Clinical supervision education session for graduates
• Linking supervisor and supervisee
• Supervisor profile
• Identifying potential new supervisors
• Maintaining accurate records
• Supervision of supervision
• Monitoring compliance
The questions remains…

Quality or Quantity?
References

- Royal Brisbane and Women’s Hospital and Health Service District. (2007). *Submission Paper: Clinical Supervision in Mental Health Nursing.* Royal Brisbane and Women’s Hospital and Health Service District. RBWH, Herston
Being valued, and connected – How Psychologists maintain their resilience in adversity

Fiona Howard
Doctoral Programme of Clinical Psychology
University of Auckland, Aotearoa New Zealand
One fern frond falls
As another unfurls
Resilience

‘...a dynamic process encompassing positive adaptation within the context of significant adversity’ (Luthar, Ciccetti, & Becker, 2000)

• Implicit within this notion are two critical conditions:
  (1) exposure to significant threat or severe adversity;
  (2) the achievement of positive adaptation despite major assaults on the developmental process

‘Vicarious resilience’ (Hernandez et al., 2007)

- Found that mental health practitioners who had worked with victims of political violence reported that witnessing their clients overcome adversity affected and changed their own attitudes and emotions regarding the human being’s capacity to heal, and also his/her perception of his/her own problems.

- This significantly shaped workers’ perceptions, relationships and environment.
Shared Traumatic Reality

- In such situations we are potentially exposed to the stress and trauma as individual citizens and as helping professionals.

- Negative effects are woven together with positive effects:
  - Loss, fear, pain and grief, threat, uncertainty and helplessness, PTSD
  - Gratification, heightened self-confidence (Soliman et al., 1998),
  - Renewed commitment and positive feelings about work (Eidelson et al., 2003),
  - Increased skills and knowledge, and sense of professional worth (Baum and Ramon, 2010),
  - Personal growth, more meaningful relationships with others, increased personal strength, changed priorities, increased appreciation of life, and richer existential and spiritual life (Tedeschi and Calhoun, 1996).
Maintaining or building resilience in a shared traumatic reality

- What does the process of resilience look like such circumstances?
- What can be learned from this situation that could have relevance to supervision?
Method

• Qualitative study in conjunction with McCormick (2014)
• 8 Clinical Psychologists were invited through a process of recommendation. All were active in the work with earthquake survivors and building resilience.
  • All over 40, average age 53
  • 6 female, 2 male
  • All Pakeha/NZ European/South African
  • Settings: 5 worked in Adult MH, 3 C & A, 2 of these in both; 3 private, 2 public, 3 mixed (predominantly public). Ave time per week 37.5 hours.
Focus group questions

• In general, how do you believe you develop and maintain resilience in this profession?

• Specifically, how has your resilience (or your methods for maintaining it) changed as a result of the stress and trauma associated with the earthquakes?

• What would you do to strengthen resilience in the caring professions?
Themes

• Experiential learning
  • ‘Double exposure’ provided ‘a shared understanding’ which gave unique insights into the nature of the threat system, post-traumatic stress and anxiety.

• Practicing self-reflection
  • the importance of ‘making sense’ of their own experience and that self-reflection

• Realistic expectations of self (compassionate)
  • The ability to moderate expectations with the reality of professional and personal limitations.
• **Staying grounded**  
  • Balancing one’s connection to familiar routines & self-care in relation to clients and their growth

• **Experiencing positive emotions**  
  • Pleasure, joy, humour, fascination, hope and inspiration from client growth; a sense of gratitude and privilege

• **Feeling deeply valued**  
  • Strong endorsement of psychologists’ value to society;
• Growth in self efficacy
  • Importance of adaptability and self-efficacy. In turn this grew, whereby psychologists came to believe more in their ability to cope under stressful circumstances and with greater flexibility

• Feeling supported and connected
  • Importance of team support and sense of connection

• Strengthened relationships
  • Quality of relationships were both instrumental in the process of resilience as well as representative of resultant post-traumatic growth.

• Spiritual and philosophical growth
  • Having something to believe in, sustaining perspectives and meaning frameworks
Resilience-building Supervision

• Feeling supported
  • Provide a strongly supportive and pro-active supervisory alliance
  • Support s’ee to build and utilise informal and formal support networks
  • A communitarian approach to competence

• Staying grounded
  • Promote the use of familiar routines & self-care practices when under adverse or challenging conditions

• Self-reflection - ‘making sense’
  • Reflection on emotional, physical and cognitive reactions, to make sense of experiences
• Tuning into clients/positive emotions
  • Facilitate noticing of and reflection on positive feeling states in relation to clients growth and change. Elicit emotions such as gratitude, pride, joy, hope.

• Realistic expectations of self (compassionate)
  • Assist s’ee to be realistic and self-compassionate in relation to their capacity and contribution.
  • Strengthen self-efficacy and sense of mastery
  • Gently challenge avoidance coping.
• Feeling valued
  • Reflections upon the value of their work to the clients, their family and society at large.
  • Advocate for recognition and support from wider professional networks.

• ‘Having something to believe in’
  • Helping the s’ee develop/connect to sustaining perspectives or meaning frameworks e.g. spiritual and/or philosophical beliefs and values.
Beyond supervision

• Team/agency/organisation:
  • Managing workplace demands (practical assistance)
  • Coaching growth fostering collegial relationships (positive, supportive, accepting, negotiative)
  • Attitudes – acceptance of vulnerability and distress
  • Values – communicate the value of the worker’s contribution

• Profession:
  • Normalise expression of vulnerability and processing of distress in relation to challenging client work
  • Facilitate use of support, training and education
  • Advocate for the value of the profession to society
The end
Beyond supervision – supervision in context

- Educational programmes on resilience and wellbeing
- Professional body practice requirements and support structures
- Organisational commitment to employee wellbeing and resilience, values and policies reflecting the centrality of these
- Leadership
<table>
<thead>
<tr>
<th>Themes</th>
<th>Subthemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Professional Culture of Care: “trust and strength in having good</td>
<td>Positive Colleague Relationships; Supervision</td>
</tr>
<tr>
<td>people with you”</td>
<td></td>
</tr>
<tr>
<td>A Separate and Protected Lifestyle: “you have to go and just be normal”</td>
<td>Looking after yourself; Supportive and normalising personal</td>
</tr>
<tr>
<td></td>
<td>relationships</td>
</tr>
<tr>
<td>Coping at Work: “it is a relationship-based thing that you’re doing</td>
<td>Managing emotional reactions to therapeutic Work;</td>
</tr>
<tr>
<td>you can be removed but you can’t be too far removed”</td>
<td>Managing workplace demands</td>
</tr>
<tr>
<td>Professional and Personal Growth Reflects Resilience: “feeling like</td>
<td>Growth through: self-reflection, personal therapy and</td>
</tr>
<tr>
<td>I’m growing and learning is a big part of resilience”</td>
<td>engagement in therapeutic relationships with clients.</td>
</tr>
<tr>
<td>Being Resilient has Benefits: “you can keep doing it, do it well</td>
<td></td>
</tr>
<tr>
<td>and enjoy doing it”</td>
<td></td>
</tr>
<tr>
<td>Contexts that Undermine Professional Well-Being: “I imagine being a</td>
<td>Undermining aspects of:</td>
</tr>
<tr>
<td>nurse in the trenches in World War I”</td>
<td>- Institutional settings;</td>
</tr>
<tr>
<td></td>
<td>- Team culture;</td>
</tr>
<tr>
<td></td>
<td>- Psychology Profession;</td>
</tr>
<tr>
<td></td>
<td>Selection and Training</td>
</tr>
</tbody>
</table>
Recommendations

• Improving preparedness in terms of learning about stress, emotion regulation, self-care, adversity and resilience (training and beyond)

• Therapy in training or within 3 years out

• Early experience in pressured environments

• Beliefs and values regarding acceptance of self and ones vulnerabilities

• Importance of therapeutic self-reflection and connection (collegial support)

Develop realistic expectations re clients and self
Témoin à Deux: An Experience of Paired Reciprocal Peer Clinical Supervision

Joy Forster  
Julie Sharrock
Principle of avoiding dual relationships

Principle of choice
Living in the reality
The Why and the How
What we have found