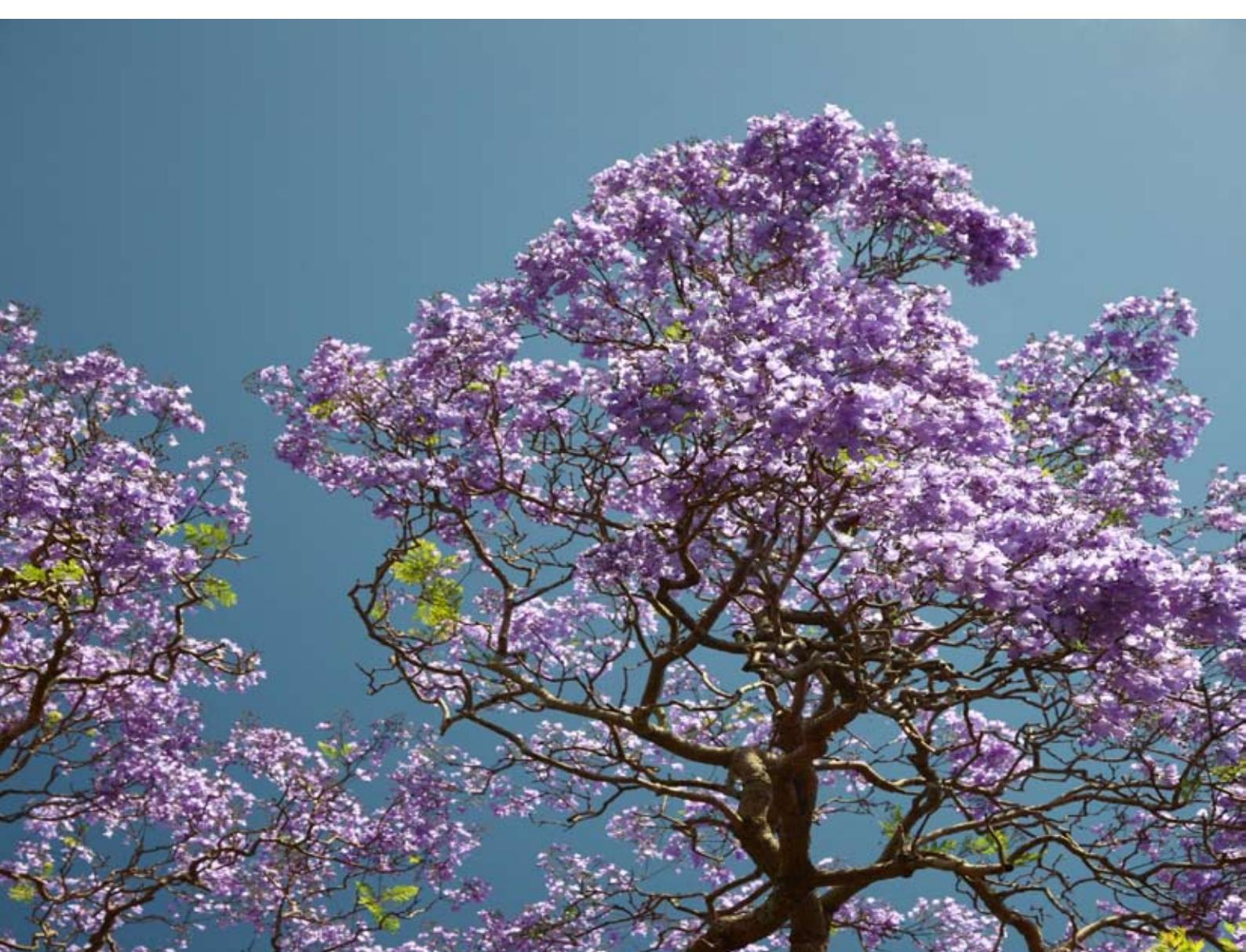


# Clinical Supervision Guidelines for Mental Health Services

October 2009



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## Executive summary

Queensland Health is committed to ensuring that the mental health workforce is adequately skilled and resourced to provide quality and safe clinical services to consumers and their carers and families. This is demonstrated through mental health reform initiatives and has been clearly identified in the *Queensland Plan for Mental Health 2007 – 2017*.<sup>1</sup>

These guidelines serve as a best practice framework for the delivery of clinical supervision in Queensland mental health services as outlined by the principles of the *Human Resources Policy G5: Practice Supervision in Allied Mental Health*.

The *Clinical Supervision Guidelines for Mental Health Services* provides a standardised, generic and flexible statewide approach to clinical supervision for all mental health professionals involved in mental health service delivery. The terms clinical supervision and practice supervision are used interchangeably in this policy.

The Guidelines recognise that clinical supervision is central to promoting the personal and professional development of mental health clinicians in Queensland Health and improving consumer care outcomes.

By providing a framework that encourages review and reflection in practice, clinical supervision improves clinical standards, reduces clinician stress and burnout and enhances the quality of consumer care.

In keeping with guideline management best practice, the *Clinical Supervision Guidelines for Mental Health Services* will undergo biennial review by the Mental Health Clinical Supervision Steering Committee, Mental Health Branch.

Dr Aaron Groves  
Senior Director  
Mental Health Branch  
12 October 2009

## Clinical supervision highlights

**Clinical supervision that is well implemented is a key component in providing:**

- high quality mental health services with positive outcomes for consumers
- a well trained, highly skilled and supported workforce
- development, retention and motivation for the workforce.

**High quality clinical supervision also contributes to:**

- meeting performance standards
- meeting the expectations of consumers, carers and families
- developing a learning culture in a changing health care environment.

**The *Clinical Supervision Guidelines for Mental Health Services*:**

- provide guidance on the roles and responsibilities for the provision and receipt of clinical supervision
- incorporate best practice principles and recognises the need for flexibility in the delivery of clinical supervision
- provide separately for the recommended approaches of the different clinical professional groups
- incorporate the requirements of clinical governance and related Queensland Health policies.

# Part one

## Guideline statement

These guidelines provide a standardised and generic, yet flexible statewide approach to clinical supervision for mental health clinicians. The principles outlined will assist clinicians, clinical supervisors and managers to understand the purpose of clinical supervision and to clarify their respective responsibilities.

Queensland Health supports and provides access to clinical supervision for all mental health professionals involved in the direct delivery of mental health services. The following groups of clinicians in mental health services are expected to participate in clinical supervision:

- medical staff
- mental health nursing staff
- allied health staff
- indigenous mental health staff
- consumer and carer workforce
- other clinical staff.

Queensland Health has a responsibility to ensure that clinicians have access to appropriate professional development and support in the exercise of their joint and individual responsibilities for clinical practice. Active participation in clinical supervision is a clear demonstration of an individual exercising their responsibility under clinical governance. Clinical supervision should take place in the context of the overall clinical governance and staff support, rather than being an individual activity carried out in isolation.<sup>2</sup>

These guidelines:

- define and formalise the clinical supervision structure and process
- highlight the roles of all parties involved in clinical supervision, the areas to be covered in clinical supervision, criteria for selection of supervisors and the importance of adequate resourcing for clinical supervision
- outline minimum audit standards of access to, and quality of, clinical supervision across mental health services
- define clinical supervision responsibilities at the level of the organisation, district, service, clinical supervisor and clinician
- highlight the role of clinical supervision in relation to performance and development of staff and clinical governance.

## **Underlying principles**

These guidelines are underpinned by the following principles for clinical supervision.

- 1.** Clinical supervision is a formal process of support and reflection and is separate to a formal system of individual performance appraisal. It is about empowerment, not control
- 2.** Clinical supervision is a core function of Queensland Health – explicitly resourced, planned, managed and evaluated at all levels of the organisation
- 3.** Clinical supervision is integral to mental health clinician role requirements and job descriptions
- 4.** Clinical supervision is one aspect of a wider framework of clinical governance activities that are designed to support staff, and manage and monitor the delivery of high quality services and effective outcomes for mental health consumers
- 5.** A variety of clinical supervision models may be used, depending on the research evidence, best practice, context and discipline group
- 6.** Effective and ethical clinical supervision means that clinical supervisors are trained, can demonstrate recency of training and experience, and participate in supervision of their supervision
- 7.** Access to clinical supervision and clinical supervision training is to be supported by a range of interventions and modalities within the context of a competency and evidence based provision model
- 8.** Clinical supervision is coordinated within a statewide framework and it is the responsibility of the districts/facilities to manage and ensure the efficiency, effectiveness and availability of clinical supervision
- 9.** Clinical supervision will be audited, evaluated and documented at an individual practitioner, district and statewide level
- 10.** Clinical supervision involves appropriate information management and confidentiality processes
- 11.** Ongoing clinical supervision for all clinical staff involved in the direct delivery of mental health services is critical to ensure quality assurance in mental health practice, regardless of experience and level of appointment.

Clinical supervision is a formal process of professional support and learning which enables individual practitioners to:

- develop knowledge and skills competence
- reflect and receive feedback on the content and process of their work
- explore ethical implications and associated work dilemmas within mental health service settings
- identify measures to manage workplace stressors
- assume greater responsibility for their practice
- clarify boundaries between the practitioner, consumer, clinical supervisor, line manager, and others such as referring agents

- plan and utilise their personal and professional resources more effectively
- enhance consumer protection and safe high quality consumer care
- develop accountability for the quality of their work and offer assurances to those who monitor that accountability.

*Clinical supervision is a designated interaction between two or more practitioners, within a safe and supportive environment, which enables a process of reflective, critical analysis of care, to ensure quality consumer services*

## Intended application of the guidelines

The *Clinical Supervision Guidelines for Mental Health Services*:

- expect that all clinical staff involved in the direct delivery of mental health services receive regular clinical supervision
- are applicable to all practitioners in mental health services who have responsibility for the provision of direct services to consumers including indigenous mental health workforce and consumer and carer workforce. In addition to meeting the general principles of clinical supervision, all professional groups must address further cultural aspects of practice and intervention in a way that meets the needs identified by the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2004 – 2009* (2004)
- acknowledge that different disciplines have different professional requirements and different levels of current clinical supervision practice, and allow flexibility in implementation while stressing the importance of mental health services developing agreed pathways for clinical supervision for key professional groups
- do not recommend a single model of clinical supervision. Mental health services retain the flexibility to implement programs and processes appropriate for their local context, and within their available resources
- are not intended to replace specific clinical supervision requirements associated with some professions, for example, the requirements for registration as a psychologist, medical registration nor credentialing of mental health nurses
- are inclusive of healthcare students on clinical placement and cadetship holders, as these groups are also required to operate within Queensland Health policies and procedures.

## Clinical Supervision Defined

Clinical supervision is a broad term encompassing a range of principles, activities and areas of work practice. To be inclusive of all mental health professionals' clinical supervision models, the terms clinical supervision and practice supervision are used interchangeably within this policy.

*Clinical supervision is broadly defined as a working alliance between two staff members where the primary intention of the interaction is to enhance the knowledge, skills and attitudes of at least one staff member.*

Clinical supervision is one component of an overall model of clinical governance and professional development for mental health professionals (see Figure 1). Other components include administrative, line management, professional supervision, performance appraisal and development processes, mentoring, clinical education and training and participation in structures such as clinical review, team meetings, clinical handovers and grand rounds.

Clinical supervision can be seen as a process that promotes personal and professional development within a supportive relationship, formed in order to promote high clinical standards and develop expertise by supporting staff and helping them to prevent problems in busy practice settings.<sup>3</sup> It involves "a regular, protected time for facilitated, in-depth reflection on practice".<sup>4</sup>

*Clinical supervision and performance appraisal are **two separate but inter-related processes**. A clinician may choose to use clinical supervision to help them prepare for a performance appraisal by identifying issues, which they may wish to raise, and to use clinical supervision to assist them in achieving the objectives that have been set during the review.*

*Clinical supervision is a **consumer-focused activity**. Therefore, the content of supervision sessions should focus on issues relating to, or impacting on clinical practice and the delivery of consumer care. Clinical supervision should **not** be regarded as personal therapy; Queensland Health recognises that, occasionally, clinical supervision may include reflecting on personal issues, which impact on care delivery. When necessary, personal therapy and support may be provided by health service district employee support programs.*

*Clinical supervision is a **clinician-led activity**. This means the clinician chooses their clinical supervisor, in conjunction with the Team Leader/Unit Manager and Discipline Leader\*, and in collaboration with their supervisor; determines the frequency of clinical supervision (within the specified standards), the purpose of clinical supervision, the focus for each session and their own learning goals.*

\* Discipline Leaders may include: Directors of Allied Health, Directors of Nursing, and other Discipline (Allied Health, Nursing and Medical) Directors and senior staff who have responsibilities for mental health staff.

Clinical supervision is supervision of practice as a staff member of the mental health service; that is, it focuses primarily on practice issues, rather than broader supervision, staff development or line management issues. It interfaces with these and other issues related to career development and a staff member's work-life, particularly in relation to training and skill acquisition required to better address clinical duties that they need to perform.

Clinical supervision can be intra-professional (conducted by members of the same profession) or cross-professional (conducted by a member of another profession). Clinical supervision can be delivered in a variety of modes including face-to-face, telephone and videoconferencing, and in either individual or group format.

Clinical supervision is not a management activity and should not be confused with Performance Appraisal and Development (PAD) or administrative supervision with line managers.

A PAD plan is used to help an employee meet the expectations of the organisation in terms of their work and includes the identification of any training or personal development needs the employee may have to help them to carry out their work effectively.

Administrative or line management supervision is supervision that primarily focuses on administrative or line management issues such as attendance, work allocation, and workplace issues.

Professional (intra-professional) supervision is distinct from clinical supervision and refers to the relationship between a clinician and their discipline leader where the focus is primarily on discipline or profession specific practice skills.

In addition to participation in clinical supervision, it is critical that mental health professionals maintain their participation in the full range of professional development activities including clinical education and training, and attendance at clinical review and team meetings, handovers and grand rounds.

The effective management and development of staff within the workplace involves overlapping and closely linked aspects of professional skills development where clinical supervision is one of the key components (see Figure 1). Due consideration should be given to each area within the management of the core business of mental health services and the context of the work unit area of practice.



**Figure 1: Conceptual map of the array of supervisory activities**

## Purposes of Clinical Supervision

Clinical supervision has three main purposes:

- **formative:** enabling the practitioner's development of expertise and skills through education and experiential learning. This learning is achieved through guided reflection on practice in a safe, time protected setting
- **restorative:** enabling the practitioner to sustain effective work by supporting those who work with stress and distress. This support is achieved by the supervisor having an unconditional positive regard for the clinician (holding a continual respect for the individual despite the circumstances). In this supportive setting, positive challenges to clinical practice can be made
- **normative:** ensuring the practitioner maintains established standards of care by dealing with the quality control aspects of practice. In the clinical supervision setting, this is most powerfully achieved through reflection on practice in a supportive relationship that is safe enough to challenge thinking. It is the shared responsibility of both the supervisor and clinician.<sup>5</sup>

## Part Two

### Six Levels of Clinical Supervision Delivery

The general responsibilities of each level of service delivery are outlined in Table 1.

| Level of Governance  | Broad Areas of Responsibility  |
|--|--|
| <b>1. Queensland Health</b>  | <ul style="list-style-type: none"> <li>• enable mental health clinician participation at all levels</li> <li>• enable choice and access to clinical supervision</li> <li>• enable quality improvement and evaluation</li> <li>• enable supervision resourcing</li> <li>• implement clinical supervision governance framework.</li> </ul>   |
| <b>2. Allied Health Statewide Professional Leaders and other Discipline Professional Leaders</b>                         | <ul style="list-style-type: none"> <li>• provide statewide coordination</li> <li>• Provide supervisor training and accreditation</li> <li>• Enable supervision of supervision processes</li> <li>• Implement evidence based research and clinical supervision practice</li> <li>• Provide auditing and benchmarking of clinical supervision</li> <li>• Provide resources and training for staff.</li> </ul>  |
| <b>3. Health Service District-Discipline Leaders in collaboration with Service Managers/ Team Leaders/ Unit Managers</b> | <ul style="list-style-type: none"> <li>• Enable coordination/collaboration at a local level</li> <li>• Enable quality assessment and evaluation</li> <li>• Manage staff clinical supervision allocations</li> <li>• Provide resources and training for staff</li> <li>• Ensure all staff are given the opportunity to participate in clinical supervision</li> <li>• Induct new clinicians into the clinical supervision policy and practice</li> <li>• Develop health service district specific policies and procedures</li> <li>• Identify potential clinical supervisors for participation in the training and accreditation program.</li> </ul>  |
| <b>4. Service Managers/ Team Leaders/ Unit Managers</b>  | <ul style="list-style-type: none"> <li>• Collaborate between local cross-sector partnerships/programs; service management, discipline seniors and staff</li> <li>• Ensure effective and efficient use of staff specialised skills including discipline-specific skills</li> <li>• Manage staff clinical supervision allocations</li> <li>• Ensure staff are given protected time to provide/receive clinical supervision</li> <li>• Ensure individual employees include clinical supervision in their personal development plans and that it is integral to the work program</li> <li>• Identify potential clinical supervisors for participation in the training and accreditation program</li> </ul> |
| <b>5. Clinical Supervisors</b>   | <ul style="list-style-type: none"> <li>• Evaluate clinical supervision outcomes</li> <li>• Provide competent and ethical supervisory practice</li> <li>• Maintain best practice standards in clinical supervision</li> <li>• If delivering specialist supervision, i.e. supervision for the purpose of developing specialist skills and interventions, then ensure own competence within the specialisation.</li> </ul>  |
| <b>6. Clinicians/ Practitioners</b>  | <ul style="list-style-type: none"> <li>• Engage in regular (not less than monthly) clinical supervision</li> <li>• Apply the learning and skills from clinical supervision to clinical work</li> <li>• Transition to supervisor education and training when and where appropriate</li> </ul>   |

**Table 1: Governance and the broad areas of responsibility**

## **Specific Responsibilities for Service (Line) Managers, Discipline Leaders, Supervisors, and Clinicians**

### **Service Managers/Team Leaders/Unit Managers/Discipline Leaders**

Responsibilities of line managers include the following areas:

- ensuring staff are aware of the clinical supervision guidelines, and the expectations of their participation
- assisting all staff (clinicians and supervisors) to manage their time effectively in conjunction with existing workloads and resources in order to participate in clinical supervision
- collaborating between local cross-sector partnerships and programs, and collaborating with service management, discipline seniors and staff
- ensuring any issues brought to their attention as a result of clinical supervision are dealt with promptly and appropriately. This includes any issues requiring investigation or disciplinary action
- ensuring clinical supervisors access supervision of supervision processes on a regular basis
- managing information obtained from clinical supervision processes according to organisational clinical supervision reporting requirements, for example, reporting attendance numbers and frequency and associated costs and resources
- maintaining quality clinical service delivery by taking reasonable steps to resolve any concerns raised by clinicians in relation to their clinical supervision
- managing staff clinical supervision allocations. This involves ensuring that staff are made aware of the processes for engaging a supervisor where an internal supervision model is in operation, and undertaking any necessary approval processes for external supervisors as guided by local policies and procedures
- ensuring effective and efficient use of staff specialised skills including discipline specific skills
- ensuring staff are given the protected time required to attend clinical supervision. This includes making any changes in the workplace required to enable staff to attend; for example, rostering arrangements, making transport available, establishing group supervision arrangements and making meeting rooms available
- ensuring that clinical supervision is integral to the work program and that individual employees have clinical supervision included in their personal development plans
- identifying future potential clinical supervisors who will engage in the training and registration program
- matching and linking practitioners to supervisors.

## Clinical supervisors

Responsibilities of clinical supervisors include:

- maintaining knowledge about organisational goals, supported treatment modalities of the mental health service, and any relevant ethical codes, guidelines or standards, and the application of this to clinical supervision
- ensuring clinicians are clear at the outset about the purpose of clinical supervision, what is expected of them, the role of the supervisor, the parameters of confidentiality, and the appropriate mechanisms for addressing any difficulties or concerns about the clinical supervision process
- working with clinicians to agree on goals for supervision sessions, and putting in place processes for regular reviews of progress
- facilitating a safe and trusting environment for clinical supervision sessions
- ensuring that clinical supervision sessions have structure, and are working toward achieving all three of the purpose areas of clinical supervision
- validating good practice and providing constructive feedback
- challenging practice that is inappropriate, or which does not fit with the agreed treatment modalities of the mental health service, and facilitating the development of sound clinical skills and ethical practice
- working within the agreed boundaries of confidentiality and taking responsibility for reporting any serious issues to line managers and informing clinicians when such a circumstance arises
- participating in any agreed monitoring or reporting mechanisms related to the provision of clinical supervision
- participating in supervision of supervision.

## Clinicians/Practitioners

Responsibilities of clinicians/practitioners participating in clinical supervision include:

- negotiating arrangements for clinical supervision, in line with organisational policies or procedures, and with line management approval
- ensuring regular attendance as agreed by the organisation and in line with local policies and procedures
- working with the supervisor to agree on the goals of clinical supervision, and agree on ways of working together
- taking action in relation to any developmental needs identified through clinical supervision
- maintaining any records related to clinical supervision sessions as set out in local policies or procedures.

## Frequency of clinical supervision

The following best practice guidelines are recommendations for implementation. It is expected that additional factors, such as the availability of supervisors, may impact upon the district's ability to implement the guidelines.

Team Leaders/Unit Managers, Discipline Leaders, clinical supervisors and clinicians, in collaboration with Statewide Professional Leaders and professional leaders as required, are best placed to ascertain the supervisory requirements of mental health clinicians within the context of their service delivery model and available resources. Transitioning between the levels of clinical supervision frequency would be discussed and included in the supervisory agreement developed between supervisor and clinician, and would involve assessment of competence on the part of the supervisor (see Table 2).

| Level of Clinical Supervision         | Weighting Factors   | Minimum Expected Frequency  |
|---------------------------------------|---|---|
| <b>Level 1</b>                        |   |   |
| High frequency clinical supervision   | Novice practitioner with less than two years of clinical experience<br><br>Clinicians with limited practice experience in mental health<br><br>Clinicians experiencing significant changes in role; e.g., from CYMHS to Adult MHS or from acute to community based work | Four hours of individual or group supervision monthly. At least 50 per cent of supervision should be on an individual basis.    |
| <b>Level 2</b>                        |   |   |
| Medium frequency clinical supervision | Sole practitioners and rural and remote clinicians<br><br>Clinicians with a higher caseload, more complex casemix and focus of care   | Two (2) hours of individual or group supervision monthly. At least 50 per cent of supervision should be on an individual basis. |
| <b>Level 3</b>                        |   |   |
| Low frequency clinical supervision    | Experienced clinicians with more than five (5) years of practice as a mental health practitioner  | One (1) hour of individual or group supervision monthly. At least 50 per cent of supervision should be on an individual basis.  |

**Table 2: Weighting factors for frequency of clinical supervision<sup>6</sup>**

### Additional factors for assessing frequency of clinical supervision include:

- **supervisory experience and developmental level** (supervisor and clinician) – duration, type and frequency of previous clinical supervision will determine the frequency of current clinical supervision
- **consumer caseload/casemix/focus of care/degree of specialisation** – higher caseloads and more complex casemix, focus of care and specialisation will require increased frequency of clinical supervision

- **practice area** – rural and remote areas of work will equate to increased frequency of clinical supervision and may include multidisciplinary as opposed to discipline specific supervision, e.g., case management supervision
- **work/team setting** – higher frequency of other means of clinical support and practitioner development, i.e., frequency of team meetings, debriefing, grand rounds and reflective practice forums will equate to decreased frequency of clinical supervision.

### **Special considerations in determining supervision frequency.**

Specific clinical supervision requirements are associated with some professions, for example, the requirements for probationary psychologists and medical staff. Peer review groups may replace individual supervision for psychiatrists. Specific requirements also apply for healthcare students on clinical placement, and cadetship holders. In order to ensure the safety of consumers and that these clinicians are engaging in evidence based and ethical practice, the special supervision needs for these individuals must be considered when determining supervision level, frequency and content.

### **Frequency of Supervision of Supervision**

The supervision of supervision assists clinical supervisors to meet their formative (learning), normative (accountability) and restorative (support) needs. Supervision of supervision should be provided only by an individual who has a high level of demonstrated competence in the provision of practice supervision.<sup>7</sup>

Table 3 provides recommended guidelines for determining the frequency of supervision of supervision for clinical supervisors.

| Level of Clinical Supervision             | Weighting Factors   | Minimum Expected Frequency                                  |
|---|---|---|
| <b>Level 1</b>                            |   |   |
| High frequency supervision of supervision | Novice supervisor with less than five (5) years of supervisory experience | One (1) hour of individual or group supervision fortnightly |
| <b>Level 2</b>                            |   |   |
| Low frequency supervision of supervision  | Experienced supervisors   | One (1) hour of individual or group supervision monthly     |

**Table 3: Weighting factors for frequency of supervision of supervision**

## **Part Three**

### **Clinical Supervision Implementation**

As shown in *Part Two*, clinical supervision is a formal organisational arrangement that sits within an overall framework of clinical governance. Clinical supervision is tailored to the needs of specific contexts and disciplines with the flexibility to change models according to research evidence, stakeholder evaluations and data generated by formal reporting mechanisms. The content of clinical supervision sessions is confidential (except in certain circumstances to be discussed below), and is also tailored to meet the needs of individual clinicians. Clinical supervision is not a private arrangement; rather, it is conducted as part of core business of workplace activities in line with the goals, organisational approaches and therapeutic modalities of Queensland Health. *Part Three* details policies and procedures for clinical supervision implementation and information management.

#### **Queensland Health Human Resources Policy G5 – Practice Supervision in Allied Mental Health**

The *Clinical Supervision Guidelines for Mental Health Services* support the Queensland Health G5 *Practice Supervision in Allied Mental Health* Human Resources policy, and provide clinicians, supervisors, discipline leaders and managers with more detailed recommendations for practice implementation.<sup>8</sup>

### **Best Practice Standards**

#### **Competency based clinical supervision**

Queensland Health is committed to competency based clinical supervision where competence is broadly defined as knowledge, skills and values. Clinical supervision is a distinct intervention and specialisation that involves a specific set of generic competencies irrespective of professional discipline, practice setting, consumer focus and service delivery model. Effective clinical supervisors are flexible, and able to utilise a broad range of knowledge, skills and qualities to deliver quality supervision and fulfil their clinical, administrative and, where applicable, evaluative responsibilities. Such competency based clinical supervision is central to the successful implementation of evidence based practices and for promoting quality assurance in mental health practice.

The primary focus of competency based clinical supervision is on the clinical practice of the clinician. Effective clinical supervision relies on the development of a strong alliance between the clinician and the supervisor. Discussion of consumers and clinical case management is an integral part of the supervision process, and provides tools for reviewing the clinical practice of the clinician. However, the focus remains on developing professional competence and support for the clinician, rather than on providing indirect treatment of the consumer.

Clinical supervision has become an organisational function with its own conceptual framework and methodology.

Key competencies for effective clinical supervision represent a broad range of knowledge and skills pertinent to the clinical, administrative, and evaluative

responsibilities of a clinical supervisor. Effective supervisors observe, mentor, coach, evaluate, inspire and create a positive atmosphere that promotes self-motivation, learning and professional development. Becoming an effective and fully competent clinical supervisor is a developmental process. As knowledge and skills are achieved over time, the supervisor's proficiency incrementally increases.

## Flexibility and Choice

### Clinical supervision frameworks

Clinical supervision is applicable for all clinical staff involved in the delivery of mental health services regardless of their level of experience or professional background. Queensland Health recognises the need for flexibility in providing clinical supervision requirements for different groups of clinicians and different levels of experience. In addressing these different needs, a range of competency based supervisory frameworks that meet the applicable formative (learning), normative (accountability) and restorative (support) needs of clinicians may be employed.

### Choosing and accessing a clinical supervisor

Effective clinical supervision relies on the development of a strong alliance between supervisors and clinicians. Staff are more likely to participate actively in, and benefit from, clinical supervision if they choose their supervisor.<sup>9</sup> Choosing and accessing a clinical supervisor is done in conjunction with the Team Leader/Unit Manager and Discipline Director/Senior. It is a planning process that is individualised to match the clinician's needs to supervisor resources. Staff in lead positions for clinical supervision may assist with knowledge of available supervisor resources across the State. Allied health staff can access a database (maintained by the Statewide Professional Leaders) of accredited clinical supervisors within their area and districts. This provision does not override the mandatory supervision and training requirements of individual registration boards and professional bodies such as RANZCP in relation to medical staff and in the case of junior doctors it is expected that the supervisor will be their line manager.

### New staff

Within six weeks of commencing employment, new staff are to be provided with education regarding clinical supervision as part of induction and orientation. Line managers will assist new staff to identify and access an appropriate and available clinical supervisor.

### Professional and practice boundaries in clinical supervision

Staff should avoid undertaking clinical supervision with:

- a colleague who is also a personal friend or family member
- their line manager or a colleague with whom they have an operational reporting relationship.

It is recommended in the *G5 Practice Supervision in Allied Mental Health Human Resources* policy that wherever possible line managers do not provide clinical supervision to staff who report directly to them. Although managers have responsibilities in the clinical supervision program (see Table 1), the purpose of

clinical supervision is different from that of line management supervision and the two processes should remain separate.

In some circumstances, clinical supervision from the line manager may be appropriate. Those circumstances include examples where:

- a line manager has particular expertise in an area of practice that would be of benefit to the clinician. These potential benefits should be documented in the clinical supervision agreement and reviewed regularly
- staff are working in small teams in rural or remote areas. However, alternative clinical supervision arrangements for these staff should be investigated and implemented, and where possible may include supervision by phone, video conference or by email. For staff in remote and rural areas, travel time and access to a vehicle may also be required to support clinical supervision.

### **Intra-district clinical supervision (internal supervision)**

Where practical, clinicians should seek clinical supervision within the mental health service or district (but not necessarily the team) in which they work.

### **Multiple supervisors**

A clinician may have more than one clinical supervisor at any given time in order to maximise access to specific practice, clinical expertise or competencies across the full spectrum of mental health service provision. Employees should consider having a primary supervisor and negotiate the use of additional supervisors on an 'as needs' basis.

The goals of the sessions provided by any additional supervisors could be added to the existing supervision agreement between the supervisee and primary supervisor. The one agreement minimises inefficiencies with administrative workloads associated with the use of multiple written agreements. Additionally, having one agreement facilitates an integrated and coordinated approach to a supervisee's clinical practice needs.

### **Supervision by a Queensland Health supervisor outside the clinician's local work area (inter-district supervision)**

In some circumstances, it may be necessary for staff to have supervision outside of the locality in which they work. This requires the approval of the line manager in conjunction with the discipline leaders for both districts. As this may attract additional costs to both districts, the clinician will have to demonstrate the need for seeking inter-district clinical supervision. The clinician may outline their reason/s and negotiate any need for travel time and a vehicle with their service/unit manager.

Reasons for accessing clinical supervision outside the clinician's local work area may include:

- needing clinical supervision in a specialist area of practice that is not available in the clinician's work locality
- lack of choice of supervisors in the clinician's work locality
- access to personal choice of a supervisor who is not available locally.

## **Clinical supervision NOT provided by Queensland Health staff (external supervision)**

Wherever possible clinicians should obtain clinical supervision in the local area in which they work from an appropriate Queensland Health clinical supervisor. Where this is not possible and external clinical supervision becomes necessary, the approval of the district/facility and accreditation of the external supervisor by the local district are required. The district's delegated authority must arrange for a credentialing process prior to the engagement of an external supervisor.

Appropriate credentials should include:

- evidence of relevant professional registration or equivalent
- evidence of recent practice relevant to the proposed supervision
- evidence of adequate professional indemnity insurance.

Names of appropriate referees must be obtained. It is the engaging district's responsibility to verify the accuracy of information obtained. In addition to providing the above information, a proposed external supervisor is required to:

- provide evidence of supervision competence that is recognised by Queensland Health through participation in a clinical supervision training program within an agreed period, for example, six months
- sign a confidentiality agreement in line with Queensland Health policy.

Credentialing information or evidence that is obtained from an external clinical supervisor should be retained by the clinician's district in accordance with corporate and local record keeping policy requirements. External supervisors are to maintain communications with the delegated district authority and other relevant interested parties, as identified in the supervision agreement.

## **Inter-professional clinical supervision**

Clinical supervision by members of other professions is recommended when:

- clinicians need to develop generic mental health practitioner competencies (e.g., suicide risk assessment)
- the clinical supervisor has expertise in a specific skill area that is needed in the specific work setting, consumer group or care procedure.

The primary criterion for selecting supervisors or consultants from outside the clinician's profession is the level of relevant supervisor knowledge and specialisation, rather than their professional discipline. Some supervision from members of the same profession is advised for all Queensland Health staff. It is recommended that at least fifty percent of clinical supervision contact be obtained from an appropriate supervisor from the same profession.

The amount and proportion of clinical supervision that is obtained depends on:

- service requirements
- the practitioner's role

- negotiations between the clinician, team leader or line manager, discipline leader, and the supervisor
- routine discussions of clinical supervision as part of the PAD planning process.

When there is legislative or professional accreditation requirements related to regulating supervision within a particular profession, those requirements should be given priority and aligned to employment related practice duties where possible.

### **Changing clinical supervisors**

Staff may change supervisors following discussion with their current supervisor and informing their line manager. The requirement to discuss changing supervisors should be documented in the current supervision agreement (see Appendix 1). As the agreement will identify the goals for supervision, it may be helpful for the clinician to change supervisors once these have been achieved. Coordination by the district, in conjunction with the team leader or line manager, and discipline leader is central to this process.

## **Structure of Clinical Supervision**

Clinical supervision sessions are formalised, have an agreed purpose, work toward outcomes and entail an element of rigour. It is expected that all three primary elements of clinical supervision will be addressed; namely, issues relevant to clinical safety, skill and knowledge development (formative), support and debriefing (restorative) and quality control (normative). Clinical supervision and clinical supervision training is to be supported by a range of interventions and modalities within the context of a competency and evidence based provision model.

Clinical supervision needs to be flexible in order to meet the needs of clinicians in different disciplines and clinicians at different stages of their development. The supervision requirements of a novice clinician are likely to be very different from that of a highly experienced clinician, whereas those of a psychologist, for example, will differ from those of a mental health nurse and also a general nurse working in a mental health setting.

This section outlines, as a guide, the *common* structures and processes involved in clinical supervision.

Clinical supervision is organised in individual or group format, is commonly of one hour's duration and is held regularly. For recommendations on the frequency of clinical supervision refer to Table 2. Clinical supervision sessions involve a clinician (or group of clinicians) and a supervisor working together in private and without interruption. The exact structure and format will depend on the clinician's needs and discipline. For clinicians with limited experience, for example, more structured sessions are common, whereas for more experienced clinicians, there is less need of structure and there is more scope for clinician-led consultation and identification of relevant issues.

Clinical supervision involves a range of processes to achieve agreed goals within the sessions. As outlined earlier, the focus of clinical supervision sessions is always on the role and clinical practice of the clinician. It is the responsibility of the supervisor to ensure that sessions are appropriately structured to engage the clinician in discussion, reflection and appropriate disclosure. A useful way of generating discussion and identifying the pertinent issues is through *case presentation or review*, in which the clinician presents a case with which they are currently working, commonly utilising an agreed presentation format. This does require, however, a degree of preparation on the clinician's part prior to the clinical supervision session.

Additional clinical supervision methods include direct supervisor observation of clinical practice, co-facilitation of clinical groups and interviews, video or audio recording of a consumer intervention, and review of case notes and documentation. Regardless of what method is used, the purpose of clinical supervision sessions is to generate discussion and reflection on a broad range of issues directly related to clinical practice.

This may include but is not limited to the following issues:

- the methods and modalities of clinical practice
- concerns the clinician has in relation to any aspect of a case or consumer
- lack of progress or difficulties with a consumer
- awareness of the potential impact of the clinician's personal values on their clinical practice
- identification of any negative impact on the clinician from a case they are managing
- issues related to establishing and maintaining appropriate boundaries with a consumer
- ethical and professional practice and compliance with codes of conduct
- professional identity and role development
- skill and knowledge development
- issues related to workload management, team functioning and career development.

### **Alternative clinical supervision modalities**

Although face-to-face clinical supervision is the preferred method of delivery, other methods of clinical supervision delivery, including email, video or teleconferencing may be employed where necessary. The use of these alternative methods may be particularly necessary for rural and remote clinicians, clinicians focussing on developing specialist competencies or within districts yet to attain a critical mass of supervisors. These alternative methods of clinical supervision need to be augmented by face-to face clinical supervision, with the recommendation that at least a quarter of devoted clinical supervision time is completed face-to-face.

## **Establishing the supervisory relationship – the Clinical Supervision Agreement**

Effective clinical supervision agreements will ensure that potential issues in clinical supervision are recognised and managed proactively. In establishing a clinical supervision arrangement, there should be discussion and agreement about how the supervisor and clinician will work together. The clinician's goals for clinical supervision need to be agreed, and the boundaries of confidentiality clarified and documented in the agreement (see Appendix 1).

*It is a condition of participation in clinical supervision within Queensland Health mental health setting for an appropriate written agreement (Clinical Supervision Agreement) to be developed and reviewed regularly.*

A written agreement protects both the supervisor and clinician and provides a forum for exploring each person's expectations at the onset of supervision. It also sets the boundaries and parameters of future sessions. Both the supervisor and clinician should mutually negotiate the agreement within the first two to three sessions.

The clinical supervision agreement will generally include:

- names of the supervisor and clinician
- names of the health service districts/facilities in which both work
- the date and location of the supervision
- the objectives for clinical supervision, for example, support, education, working through personal objectives, or developing specific skills
- frequency and length of sessions, including agreement and responsibilities related to cancelling sessions
- privacy and confidentiality, including a statement about the limits of confidentiality
- record keeping and responsibilities for documentation
- outline of any particular responsibilities of each party
- review and renegotiation – date/s to review the success of the agreement and whether changes need to be made
- signatures of both the clinician and supervisor (although not required, the supervisor and clinician may choose to also have the clinician's line manager sign the agreement).

Supervision agreements are subject to regular review and renegotiation and to unforeseen circumstances such as changes in workload, duties or workplace location. The guidelines suggest review and renegotiation on a yearly basis, whereas the written agreement can be negotiated by the parties at any time.

## Clinical Supervisor Competence, Training Accreditation and Registration

### Supervisor competence

Clinical supervision will be provided by clinicians with demonstrated competence in both the clinical and supervisory practice settings.

Clinical supervision will be obtained from a supervisor who has:

- at least two (2) years of full time employment (FTE) in mental health practice with a preference of five (5) or more years of experience
- demonstrated advanced skills in core competencies in mental health
- expert or advanced competencies in mental health
- for allied health staff, the practice supervisor's competencies are to be relevant to the clinician's current practice supervision needs.
- only accredited RANZCP supervisors may provide registrar supervision.

Developmentally, the supervisor will have at least the same or higher level of practice skills than the supervisee in the majority of specific competencies that are the primary focus for supervision. Whenever possible, at least fifty percent of the minimum contact levels will be obtained from a supervisor with at least five (5) years of experience in mental health practice and advanced relevant practice skills.

Supervision contact will usually be face-to-face, although supervision via electronic means is encouraged when face-to-face contact is not possible.

Supervisors need to ensure that their clinical supervision practices remain within ethical and professional parameters. Supervisors also need to take appropriate steps to safeguard themselves, the clinician and the organisation by ensuring that:

- they are appropriately trained to provide clinical supervision
- their clinical supervision practice remains within their level of competence and capabilities
- they operate with clear contractual arrangements in relation to their role and responsibilities within the organisation, and in relation to their work with clinicians
- they operate within the agreed parameters of confidentiality
- they do not develop inappropriate boundaries or relationships with their supervisees.

### Supervisor caseloads and clinical practice

In order to sustain best practice standards, it is recommended that supervisors limit their supervisory caseloads to three (3) clinicians or two (2) supervision groups at any one time. Clinicians employed by Queensland Health in specialist clinical supervisor roles, however, are exempt from this recommendation. Consultant psychiatrists are limited to the requirements of the RANZCP in relation to numbers of trainees supervised.

In addition, it is recommended that clinicians engaged in the provision of clinical supervision continue to engage in clinical practice and maintain a clinical caseload.

### **Training**

It is crucial that clinical supervisors undertake comprehensive training in understanding the goals and tasks of clinical supervision, specific clinical supervision skills and methods and how to exercise supervisory responsibilities in a respectful, fair, and objective manner.

*Training in supervision is a requirement for all clinical supervisors providing clinical supervision within Queensland Health mental health settings.*

### **Core competencies for supervisor training**

The recommended core competencies for clinical supervisors include knowledge and skill development in:

- models of supervision
- practitioner development
- development of the supervisory relationship
- supervision methods and techniques
- ethical, legal, professional and organisational regulatory issues
- evaluation tools and processes
- administrative skills.

Research on the effectiveness of supervisor training supports the notion that supervision specific training increases supervisor competency and generates improved supervisory outcomes.

Training will be overseen and implemented by the Statewide Professional Leaders in conjunction with health service districts and facilities.

### **Professional Development and Role**

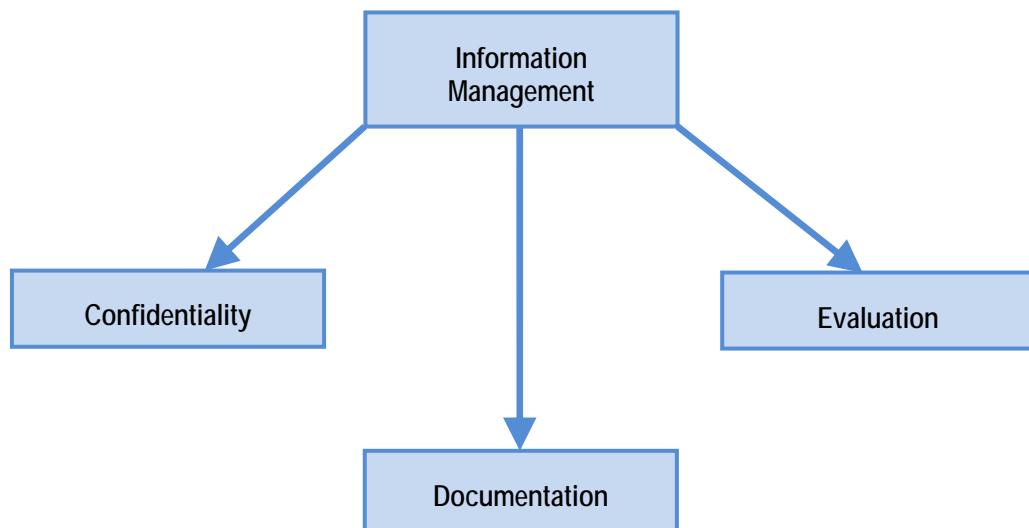
Participation in clinical supervision is expected for all clinical positions in mental health services including mental health nurses, general nurses working in mental health, medical staff and indigenous health workers. For allied mental health staff, role requirements and role descriptions identify the need for engagement in regular clinical supervision. Line managers will take responsibility for supporting staff to engage in regular clinical supervision. Participation should also be documented as part of the PAD process.

Participation in clinical supervision is mandatory for all Authorised Mental Health Practitioners under the *Mental Health Act 2000*.

*Clinical supervision is integral to mental health clinician role requirements and role descriptions.*

## Information Management

Appropriate and discreet information management is essential for effective clinical supervision. Clinicians and supervisors should be aware of the policy and procedures in relation to confidentiality, record keeping and evaluation. See Figure 2 below for the process of information management in clinical supervision processes.



**Figure 2: Information Management**

## Confidentiality

### Confidentiality in the supervisory relationship

The establishment of trust in the supervisory relationship is a critical factor for successful clinical supervision. Clinicians have the right to expect that material presented to their supervisor be maintained by the supervisor in strict confidence with appropriate ethical requirements for all parties.

The content of clinical supervision is confidential except in circumstances of serious concern related to the ethical or professional conduct of the clinician or the safety of a consumer. The intent is to allow for frank and open discussion about clinical practice in a safe environment, while developing essential trust in the supervisory relationship. Clinicians, generally, have the right to expect that material presented in supervision is kept in strict confidence. Any material used in supervision of supervision sessions (i.e. with the supervisor's own supervisor) should be de-identified and not include information that identifies the clinician, their consumer/s or colleague/s.

Nonetheless, there are limits to confidentiality that need to be clearly understood by supervisors and clinicians. On the one hand, there is an imperative to ensure the confidentiality of individual sessions in order to provide a safe and constructive learning environment and to encourage a sufficient level of disclosure. Conversely, there is a need to ensure that any sufficiently serious issues related to clinical practice are dealt with transparently, given the role of clinical supervision as a mechanism for clinical quality and safety. The parameters of confidentiality need to be clearly documented and communicated to all participants in order to balance these two legitimate concerns.

To ensure an appropriate measure of accountability for clinical supervision, confidentiality is limited in circumstances where there is:

- a breach of the *Queensland Health Code of Conduct* or evidence of unsatisfactory performance, as defined in the *Health Services Act*
- a breach of professional ethics
- a breach of duty of care
- serious concern about the safety of the clinician or a consumer
- an issue identified that is subject to mandatory reporting requirements.<sup>10</sup>

A statement about confidentiality and its limits in relation to clinical supervision and the process for managing detected impaired or inappropriate practice should be included in all clinical supervision agreements. A clear agreement is especially important where clinical supervision is delivered by the person who is also a line manager undertaking performance appraisal. Adherence to these parameters requires that supervisors understand the particular professional role of the clinician, and are cognisant of professional codes of ethics and conduct, duty of care standards and mandatory reporting requirements. In instances where multidisciplinary or inter-disciplinary clinical supervision is undertaken, and the clinical supervisor's background is in a different profession to the clinician, it is advisable that supervisors familiarise themselves with that profession's ethics and standards or seek the relevant information or resources.

### **Managing performance issues and confidentiality**

In any of the circumstances outlined above, it is the clinical supervisor's responsibility to first inform the clinician of their concerns and then to encourage them to take the issue to their support team or line manager within a stipulated period of time (e.g., 48 hours). If the clinician is unwilling or unable to take this step, the supervisor must take responsibility to involve the clinician's line manager as soon as is practical. In that instance, the clinical supervisor must inform the clinician of their actions, prior to consulting with managerial staff.

Problems arising within supervision should be addressed immediately through the following process:

- problems should first be addressed within the supervision
- unresolved issues and problems should be raised with the support team, line manager, team leader or discipline senior

- both clinician and supervisor should be kept informed of the resolution process.

If necessary, either supervisor or supervisee can engage a third party to assist in resolution of any issues arising in the supervision relationship.

Confidentiality aspects of clinical supervision and resolution of performance issues arising from clinical supervision are integral to effective work practice and service delivery. Confidentiality in this circumstance needs to be understood essentially as discretion within the support team (i.e., the clinician's supervisor, team leader or line manager, and consultant), and should be treated in the same way as confidentiality in relation to consumer care. Members of the support team may also consult with the clinician's supervisor. (See *recording in exceptional circumstances* in the following section on documentation guidelines).

If clinical supervision is to facilitate real staff development, then clearly, it will require considerable trust on the part of both parties. This presents a considerable challenge to organisations, clinicians and supervisors. This cannot be taken for granted and requires a conscious commitment from both supervisor and clinician.

## Documentation

### Minimum standards

The minimum standards for documentation of clinical supervision sessions include:

- a completed supervision agreement signed by the supervisor and clinician
- a continuing record maintained by the supervisor of attendance at clinical supervision by the clinician and signed by both parties at each occasion of supervision.

This information will be used in auditing and the information is owned and confidentially stored by Queensland Health.

### Best practice standards

It is recommended that supervisors maintain further records of supervision that include:

- time and date of the session
- name of clinician
- outline of agenda for discussion
- outcomes and action plan
- date and time of next session.

It is recommended that the clinician maintains their own notes of supervision including:

- professional and other issues raised in supervision

- a reflective diary of their supervision and professional growth, which may form part of their professional development portfolio.

If the outcome of a supervisory session involves any proposed change to a consumer's mental health care plan, a clinical team case review is required. Clinical case review discussions are documented in the consumer's case notes without identifying the supervisor.

### **Records storage**

Storage and ownership of process notes is to be negotiated between clinician and supervisor within the policy guidelines and to be noted in the clinical supervision agreement. Process notes written by the supervisor may be handed over to the clinician at the termination of clinical supervision. Under ordinary circumstances, the written record should stay with the clinician, in confidential storage.

Notwithstanding potential impaired performance or code of conduct issues, access to clinical supervision documentation remains only with the supervisor and clinician and is the property of Queensland Health. Where a supervisor keeps a record of any aspect of the session/s, they must ensure the record is kept in locked storage.

### **Recording of exceptional circumstances**

On occasion, including but not limited to a breach of the *Queensland Health Code of Conduct*, or detection of impaired competence or performance, the supervisor may decide to give direct advice or instruction to the clinician on what actions or interventions to take.<sup>11</sup>

Where clinical advice is offered, the following guidelines are recommended:

- the supervisor will make a written record of the advice
- the record will be made available to the clinician and signed by both parties
- clinicians will be provided with a photocopy of the supervisor's record
- the original record will be stored securely by the supervisor.

Documentation concerning impaired performance or detailing a breach of ethical or professional guidelines, duty of care or other problematic behaviour remains the property of Queensland Health.

### **Discipline standards**

Record keeping by supervisors and clinicians will also be guided by the professional requirements or policies of their discipline. In some cases, an ongoing record is required for maintaining professional registration. There are also specific professional and ethical codes that apply to the individual professions, and supervisors and clinicians need to be aware of appropriate codes. Specific codes apply to the following professions: Psychiatry; Mental Health Nurses; Social Workers; Psychologists and Occupational Therapists.<sup>12</sup> Additional ethical codes are applicable for all professionals working in Queensland Health.<sup>13</sup>

## Evaluation

Evaluation within supervision is a complex dynamic process that can be fraught with concerns and difficulties for both supervisors and supervisees. Evaluation and quality assurance of the clinical supervision program will be conducted on a regular basis and will be co-ordinated through Mental Health Branch in collaboration with statewide professional leaders. Managers, supervisors and clinicians are expected to engage in these processes. Records will be required for audit and review of the effectiveness of clinical supervision and can also be used to provide evidence for the clinician that they are participating in the service governance process.

The evaluation task within supervision consists of two components.

1. **formative (informal)** evaluation – involving the ongoing feedback mechanisms built into supervision, including feedback from the supervisor to the supervisee, self-feedback by both the supervisor and supervisee, and feedback from the supervisee to the supervisor
2. **summative (formal)** evaluation – involving the formal assessment of competence from a professional and organisational perspective.

Informal evaluations should occur as part of the ongoing process of feedback and learning, whereas formal evaluations will be carried out less regularly and will have functions related to managerial and organisational assessment functions.

When undertaking evaluation, the following points are important:

- the aim of clinical supervision and the component of evaluation are to increase supervisee self-assessment and self-regulated learning
- exactly what is to be evaluated, and how the evaluation takes place should be negotiated with the supervisee
- evaluation should have a clear and constructive focus on the supervisee's practice and never become an evaluation of the person
- evaluation is not punitive
- evaluation should centre on the review, achievement or setting of goals as specified in the supervision agreement or PAD review
- feedback should be clearly related to how the issues evaluated affect service delivery to consumers
- evaluation of the quality and process of the supervisory relationship should also occur as part of the formal process.

There are three (3) primary domains for evaluation – the supervisee, the supervisor and the supervision itself. Supervisors can draw on a broad range of professional practice competencies and standards in order to inform what needs to be evaluated. What constitutes 'competent performance' must be clear between the parties, and may be drawn from relevant documents such as existing clinical standards, including the National Mental Health Strategy (NMHS) document: the *National Practice Standards for the Mental Health Workforce*, as well as state Mental Health Service

standards, professional competencies and standards, and the organisational context and policies.<sup>14</sup>

## Notes

<sup>1</sup> Queensland Government (2008a)

<sup>2</sup> Queensland Government (2007b); Butterworth & Woods (1999)

<sup>3</sup> Faugier & Butterworth (1994)

<sup>4</sup> Bond & Holland (1998)

<sup>5</sup> Proctor (1986)

<sup>6</sup> Queensland Government (2008b)

<sup>7</sup> Queensland Government (2008b)

<sup>8</sup> Queensland Government (2008b)

<sup>9</sup> Driscoll (2006)

<sup>10</sup> Queensland Government (1991); Queensland Health (2006)

<sup>11</sup> Queensland Government (2006)

<sup>12</sup> Medical Board of Queensland (2008); RANZCP (2004); Australian Medical Association (2001); Queensland Nursing Council (1999, 2008); Australian Nursing and Midwifery Council (2002a, 2002b, 2003, 2006); Australian College of Mental Health Nurses (1995); Australian Association of Social Workers (2003, 2004, 2007); The Australian Psychological Society Ltd (2007a, 2007b); Occupational Therapists Registration Board of Queensland (2007); Australian Association of Occupational Therapists (1999, 2003)

<sup>13</sup> Queensland Health (2006); Health Practitioner Boards (2005)

<sup>14</sup> Commonwealth of Australia (2002)

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# Appendix 1

## Sample Clinical Supervision Agreement

### Mental Health Services

#### Clinical Supervision Agreement between

\_\_\_\_\_ and \_\_\_\_\_.

From \_\_\_\_\_ to \_\_\_\_\_

#### 1. Goals of Supervision

Please detail the knowledge and skills that the supervisee and supervisor would like the supervisee to develop in supervision sessions. This will require regular review and renegotiation as the needs and skills of the supervisee change over time.

|                            |  |
|----------------------------|--|
| <b>Supervisor's Goals:</b> |  |
| <b>Supervisee's Goals:</b> |  |

#### 2. Expected Outcomes (Specific Objectives)

|                                 |  |
|---------------------------------|--|
| <b>Supervisor's Objectives:</b> |  |
| <b>Supervisee's Objectives:</b> |  |
| <b>Shared Objectives:</b>       |  |

#### 3. Mutual Obligations (Responsibilities)

|  |  |
|--|--|
| <b>Supervisor's Obligations:</b>   |  |
| <b>Supervisee's Obligations:</b>   |  |
| <b>How will dual roles (eg line manager and practice supervisor) be managed?</b><br>(eg line management issues will not be discussed in practice supervision sessions without mutual consent by way of inclusion in a pre-agreed session agenda) |  |

#### **4. Structure of Supervision**

|   |  |
|---|--|
| <b>Frequency:</b>   |  |
| <b>Duration:</b>  |  |
| <b>Location:</b>  |  |
| <b>What resources do we require for effective supervision?<br/>(e.g. time; space; absence of interruptions)</b> |  |
| <b>What preparation will be required prior to each session?</b>   |  |
| <b>How will agendas for each session be set?</b>  |  |
| <b>Availability between sessions:</b>   |  |
| <b>Is supervisee currently receiving other supervision?</b>   |  |
| <b>If yes, how will different forms of supervision be integrated?</b>   |  |

#### **5. Evaluating Supervision**

|  |  |
|--|--|
| <b>What is the preferred process for evaluating supervision?</b> |  |
| <b>When will the supervision agreement be reviewed?</b>          |  |

#### **6. Limits to Confidentiality**

|   |  |
|---|--|
| <b>How will difficulties in supervision be dealt with?</b>          |  |
| <b>What if the supervision relationship completely breaks down?</b> |  |

#### **7. Supervision Records**

|  |  |
|--|--|
| <b>What form will supervision records take? (e.g. agendas)</b> |  |
|--|--|

## 7. Supervision Records

|  |  |
|--|--|
| How will these supervision records be used?  |  |
| <b>Who will have access to them and in what circumstances?</b><br>(note: if a supervisor has concerns about, or identifies any performance issues regarding ongoing clinical competence it should be referred to the appropriate service manager who has responsibility for managing the unsatisfactory performance process) |  |
| Where will be records be stored:   |  |
| Duration of storage:   |  |
| What records will be used/ provided for performance purposes? (e.g. that practice supervision has occurred)  |  |

## 8. Ethical Issues

|  |  |
|--|--|
| What do your professional code and organisational policies outline as ethical conduct for supervision? |  |
| In general, which issues raised in supervision will be kept confidential to this relationship?         |  |
| Which aspects may be discussed and with whom?  |  |

## 9. Content of Supervision

To be negotiated in confidence between supervisee and supervisor and should include a list of the knowledge and skills that the supervisee would like to develop in supervision sessions and should be regularly reviewed and renegotiated between the supervisor and supervisee.

(Note: refer to supervision policy and accompanying guidelines for guidance when developing supervision objectives)

|                  |  |                  |  |
|------------------|--|------------------|--|
| Supervisee Name: |  | Supervisor Name: |  |
| Signature:       |  | Signature:       |  |
| Date:            |  | Date:            |  |

## Line Manager Agreement

|                    |
|--------------------|
| Line Manager Name: |
| Signature:         |
| Date:              |

## Appendix 2

## **Sample Record of Supervision Meetings**

**Supervisee's Name:** .....

**Supervisor's Name:** .....

- |  |  |   |
|--|--|---|
| 1. Review of clinical notes/reports        | 4. Discussion of additional skills or strategies       | 7. Discussion of secondary practice issues<br>(e.g. team relationships, responses to work demands). |
| 2. Reflection about practice by supervisee | 5. Demonstration of skills or strategies by supervisor | 8. Personal or career development.  |
| 3. Problem solving about practice issues   | 6. Demonstration/rehearsal by supervisee               |   |