Clinical supervision, burnout and intent to leave: An Australian mixed methods study of community-based allied health professionals

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A thesis submitted for the degree of Doctor of Philosophy at
The University of Queensland in 2016
School of Nursing, Midwifery and Social Work
Abstract

Objective
Clinical supervision is widely recognised for providing professional support, professional development and clinical governance for healthcare workers. Despite the growing uptake of clinical supervision, there have been few studies about the effectiveness of supervision for allied health professionals and fewer studies conducted within the Australian health context.

This study aims to identify the perceived effectiveness of clinical supervision of allied health professionals in an Australian metropolitan community health setting. The study also sought to identify those factors that contribute to effectiveness and the relationship between clinical supervision effectiveness, burnout and intention to leave, as well as any profession-specific differences.

Methodology
The research has a two-phase, explanatory-sequential, mixed methods design. In Study 1, participants (n = 82) anonymously completed an on-line questionnaire, administered through the health service’s intranet at 8 months post-implementation of the intervention, a structured model of clinical supervision. Study 2, commenced 12 months post-implementation and comprised several focus groups (n = 26), separately attended by supervisees (n = 15), and supervisors (n = 11). The sample was drawn from the population of allied health professionals (N = 120) who were receiving or providing supervision within the study location.

The on-line questionnaire sought demographic data, work history and the number and length of supervision sessions. Clinical supervision effectiveness was operationalised using the Manchester Clinical Supervision Scale-26 (MCSS-26©); burnout was measured using the Maslach Burnout Inventory; and intention to leave was operationalised using the Intent to Leave Scale.

Results
Eighty-two allied health professionals participated in Study 1, resulting in a 68% response rate. Ages ranged from 24 to 66 years, and females accounted for 89% (n = 71) of all respondents. The professions of occupational therapy, physiotherapy and social work together comprised 73% of the total number of participants. Twenty-six allied health
professionals participated in the five focus groups of Study 2. All participants were female, with 81% belonging to the professions of occupational therapy, physiotherapy and social work.

Overall, clinical supervision was perceived as effective. In the main, supervisee’s responses illustrated that supervision provided effective professional support, education and guidance for professional practice.

‘Time’, as well as specific procedural factors, were found to be important in relation to perceived efficacy of clinical supervision. Time, as defined by length of supervision session, number of sessions and total period supervision had been received, were significantly and positively associated with clinical supervision effectiveness. The significance of time was confirmed by focus group findings. There was consensus that a minimum period of time was required to create a climate of trust in supervisory relationships. Additionally, and through exposure to a range of supervision experiences, supervisees learnt over time what worked best for them in supervision. Lack of time for supervision was frequently reported and was viewed by supervisors and supervisees as a major barrier to effectiveness. Lack of time and variations in supervision processes suggested that supervision was not supported by all areas of management. In relation to procedural factors, the findings suggest that the receipt of clinical supervision delivery would be effectively supported by providing supervisees with some choice in the selection of their supervisor and ensuring that supervisors and supervisees complete formal supervision agreements.

Significant associations were found between clinical supervision effectiveness and burnout and intention to leave. Highly efficacious supervision was significantly and negatively associated with Emotional Exhaustion and Depersonalization. In addition, higher scores on “Finding Time” were significantly correlated with lower scores of Emotional Exhaustion. Effective supervision was significantly and positively associated with Personal Accomplishment, while it was significantly and negatively associated with intention to leave. Findings from the qualitative phase confirmed that efficacious supervision assisted supervisees to feel supported and affirmed, manage work stress, and feel that their work was worthwhile. Strategies provided in supervision helped supervisees to negotiate the changing environment and retain a sense of connection to the organisation.
Conclusion
The findings of this research indicate that when specific supervision procedures are implemented, such as agreement documents, choice of supervisor, and allocated supervision time, clinical supervision is effective at delivering professional development, guidance and support for allied health workers. Furthermore, clinical supervision effectiveness was achieved despite the relatively short time-frame of supervision implementation and in the context of considerable organisational change in the study location. The findings also identified significant differences associated with supervision effectiveness between the individual allied health professions. In addition, the findings demonstrated that allied health workers who received effective clinical supervision had significantly reduced burnout and significantly reduced intention to leave. Lack of time and variations in supervision processes were identified as key barriers to effectiveness. Further research is warranted to examine whether the variables identified in this study are associated with clinical supervision outcomes in similar allied health populations.
Declaration by author

This thesis is composed of my original work, and contains no material previously published or written by another person except where due reference has been made in the text. I have clearly stated the contribution by others to jointly-authored works that I have included in my thesis.

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Publications during candidature

Peer Reviewed Paper

Conference Paper

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Publications included in this thesis

No publications included.
Contributions by others to the thesis

My Advisors, Professor Jill Wilson and Associate Professor Peter Newcombe provided consultation to all stages of the study and critical appraisal of the written work. Statistical analysis was completed with the assistance of my Advisor, Associate Professor Peter Newcombe. Thematic analysis was completed with the assistance of my Advisor, Professor Jill Wilson. Anne Li provided assistance with note-taking during focus group interviews.

Statement of parts of the thesis submitted to qualify for the award of another degree

None.
Acknowledgements

I wish to thank my academic advisors, Professor Jill Wilson and Associate Professor Peter Newcombe, for their expert advice and encouragement during all stages of my candidature.

I wish to thank the Queensland Health Management of the Community Health Service for their support for this research. I wish to thank the allied health professionals for their interest and participation in this study.

I wish to thank my professional colleagues for their encouragement and acknowledgement of the importance of undertaking research in this area of practice.

I wish to thank my friends for their encouragement and good humour.

I wish to thank my adult children for supporting me in doing something that they understood was important to me.

Lastly, I wish to thank my partner, Kerrie, who has always believed in my capacity to achieve, even at times when I didn’t believe it, and for doing the lion’s share of the shopping, cooking and cleaning in our household during this period of study. Thank you so much.
Keywords
Supervision, allied health, effectiveness, clinical governance, burnout, intent to leave, professional support.

Australian and New Zealand Standard Research Classifications (ANZSRC)
ANZSRC code: 160508, Health Policy, 60%
ANZSRC code: 111708, Health and Community Services, 20%
ANZSRC code: 160701, Clinical Social Work Practice, 20%

Fields of Research (FoR) Classification
FoR code: 1117, Public Health and Health Services, 40%
FoR code: 1605, Policy and Administration, 40%
FoR code: 1607, Social Work, 20%
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1 Introduction

The practice of clinical supervision is being increasingly adopted internationally across diverse practice arenas and across a varied range of professions (Carpenter, Webb, & Bostock, 2013; Gallagher, 2006). Within the health care setting there is now an expectation that health professionals, including allied health workers, will regularly engage in clinical supervision practice (Health Workforce Australia, 2013b). Government bodies view clinical supervision as a clinical governance strategy to ensure the safety and quality of health care services (Australian Health Ministers’ Conference, 2004). Professional associations stipulate the necessity for supervision practice for the purposes of monitoring standards, providing ongoing skill and knowledge development, facilitating professional support and ensuring accountability to stakeholders (Australian Association of Social Workers, 2012; The Speech Pathology Association of Australia Limited, 2007). In recent years there has also been increased recognition of clinical supervision as an approach to increase job satisfaction, reduce unwanted worker turnover and mitigate burnout (Koivu, Saarinen, & Hyrkas, 2012a; Scanlan, Still, Stewart, & Croaker, 2010). An international shortage of health care workers (World Health Organization, 2010a) has meant that governments and health service organisations are keen to adopt workforce strategies that encourage staff retention and reduce burnout. For these reasons, employer organisations have taken a greater interest in facilitating the provision of clinical supervision for their health workforce.

At the same time that clinical supervision is being increasingly adopted as a standard practice within health services and across professions, uncertainty remains about the outcomes of supervision, including those related to reduction in burnout and intention to leave. For example, some studies show positive links between clinical supervision and professional development (Butterworth, Bell, Jackson, & Pajnkihar, 2008; Martino, Ball, Nich, Frankforter, & Carroll, 2008; Roche, Todd, & O’Connor, 2007), as well as decreased intent to leave and decreased burnout of workers (Begat & Severinsson, 2006; Hyrkas, Appelqvist-Schmidelechner, & Haataja, 2006). However findings from clinical supervision studies have been mixed, with some reports that supervisees have perceived clinical supervision to be ineffective for their practice (e.g. Ellis, 2010; Snowdon, Millard, & Taylor, 2015). Methodological problems have impeded attempts to clarify the outcomes of clinical supervision (Bogo & McKnight, 2006; Roche et al., 2007) or to determine the
characteristics of clinical supervision that are linked to effectiveness (Carpenter et al., 2013). In addition, as profession-specific differences are evident in clinical supervision practice (Dawson, Phillips, & Leggat, 2012), some have questioned whether a common supervision framework will be appropriate for a diverse range of allied health professionals (Kumar, Osborne, & Lehmann, 2015).

This research investigates whether individual clinical supervision delivered within a district community health service is perceived by allied health supervisees to be effective. The study also examines the association between the effectiveness of clinical supervision and measures of burnout and intention to leave. Specifically, the research seeks to establish (a) whether clinical supervision is perceived to be effective by supervisees and (b) whether perceived effectiveness is linked negatively to perceived burnout and negatively to perceived intention to leave. Factors that are perceived to enhance or hinder clinical supervision effectiveness will be identified. This mixed-methods study examines community allied health workers’ experiences of a common model of clinical supervision. It presents an opportunity to evaluate the effectiveness of clinical supervision for a range of allied health professionals within a large multi-profession community setting that implemented a structured supervision framework. Any profession-specific differences in supervision practices or outcomes will be identified. In the current health care context of workforce shortages, increasing service demands and fiscal constraints, determining the association between effective clinical supervision, decreased burnout, and decreased intention to leave is critical.

1.1 Justification for the research

The research is justified by six primary points.

1) There is a need to establish the effectiveness of clinical supervision in delivering outcomes given the resources required and need for fiscal responsibility

High quality clinical supervision has been linked to positive benefits for clinicians, clients and organisations (Edwards et al., 2006; Roche et al., 2007). Hence, within Australia there has been a national drive to implement clinical supervision across public health services (Health Workforce Australia, 2010). However, at the same time that clinical supervision is being increasingly adopted as a standard practice within health services (Clinical
uncertainty remains about the outcomes of supervision, including whether it is an effective mechanism for improving the safety and quality of health services (Buus & Gonge, 2009; Watkins & Milne, 2014). While the clinical supervision literature is considerable, there is a lack of agreement about what constitutes the practice of clinical supervision (Lynch, Happell, & Sharrock, 2008) and there have been a limited number of studies investigating clinical supervision outcomes (Carpenter et al., 2013). Further, methodological problems such as poorly described interventions (Dawson, Phillips, & Leggat, 2013a), and reliance on measures that were not psychometrically robust (Creaner, 2014) have made it difficult to draw conclusions from clinical supervision findings. Most studies have paid little attention to the detailed practices that underlie the supervision being evaluated (Watkins & Milne, 2014). For these reasons, researchers have signalled concerns about the wholesale uptake of clinical supervision practice (Hyrkas, 2005; White & Winstanley, 2014), claiming that ineffective supervision may be harmful for supervisees and service recipients (Ellis, 2010; Gaitskell & Morley, 2008) and represent poor use of scarce public resources (Snowdon et al., 2015). There is a need to establish the effectiveness of clinical supervision in delivering outcomes given the resources required and need for fiscal responsibility. Further research is required to examine the outcomes of clinical supervision and to determine the characteristics that are linked to effectiveness of clinical supervision practice.

2) A gap exists in the empirical clinical supervision literature in relation to the allied health population

Clinical supervision has a vast literature, however much of the empirical clinical supervision literature focuses on the nursing population (Carson, 2007; Edwards et al., 2006). Although Spence et al. (2001) in their landmark Australian study proposed that there was little difference in supervisory practices across the various human service disciplines, Dawson et al (2013b) have since suggested that caution be exercised when generalising clinical supervision findings from nursing populations to the allied health professions. There is now a broad expectation that allied health professionals providing health care services receive regular clinical supervision of their practice (Health Workforce Australia, 2011d; Queensland Health, 2009). Despite this seemingly universal endorsement of clinical supervision, there is a lack of agreement about what constitutes effective clinical supervision practice for allied health staff (Fitzpatrick, Smith, & Wilding,
2012, p. 464) and an absence of evidence about clinical supervision outcomes, especially for this population (Livni, Crowe, & Gonsalvez, 2012; Watkins & Milne, 2014). It is important to establish the elements of clinical supervision that contribute to effectiveness as well as identify characteristics associated with ineffective supervision practice. Hence, this research seeks to fill this void as findings have the potential to make a significant contribution to the allied health clinical supervision empirical literature.

The allied health workforce comprises a valuable but under-researched section of the health care population. It has been argued that the allied health population is well positioned to contribute to health care reform and assist to address the current and future challenges faced by health care systems (Markham, 2015). Rising pressures on health care systems have been well documented and include aging populations, rising chronic health conditions, increasing costs, workforce shortages, and increasing consumer demand (World Health Organization, 2010b). As allied health workers are particularly skilled at prevention of chronic health diseases and rehabilitation of health functioning, allied health services present opportunities for delivering cost-effective interventions (Markham, 2015). Recent initiatives such as extended and advanced scope of practice have seen allied health professionals move to roles beyond traditional interventions and contribute in innovative ways to broader areas of health service delivery (Kumar, 2011). Greater utilization of the allied health workforce is seen as representing opportunities for improved primary health care (Australian Government, 2010) and reducing acute hospital admissions (Markham, 2015). Despite this, the allied health professions lack a solid practice evidence base, attributed to low levels of research activity in comparison with other areas of health care practice (Pager, Holden, & Golenko, 2012). Building empirical knowledge in areas of allied health practice is critical for the delivery of effective and safe health care services. This is particularly so in relation to clinical supervision as the practice is being implemented broadly as a key clinical governance strategy (Queensland Health, 2008). Undertaking robust research of clinical supervision outcomes for allied health workers will also contribute to the empirical evidence base for allied health practice.

3) Current approaches to the implementation of clinical supervision promote a “united model of clinical supervision” for allied health workers regardless of their individual profession (Fitzpatrick et al., 2012, p. 464)
Researchers have suggested that the allied health professions share more commonalities in their clinical supervision practice than divergences (Fleming, 2012; Spence, Kavanagh, et al., 2001). While this may be so, allied health professionals, through their distinctive undergraduate training, are equipped with different skill sets and expertise and these differences emerge in supervision practice. For example, Dawson and colleagues (2012), following their clinical supervision study of the allied health professions across nine disciplines, claimed that the disciplines of psychology and social work may be more effective than other allied health professions in addressing supervisees’ personal issues when they arise during supervision. This would suggest that the skills required by supervisors may differ between the allied health professional groups. Some advocate for the introduction of a standardised national supervision approach across the allied health professions (Fitzpatrick et al., 2012; Health Workforce Australia, 2010). Thus far, there is a paucity of research comparing the experiences of allied health professionals utilising a common model of clinical supervision (Dawson et al., 2012). However, findings from a recent study led the researchers to state that the diversity between the allied health professions indicated that “no one size fits all” regarding models of clinical supervision for allied health staff (Kumar et al., 2015, p. 270). Currently, it is unclear whether clinical supervision implementation practices take into account the needs of all allied health professional groups. Further research is required to determine any similarities or differences between the allied health professions in how they engage in clinical supervision practice and to examine any differences in clinical supervision outcomes for this population.

4) **There is a worldwide shortage of health care workers making strategies directed at workforce retention an important area**

Australia, in common with many other countries, experiences workforce shortages in the healthcare industry (Alkorashy & Baddar, 2016; Health Workforce Australia, 2010), including in the allied health professions (Australian Government, 2014). As well, unwanted employee turnover has been linked with diminished service quality, reduced customer satisfaction and a preventable loss in public expenditure (Alkorashy & Baddar, 2016; Ellett, Ellett, & Rugutt, 2003). The prevalence of staff shortages has led to an increased expectation that organisations will promote human resource strategies that increase staff retention (Davey, Delousa, Robinson, & Murrells, 2006; Ng & Sim, 2011). Clinical supervision is recognised as one such approach. It may be that clinical supervision
can contribute to workforce retention however clinical supervision has been linked to both high and low job satisfaction (Koivu, Saarinen, & Hyrkas, 2012b). Currently, the limited number of clinical supervision studies of allied health workers, variations in the findings and methodological problems (Carpenter et al., 2013) make it difficult to draw conclusions, making this an important area of investigation.

5) **Health care workers exhibit high levels of stress and burnout and are located within health care systems which will be under increasing pressures into the future**

High levels of stress and burnout have been found in health care workers (Barker, Cornwell, & Gishen, 2016; Marine, Ruotsalainen, Serra, & Verbeek, 2009), including amongst the allied health professions (Chiller & Crisp, 2012; Fischer et al., 2013). There is evidence that healthcare workers experience higher levels of stress and burnout in comparison to the general workforce (Michie & Williams, 2003; Wells, 2011). Chronically stressed workers who have frequent and intense interactions with their care recipients can develop burnout (Maslach, Jackson, & Leiter, 1996). Burnout carries significant costs for the health care industry (Marine et al., 2009), is negatively associated with patient satisfaction (Fredette-Carragher, 2016) and is consistently linked to worker intention to leave (Alkorashy & Baddar, 2016). The provision of clinical supervision is recognised as one strategy to combat burnout (Collins-Camargo, Sullivan, Washeck, Adams, & Sundet, 2009; Edwards et al., 2006) however findings have been inconclusive (Kim & Lee, 2009). For example, findings from a study of 132 physiotherapists working in Italian hospitals reported no association between the use of supervision and levels of burnout (Fischer et al., 2013). Further research, employing rigorous methods and psychometrically valid measures, is required to clarify this relationship and to determine the characteristics of clinical supervision that are linked to effectiveness.

6) **The potential translation of the research findings can make a valuable contribution to policy and practice**

Current approaches to clinical supervision for allied health within the Australian health context are fragmented and poorly coordinated (Fitzpatrick et al., 2012). The current study provides an opportunity to examine a clinical supervision intervention that was applied across several allied health professions, spanning a number of service sites within one community health service setting. The supervision intervention comprised several best
practice principles, including supervision training (Kavanagh et al., 2008), supervision guidelines (Ayers, Watkeys, & Carthy, 2014), supervision agreements (Fleming, 2012), and providing supervisees with choice of supervisor (Dawson et al., 2013b). As the research site encompassed one organisation, it presented an opportunity to hold constant many of the clinical supervision intervention variables. In addition, this research program will utilize a mixed methods research design that draws from a number of data sources, and seeks perspectives from both supervisees and supervisors. Unlike the vast proportion of the clinical supervision empirical literature, this study will employ methodological rigour in defining and operationalising clinical supervision effectiveness. Therefore this study provides a significant opportunity to identify variables associated with clinical supervision effectiveness, to investigate the relationship between clinical supervision and burnout and intention to leave, and to examine any profession-specific differences across the allied health professionals. It offers a unique capability to make a valuable contribution to clinical supervision research translation through it potential contribution to policy and practice.

1.2 Research aim and research questions

1.2.1 Research Aim
This research aims to identify whether clinical supervision delivered under a newly implemented clinical supervision program within a district community health service:

- Is perceived by the supervisees to be effective.
- Has a negative effect on supervisees’ perceived levels of intent to leave.
- Has a negative effect on supervisees’ perceived levels of burnout.
- Demonstrates any profession-specific differences.

1.2.2 Research Questions
This research seeks to address the following questions:

1. How do allied health staff who receive clinical supervision rate the effectiveness of that clinical supervision in providing support, professional development and guidance for their professional practice?

2. What factors affect the perceived effectiveness of clinical supervision in providing support, professional development and guidance for supervisees’ professional practice?
3. What is the relationship between perceptions of effectiveness of clinical supervision and supervisees' reports of levels of intention to leave?

4. What is the relationship between perceptions of effectiveness of clinical supervision and supervisees' reports of levels of burnout?

5. What are the profession-specific differences in perceived effectiveness of clinical supervision, reports of levels of intention to leave, and reports of levels of burnout?

The research questions relate to the study's focal hypotheses,

1.2.3 Hypotheses

1. Effective clinical supervision will be negatively correlated with intent to leave and with burnout.

2. Those receiving effective clinical supervision will report higher levels of professional development, guidance and support for their professional practice than those receiving ineffective clinical supervision.

1.3 Context of the study

During the period of the research (mid-2012), the researcher was employed within a large Queensland community health service that had implemented its first formal clinical supervision program for allied health professions. The researcher had earlier been employed in a community health service where she had been a member of two short project reference groups during 2007 and 2008 that had explored options for clinical supervision models for possible implementation. That service went on to become part of a larger health service, later to be the research study location.

The clinical supervision framework in the study location was based on best practice principles drawn from the empirical literature (details of the supervision framework are described below). This particular service provided a valuable site for the location of this research. The clinical supervision framework was embedded in organisational guidelines. Consistent with best practice it specified required documentation for supervision practice including a supervision agreement (Clinical Education and Training Institute, 2011; Lynch & Happell, 2008) as well as guidelines for frequency and duration of sessions. Also guided by best practice, the organisation had provided in-house training for supervisees
and supervisors (Bradley & Hojer, 2009; Dawson et al., 2013b) and facilitated supervisees’ choice of supervisor (Dawson et al., 2012; Edwards et al., 2005). Leading up to the service’s implementation of clinical supervision for allied health, several presentations were provided at all staff forums to raise awareness about the introduction of the practice. Prior to the implementation, clinical supervision had sometimes occurred infrequently and on an *ad hoc* and unstructured basis, although supervision had not been available to all allied health staff. The structured clinical supervision framework and practice was implemented for the organisation’s allied health staff. Details of the implemented structured clinical supervision framework are listed below.

### 1.3.1 Structured Clinical Supervision Framework

Within the study location, the organisation had developed a framework for clinical supervision for allied health staff, which included:

- Organisational guideline prescribing clinical supervision principles and responsibilities, as well as frequency and duration of sessions
- Suite of standardised supervision templates (e.g., agreement for establishing roles, responsibilities, and learning goals; log for recording clinical supervision activity; record of session including any agreed follow-up actions)
- On-line activity data reporting for time spent in clinical supervision
- In-house training for both supervisees and supervisors, comprising a one-day format with content largely derived from recommendations from a research collaboration between The University of Queensland and Queensland Health (Kavanagh et al., 2001).
- Structured process for selection of supervisors including an Expression of Interest and a supervisor interview and selection panel.
- Structured process for matching supervisees with supervisors, based on the principle of supervisee choice, that included,
  - Supervisees requested to nominate three supervisor preferences based on a list of available supervisors including supervisor biographies
  - Senior allied health staff and managers matched supervisees with supervisors, taking into account supervisee preferences, required skill-sets and practical considerations such as work location
Prior to matching, supervisors were consulted to ensure there were no known conflicts of interest regarding proposed supervisees.

Although recently recommended by some, (Fitzpatrick et al., 2012; Health Workforce Australia, 2011e), at the time of the study it was not common in Australian health services for a single framework of clinical supervision to be implemented across several allied health professions (except in mental health services). Similarly, it was also uncommon to offer supervision training simultaneously to both supervisees and supervisors, although this is recommended best practice (Kavanagh et al., 2008). Likewise, supervisees were seldom provided with choice of supervisor, despite being regarded as best practice (Edwards et al., 2005). Having one overall clinical supervision framework, with principles based on best evidence, provided an ideal opportunity to identify supervision outcomes and examine any differences in application and outcomes between the several allied health professions employed in the service.

Community allied health staff work in multi-disciplinary teams. Despite operating as members of a health care team, allied health professionals often work as sole practitioners. That is, they frequently visit clients on their own, without the presence of another health care worker and may also be the only staff member of their profession within their particular team. Most visits occur in the client’s homes which comprise a variety of living situations. These can range from high-rise inner-city apartments to small shared rooms in old boarding houses or cramped, long-forgotten hotel rooms. Sometimes clients are homeless and they will be visited in other locations, such as drop-in centres.

Allied health clinicians working in community settings usually see people who have complex, chronic health conditions, who are frequently unwell, often very frail, sometimes confused, sometimes suffering from mental illness, sometimes under the influence of drugs and/or alcohol and sometimes living with abuse and violence (Noblet et al., 2016). Prior to the home visit, the allied health worker may have limited information about the person’s health and social circumstances, and little or no knowledge of other people who might be sharing the accommodation. Policies focused on reducing pressure on hospitals, have seen a growth in the delivery of community post-acute services (Australian Government, 2009, 2010). This has meant that community allied health practitioners confront increased acuity in their clinical casework. Unlike their hospital counterparts,
practitioners in the community constantly operate in an unpredictable environment, with no immediate backup present. Also, unlike their hospital counterparts, many of the allied health staff within the study location were operationally managed by Nurse Managers while allied health staff in many acute settings have transitioned from being medically managed to having distinct allied health governance (Boyce, 2001).

An important additional contextual feature of this research is that when allied health clinicians were participating in the study, they were operating in an uncertain environment of rapid and frequent change. The health care service was undergoing a major transformation as the result of the implementation of the Commonwealth health reforms (Commonwealth of Australia, 2010; Council of Australian Governments, 2008). Significant changes were occurring, affecting models of service delivery, governance structures and funding arrangements which included the transfer of management responsibilities from the Health Service District to the Hospital and Health Boards (State of Queensland, 2012). These significant and rapid changes were amplified by events occurring at the State Government level, which resulted in a high degree of job insecurity within the public sector workforce (ABC Local Radio Brisbane, 2012; Brace, 2013). It is possible that this context had an influence on the participant’s responses and this aspect will be discussed at various points throughout the presentation of results.

As mentioned earlier, the researcher was employed by the organisation where the research was located. Research being undertaken by practitioners within a study location is not new or unusual (e.g. for discussion, see Ward, 2014), however the process of “insider research” (Humphrey, 2012) does require discussion as it carries with it potential implications. Being an insider researcher, there was an increased emphasis on the need to preserve the “pivotal role of researcher-as-instrument” (Padgett, 1998, p. 93), and for the researcher to be engaged in the process of reflexivity, an activity that involves having an awareness of the “interrelationships between the sets of assumptions, biases and perspectives that underpin different facets of the research” (Weber, 2003, pp. xi). A detailed discussion of this topic is contained in the Methodology Chapter (Chapter 4).

1.4 Methodology

A mixed methods research approach utilising validated survey measures and focus group interviews was chosen as the optimum design to address this study’s research aims.
Combining quantitative and qualitative methods provides a completeness not possible with single method studies (Bryman, 2006). This mixed methods study adheres to an explanatory sequential design: the quantitative phase is followed by a qualitative phase with the purpose of elucidating the findings from the initial quantitative study to improve the final interpretation and inferences (Creswell & Plano Clark, 2011). A mixed methods approach is particularly relevant when both outcomes and processes are under investigation and a depth and breadth of the topic is sought (Aarons, Fettes, Sommerfeld, & Palinkas, 2012). For instance, this study seeks to investigate whether clinical supervision leads to specific outcomes, such as providing professional development, guidance and support and whether effective clinical supervision is related to intent to leave and burnout, as perceived by supervisees. Survey and focus group participants included allied health staff working within the prescribed community health service district and who were receiving and/or providing individual clinical supervision.

The methodology for the research draws from two distinct paradigms. Study 1, the quantitative component of the research, sits in the positivist tradition which views patterns of behaviour as observable and explainable through objective causal laws in science (Fossey, Harvey, McDermott, & Davidson, 2002; Rubin & Babbie, 1989). Study 2, the qualitative component of the research, adopts an interpretive stance (Brady & O'Regan, 2009; Weber, 2003). Further details of how these different paradigms sit together are contained within the Methodology Chapter (Chapter 4).

Interpretation of the mixed methods findings followed a process suggested by Creswell and Plano Clark (2011), whereby the major findings from Study 1 and Study 2 were connected and compared through the identification and selection of data that converged and data that conflicted. Through this process the qualitative results were utilised to explain the quantitative results. This was followed by an interpretation of the connected mixed methods findings to form the “meta-inferences”, to respond to the research questions set out in the study (Creswell & Plano Clark, 2011, pp. 237).

In brief, the stages of the methodology comprised study design, instrument selection, pilot of survey instruments, recruitment for Study 1, implementation of survey package, analysis and interpretation of Study 1 data. This was followed by recruitment for Study 2, implementation of focus group semi-structured interviews, analysis and interpretation of
Study 2 data, and finally interpretation of the mixed methods findings. The study concluded with consideration and discussion of how the mixed-methods findings answer the research questions and contribute to the clinical supervision empirical evidence base.

1.5 Outline of the thesis

The current chapter has presented an overview of the research topic and provided a justification for the study. The next chapter will present a discussion of the clinical supervision empirical literature regarding the current evidence about supervision outcomes, including the relationship between supervision and worker intention to leave and burnout. Chapter 3 describes the study’s conceptual framework and will commence with a description of the Social Ecological Theory (Bronfenbrenner, 1977) and the Job Demands-Resources Model (Bakker, Demerouti, & Euwema, 2005), including how these theoretical models inform the research study.

Chapter 4 will provide details of this mixed methods study and will be discussed in the following order. Firstly, the overall format will be addressed in relation to the research questions, hypotheses, method design, associated paradigms, and study sample, followed by a description of the two phases: Study 1 and Study 2. A section will be devoted to a discussion about how the quantitative and qualitative data will be integrated to inform the research findings. The chapter will include a discussion of the study’s rigour as well as any ethical considerations.

Chapters 5, 6 and 7 will discuss the findings from the survey, and the supervisor and supervisee focus groups, respectively. Chapter 8 will present an interpretation of the mixed methods findings drawn from Study 1 (surveys) and Study 2 (focus groups). This will include a discussion on how the findings connect with the empirical clinical supervision literature, as well as the fit between the conceptual framework and this research study.

The final chapter will commence with a discussion detailing the research limitations and strengths, followed by a presentation of the interpreted mixed methods findings, including how they respond to the central research questions. The thesis will conclude with a presentation of how the findings relate to the empirical clinical supervision literature and recommendations for future clinical supervision research.
1.6 Key conceptual definitions

1.6.1 Clients:
Rather than “patients”, the terminology “clients” has been adopted to facilitate consistency, as this is the term commonly used by allied health professionals in the community health study location.

1.6.2 Clinical Supervision:
In the present study, the term “clinical supervision” is defined to be consistent with that used in the organisation’s guidelines. This definition had been based on an existing Queensland Health policy where “supervision” was defined as a “working alliance between two employees where the primary intention of the interaction is to enhance the knowledge, skills and attitudes of at least one employee” (Queensland Government, 2008, p. 13).

Wherever the term “supervision” is used within this thesis, it will refer to clinical supervision, as defined above, unless otherwise specified.

1.6.3 Operational Supervision:
In the present study, the term “operational supervision” is defined to be consistent with that used in an existing Queensland Health policy where “administrative or line management supervision” was defined as “supervision that primarily focuses on administrative or line management issues such as attendance, work allocation and workplace issues” (Queensland Health, 2008, p. 11).

1.6.4 Effectiveness of clinical supervision:
Clinical supervision effectiveness refers to supervisee’s perceptions of how well clinical supervision meets their needs in providing support, education and guidance for their professional practice. This definition was chosen because it straddles the core functions of clinical supervision as suggested by several authors (Kadushin, 1976, cited in Baglow, 2009; Proctor, 2001). Also, these primary supervision functions map closely to those described by Proctor (2008) being the Normative (clinical governance tasks, standards and ethics), Restorative (“refreshment” and support for the worker) and Formative (facilitating learning) functions respectfully. The functions of the Proctor Model align with the domains of the MCSS-26© scale (Winstanley & White, 2011) which has been adopted
for use in this study. It is recognised that overlap of these functions occurs in actual practice (Clinical Education and Training Institute, 2011).

1.6.5 Burnout:
Burnout has been defined by Maslach et al. (1996) as “a psychological syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who work with other people” (p. 192). Occupational Burnout Syndrome is considered to result from chronic stress in workers who have frequent and intense interactions with others (Maslach et al., 1996, p. 192). According to Maslach and Jackson (1986), burnout is a syndrome of Emotional Exhaustion (depletion of psychological resources), Depersonalization (negative attitudes towards clients), and reduced Personal Accomplishment (negative evaluation of one’s work achievements). Some authors consider that Emotional Exhaustion forms the core component of burnout (Garman, Corrigan, & Morris, 2002). The second element, Depersonalization, is a coping response that presents as distancing behaviour and can result in the worker treating the patient with indifference. The third element, low Personal Accomplishment is thought to occur as a result of the other two components, leading to a loss of confidence and feeling of inadequacy (Hawes, 2009).

1.6.6 Intention to leave:
Intention to leave is defined as whether one is contemplating leaving their current job (Wilson, 2015). Intention to leave is the strongest indicator of actual worker turnover (Nissly, Mor Barak, & Levin, 2005).

1.7 Summary
This chapter has presented the background to the study topic, justification for the research study, the study context, the research aims and the research questions. This was followed by an explanation of the research methodology and an outline of the thesis. The chapter concluded with a description of the key conceptual definitions and study terminology.

In the next chapter, the Literature review will briefly describe the origins of supervision and then move to a discussion of supervision practice in the current health care system. This will be followed by an examination of profession-specific differences, supervision training,
and supervision outcomes as they relate to professional development, intention to leave and burnout. The review will conclude with a summary of the main points including how they link with the research study.
Clinical supervision has a vast literature, however much of the empirical literature focuses on the nursing population (Carson, 2007; Edwards et al., 2006). Although Spence et al. (2001) propose that there is little difference in supervisory practices across the various human service disciplines, others have noted that the nursing profession can perceive supervision as hierarchical and punitive (Bogo, Paterson, Tufford, & King, 2011), have difficulty engaging in supervision (Fletcher, 2008; Stein-Parbury, 2013; White & Winstanley, 2006), and be reluctant to fully incorporate the practice (White, 2016). Dawson et al. (2013b) have suggested that caution be exercised when generalising clinical supervision findings from nursing populations to the allied health professions. Therefore, in this review, where possible, examples have been drawn from studies of the allied health professions.

This chapter firstly focuses briefly on the origins of supervision and then moves to a discussion of supervision practice in the current health care system. The functions of supervision will then be considered, followed by supervision effectiveness in relation to professional practice. Next, there will be a presentation on supervision training, followed by an examination of profession-specific differences regarding the allied health professions and clinical supervision practice. The relationship between clinical supervision and intention to leave and burnout will then be considered. The review concludes with a summary of the main points and describes how they link with the research study. Wherever the term “supervision” is used, it will refer to clinical supervision (as defined in Chapter 1), unless otherwise specified.

2.1 Clinical supervision origins and its current place in health care systems

Different views prevail about when the practice of clinical supervision began (Lynch et al., 2008), however supervision within the helping professions derives its origins from the supervision of volunteers of welfare and home visiting services offered by the charity societies of the nineteenth century (Baglow, 2009; White & Winstanley, 2014). The early work of supervision focused on casework assessment and ensuring work was aligned to the administration goals of the agency. The 1920s saw the introduction of psychotherapy supervision for those training in the field of psychoanalysis (Baglow, 2009; White &
In the early 20th century, formal Schools of Social Work commenced. Social work students' educational needs were partly met through placement within social service agencies where oversight and instruction was provided by experienced employees (Gallagher, 2006). This approach has frequently been referred to as the apprenticeship model (O'Donoghue & Tsui, 2011) and is not unlike the current practice of supervision whereby a more experienced clinician provides support and guidance to a less experienced clinician (Health Workforce Australia, 2010). Although the professions of social work, psychology and nursing were early adopters (Holloway, 1995; White & Winstanley, 2014), over time a wide range of health professions instigated supervision practice, often beginning as part of their undergraduate training (Kirk, Eaton, & Auty, 2000).

Professional associations’ endorsement of supervision has provided ongoing momentum for the practice (e.g., Australian Psychological Society, 2007; Occupational Therapy Board of Australia, 2012). Many professional boards expect their members to participate in supervision as part of their continuing professional development requirements (Australian Association of Social Workers, 2012; The Speech Pathology Association of Australia Limited, 2007). Professional organisations advocate the practice of supervision for the purposes of improving competence, providing ongoing skills and knowledge development, facilitating reflection and self-awareness, monitoring practice, providing professional support and ensuring accountability to stakeholders (Australian Association of Social Workers, 2012; The Speech Pathology Association of Australia Limited, 2007). These organisations claim that supervision reaps positive benefits for their professional members, employers and service recipients alike.

Driven by the desire to ensure safe practice standards, recent government initiatives have included clinical supervision as a key governance strategy (Hall & Bell, 2013; Winstanley & White, 2003). As a result of these initiatives, such as the United Kingdom’s National Health Service Scheme (Gallagher, 2006), the Australian National Standards for Mental Health Services (Commonwealth of Australia, 1996), National Health Workforce Strategic Framework (Australian Health Ministers’ Conference, 2004) and Health Workforce Australia (2010), clinical supervision has become a standard requirement for most health practitioners across diverse practice arenas. This agenda has spurred employer
organisations to take a greater interest in providing clinical supervision for the health workforce.

Some authors have been critical of this trend, claiming that a focus on quality and safety has led to a narrow managerial view of supervision (Baglow, 2009; Beddoe, 2010; O'Donoghue & Tsui, 2011). They suggest that this has resulted in clinical supervision being employed as an instrument for surveillance and risk management, at the expense of offering support and educational functions. Regardless of this current debate, there is now a broad expectation that allied health professionals providing clinical services, receive regular clinical supervision of their practice (Health Workforce Australia, 2011d; Queensland Health, 2009).

2.2 Clinical supervision functions

While there is no universal consensus about the definition of clinical supervision (Dawson et al., 2013b; Fitzpatrick et al., 2012), there is general agreement that supervision fulfils three broad functions, sometimes referred to as the three-function-model (Bogo & McKnight, 2006; Bradley & Hojer, 2009). For example, Kadushin articulated the functions of social work supervision as administrative, educational, and supportive, within the context of a positive supervisory relationship (Kadushin & Harkness, 2002). Kadushin’s description shares similarities with another version, commonly known as the Proctor Model (Proctor, 2001). The Proctor Model has gained prominence within the supervision literature, especially within the nursing domain (Winstanley, 2000). Central to this model are three tasks of clinical supervision; described as normative (monitoring standards), formative (facilitated learning), and restorative (support and “refreshment” of the worker) (Proctor, 2008, p. 7). While the administrative and professional development functions of supervision are central for maintaining safe clinical practice, the support function is considered pivotal for health care workers to manage the psychological and emotional aspects of their professional roles (Jones & Cutcliffe, 2009; Paice & Hamilton-Fairley, 2013). Proctor (2001) has emphasised the importance of the restorative/support function, claiming that it enables the effective operation of the normative and formative functions of supervision.
2.3 Effectiveness of clinical supervision

Clinical supervision is widely acknowledged as a valuable professional development activity (Australian Association of Social Workers, 2012; Occupational Therapy Board of Australia, 2012; Snowdon et al., 2015). However while the clinical supervision literature is vast, there is limited evidence available about the effectiveness of clinical supervision, especially for the allied health professions (Dawson et al., 2012; Fitzpatrick et al., 2012). Overall, clinical supervision studies have lacked methodological rigour (discussed later in the chapter) and findings have been mixed. For example, some studies have reported positive links between clinical supervision and professional development (Butterworth et al., 2008; Martino et al., 2008; Roche et al., 2007), while other studies have shown that supervisees have perceived clinical supervision to be ineffective for their practice (e.g. Ellis, 2010; Snowdon et al., 2015). Possible explanations for the inconsistencies in clinical supervision research findings will be discussed shortly. As well as ambiguity about clinical supervision outcomes, uncertainty remains about the characteristics of supervision that contribute to its effectiveness (Fitzpatrick et al., 2012).

One variable has been well established as contributing to supervision effectiveness and this is a quality supervisory relationship (Bambling, 2003). For example, researchers exploring allied health practitioner’s perceptions of the impact of supervision on their practice in mental health services found that having a positive relationship with the supervisor was significantly associated with perceived impact on practice (Kavanagh et al., 2003). Another example draws from an exploratory qualitative study of the introduction of allied health assistants in an occupational therapy health service in the United Kingdom (Nancarrow & Mackay, 2005). All participants perceived that formal supervision had facilitated practice competency in the new assistant roles and the supervisory relationship was considered to be an important component in this process. These studies and others (e.g., Bambling, 2003; Ellis, 2010) provide support for the link between the quality of the supervision relationship and supervision effectiveness. Qualities that contribute to an effective supervisory relationship include the supervisor showing respect, empathy and interest in the supervisee (Falender & Shafranske, 2014; Spence, Wilson, Kavanagh, Strong, & Worrall, 2001), facilitating a safe and trusting supervisory environment (Bogo et al., 2011; Livni et al., 2012), affording validation and empowerment to the supervisee (Bogo et al., 2011; Umlah, 2006), providing frequent clear non-judgmental feedback (Kilminster & Jolly, 2000), taking account of the supervisee’s learning style when
presenting information (Rodger, Fitzgerald, Davila, Millar, & Allison, 2011), and ensuring confidentiality and separation from managerial supervision (Cutcliffe & Hyrkas, 2006). A uniformity of views about preferred supervisor characteristics exists across the allied health professions (Hall & Bell, 2013; Spence, Wilson, et al., 2001).

While the significance of the supervisory relationship has been well established, other aspects of supervision practice are less well understood. Authors have highlighted several contextual variables thought to be related to positive supervision outcomes, including the length of supervision session (Edwards et al., 2005), choice of supervisor (Dawson et al., 2013b; Edwards et al., 2005), place of supervision (Hyrkas, 2005), supervision training (Cutcliffe, 2011; Kavanagh et al., 2008), supervision and support for supervisors (Butterworth et al., 2008), structured supervision processes (Ayers et al., 2014; Kuipers, Pager, Bell, Hall, & Kendall, 2013), and being located in an organisation with a culture that values and supports supervision (Butterworth et al., 2008; Winstanley & White, 2003). It is only in recent times that research has examined the association between supervision effectiveness and the structures and context within which supervision takes place. Currently, these aspects around supervision practice are less clear in terms of their impact on supervision effectiveness (Milne, Aylott, Fitzpatrick, & Ellis, 2008).

Although the contextual features of supervision are of interest, to date, findings from studies have been inconclusive. For example, researchers have suggested that it is important to have a structured framework for supervision implementation that includes resources such as supervision procedures, supervision agreements, and training (Dawson et al., 2012). However, although formally structured supervision processes are recommended practice (Ayers et al., 2014; Spence, Kavanagh, et al., 2001), they are not always the preferred format for supervisees (Umlah, 2006) or linked with better supervision outcomes (Bowles & Young, 1999). For example, Kuipers and colleagues (2013) drew findings from service analysis data derived from surveys of 192 Queensland allied health participants who had attended peer group supervision training. The results showed that groups that adopted some type of formal documentation, including evaluation of some kind, scored significantly higher on the supervision evaluation measure than did participants in groups without these processes. Unfortunately there was insufficient information on the type of documentation and processes used by the groups and, surprisingly, participants in groups who had completed supervision agreements did not
differ significantly from those without agreements in place. This is an interesting finding as supervision agreements are considered to be an important component in establishing effective supervisory relationships (Falender & Shafranske, 2014) as they provide opportunity to clarify roles, responsibilities and boundaries of confidentiality (Clinical Education and Training Institute, 2011). However, it was unclear from the study whether the peer group training included education in establishing a supervision agreement. If not included in the training, the omission may have influenced the findings. The completion of an agreement is a collaborative process (Queensland Health, 2009) that requires skilful negotiation. As such, it is frequently included as part of clinical supervision training (Faculty of Medicine Dentistry and Health Sciences, 2009; Morrell, 2015). Also, as the study participants derived from 23 different health sites across Queensland, it is possible that the agreements varied in terms of their content and usefulness and this may also explain this result.

Other authors have suggested links between structured processes and clinical supervision outcomes but have failed to investigate these associations in their research. For example, an English study of 46 occupational therapists working in the mental health field reported high scores of supervision effectiveness (Ayers et al., 2014) and the researchers proposed that the high effectiveness scores may have been related to the provision of supervision resources that included guidelines, supervision contracts, and training. Unfortunately, there was no analysis undertaken to determine whether these variables were linked to supervision effectiveness, hence the association was unable to be ascertained. In another example, an Australian study of 60 hospital-based physiotherapists reported that over half of the responses failed to meet the published supervision efficacy threshold for the administered supervision scale (Snowdon et al., 2015). The researchers suggested the low scores may have been linked to the workplace not having a clear supervision framework, including supervision agreements. Again, this aspect of the supervision practice was not measured in the study and was therefore unable to be established. At present, current findings are inconclusive about whether contextual elements such as structured supervision processes are associated with supervision effectiveness, and if so, which specific components contribute to effectiveness. Further investigation is warranted to determine the influence of structured supervision processes on clinical supervision outcomes.
One reason attributed to the inconclusive findings in empirical clinical supervision literature is the poor quality of many of the studies (Creaner, 2014; Kilminster & Jolly, 2000). Common problems identified include the use of small sample sizes (Bogo & McKnight, 2006; Pront, Gillham, & Schuwirth, 2016), unrepresentative samples (Mor Barak, Travis, Pyun, & Xie, 2009), poor conceptualization (Milne et al., 2008), dependence on one source of data (Crow, 2008), interventions poorly described (Dawson et al., 2013a), and reliance on measures that were not psychometrically robust (Creaner, 2014). In some studies, the intervention being applied is not being implemented in ways consistent with best practice. For example, Snowden and colleagues’ (2015) study of hospital-based physiotherapists provides little information about the clinical supervision practice under investigation. However, it reports that 24% of supervisors had dual roles in that they were providing clinical as well as operational supervision. Given that the organisation had no clear supervision framework, it is difficult to know whether the supervision being provided was, in effect, clinical or operational supervision. The provision of clinical supervision by line managers is thought to negatively impact the effectiveness as it can undermine the foundation of trust in the supervisory alliance (Cleary, Horsfall, & Happell, 2010; Dawson et al., 2012). In addition, participants’ most frequently reported supervision session duration was 15 to 30 minutes, which was highlighted by the researchers as possibly being an inadequate allocation of time. Others suggest that a minimum session time of 60 minutes is required in order to obtain measurable benefit (Edwards et al., 2005; Watkins, 2011). Therefore the findings from Snowden and colleagues’ study (2015) tell us little about the outcomes we could expect from well implemented supervision. Methodological problems have presented barriers to advancement in knowledge about clinical supervision effective practice and outcomes.

There is an increasing imperative to establish the antecedents of effective clinical supervision due to growing concerns about the possible implications from ineffective supervision practice. A number of researchers have suggested that supervision practice does not always deliver beneficial outcomes (Falender & Shafranske, 2014; White & Winstanley, 2009), with some studies showing supervision to be perceived as ineffective for improving professional practice (Hyrkas, 2005; Snowdon et al., 2015). For instance, an English study of 30 occupational therapy supervisors reported that respondents often felt uncomfortable in the supervisor role, lacked theoretical knowledge about supervision and generally viewed supervision practice as futile (Sweeney, Webley, & Treacher, 2001). The
researchers acknowledged that most supervisors in the study had not received any supervisor training. Bradley and Hojer (2009), in their review of two supervision research projects, one English and the other Swedish, found that the majority of the English social workers in the study were dissatisfied with their supervision and half of the Swedish participants did not think supervision improved their theoretical knowledge. The educational function of supervision is considered to be central to facilitating the supervisee’s capacity to develop new skills and knowledge (Kadushin & Harkness, 2014). Also defined as “task assistance”, this function requires the supervisor to have a high level of practice expertise and supervisory capacity to effectively provide advice and direction to the supervisee (Mor Barak et al., 2009). It may be that findings of supervision ineffectiveness derive from studies where supervisors lacked the expertise to fulfill the educational function, resulting in the delivery of sub-standard supervision. Some researchers have suggested that ineffective supervision may be harmful for supervisees and service recipients (Ellis, 2010; Gaitskell & Morley, 2008; White & Winstanley, 2010), highlighting this potential risk and the need to establish the antecedents of effective supervision (Watkins & Milne, 2014).

In summary, this literature review reveals there is a pressing need to establish the outcomes associated with clinical supervision and the elements that contribute to clinical supervision effectiveness. This is especially so for the allied health workforce. The vast majority of studies have examined nursing populations (Carson, 2007). There is an even greater need to for allied health workers located in community health settings as the small number of clinical supervision studies of allied health populations have focused on the sectors of alcohol and drugs, child safety, mental health and acute tertiary hospital settings.

Having presented a discussion of the clinical supervision literature as it relates broadly to providing guidance, support and professional development for practice, the next topic to be addressed is clinical supervision training. It is generally agreed that participating in clinical supervision is a complex task that requires a different skill-set to the clinical skills applied in the particular health practitioner role (Health Workforce Australia, 2010; Siggins Miller Consultants, 2012). Consequently there is now wide acceptance of the need for clinical supervision training in order to increase the effectiveness of supervision (Kavanagh et al., 2008; Kuipers et al., 2013), hence supervision training forms the topic of the next section.
2.4 **Clinical Supervision and the place of training**

Research on supervision training outcomes is still in its infancy (Fleming, 2012) with evidence-based principles yet to be determined (Milne, 2014). Historically, most supervisors have not received supervision training (Crow, 2008; Spence, Kavanagh, et al., 2001) however this has changed in recent times and it is now an expectation that supervisors will attend training (Fleming, 2012; Health Workforce Australia, 2010). Despite this, currently, there is a lack of consistency in the content and methods employed in supervision training. A recent review of 11 controlled studies led the researchers to conclude that the only methods found to be empirically supported were providing feedback, use of role plays and video or live modeling (Milne, Sheikh, Pattison, & Wilkinson, 2011). Although clinical supervision training is recommended (Watkins & Wang, 2014), and at times required (e.g., Australian Association of Social Workers, 2014), there is limited empirical evidence to inform the content, format and process of supervision training.

None-the-less, important steps have been taken to bridge the gap between evidence and practice. One of the earliest randomized controlled studies of clinical supervision training investigated the impact across three different intervention conditions (Kavanagh et al., 2008). The three conditions included “immediate” (supervisor-supervisee pair trained at the same time), “split” (supervisor trained first and supervisee trained three months later) and “delayed” (training delay of three months for supervisor-supervisee pairs). The research was undertaken in Queensland, Australia, and involved a survey of 46 supervisor-supervisee pairs working in mental health services. The supervisor-supervisee pairs had been in existing supervision arrangements for an average of 14.6 months and were randomly assigned to one of the three intervention conditions. Participants attended a two-day supervision training workshop, which utilised presentations, demonstrations and practice sessions. Findings showed benefits for the “immediate” group, that is, concurrent supervisor-supervisee pairs training condition. For instance, the immediate trained pairs showed a significantly higher number of specified items in their supervision agreements than did the delayed trained pairs. As well, the immediate pairs had a significant drop in supervisor perceived supervision problems over time, compared to the delayed pairs. The split group was not significantly different to either the immediate or the delayed pairs. The researchers acknowledged the limited outcomes from the training, suggesting the short
training exposure may have been insufficient to render detectable outcomes. They advised that there was no agreement about the most appropriate duration for supervision training workshops. Still, the researchers reported that the study provided sufficient evidence to recommend supervision training be offered simultaneously to supervisors and supervisees as this mode encouraged a collaborative approach and mutual understanding of the process.

Although the evidence base for supervision training is underdeveloped, researchers have warned that the absence of training for supervisors negatively affects supervision effectiveness (Dawson et al., 2013b; Snowdon et al., 2015). For example, Dawson and colleagues’ (2012) study of Australian allied health professionals working in Victoria, reported that although the majority of respondents rated supervision as effective, low ratings were given for the “personal issues” factor of the Manchester Clinical Supervision Scale. This factor is a measure of “how supported the supervisee feels with issues of a personal nature and/or reflecting on complex clinical experiences” (Winstanley, 2000, p. 32). This led the researchers to suggest that the low scores may have been due to a deficit in supervisor support skills as the participants had not felt comfortable debriefing during supervision sessions (Dawson et al., 2012). Although the level of supervisor education was not measured in this study, the researchers recommended supervisor training to address any skill deficits. Hence, without adequate supervisor training, supervisors may not possess the skills to confidently manage all aspects of the supervisor role and this may reduce the capacity of supervision practice to provide the desired outcomes of providing guidance for practice, support and professional development.

The current study provides an opportunity to investigate the outcomes of a clinical supervision model, employing a standardised supervision training format, for supervisors and supervisees. Although it is recommended practice for supervisors, as well as supervisees, to participate in supervision training (Kavanagh et al., 2008), at the time of the study it was common for supervisors, but not supervisees, to be given access to supervision training (e.g. see Dawson et al., 2012; Health Workforce Australia, 2010; White & Winstanley, 2009). The location of the current study, a community health service, adopted a common model of clinical supervision across the allied health workforce. The staff comprised allied health professions including dietetics, occupational therapy, physiotherapy, podiatry, psychology, social work, speech pathology, and allied health
assistants. As well as examining the effectiveness of clinical supervision, this research affords an opportunity to determine any profession-specific differences in the findings. Hence, a discussion of clinical supervision and profession-specific differences is presented next. This section will focus on allied health, a group of professions “bonded through being separated from medicine and nursing” (Fitzpatrick et al., 2012, p. 462).

### 2.5 Clinical Supervision and Profession-specific differences

Allied health professionals, through their distinctive undergraduate training, are equipped with different skill sets and expertise and these differences emerge in supervision practice. For example, some allied health professions, such as physiotherapy, are concerned with interventions that are primarily task focused (Physiotherapy Alberta College and Association, 2015), whereas professions, such as social work, are both process and task oriented in their practice (Australian Association of Social Workers, 2015). In supervision, these variations become evident. For instance, Dawson and colleagues (2012), following their clinical supervision study of nine allied health professions, claimed that the professions of psychology and social work, due to their undergraduate training, may be better equipped to address supervisees’ personal issues when they arise during supervision.

Distinctions in supervision across the allied health disciplines are also thought to derive from differences in professional traditions and variations in exposure to clinical supervision formats (Health Workforce Australia, 2010). This may be so, as Lynch and colleagues (2008), following their review of the origins of clinical supervision, claim that the majority of the clinical supervision literature in the health sciences has been largely discipline-specific and developed in isolation from the work of parallel disciplines. Certainly, some allied health professions, such as social work and psychology, were early embracers of supervision (Lynch et al., 2008). It has been suggested that these individual professions have supervision embedded within their histories and hence perceive supervision to be part of how they provide clinical practice and maintain their professionalism more broadly (Dawson et al., 2012; Roche et al., 2007). Other professional groups, such as physiotherapy and dietetics have been late adopters of the practice and are in the early stages of developing their knowledge and understanding about the purpose and processes of clinical supervision (Burton, 2008; Hall & Cox, 2009). These types of variations may
explain why the skills required by supervisors can differ between the professions (Health Workforce Australia, 2010).

While profession-specific differences are evident, it has been argued that the allied health professions share more commonalities in their clinical supervision practice than divergences (Fleming, 2012; Spence, Kavanagh, et al., 2001). For instance, allied health professions have a shared view about what elements constitute a good supervisor (Health Workforce Australia, 2011c). A few studies have considered the impact of a clinical supervision model across a varied number of allied health disciplines and some variations have been identified (Ducat & Kumar, 2015; Kavanagh et al., 2008). For example, Kavanagh et al (2003) in their survey of occupational therapists, psychologists, social workers and speech therapists found that psychology and social work supervisors were more likely to receive supervision for their supervisory role, and occupational therapists were least likely to receive this form of supervision. Despite these differences, the large degree of commonality that exists between the allied health professions has prompted the call for the professions to adopt a collaborative approach to clinical supervision (Fitzpatrick et al., 2012, p. 462). It has been suggested that identification of common policies and procedures could support a standardised national supervision framework and contribute to the effectiveness of clinical supervision across the allied health professions. Still, some have cautioned against adopting a “one-size-fits-all” approach, suggesting that it may not accommodate the diverse needs of the individual allied health professions (Kumar et al., 2015). This is an area that is under-researched and requires further investigation given recent Australian initiatives to apply a single clinical supervision model across all health professionals, including allied health (Health Workforce Australia, 2013b).

The next topic to be addressed in this chapter is the relationship between clinical supervision and intention to leave. Australia, in common with many other countries, experiences workforce shortages in the healthcare industry (Alkorashy & Baddar, 2016; Health Workforce Australia, 2010), including amongst the allied health professions (Australian Government, 2014). The Australian health care system is expected to deliver services that are safe, effective, and of a world-class standard. Unwanted employee turnover has been linked with diminished service quality, reduced customer satisfaction and represents a preventable loss in public expenditure (Alkorashy & Baddar, 2016; Ellett et al., 2003). The prevalence of staff shortages and its associated costs has led to an
increased expectation that organisations will promote human resource strategies that increase retention (Davey et al., 2006; Ng & Sim, 2011). Clinical supervision is recognised as one such approach.

2.6 Effectiveness of clinical supervision and intention to leave

There is growing awareness that the provision of supportive work environments improves workforce retention (LLoyd et al., 2014; Schoo, Stagnitti, Mercer, & Dunbar, 2005) and this sentiment is being increasingly reflected in government statements (Australian Government, 2009; Australian Health Ministers’ Conference, 2004). Supportive environments include professional support such as access to training, professional development and supervision (Asquith, Sardo, & Begley, 2008; Educator Pathway Program, 2010; Ellett, Ellis, Westbrooke, & Dews, 2007). Lack of professional support can negatively affect job satisfaction (Smith, Fisher, Kearne, & Lincoln, 2011), and is consistently associated with intention to leave (Belbin, 2011). Insufficient professional support, such as clinical supervision, is frequently cited as a major reason that health care workers leave their place of employment (Humphreys, Jones, Jones, & Mara, 2002; Scanlan et al., 2010). Studies suggest that health employers who fail to provide their employees with access to professional support are likely to have higher numbers of employees with intent to leave than they would otherwise (Alkorashy & Baddar, 2016; Allan & Ledwith, 1998). Furthermore, allied health staff without access to professional support in the workplace are unlikely to commend their workplace to others (Schoo et al., 2010).

Clinical supervision is being increasingly viewed by government bodies and professional associations as a key strategy for providing professional support (Australian Association of Social Workers, 2014; Health Professions Council of Australia, 2005; Health Workforce Australia, 2011b; The Speech Pathology Association of Australia Limited, 2007). The provision of clinical supervision is thought to enhance job satisfaction and minimise workers’ intention to leave (Chiller & Crisp, 2012; Collins, 2008; Dodd, Saggers, & Wildy, 2009). Hence, the drive to retain allied health staff in the health care workforce is one reason for the broad introduction of clinical supervision in recent years (Clinical Education and Training Institute, 2011).
There is some evidence to support an association between clinical supervision and decreased intention to leave. For example, Ellett et al (2007), in their study of 369 child welfare professionals in the United States of America, sought participants’ perspectives about factors that contributed to employee retention and employee turnover. The participants were of mixed profession with the three largest professional groups holding degrees in psychology, sociology, and social work. The researchers found that high quality supervision was linked to increased employee retention, whereas lack of professional development opportunities contributed to increased worker turnover. Similarly, in a mixed methods study of 823 substance abuse treatment counsellors across 109 American treatment centres, Knudsen et al (2008) found that perceived high quality of supervision was significantly related to reduced turnover intention. They also identified that participants who had positive relationships with their supervisors perceived greater job autonomy, increased procedural fairness, and equity in distribution of tasks and rewards. Thus, when the supervisory relationship was positive, supervisors were seen by supervisees as affirmative representatives of the broader organisation.

While clinical supervision is being increasingly adopted as a standard practice within health services (Clinical Education and Training Institute, 2011; Council of Australian Governments, 2008), uncertainty remains about the outcomes of supervision, including those related to reduction in intention to leave (Buus & Gonge, 2009; Watkins & Milne, 2014). Low job satisfaction is a significant predictor of increased turnover (Wilson, 2015), however clinical supervision has been linked to both high and low job satisfaction (Koivu et al., 2012b). For example, in a study of 569 Finnish mental health nurses, Hyrkas (2005) found evidence that ineffective supervision, as defined by scoring less than the minimum criteria on the Manchester Clinical Supervision Scale, was significantly related to increasing job dissatisfaction. The author called for improved resourcing of supervision, especially the provision of supervision training for supervisees and supervisors to reduce the variability of supervision quality. While training may be one important element, this study highlighted other variables that were also associated with supervision effectiveness, including choice of supervisor, supervision frequency and period of time that supervision had been received. This is an important area for further investigation, as there is a need to establish the relationship between supervision and intention to leave and to better understand the conditions under which supervision might lead to job dissatisfaction.
Even though researchers have operationalised clinical supervision effectiveness by various measures, findings suggest that the effectiveness of the supervision practice is an important variable in relation to worker intention to leave outcomes (Butterworth et al., 2008; Carson, 2007; Hyrkas et al., 2006). While it seems that supervision effectiveness is important in relation to outcomes, researchers are not always clear about details of the supervision intervention under investigation (Carpenter et al., 2013). For instance, in their survey of 304 Finnish hospital nurses, Koivu and colleagues’ (2012b) identified a relationship between the receipt of effective supervision and increased worker commitment to the employing organisation. Yet, not all supervisees in the study reported supervision as effective. Indeed, the overall group mean fell below the efficacy threshold suggested for the measure being employed. Unfortunately, lack of information about the supervision practice prevents drawing inference about the low levels of effectiveness and from identifying how the effective supervision differed from the ineffective supervision.

As mentioned earlier, the empirical clinical supervision literature has many instances of methodological problems making it difficult to draw conclusions (Bogo & McKnight, 2006; Carson, 2007). For example, Wilson’s (2015) study of 90 hospital-based allied health workers in Australia identified a significant relationship between high quality supervision and decreased intention to leave. Rather than utilising a validated supervision measure, data was collected using a modified job satisfaction scale which contained one supervision item. Authors have suggested that supervision effectiveness requires the satisfactory fulfilment of three primary supervision functions (Proctor, 2008), as well as other aspects such as a quality supervisory relationship (Bambling, 2000); hence it seems unlikely that a single item would be capable of detecting the multi-faceted features of supervision effectiveness. In addition, Wilson (2015) reported that having a sense of accomplishment and receiving recognition were linked to increased job satisfaction though it was unclear whether these factors were attributable to the receipt of supervision. Given the above, it is hard to have confidence in the study’s findings.

In summary, it is important to establish the relationship between supervision and intention to leave and increase understanding about the elements of clinical supervision that contribute to improved job satisfaction and worker retention. While existing evidence suggests that the effectiveness of supervision is associated with reduced intention to leave
and improved job satisfaction, variations in supervision practice, and how supervision effectiveness is defined and operationalised, make it difficult to draw conclusions.

One precursor consistently linked to intention to leave is burnout (Alkorashy & Baddar, 2016). As mentioned in Chapter 1, Burnout is a syndrome of emotional exhaustion (depletion of psychological resources), depersonalization (negative attitudes towards clients), and reduced personal accomplishment (negative evaluation of one’s work achievements) (Maslach & Jackson, 1986, p. 192). Chronically stressed workers who have frequent and intense interactions with their care recipients can develop burnout (Maslach et al., 1996). The provision of professional support, such as clinical supervision, is recognised as an important strategy to combat burnout (Collins-Camargo et al., 2009; Edwards et al., 2006). The following section will address the empirical literature as it relates to the relationship between clinical supervision and burnout of workers. As much of the clinical supervision literature refers to both stress and burnout; both will be discussed in this section, however this study’s focus is on burnout.

2.7 Effectiveness of clinical supervision and burnout

The empirical literature documents the occurrence of high levels of stress and burnout in health care workers (Barker et al., 2016; Lloyd, King, & Chenoweth, 2002; Marine et al., 2009), including allied health professionals (Chiller & Crisp, 2012; Fischer et al., 2013). There is evidence that healthcare workers experience higher levels of stress and burnout in comparison to the broader workforce (Michie & Williams, 2003; Wells, 2011). Some have suggested that staff based in community settings have higher levels of stress than staff located in in-patient facilities (Lloyd et al., 2002; Spence, Kavanagh, et al., 2001; Wykes, Stevens, & Everitt, 1997), while public sector employees may be at greater risk of work-related stress owing to the prevailing discourse about the need for job reductions in this sector (Gamble, Lincoln, & Adamson, 2009; Wells, 2011).

There are a number of contributing factors associated with stress and burnout in health care workers. In recent times health services have experienced increasing fiscal constraints (Kim, 2008), changed demographics with ageing populations (Kumar, 2011), increased levels of chronic health conditions (Leggat, Bartram, & Stanton, 2011), and a need to reduce pressures on the tertiary hospital sector (Australian Government, 2010). These occurrences are felt at the coal-face of service delivery with community-based
Clinicians called upon to provide care to increasingly complex and seriously ill patients (Rodger et al., 2008). The rise in the clinical acuity of caseloads means that allied health professionals are more frequently caring for patients with challenging situations (Bland & Rossen, 2005), while sometimes seeing little improvement in their patients’ health conditions (Edwards & Burnard, 2003). Practicing in an ever-changing work environment (Sawbridge & Hewison, 2011) where there are uncertain health outcomes (Lloyd & King, 2001) are additional challenges associated with stress. At the same time that allied health professionals are encountering rising expectations of their practice capacity, they are reporting staff shortages (Kim & Stoner, 2008), lack of professional support (Jervis-Tracey et al., 2016; White & Winstanley, 2009) and the requirement to complete escalating and unrewarding administrative tasks (Kim & Lee, 2009; Noblet et al., 2016). These sources of occupational strain further contribute to stress and burnout in the allied health workforce.

Burnout carries significant costs and risks for the healthcare industry (Marine et al., 2009). Empirical studies have established that burnout has a negative impact on productivity, clinical performance, the quality of service provision, and service continuity (Hawes, 2009; Nissly et al., 2005; Thanacoody, Bartram, & Casimir, 2009). Burnout is also negatively associated with patient satisfaction (Fredette-Carragher, 2016; Garman et al., 2002) and has been shown to contribute to patient mistrust of the service (Kim & Stoner, 2008). Stress and burnout pose a risk to health service sustainability because it is one reason that workers choose to leave their place of employment (Bennett, Plint, & Clifford, 2005; Edwards & Burnard, 2003; Lloyd et al., 2002), and this places increased pressure on remaining team members left to fill the gaps (Belbin, 2011; Michie & Williams, 2003). In addition, burnout has important ramifications for health care workers and these include decreased job satisfaction, poor job performance (Edwards & Burnard, 2003; Livni et al., 2012), increased absenteeism (Hawes, 2009; Lloyd & King, 2001), and depression (Begat & Severinsson, 2006; Weigl et al., 2016). Health care organisations bear a heavy financial cost as a result of occupational stress, burnout and staff turnover (Fredette-Carragher, 2016; Wells, 2011). It is estimated that, in the UK alone, work-related stress costs the National Health Service £555 million annually and a loss of 3.4 million working days (Wells, 2011). Whereas, the cost to replace a health care professional, including recruitment and training, has been estimated to be around 150% of the employee’s wage (Belbin, 2011). This represents a preventable loss in public expenditure (Ellett et al., 2003).
which is indefensible at a time of increasing budget constraints and an ever present focus on workforce productivity (Wells, 2011).

Clinical supervision may be one strategy to protect health care workers against burnout (Livni et al., 2012; Queensland Health, 2009) as it has been suggested that increasing job resources such as professional support, mediates levels of burnout (Alkorashy & Baddar, 2016; Demerouti, Bakker, Nachreiner, & Schaufeli, 2001). Authors have proposed that clinical supervision can assist supervisees to reduce stress and burnout through a range of mechanisms, including support to understand and manage emotional responses to their caring roles, combating emotional fatigue, increasing resilience (Howard, 2008; Jones & Cutcliffe, 2009), affording reassurance and encouragement (Bogo & McKnight, 2006), and assisting to develop self-care strategies (Australian Association of Social Workers, 2012). These views appear to be supported by findings from a qualitative study of 18 trauma counsellors working in New South Wales, Australia. Ling, Hunter and Maple (2014) found that the counsellors utilised supervision as a supportive strategy to debrief distressing events. The participants reported that clinical supervision assisted by reducing the stressful effects of the indirect trauma exposure, enabling supervisees to continue functioning effectively as trauma counsellors.

It may be that clinical supervision can shield workers from burnout however there has been limited evidence to support these claims (Clegg, 2001; Koivu et al., 2012b), with varied and equivocal findings (Collins, 2008; Kim & Lee, 2009; Tilley & Chambers, 2003). For example, findings from a study of 132 physiotherapists working in Italian hospitals reported no association between the use of supervision and levels of burnout (Fischer et al., 2013). The researchers defined the term supervision to cover a broad range of activities comprising individual supervision, group supervision and psychotherapy. These activities appear quite diverse and there was no information provided about what common functions, if any, the ‘supervision’ practices provided. Without a clear and unambiguous definition for supervision, there is a lack of comparability. Also, it is unknown whether a support function formed part of the ‘supervision’ practice. The authors did not attempt to measure the effectiveness of the ‘supervision’ practice; therefore it is not possible to know whether the effectiveness of the intervention had any bearing on the results. In another example, Boyas and Wind (2010), in their survey of 209 child welfare employees in Texas, USA, found that those who reported higher levels of supervisory support had significantly
higher emotional exhaustion than did others in the study. The authors failed to provide any information about the supervision model being applied, nor whether the intervention was clinical supervision or operational supervision by line managers. The shortcomings in these studies prevent drawing inferences from the findings about the association between clinical supervision and burnout.

While there is limited evidence about the association between supervision and burnout of workers, findings suggest that the perceived effectiveness of supervision is an important factor in determining this relationship. For instance, a Finish survey of 569 nurses found that although one-third scored highly for emotional exhaustion, participants receiving effective supervision, as defined by meeting the minimum criteria on the Manchester Clinical Supervision Scale, had lower levels of burnout than those who did not receive effective supervision (Hyrkas, 2005). Supervisees who also provided supervision to others had significantly lower levels of burnout indicating beneficial results for those undertaking supervisor roles. Similarly, in a survey of 166 community nurses working in the United Kingdom, Edwards et al (2006) demonstrated that supervisees, who rated their clinical supervision as effective, again employing the Manchester Clinical Supervision Scale to measure effectiveness, had significantly lower levels of measured burnout.

Even when clinical supervision effectiveness has been examined, research findings have been mixed. Livni and colleagues’ (2012) Australian survey of nurses, psychologists and counsellors working in the Alcohol and Other Drugs field, found that an effective supervisory alliance was significantly associated with increased job satisfaction and increased staff well-being. However, the study’s results also showed that over the time of the 6-month supervision period, levels of burnout increased, and staff well-being decreased from the baseline measures. The researchers questioned whether the small sample size of 42 supervisees was sufficient to demonstrate reliable findings and they also reported that several of the implemented measures had low or unestablished levels of reliability. In addition, findings were drawn from both individual and group supervision formats and supervisees were allocated to formats without choice of supervisor or supervision format. These variations make it difficult to draw conclusions from the study’s findings.
While some studies have demonstrated links between clinical supervision and reduced burnout of workers, the measures implemented have prevented an accurate examination of supervision effectiveness. For example, a large mixed methods study of substance abuse treatment counsellors in America found a significant association between perceived effectiveness of clinical supervision and improved occupational well-being (Knudsen et al., 2008). The researchers noted that the study’s measure of supervision effectiveness targeted the instrumental tasks of supervision and as such, lacked the capacity to capture components related to the provision of emotional support. They suggested that attending to the supervisees’ emotional needs may have been an important element in protecting the workers from emotional exhaustion and recommended this as an area for further examination. The support component of supervision, along with the other functions, appears to be important for lessening the impact of emotionally charged events. Unfortunately many clinical supervision studies fail to adopt psychometrically valid scales to measure supervision effectiveness and this aspect is discussed next.

Methodological problems have impeded attempts to clarify the association between clinical supervision and burnout (Bogo & McKnight, 2006; Roche et al., 2007). For example, researchers have used a range of measures to determine supervision effectiveness, making it difficult to compare results. For instance, Hyrkas (2005) and Edwards et al (2006) employed the Manchester Clinical Supervision Scale (Winstanley, 2000), whereas Knudsen, Ducharme, & Roman (2008) used a measure adapted from two scales, the Supervisory Working Alliance Inventory (Efstation, Patton, & Kardash, 1990), and the Rahim Leader Power Inventory (Rahim, 1988). Psychometrically valid scales to measure supervision effectiveness have been available for the past decade (Carson, 2007), yet some studies have failed to implement them. For example, an Israeli study of 143 social workers employed in domestic violence services instituted the “Multifactor Leadership Questionnaire” to measure supervisees’ satisfaction with supervision effectiveness (Ben-Porat & Itzhaky, 2011). The results showed no association between supervision effectiveness and burnout. The researchers had modified the questionnaire by changing the word “director” to “supervisor”, even though the authors of the scale advise against its modification (Avolio & Bass, 1999, p. 442). Researchers have been cautioned against the use of non-specific supervision scales, given the availability of valid instruments designed for this purpose (Watkins & Milne, 2014). The above examples of methodological
problems may explain the lack of consistent findings regarding the association between clinical supervision and burnout.

In summary, the above empirical examples suggest a link between the perceived effectiveness of supervision and levels of burnout however variations in findings and methodological problems make it difficult to draw conclusions. Further research, employing rigorous methods and psychometrically valid measures, is required to clarify this relationship and to determine the characteristics of clinical supervision that are linked to effectiveness.

2.8 Conclusion

The advancement of clinical supervision has been endorsed by professional bodies and government agencies alike (Health Workforce Australia, 2013b; Occupational Therapy Board of Australia, 2012), with anticipation that subsequent benefits will flow on to health care workers, organisations and health care recipients. Despite this seemingly universal endorsement of clinical supervision, there is a lack of agreement about what constitutes effective clinical supervision practice (Fitzpatrick et al., 2012, p. 464) and a lack of evidence about clinical supervision outcomes (Livni et al., 2012; Watkins & Milne, 2014). This chapter has argued that although the empirical clinical supervision literature is vast, the evidence for clinical supervision effectiveness is inconclusive.

Researchers have signalled concerns about the wholesale uptake of clinical supervision practice (Hyrkas, 2005; White & Winstanley, 2014), claiming that ineffective supervision may be harmful for supervisees and service recipients (Ellis, 2010; Gaitskell & Morley, 2008) and represent poor use of scarce public resources (Snowdon et al., 2015). It has been suggested that clinical supervision practice, in its present variable form, may not represent good value or good practice when it is applied across-the-board within health services (White & Winstanley, 2010). Consistent with all health service practice, clinical supervision implementation needs to be based on sound evidence. Currently that evidence is obscure, making it critical to establish the antecedents of effective supervision (Watkins & Milne, 2014) when examining the relationship between effective supervision and burnout and intention to leave. It can be argued that there is even a greater need to ascertain this evidence for the allied health professions as the majority of the empirical clinical
supervision literature has examined nursing populations and it cannot be assumed that the findings can be generalised to allied health (Dawson et al., 2013b).

In summary, there is emerging evidence to suggest that effective clinical supervision may be useful for providing guidance, support and professional development for clinical practice, may have a positive effect on workforce retention and may be a protective strategy against burnout. However, the number of inconsistencies found in the literature makes it difficult to draw firm conclusions (Crow, 2008; White & Winstanley, 2006). In Watkins and Milne’s (2014) recent appraisal of the clinical supervision literature, they lament the dearth of process-outcome research, that is, studies that examine “the relationship between what was done and its effect” (p. 683). The current study provides an opportunity to do just that; to examine the process and outcomes of clinical supervision practice within a district community health setting. The supervision intervention comprised several best practice principles, including supervision training (Kavanagh et al., 2008), supervision guidelines (Ayers et al., 2014), supervision agreements for documenting learning goals, roles, responsibilities and boundaries of confidentiality (Fleming, 2012), and providing supervisees with choice of supervisor (Dawson et al., 2013b). As the research site encompassed one organisation across several services, it presented an opportunity to hold constant many of the clinical supervision intervention variables. In addition, this research program will utilize a mixed methods research design that draws from a number of data sources, and seeks perspectives from both supervisees and supervisors. Unlike the vast proportion of the clinical supervision empirical literature, this study will employ methodological rigour in defining and operationalising clinical supervision effectiveness. Therefore this study provides a significant opportunity to identify variables associated with clinical supervision effectiveness and to investigate the relationship between clinical supervision and burnout and intention to leave for allied health professionals. Hence, the current study offers a unique capacity to make a valuable contribution to the clinical supervision evidence base.

The next chapter presents the conceptual framework which describes theories that inform the discussion as well as highlight the significance of the prevailing environment in which clinical supervision takes place.
3 Conceptual Framework

This chapter will describe Social Ecological Theory (Stockols, 1992) which is the major conceptual framework for this research. A social ecological approach has been adopted as it provides a useful context in which to locate and understand clinical supervision practice. This theory provides the backdrop to the conceptual framework and is complemented by the theoretical construct, the Job Demands-Resources Model (Bakker et al., 2005). This model will be discussed in relation to how it enhances an understanding of the relationship between effective clinical supervision, burnout and intent to leave (see Figure 3.1 for an overview of the conceptual framework and Figure 3.2 for Social Ecological Theory as it applies to clinical supervision). Finally, the chapter will conclude with a presentation of the mixed methods study design selected for the methodology and how it fits within this study’s conceptual framework.

3.1 Social ecology and its application to this research

Derived from systems theory, the social ecological model places emphasis on the importance of the dynamic interrelations between individuals and their multi-faceted environments (Stockols, 2000). The social ecological perspective understands human well-being to be influenced by personal aspects, as well as physical, social, institutional, and cultural factors within both immediate and outlying environments (Goodman, 2000; Stockols, 2000). Bronfenbrenner (1977) has described the ecological environment as a nested arrangement of structures containing several layers, which he termed the microsystem, mesosystem, exosystem, and macrosystem. These multiple systems are constantly bi-directionally modified through elements in the systems as well as people’s individual and collective actions (Stockols, Perez Lejano, & Hipp, 2013). With this focus, social ecological theory, provides a useful lens through which to consider change, especially change that requires a number of interventions at different levels (Hawe, Shiell, & Riley, 2009).
Figure 3-1 Overview of Conceptual Framework
Figure 3-2 Social Ecological Theory as it relates to supervision
In this study location, clinical supervision implementation took place within a complex, rapidly changing, reactive environment. The community health service, within Queensland Health, was connected to broader structures with their commentary on clinical supervision, including state-wide guidelines (Allied Health Professions Office of Queensland, Undated) and national workforce development strategies (Health Workforce Australia, 2011a). In common with many public health services, the organisation was experiencing and responding to several challenges including the drive for cost-effective, safe, evidence based interventions (Australian Government, 2008); access to shrinking resources; a high level of public scrutiny (Lloyd et al., 2002; McCracken & Wallace, 2000); political events (ABC Local Radio Brisbane, 2012; Brace, 2013) and workforce shortages (Belbin, 2011; Health Workforce Australia, 2010; Walker, Bull, & Dalton, 2002). Challenges confronting the macro level within the system result in adjustments at the meso and micro levels. For example, it has been suggested that public sector employees may be exposed to higher levels of work-related stress due to the dominant discourse about the need for reductions in the public sector (Wells, 2011). This approach suggests that when human service organisations respond to external pressures, such as fiscal constraints and demands for changed health care models, the consequences of those responses are felt at the ‘coal face’ of the workforce. It is argued that the dynamics of this complex context can impact the implementation of clinical supervision and therefore impact the outcomes from the clinical supervision practice.

Adopting a social ecological view suggests that change to people’s behaviour requires consideration of the many aspects of the prevailing context and this frequently necessitates multiple interventions (Goodman, 2000). Indeed, the health service’s introduction of clinical supervision in the study location involved changes to several key areas of the service’s infrastructure, reaching across multiple interacting layers, from the individual allied health worker to all levels of the organisation’s management. Levine and Perkins state that if “change must touch a large number of ‘switches’ … all ‘switches must be lined up properly” (p. 359, cited in Visser & Schoeman, 2004), suggesting that successful implementation requires several simultaneous interventions at critical “leverage points” (Goodman, 2000, p. 313). Changes involved in the health service’s implementation of clinical supervision included the introduction of new procedures and processes, adjustments to allied health timetabling
and practice, the introduction of clinical supervision training, new systems for recruiting and interviewing potential clinical supervisors and additional data collection processes for recording clinical supervision activity. Thus there were a number of critical points that needed orchestrating to ensure that change occurred cohesively, at the same point in time. In addition to the above tangible changes, the service had to undertake a degree of cultural transformation. Not all staff within the service, allied health and otherwise, had the same understanding and knowledge of clinical supervision and yet successful implementation necessitated a common valuing of the practice. It was important for all managers to support and resource the introduction of clinical supervision and for all allied health clinicians to embrace the new practice. The contextual elements of the clinical supervision implementation are described in the Introduction (see Chapter 1) and discussed again in the study’s findings (see Chapter 8).

Clinical supervision practice, viewed as a relational interaction, operated within a complex, rapidly transforming, bureaucratic organisation. At times, components of this large bureaucratic structure can appear to be anonymous and intangible. In contrast, the micro processes of clinical supervision most commonly occur face-to-face between two health professionals, engaged in a supervisory relationship. The empirical clinical supervision literature suggests that the supervisory relationship, complex as it is, is a significant contributing factor in relation to outcomes for clients, workers, and organisations (Bambling, 2000; Ellis, 2010; Falender & Shafranske, 2014). Several other elements in the clinical supervision environment are thought to influence the supervisee’s perception of the effectiveness of clinical supervision, including supervision training (Kavanagh et al., 2008), supervision agreements (Ayers et al., 2014) and choice of supervisor (Dawson et al., 2013b). An enhanced knowledge of clinical supervision requires awareness and understanding of these interdependencies between the people involved and the variables in their multiple environments (Stockols et al., 2013) and these aspects are examined in the study’s findings (see Chapter 8). It is argued that a social ecological approach provides a useful theoretical lens for explaining how the interconnecting layers might interrelate and influence each other.
Having detailed the Social Ecological Theory and its application to this research, attention will now focus on the Job Demands-Resources Model. Incorporation of the Job Demands-Resources Model complements the overarching Social Ecological Theory because its use enhances exploration of the relationship between effective clinical supervision, burnout and intention to leave. These elements are discussed next.

### 3.2 Job Demands-Resources Model

The Job Demands-Resources Model (JD-R) proposes that burnout of workers can occur when the level of job demands is greater than the level of job resources (Bakker et al., 2005). Job resources refer to elements of a job that assist employees to reach their work goals, decrease job pressures, and contribute to the employee's ongoing development (Bakker, Demerouti, de Boer, & Schaufeli, 2003, p. 344). Job resources include situational variables in the workplace, such as social support (supportive interactions with colleagues), job autonomy, a satisfactory relationship with immediate supervisor or leader, and receiving constructive feedback on work performance. Job demands refer to elements of a job that require ongoing cognitive or physical exertion, such as high workload or high work pressure. Job-related stressors, such as lack of feedback on job performance and worker role conflict, in the presence of insufficient job resources are predictors of burnout (Schaufeli & Buunk, 2003). High job demands in the absence of adequate job resources are associated with poorer outcomes for employees and organisations. For example, these occupational conditions are linked to increased job dissatisfaction (Um & Harrison, 1998), worker disengagement (Demerouti et al., 2001) and represent one reason that workers give for leaving their place of employment (Kim & Stoner, 2008). According to principles of the JD-R Model, these are areas that could potentially be mitigated through offering increased job resources.

Continuous high job demands, without adequate job resources, deplete employees’ reserves, leading to significant physiological and psychological deterioration, including exhaustion, stress and burnout (Bakker et al., 2005, p. 170). Studies confirm high levels of stress and burnout in the allied health workforce as defined by criteria levels on the Maslach Burnout Inventory (Bennett et al., 2005; Fischer et al., 2013). Findings suggest that health care workers who experience high job demands, without sufficient job resources, may be at
increased risk of adverse health outcomes, compared with similar conditions in other sectors of the workforce (Hu, Schaufeli, Toon, & Taris, 2011).

Burnout carries heavy costs for individual workers and health care services. Workers’ experience of ongoing stress associated with job demands impacts the employing organisation, with reports of increased absenteeism (Hawes, 2009; van Woerkom, Bakker, & Nishii, 2015), decreased commitment to the organisation and increased turnover (Hu et al., 2011). Poor employee performance (Hawes, 2009) and low worker morale (Maslach et al., 1996) have also been associated with burnout. In this context, it may well be asked, how health care workers can provide high quality services to patients with varied and complex needs, if their own well-being is compromised within their occupational setting? It is therefore not surprising that researchers have found that burnout of health care workers is linked with negative consequences for patient safety (Gartner et al., 2011; Koivu et al., 2012b) with reports of reduced quality of care (Bennett et al., 2005; Dawson et al., 2012) and decreased patient satisfaction (Garman et al., 2002; Hawes, 2009).

The JD-R Model asserts that an increase in job resources can act to buffer the effects of job demands through reducing stress reactions and thereby protecting employee well-being (Bakker et al., 2005; Prins et al., 2007). This occurs when receipt of job resources facilitates a change in the employee’s perception of the job demand, thus modifying the individual’s cognitive response to the demand and reducing or mitigating the negative consequences that would have otherwise followed. Additionally, job resources that assist workers prepare for a job stressor, help them understand the need for the emergence of the stressor, and facilitate the perception of some sense of control in the presence of the stressor are considered to be moderators of job stress (Bakker et al., 2005, p. 171). As well as moderating stress, job resources are linked with increased worker motivation, greater engagement with the organisation and decreased turnover intention (Hu et al., 2011; Spence Laschinger, Grau, Finegan, & Wilk, 2012). Hence, researchers have recommended that employers increase the availability of job resources as this can have benefits for organisations and employees alike (Spence Laschinger et al., 2012).
It has been suggested that within the milieu of an effective supervisory relationship, clinical supervision can increase job resources, thereby buffering against burnout and reducing worker turnover intention (Howard, 2008). Clinical supervision is considered to moderate stress through its capacity to build supportive work conditions (Koivu et al., 2012a) including the provision of constructive feedback, enhancement of professional competence, assistance with workload management and clarification of worker role ambiguity (Clinical Education and Training Institute, 2011). Clinical supervision can also assist workers to predict, understand and manage stressors. These educative and support functions are considered to be important aspects of job resources (Bakker et al., 2005). Supportive work environments have been associated with increased job satisfaction and sense of attachment to the employing organisation (Kim & Stoner, 2008; Stalker, Mandell, Frensch, Harvey, & Wright, 2007). Some studies have shown links between clinical supervision and reduced burnout (Edwards et al., 2006; Walsh & Freshwater, 2009) and reduced worker turnover intention (Kim & Stoner, 2008). In contrast, lack of access to professional support has been identified as a major reason that professional staff choose to leave their employer (Cashwell & Dooley, 2001; Ellett et al., 2003; Lloyd et al., 2002).

Although clinical supervision is considered to be a job resource, evidence suggests that not all clinical supervision acts as a job resource (Hyrkas, 2005; Koivu et al., 2012b). For instance, lack of satisfaction with emotional support from a supervisor has been found to be a predictor of burnout (Prins et al., 2007). Therefore clinical supervision needs to be perceived as effective by the recipient in order for it to be deemed a job resource.

The final section of this chapter considers the mixed methods study design and its application within this conceptual framework. Employing mixed methodologies presents a number of challenges due to the distinctive paradigms on which the different methodologies are founded. This topic will be the focus of the next discussion.

### 3.3 Study Design

A social ecological framework embraces diverse methodologies as it advocates analysis that employs varied means and targets more than one level of data source (Stockols, 1992). This
approach recommends evaluation by various methods at different stages following implementation because it “permits accurate records of the 'unfolding' of the program” (Goodman, 2000, p. 313). Hence, the mixed methods sequential design was selected as an appropriate methodology for this study as it draws from distinctive sources of information, by diverse means, at different points in time. The data sources were drawn from both individual and group format responses. Varied perspectives were encouraged through the inclusion of supervisees and supervisors, from across assorted sites and services within the study location. Thus, the selected methodology provided capacity to examine the interplay between the systems within which clinical supervision was embedded. This allowed for greater exposition of “people-environment transactions” (Stockols, 2000, p. 29), a central feature of the social ecological model. Therefore, a mixed methods research design fits well within this conceptual framework.

This mixed methods sequential study design employs two distinct paradigms. Study 1, the quantitative component of the research, sits in the positivist tradition which views patterns of behaviour as observable and explainable through objective causal laws in science (Fossey et al., 2002; Rubin & Babbie, 1989). A positivist research strategy employs a methodology of precise measurements for the quantification of data collection and analysis. It uses a deductive approach for the purpose of testing the study’s hypotheses (Bryman, 2008). Study 2, the qualitative component of the research, adopts an interpretive stance (Brady & O'Regan, 2009; Weber, 2003) and is inductive. A qualitative methodology affords detailed insight into a specific social interchange, in this case, to gain an understanding of supervisees and supervisors perceived and constructed meaning of their clinical supervision experience (Fossey et al., 2002; Padgett, 1998). The richness and depth offered by this paradigm provided an opportunity to identify any themes that had not previously been identified as being relevant to this population, to explore these identified themes further, and also to identify any themes that challenged the existing literature (Padgett, 1998).

While there has been much debate about how mixed methods studies manage to make sense of their often opposing philosophical positions, it has been suggested that it is possible to successfully achieve “epistemological compatibility” with mixed methods research (Padgett, 1998, p. 127). The adoption of a problem-centred pluralistic methods approach has been
described as pragmatism where both inductive and deductive thinking are embraced within a social science theoretical framework to address specific research questions (Creswell & Plano Clark, 2011). Tashakkori and Teddlie (2010) have referred to this approach as a process of “methodological eclecticism” (p. 274), where the researcher is not constrained to one particular paradigm, instead selecting the most appropriate methods from the full range of methodological tools. Taking a different approach, Carroll and Rothe (2010) propose that all observations, subjective and objective, are influenced by interpretation and reconstruction. Therefore they understand the seemingly opposing approaches of inductive and deductive thinking as being located within a continuum of reconstructed meaning and they have termed this conceptual approach as “complementarity” (p.478). Mixed methods research is a developing field and work continues on the refinement of combining different methodologies (Castro, Kellison, Boyd, & Kopak, 2010), including the synthesis of diverse epistemologies. However, adopting a methodology that straddles multiple world views can lead to a more comprehensive understanding of both the breadth and depth of the study topic (Aarons et al., 2012).

Having discussed how the research’s study design aligns with a social ecological approach, the chapter will conclude with a summary of the major points.

### 3.4 Conclusion

In summary, the social ecological conceptual framework adopted for this research utilises a systems approach that proposes worker’s well-being is influenced by a range of factors within both the immediate and outlying environments (Bronfenbrenner, 1977). This perspective advocates that human interactions and their associated systems are interrelated, with the influence being bi-directional and therefore awareness and understanding of the multi-layered context is important for knowledge of a subject area. A social ecological framework embraces diverse methodologies (Stockols, 1992) and therefore the mixed methods sequential design of this study fits well within this framework. The Job Demands-Resources Model was selected as an additional theoretical component to complement this systems approach. The JD-R Model proposes that burnout of workers can occur when there are insufficient job resources to balance the level of job demands in the occupational environment (Bakker et al., 2005).
Together these theoretical models explain how complex processes within the work environment may affect the effectiveness of the clinical supervision.

Clinical supervision is recognised as a job resource as it contributes to building supportive work conditions (Koivu et al., 2012a). As a mechanism to increase job resources, clinical supervision is thought to protect the worker against burnout and reduce turnover intention (Edwards et al., 2006; Kim & Stoner, 2008). Within this conceptual framework, clinical supervision can be viewed as a whole-of-system strategy to maintain a functional workforce. It is suggested that the extent to which clinical supervision is perceived to be effective by the supervisees, is likely to be influenced by the prevailing multi-system environment.

The next chapter will address the methodology adopted for this study.
4 Methodology

This mixed methods research comprises two phases, Study 1 and Study 2. Firstly, the overall format will be addressed in relation to the research questions, hypotheses, method design, associated paradigms, and study sample. Next there will be a detailed description of Study 1, followed by a description of Study 2. A section will be devoted to a discussion about how the quantitative and qualitative data will be integrated and interpreted to inform the study’s findings. The chapter will conclude with a discussion of ethical considerations and rigour in relation to this research (the limitations and strengths of this research are detailed in Chapter 9).

4.1 Research Questions

This study seeks to address the following questions:

1. How do allied health staff who receive clinical supervision rate the effectiveness of that clinical supervision in providing support, professional development and guidance for their professional practice?
2. What factors affect the perceived effectiveness of clinical supervision in providing support, professional development and guidance for supervisees’ professional practice?
3. What is the relationship between perceptions of effectiveness of clinical supervision and supervisees’ reports of levels of intention to leave?
4. What is the relationship between perceptions of effectiveness of clinical supervision and supervisees’ reports of levels of burnout?
5. What are the profession-specific differences in: perceived effectiveness of clinical supervision, reports of levels of intention to leave, and reports of levels of burnout?

The research questions relate to the study’s focal hypotheses,

4.1.1 Hypotheses

1. Effective clinical supervision will be negatively correlated with intent to leave and with burnout.
2. Those receiving effective clinical supervision will report higher levels of professional development, guidance and support for their professional practice than those receiving ineffective clinical supervision.

4.2 Mixed Methods Approach

A mixed methods approach utilising validated survey measures and focus group interviews was chosen as the optimum design to address the aims of this research and respond to the research questions. Mixed methods research has been described as "the combination of at least one qualitative and at least one quantitative component in a single research project or program" (Bergman, 2008a). This mixed methods research adheres to an explanatory sequential design as the quantitative study is followed by the qualitative study with the purpose of elucidating the findings from the initial quantitative study to improve the final interpretation and inferences (Creswell & Plano Clark, 2011).

Combining quantitative and qualitative methods provides a completeness not possible with single method studies (Bryman, 2006). A mixed methods approach is particularly relevant when both outcomes and processes are under investigation and a depth and breadth of the topic is sought (Aarons et al., 2012). For instance, this study seeks to investigate whether clinical supervision leads to specific outcomes, such as providing professional development, guidance and support as perceived by supervisees. Another outcome under examination is whether clinical supervision is related to lower levels of burnout and lower levels of intent to leave. As well as outcomes, the study is interested in whether certain processes were adhered to in the delivery of clinical supervision. The study seeks to develop a broad range of information from allied health professionals and develop a discerning understanding of individual participant’s clinical supervision experiences through focus group discussions. Employing a mixed methods structure has gained increased utility across a range of discipline fields (Creswell & Plano Clark, 2011). Adopting more than one method for the inquiry and explanation of a research study’s findings can, when employing methodological rigour, increase the integrity and credibility of the results (Creswell & Plano Clark, 2011) and increase the relevance and ecological validity of the findings (Bryman, 2008; Padgett, 1998).
Mixed methods research is a developing field and work continues in the refinement of the process of combining quantitative and qualitative methodologies (Castro et al., 2010). However, drawing from multiple paradigms can be beneficial for the explanation of complex research problems (Creswell & Plano Clark, 2011), such as those found in the social science field. Examples of studies where mixed methods research have been successfully employed in this field include the examination of the adoption of evidence-based practice by community mental health practitioners (Gioia & Dziadosz, 2008), the investigation of sensitive organisational issues (Jehn & Jonsen, 2010), and the evaluation of a youth mentoring program (Brady & O'Regan, 2009).

4.3 Methodological Design

Utilising both a quantitative approach and a qualitative approach in this study offered several benefits. The quantitative enquiry allowed the researcher the opportunity to test for relationships between key variables (Castro et al., 2010) using psychometrically sound instruments; such as perceptions of effectiveness of clinical supervision, intention to leave and burnout. Quantitative methodology also permitted comparison between certain groups, for example the allied health professional disciplines. The selection of an on-line survey provided the ability to collect quantifiable data from a large number of participants. Consequently, it may be possible to identify trends or significant relationships that allow hypotheses to be confirmed or refuted. Quantitative design, with its capacity to accommodate larger numbers of participants, facilitates replication of study design if seeking to test whether findings are generalisable to other populations (Creswell & Plano Clark, 2011). While quantitative methods offer a breath of information across research questions, it was crucial to incorporate a qualitative method as an equal and essential component of the methodology in order to provide a comprehensive investigation of the study topic.

The qualitative method provides detail about how the supervisees and supervisors perceived their experiences of clinical supervision. Application of this method offers opportunity to privilege the views of a range of stakeholders within the organisation, including less senior staff (Fossey et al., 2002; Padgett, 1998). The focus group setting permits the researcher to hear individual participant’s voices and provides opening for various perspectives to emerge
(Creswell & Plano Clark, 2011). This allows for the potential discovery of rich contextual data (Fossey et al., 2002; Padgett, 1998) that can contribute to the interpretation, explanation and clarification of the quantitative outcome data (Bryman, 2006). Qualitative data affords opportunity to gain insights into areas where the clinical supervision is working or failing and can reveal any challenges or issues specific to this study location.

Creswell and Plano Clark (2011) advocate that researchers who employ mixed methods designs do well to clearly articulate the links between how their study’s conceptual framework leads to their specific research questions and their chosen methodologies. Their recommendation has been adopted in this research (see Figure 4.1, for a diagrammatic representation of the methodological design demonstrating these links). The connections between the conceptual framework and the methodological design were discussed in Chapter 3. The research questions for this study were developed through an interpretation of the empirical clinical supervision literature; the researcher’s own experience of providing and receiving clinical supervision within a large bureaucratic organisation; and a theoretical understanding based on the lens provided by the conceptual framework (see Chapter 3). The research questions pay attention to both the impact of clinical supervision on the individual supervisee in terms of the receipt of support, professional development and guidance for their practice, as well as the impact on their intention to leave and their level of burnout.
Examining the relationships between key variables

Exploring the richness and depth of individual's experience

Integrate Study 1 and Study 2 findings

Increased Validity & Integrity

Social Ecological Theory

Themes from the Clinical Supervision literature

Researcher's own experience of clinical supervision

Development of research questions

QUANT Study 1 Surveys

QUAL Study 2 Focus Groups

Figure 4-1 Methodology
The professional discipline of the worker is also considered within the study in order to investigate whether outcomes are consistent across professions. It has been identified that there are both commonalities as well as differences between professions regarding the clinical supervision experience (Dawson et al., 2012; Kumar et al., 2015). In addition, the research questions seek information about any factors either within the clinical supervision relationship, or within the broader organisation, that affect, either negatively or positively, the effectiveness of clinical supervision in delivering the identified outcomes of support, professional development and guidance for clinical practice. Therefore, the research questions are designed to detect areas within the study context that are contributing to or detracting from effective clinical supervision.

As suggested in the conceptual framework (Chapter 3), the study's environment is a complex and dynamic structure that both impacts, and is impacted by, the interactions within its many systems. Therefore, prior to embarking on further discussion about the methodology, it is helpful to consider the specific setting for this study.

4.4 Study Context

During the data collection period for this research there were a number of events that resulted in significant changes within the organisational setting of this study. These events were discussed in detail in Chapter 1. In brief, they involved the pending introduction of the Commonwealth health reforms (Council of Australian Governments, 2008), change of state government, widespread fears about job security in the public service (ABC Local Radio Brisbane, 2012) and transfer of management of the health service's finances, services and staffing to the Hospital and Health Board (State of Queensland, 2012). These major events meant that staff were exposed to a prolonged period of uncertainty and instability, not previously experienced on such a scale. Given this particular context, it is reasonable to suggest that this time of considerable flux may have had an influence on the delivery of clinical supervision and therefore on the participant's responses. This particular study context underscores the importance of adopting a comprehensive theoretical framework for informing the process of analysis and an appropriate methodology for the investigation.
4.5 Sample

The sample comprised the total population of allied health clinical staff (n=120) who were within a Queensland metropolitan district community health service and who were receiving and/or providing individual clinical supervision. Operational managers were not the target of this research as the focus was on the provision of clinical supervision. This particular site within community health services was selected because a structured model of clinical supervision, based on best practice principles was implemented there from mid-year 2011 (see Introduction, Chapter 1 for a detailed discussion). A two day training program was available to both allied health supervisors and supervisees prior to the introduction of clinical supervision. Previously the clinicians within this site had received some clinical supervision but it had been delivered on an ad hoc basis. The population varied in terms of: type of profession (dietitians, occupational therapists, physiotherapists, podiatrists, psychologists, social workers, speech pathologists, and allied health assistants), gender, years of experience, time in current position, role in supervision (e.g., supervisor, supervisee, both supervisor and supervisee), prior experiences of clinical supervision and exposure to other supervision formats such as peer group supervision. As the implementation of the structured clinical supervision program was phased in over a period of time, the population also varied in length of time of exposure to the structured clinical supervision. There was an organisational realignment between the two phases of data collection which resulted in some allied health clinicians being reallocated to a different health service district. Consequently there was a small reduction (n=15) in the overall population size which affected the professions of psychology, social work, and occupational therapy. As a result of service realignments, it was difficult to obtain accurate overall staffing numbers at the time of the survey.

4.6 Data Collection

The researcher received oversight from a Queensland Health clinical supervision research reference group who were consulted regarding the timing of data collection. The selected time frame gained organisational approval as it avoided clashes with any additional operational events. The composition of the reference group was determined by the Allied Health Director in consultation with the Assistant Allied Health Director and the health service’s Senior Research Fellow. The reference group comprised the Allied Health Director, the Assistant Allied Health Director, the Director of Occupational Therapy,
Director of Social Work, an Allied Health Program Manager, the health service’s Senior Research Fellow, the health service’s Librarian, an allied health supervisor and an allied health supervisee.

Data collection occurred at two points in time (see Table 4.1). Study 1 data was collected at 8.5 months post-implementation of structured clinical supervision for allied health staff. The data was collected via an anonymous on-line questionnaire package of self-rated surveys. At 12 months post-implementation, Study 2 data was collected using focus group interviews. This order of data collection was chosen to mitigate the chance that focus group participation might alter how participants responded to the survey (Creswell & Plano Clark, 2011) and to offer possible explanations for the quantitative findings.

**Table 4.1 Data Collection by time**

<table>
<thead>
<tr>
<th>Implementation of clinical supervision</th>
<th>8 months</th>
<th>8 ½ months</th>
<th>12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study 1 Quantitative</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pilot study of survey</td>
<td>Survey</td>
<td>Focus groups</td>
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</tbody>
</table>

The research literature is not definitive about the most appropriate timeline for data collection following the introduction of clinical supervision (see Hyrkas, 2005, p. 534). However findings suggest that supervisees require several sessions to make best use of supervision (Kavanagh et al., 2008) and a minimum of 3 to 5 sessions has been suggested (Hyrkas et al., 2006, p. 532). Other authors suggest that six sessions are required prior to data collection to measure effectiveness (Edwards et al., 2005). In an Australian study of clinical supervision effectiveness by Dawson et al. (2012), participants had to have received a minimum of six sessions for inclusion in the study. The time period of 8.5 months post-implementation of clinical supervision was chosen for administration of the surveys. This period provided sufficient time for the minimum recommended number of 3 to 6 sessions as the organisation’s minimum frequency for supervision was monthly.
The time period of 12 months post-commencement of the structured clinical supervision program was chosen for the implementation of the focus groups. This both allowed time for several supervisory sessions per supervisee and recognised the need for pragmatism in fitting in this research when the organization was about to undergo significant structural changes as a result of the introduction of the Commonwealth health reforms (Council of Australian Governments, 2008; State of Queensland, 2012) and the introduction of the Hospital and Health Boards (State of Queensland, 2012). This time period also allowed time to finalise and interpret the results from Study 1, which informed the development of the focus group interview guide.

4.7 Study 1: Quantitative Methodology

An on-line survey using self-report scales was selected. This population of allied health staff were already familiar with the use of survey questionnaires and had access to computers making the on-line version a suitable choice. The use of self-report scales has been found to be acceptable within the social science field. For example, the clinical supervision literature has a strong history in the use of self-perceived ratings by study respondents (for example, see Fletcher, 2008; Kavanagh et al., 2001). Also, self-report scales have previously been found to be valid in accessing stress and supervision needs in allied health staff (Allan & Ledwith, 1998). In addition, Schaufeli and Buunk (2003), in their review of research on burnout, stated that self-report scales correlated more highly with burnout, than other data such as records and observations.

4.7.1 Inclusion criteria

All allied health staff working within the prescribed community health service district and who were receiving and/or providing individual clinical supervision.

4.7.2 Exclusion criteria

There were no exclusions applied to Study 1 population. Due to the anonymous on-line delivery format it was not possible to apply exclusions. While it may have been useful to apply exclusions, such as excluding anyone who did not meet the inclusion criteria (the inclusion criteria were clearly stated at the beginning of the survey), the benefits of anonymity were considered to outweigh this need. The provision of anonymity was thought
to be important for increasing the confidence of participants regarding the confidentiality of their responses. Anonymity was expected to increase motivation to participate in the study. Anonymity was also thought to reduce the potential for social desirability bias in the survey responses (Rubin & Babbie, 1989) given the researcher is known to some of the participants.

4.7.3 Measures

The methodological difficulties of attributing practitioner change (e.g., level of skills, knowledge, beliefs, expectations or attitudes) following the delivery of clinical supervision interventions have been extensively noted in the literature (Bambling, 2000; Bishop, 2007; Buus & Gonge, 2009; Spence, Kavanagh, et al., 2001). This made the selection of the instruments an important consideration in the design of this phase of the research. Carson’s (2007) review regarding the evaluation of clinical supervision recommended three instruments: the Manchester Clinical Supervision Scale (Winstanley, 2000), the Maslach Burnout Inventory (Maslach & Jackson, 1986), and the Minnesota Job Satisfaction Scale (Dawis, Lofquist, & Weiss, 1968) as being sensitive to measuring change resulting from clinical supervision.

For this study the two former scales were selected for use with the Minnesota Job Satisfaction Scale being excluded in favour of the Intention to Leave Scale (Abrams, Ando, & Hinkle, 1998). This decision was taken partly because the large volume of survey requests received by clinicians meant the shorter Intention to Leave Scale was likely to increase the response rate. Also, following his review of evaluation instruments, Carson suggested that the Personal Accomplishment subscale of the Maslach Burnout Inventory was a proxy measure for job satisfaction and recommended that it be used in place of the Minnesota Job Satisfaction Scale (personal email communication, Carson, 2009). This view, regarding the Maslach Burnout Inventory, seems to have been confirmed by other authors who state that they regard the scale’s core component of burnout to be the Emotional Exhaustion subscale (Koeske & Koeske, 1989; Stalker et al., 2007).

The on-line questionnaire package included a participant information sheet, a consent section, a demographic questionnaire (see Appendices 1 and 2) and the following three instruments:
- MCSS-26®, previously known as the Manchester Clinical Supervision Scale (Winstanley & White, 2011)
- Maslach Burnout Inventory – Human Services Survey (Maslach et al., 1996)
- Intention to Leave Scale (Abrams et al., 1998)

The original Manchester Clinical Supervision Scale has been used internationally for several years to measure the effectiveness of clinical supervision as perceived by supervisees. The scale recently underwent Rasch analysis which resulted in a revised shortened version; the MCSS-26® (Winstanley & White, 2011). The MCSS-26® has 26 items rated on a 5-point response scale ranging from “Strongly disagree” to “Strongly agree”. The revised scale has the advantage of being quicker to complete while maintaining good internal consistency (α=.658 to .868, Winstanley & White, 2011). The scale measures three domains of clinical supervision as outlined in the Proctor model: normative, formative and restorative; using six subscales: trust/rapport (“My supervisor gives me support and encouragement”), supervisor advice/support (“I learn from my supervisor’s experiences”), improved care/skills (“Clinical supervision makes me a better practitioner”), importance/value of clinical supervision (“CS sessions are not necessary/don’t solve anything”), finding time (“It is difficult to find the time for CS sessions”), reflection (“CS gives me time to reflect”) (Winstanley & White, 2011). The scale is scored by summing the items (several negatively worded items are reverse scored), with greater effectiveness indicated by higher scores. Although the MCSS-26® was originally developed for use with nursing populations, it has been satisfactorily employed with an Australian allied health population (Dawson et al., 2012) and means for allied health staff have been developed from amalgamated datasets (Winstanley & White, 2011).

The Maslach Burnout Inventory – Human Services Survey (MBI-HSS) was used to measure burnout. It is designed for professionals who work in direct human service delivery and measures three different aspects of burnout: emotional exhaustion (“I feel emotionally drained from my work”), depersonalization (“I feel I treat some recipients as if they were impersonal objects”), and reduced personal accomplishment (“I have

\[\text{CS = Clinical Supervision}\]
accomplished many worthwhile things in my job” (Maslach & Jackson, 1986; Maslach, Jackson, & Leiter, 1997). Despite early comments about the scale, it is widely accepted and the most frequently used instrument for measuring burnout (Schaufeli & Buunk, 2003, p. 391). It has 22 items rated on 7-point response scales ranging from “Never” to “Every day”. The scale is scored by totalling the item responses, with greater emotional exhaustion and depersonalisation indicated by higher scores and greater personal accomplishment indicated by lower scores (Maslach et al., 1996). In a large survey of Finnish nurses, Cronbach’s alpha was reported to be 0.74-0.90 (Hyrkas, 2005, p. 537). In a study of social workers, internal consistency and test-retest reliability at 2 to 4 week intervals were reported to be between 0.60 and 0.82 (Kim & Lee, 2009, p. 373).

The Intention to Leave Scale (Abrams et al., 1998) is a 4-item scale proposed to measure a worker’s intention to leave their employer. The items are, “In the next few years I intend to leave this company”; “In the next few years I expect to leave this company”; “I think about leaving this company”; “I’d like to work in this company until I reach retirement age”. The wording of the scale was modified, and “company” was replaced by “organisation” to make the scale context specific for the present study. The scale is scored by summing the items (the fourth item is reverse scored), with greater intention to leave indicated by higher scores (Nissly et al., 2005). This scale has been successfully used in a Californian study to measure turnover intention in public child welfare workers with Cronbach’s alpha = 0.77 (Nissly et al., 2005, p. 87). A strong link between turnover intention and job satisfaction has been found (Bennett et al., 2005; Griffeth, Hom, & Gaertner, 2000), with reports of a significant negative relationship \( r = -0.50 \) (Lee, Joo, & Johnson, 2009).

4.7.4 Pilot Study

Prior to data collection a pilot study was conducted to test the operation of the instruments (e.g., length, wording) and appropriateness of the process (Bryman & Cramer, 2008, p. 247). The questionnaire package was completed by a representative group of five allied health staff from a range of professions. Overall the feedback was positive with comments such as; “very readable for the target group”; “instructions were clear and easy to follow”; “liked the bar providing me with feedback on my progress of completing the survey, which enhanced my motivation”; “length and readability is good”.

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2 Item interpreted in opposite direction.
There were no consistent themes across the pilot responses apart from the above positive feedback. Based on the feedback, minor modifications were incorporated in the demographic questionnaire to enhance the clarity of wording; for example, “Yes I have had a change of two different clinical supervisors” was changed to “Yes I have had a change resulting in two different clinical supervisors”.

Two participants questioned the suitability of the response format for age of participants. As put by one of those respondents: “I would feel more comfortable with a grouping of ages (e.g., 40-45 years) rather than putting an exact age in. Is there sufficient explanation re anonymity of results?” In my feedback to the Clinical Supervision Research Advisory Group, I acknowledged the concerns regarding anonymity in relation to the response format for age of participant. I explained that the reason the ages were not grouped was because such grouping would prevent more refined and sensitive descriptive and inferential analyses. More importantly, exact ages were necessary for analyses relating to the study’s focal research questions. As a further attempt to address the concern regarding anonymity, the researcher inserted an extra statement at the commencement of the demographic section, which stated “When information is analysed and reported back, it will be presented in a group format and not as individual data. All care will be taken when reporting these groups, to protect anonymity” (This statement also appeared in the Participant Information Sheet). The Clinical Supervision Research Advisory Group agreed that this statement would assist to allay possible concerns about this response format. Participants also had the option of omitting their response to any question however in relation to this question, only 4 out of 82 participants chose not to answer.

4.7.5 Recruitment and data collection

Data was collected from respondents via an anonymous on-line questionnaire package containing self-rated surveys. Potential respondents were encouraged to participate through:

- Promotion by Discipline Directors via regular professional meetings.
- Promotion by Allied Health Director via email communication.
- Presentation of study’s progress to allied health forums.
- Promotion through email-based allied health newsletters
All allied health staff received an invitation to participate in Study 1. This invitation was sent to the Director of Allied Health of the district community health service who then distributed it through the usual communication pathways via Queensland Health’s internal email system. To maximise participation, one week after the initial invitation was delivered, a reminder email via the Director of Allied Health, was sent to allied health staff through the internal email system. The invitation contained an electronic link which took participants to an external site where they could access further information about the survey. The health service’s intranet Home Page for Clinical Supervision, also contained information about the study and the survey, including an electronic link which took participants to an external site where they could access further information about the survey. From the external site, allied health staff could then choose to access the package containing a Participant Information Sheet (see Appendix A), a consent section and self-rated surveys. The Participant Information Sheet explained that once surveys were submitted they could not be returned or excluded from the analysis, as they could not be identified from other anonymous surveys. Those who agreed to participate were required to tick a box to indicate that they had read the information in the Participant Information Sheet and that they consented to participate in this phase of the study. Participants were not able to proceed to the survey without ticking the box to acknowledge their consent to participate. Once the consent section was ticked the participant was directed to the survey via an electronic link. Participants were then requested to complete the online survey and submit it. Submitted surveys were sent to the researcher via an email address external to Queensland Health.

4.7.6 Participants

A total of 82 allied health staff participated in the survey resulting in a 68% response rate. Females accounted for 89.9% (N=71) of all respondents, consistent with the gender bias found in the Australian health workforce (AIHW, 2009; Health Workforce Australia, 2013a). Participants’ ages ranged from 24 years to 66 years with a mean of 41.97 years (SD = 11.80 years). The majority were born in Australia (n=65, 79.3%), seven (8.5%) in the United Kingdom and the remaining ten participants (12.2%) originated from ten different
countries. Overseas born allied health workers accounted for 21.7% of the sample, slightly less than the overall percentage (25.3%) of allied health workers in the Australian workforce who were born overseas (AIHW, 2009). Nearly all participants (n=79, 96.3%) reported that the main language spoken at home was English, and the remainder (n=3, 3.6%) reported three other languages as the main language spoken at home. There were no participants who reported that they identified as Aboriginal or as Torres Strait Islander Australian. This finding is not surprising given that the percentage of Indigenous allied health workers in the Australian workforce is 0.7% (AIHW, 2009).

The aim of recruitment was to have as complete and proportionate representation in the sample as possible in terms of mix of allied health professionals who were receiving or providing supervision. Steps were taken to encourage proportionate representation from all allied health disciplines. For example the Clinical Supervision Research Advisory Group had cross-discipline representation including a number of profession-specific Discipline Directors. Despite these measures, and as the survey was voluntary, proportional representation could not be guaranteed. At the time of the survey the total sample available was social workers (n=34), occupational therapists (n=28), physiotherapists (n=24), psychologists (n=12), dietitians (N=8), speech pathologists (n=6), and podiatrists (n=6). The survey participants comprised: social workers (n=27, 33% of the sample), occupational therapist (n=23, 28%), physiotherapists (n=10, 12%), dietitians (n=5, 6%), speech pathologists (n=5, 6%), podiatrists (n=4, 5%), psychologists (n= 3, 4%), and those who identified as “other” (n=5, 6%). The lower numbers of psychologists participating in the study may have been due to their profession-specific Supervisor Training and Accreditation Program, “STAP” (Psychology Board of Australia, Undated). This meant that there was not the same expectation by the employing organisation for the psychologists to participate in the organisation’s own model of clinical supervision.

Although proportional representation of the various disciplines was the goal of data collection, the low response rate from several allied health areas did not permit this as it would have led to a reduced sample size leading to concerns with Type II error rates. As expected, the three largest professions of social work, occupational therapy and physiotherapy, together comprised 73% of the total number of responses. A breakdown of participants by profession is provided in Table 4.1.
Participants varied in number of years experience in their profession. The largest group (n=25, 30.5%) had 16 or more years of experience working in their current professional discipline. A breakdown of number of years experience in their profession is shown in Table 4-2. The above pattern reversed when participants were asked about their years of experience working in their current allied health position. Sixty participants (74.1%) reported they had been working in their current allied health position for five years or less, with 14 (17.3%) between six and ten years, and the remaining seven participants (8.6%) for 11 or more years (see Table 4-2). This contrast is likely to reflect the increased staff movements in the workplace. It is interesting to note that over half the participants (n=47, 57.3%) had been working in some type of health position for 11 or more years indicating that the sample comprised an experienced group of health professionals (see Table 4-2).

Table 4-1 Population and Sample: Participants by Profession (at commencement of Study 1)

<table>
<thead>
<tr>
<th>Profession</th>
<th>Population N=</th>
<th>Sample N=</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dietitian</td>
<td>8</td>
<td>5</td>
<td>6.1</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>28</td>
<td>23</td>
<td>28.0</td>
<td></td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>24</td>
<td>10</td>
<td>12.2</td>
<td></td>
</tr>
<tr>
<td>Podiatrist</td>
<td>6</td>
<td>4</td>
<td>4.9</td>
<td></td>
</tr>
<tr>
<td>Psychologist</td>
<td>12</td>
<td>3</td>
<td>3.7</td>
<td></td>
</tr>
<tr>
<td>Social Worker</td>
<td>34</td>
<td>27</td>
<td>32.9</td>
<td></td>
</tr>
<tr>
<td>Speech Pathologist</td>
<td>6</td>
<td>5</td>
<td>6.1</td>
<td></td>
</tr>
<tr>
<td>Other (^3)</td>
<td>2</td>
<td>5</td>
<td>6.1</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>120</td>
<td>82</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

\(^3\) The frequency for "other" profession was greater than for the population. It is possible that participants selected "other" as a default response in order to increase their anonymity, given that some professions contained small numbers.
Table 4-2 Participants by number of years experience

<table>
<thead>
<tr>
<th>Item</th>
<th>Number of years experience</th>
<th>Total N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-5 years</td>
<td>6-10 yrs</td>
</tr>
<tr>
<td>Working in allied health profession</td>
<td>16 (19.5%)</td>
<td>20 (24.4%)</td>
</tr>
<tr>
<td>Working in current allied health position</td>
<td>60 (74.1%)</td>
<td>14 (17.3%)</td>
</tr>
<tr>
<td>Working in a health position</td>
<td>17 (20.7%)</td>
<td>18 (22%)</td>
</tr>
</tbody>
</table>

Participants differed by their level of Health Practitioner classification. Allied health clinicians working in Queensland public health services are generally employed under the Health Practitioner’s Certified Agreement (Queensland Industrial Relations Commission, 2011) that details the various Health Practitioner (HP) levels. While HP levels range between 1 and 8, the clinical stream falls between bands 3 and 7. Most commonly, clinical health positions fall between the HP 3 level (minimum requirement is tertiary or equivalent qualification) and the HP 5 level (requiring specialist level clinical skills that are acknowledged at an Area Health level). The HP 6 and HP 7 levels refer to health practitioners whose skills are recognised at state-wide or national levels respectively and these positions are fewer in number. The HP 8 level applies only to management positions with state-wide responsibility (Queensland Industrial Relations Commission, 2011). In this current study, health practitioners were between the HP3 and HP6 bands (see Table 4.3). The majority of participants (n=45, 54.9%) were working at the HP 4 level, which indicates a “High” level practitioner and again reflects the degree of experience in this particular workforce.
### Table 4-3 Participants by Health Practitioner Classification Level

<table>
<thead>
<tr>
<th>Health Practitioner (HP) classification level</th>
<th>Frequency</th>
<th>Valid Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>HP3</td>
<td>16</td>
<td>19.5</td>
</tr>
<tr>
<td>HP4</td>
<td>45</td>
<td>54.9</td>
</tr>
<tr>
<td>HP5</td>
<td>18</td>
<td>22.0</td>
</tr>
<tr>
<td>HP6</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>Not under HP†</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>82</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

† Those identifying as “Not under HP”, that is not under a Health Practitioner classification, may have been allied health therapy assistants or participants who selected this category as a default response to increase their anonymity.

#### 4.7.7 Data Analysis

Data analysis was undertaken using SPSS Version 20 software to respond to the study hypotheses. The demographic data was described using frequencies and measures of central tendency and variability (means and standard deviation). Data from the three scales were described, compared against each scale’s published normative benchmarks, and screened to check for violations of statistical assumptions related to the focal analyses (e.g., normal distributions, outliers, homogeneity of variance). Missing data was checked for any non-random patterns. Any non-random patterns were investigated and suitable management strategies were determined (e.g., deleting the respondent’s data, replacing with group mean).

To address the first part of Hypothesis 1, the perceived effectiveness of clinical supervision was operationalised using the MCSS-26© (Winstanley & White, 2011). The six factors of the MCSS-26© scale formed the predictors in a multiple regression with intention to leave (Intention To Leave Scale) as the outcome. To establish the relationship between effectiveness of clinical supervision and supervisees' levels of burnout (second part of Hypothesis 1), burnout was operationalised using the Maslach Burnout Inventory– Human Services Survey (Maslach et al., 1996). This measure has three subscales of burnout and each was an outcome variable in separate multiple regressions with the six factors of

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4 (Queensland Industrial Relations Commission, 2011)
clinical supervision as predictors. This analysis also permitted an investigation of the relative importance of each of the factors. The data from the MCSS-26© was benchmarked against the scale’s normative dataset for allied health staff (Winstanley & White, 2011).

To determine any profession-specific differences in effectiveness of clinical supervision, intent to leave, and burnout, a series of one-way analyses of variance (ANOVAs) with professional discipline as the between-subjects factor were performed. ANOVAs were completed with the professions of occupational therapy, physiotherapy and social work as levels of the between-subjects factor. The small cell sizes of the remaining professional groups prevented their inclusion in these analyses.

“Effective” clinical supervision was defined as attaining a score of 73 or above on the MCSS-26© scale as this is the suggested efficacy threshold (Winstanley & White, 2011). To determine if certain elements made a difference to the efficacy of clinical supervision, specific principles that addressed the procedural infrastructure around the clinical supervision practice were identified. A focus on the procedural infrastructure was adopted because the MCSS-26© scale has the capacity to detect the relational aspects of the clinical supervision practice. In addition, although some studies of allied health professionals have accessed the impact of specific procedural aspects of clinical supervision, such as supervision training (Kavanagh et al., 2008), and supervision format (Livni et al., 2012), no other identified study has considered the impact of a suite of procedural practices. Therefore, a definition of “Best practice” clinical supervision was developed based on principles identified in the clinical supervision literature (Bradley & Hojer, 2009; Clinical Education and Training Queensland, 2010; Clinical Education and Training Institute, 2011; Spence, Wilson, et al., 2001) and was defined as meeting all of the following five criteria:

1. Receiving clinical supervision
2. Having some choice in the allocation of clinical supervisor
3. Attendance at clinical supervision training
4. Having a completed clinical supervision agreement
5. Having a clear understanding about the boundaries of confidentiality in the clinical supervision relationship
Based on the above criteria, a “Best practice” group could then be compared to a “Less than best practice group”. Analysis using independent-samples t-test was undertaken to determine any differences between the two groups.

4.8 Study 2: Qualitative Methodology

Focus group interviews were selected as the method of data collection in Study 2 as they are an effective avenue for the expression of information and emotions that could not be collected through a survey (Patton, 1987). Focus groups provide an efficient procedure for data collection and a useful process for identification of the most important issues among participants (Patton, 1987). They have been successfully used to explore themes in clinical supervision research (Bogo et al., 2011) and are recommended by Winstanley and White (2011) for use when there are small sample sizes, such as the exploration of profession specific themes within this research.

4.8.1 Sample

The sampling strategy adopted for Study 2 was a non-probability, purposive sample. This approach is appropriate as it allows location of participants who can provide information to meet the particular purposes of this phase of the study (Rubin & Babbie, 2007). The sample consisted of supervisees and supervisors drawn from the eight professions and comprised a subset of the larger sample of Study 1. Drawing samples from the same population increases the validity of a mixed method study (Creswell & Plano Clark, 2011).

Focus group processes work best when members are drawn from within the same hierarchical level (Padgett, 1998). Therefore, separate focus groups were arranged for supervisees and supervisors to accommodate perceptions that might reflect different aspects of the clinical supervision experience. Five focus groups were convened. They were made up of two groups of mixed-profession supervisors, and three groups of mixed-profession supervisees. A mixed-profession structure was chosen as it provided a greater opportunity to reveal any similarities or differences between the professions. This structure also allowed more opportunity for a greater number of clinicians to participate as it is difficult for organizations to simultaneously release large numbers of the same profession from clinical duties due to the need to ensure the ongoing provision of health care services.
4.8.1.1 Inclusion criteria:
Allied health staff working within the prescribed community health service district and who were receiving and/or providing individual clinical supervision.

4.8.1.2 Exclusion criteria:
Development of the exclusion criteria was in consultation with the health service’s research reference group.

1. Any allied health staff being supervised by the researcher during the previous preceding 12 month period.
2. Any allied health staff providing supervision to the researcher during the preceding 12 month period.
3. Members of the health service’s clinical supervision research reference group.

Establishing exclusion criteria for Study 2 of the research was an important consideration given the face-to-face mode of the focus group interviews. The rationale for the above exclusions was to avoid any potential power dynamics occurring between the participants and the researcher with the potential to influence responses. The exclusion criteria mitigated this risk by excluding any allied health staff who had working relationships with the researcher that related to clinical supervision. This exclusion potentially affected eight allied health staff who would have otherwise met the inclusion criteria, with four staff having indicated their interest in participating in the focus groups.

4.8.2 Recruitment
Recruitment was by Expression of Interest, adopting the same recruitment strategies as in Study 1, except that an electronic link took interested participants to the researcher’s University email address. This was to enable the researcher to provide participants with further information about the study, and obtain preferences for locations and times of Focus Group interviews.

It was proposed that six focus groups would be convened: two groups of mixed-professional supervisors, and four groups of mixed-profession supervisees. The sample of
supervisees would comprise a maximum of 10 participants from each of the larger professional groups of: occupational therapy, physiotherapy, social worker; and up to 10 participants in total from the smaller professions of allied health assistants, dietetics, podiatry, psychology, and speech pathology. The sample of supervisors would comprise a maximum of 5 participants from each of the larger professional groups; and up to 5 participants in total from the smaller professional groups. This would give a maximum total of 60 participants. Selection would be determined on a “first-in” basis whereby the first received in each of the nominated categories would be selected up to the maximum number required. It is acknowledged that this recruitment process using Expression of Interest could result in an over-representation of those participants who held strong views; however, those who held strong views, either in favour or against matters relating to the clinical supervision program, had an equal opportunity to participate.

Eligible respondents received an email with a Participant Information Sheet (see Appendix D) and information about available times and locations for the focus groups. Participants were then allocated to a specific focus group based on their preferred time and location. Ineligible respondents received an email thanking them for their interest, with an explanation of why they could not participate and information about how they might receive future updates about the study.

The number of Expressions of Interest received was fewer than anticipated and this is likely due to the reduction in staff numbers as a result of the organisational restructure and other situational events as described under the Study Context (see Chapter 1). All allied health staff who met the inclusion criteria were accepted as participants for the focus groups. The total number of responses received was 41; however the final number of Focus Group participants totalled 26. Fifteen respondents who submitted an Expression of Interest were unable to participate (eight were excluded as they did not meet the inclusion criteria; seven were unable to participate due to a range of other reasons such as unable to be released from clinical duties, and time of focus group not suitable). The actual composition of the focus groups is shown in Table 4.4 and Table 4.5 shows the supervisor and supervisee breakdown. There was a mix of supervisees and supervisors and all eight allied health professions were represented. The three largest professional groups of occupational therapy, physiotherapy and social work comprised over 80% of the sample. Social work participants made up 50% of the total, perhaps reflecting the profession’s
greater familiarity with clinical supervision due to the discipline’s early adoption of the practice (Lynch et al., 2008).

Five Focus Groups were held over eight days, at two different geographical locations within the health service. At the commencement of each focus group, participants were requested to complete a Consent Form (see Appendix E) and a demographic questionnaire (see Appendix F). A copy of the Participant Information Sheet, which had been emailed to participants, was also available at the Focus Group locations. Participants were free to withdraw from the study at any time however all who arrived participated in the focus groups.

Table 4-4 Focus Groups by number of participants, type and profession

<table>
<thead>
<tr>
<th>Group</th>
<th>Participants</th>
<th>Type</th>
<th>Profession</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N= 26</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 1     | 4             | Supervisees | 1 x Dietitian  
|       |               |      | 1 x Occupational Therapist  
|       |               |      | 1 x Physiotherapist  
|       |               |      | 1 x Social Worker |
| 2     | 3             | Supervisees | 1 x Occupational Therapist  
|       |               |      | 2 x Social Worker |
| 3     | 8             | Supervisees | 1 x Physiotherapist  
|       |               |      | 1 x Allied Health Assistant  
|       |               |      | 6 x Social Worker |
| 4     | 4             | Supervisors | 1 x Psychologist  
|       |               |      | 1 x Speech Pathologist  
|       |               |      | 2 x Social worker |
| 5     | 7             | Supervisors | 2 x Physiotherapist  
|       |               |      | 1 x Podiatrist  
|       |               |      | 2 x Occupational Therapist  
|       |               |      | 2 x Social Worker |
Table 4-5 Participants by supervisee/supervisor by profession

<table>
<thead>
<tr>
<th>Participants</th>
<th>N=26</th>
<th>SW</th>
<th>OT</th>
<th>PT</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisors</td>
<td>11</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>1x POD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1x SP</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1x PSY</td>
</tr>
<tr>
<td>Supervisees</td>
<td>15</td>
<td>9</td>
<td>2</td>
<td>2</td>
<td>1XDT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 x AHA</td>
</tr>
</tbody>
</table>

\* AHA=Allied Health Assistant; DT=Dietician; OT=Occupational Therapist; POD=Podiatrist; PT=Physiotherapist; RO=Recreation Officer; SW=Social Worker; SP=Speech Pathologist.

4.8.3 Data Collection

Data was collected from the participants through semi-structured focus group interviews (Gibbs, 2007; Patton, 1987). To facilitate this process the researcher made use of an Interview Guide of open-ended questions (see Appendix G). Question examples include, “In the past, people have described both positive and negative experiences of clinical supervision, how would you describe your experience of clinical supervision?” and “Can you describe any factors that reduce the effectiveness of clinical supervision?” Participants were also free to discuss their clinical supervision experiences without being limited to boundaries predetermined by the researcher. Development of the interview guide was based on the empirical clinical supervision literature, the conceptual framework, the researcher’s own clinical supervision experience, and the findings from the quantitative study.

Data was recorded via the use of paper-based field notes and audio recordings. Two audio recorders were used as a precaution in case one audio recorder failed. This did eventuate during one focus group when the audio recorder lost charge and ceased functioning. In this situation, transcription was derived from the alternative audio player. The researcher facilitated the focus groups and had an assistant attend as an additional note taker. Each group was mapped out regarding participants’ seating locations, first names and profession, allowing responses to be matched to participants. Participants were then
allocated a pseudonym to identify where quotes had originated. A referencing style was used for the reporting of responses; the first letter of the name identifies the participant’s focus group. For example, names beginning with “A” indicate that those participants originated from focus group one, and names beginning with “B” originate from focus group two.

The group process provided opportunity for participants to corroborate each other’s experiences or provide a contrast when their experiences differed to other participant’s reports. The group dynamics differed between groups depending upon their composition, and the distinct clinical supervision history of the participants and their profession. Opportunity was provided for a broad and varied discussion which reduced the chance of missing new and emergent trends.

4.8.4 Data Analysis

Data analysis was undertaken using verbatim transcripts from audio recordings of the focus groups, as well as observations from paper-based field notes. The paper-based notes were reviewed by the researcher after the interviews to check for clarity of the information (Patton, 1987). The content of the notes later assisted with accuracy of the data when transcribing the audio recordings. The researcher completed the transcription of the audio recordings and this process was reviewed by a member of the research team. The breath of the data for analysis included 108 pages of field notes scribed by the researcher and the assistant note-taker, 394 minutes of audio recording and 36,192 words of transcription.

Thematic analysis was conducted to facilitate retrieval of related themes and patterns from the data (Padgett, 1998). A number of steps were adopted that accord with an eclectic coding method. Eclectic coding has been described as an appropriate method “when a variety of processes or phenomena are to be discerned from the data” (Saldana, 2013, p. 189). Firstly, the data was coded manually using an “initial coding” process to both reflect on and provide a preliminary sorting into provisional codes (Saldana, 2013, p. 100) (see Appendix H for example). The data then underwent further analysis to identify common themes and patterns for the first level coding (see Appendix I for example). Colour-highlighting was applied to narratives to assist with linking data of common themes (e.g.,
data associated with structured supervision procedures were highlighted in green). Systematic comparison was then employed to facilitate moving the data from descriptive terms to more inclusive groups that reflected categorical and theoretical analysis (Gibbs, 2007). A member of the research team read the transcripts, reviewed the coding process and provided feedback on the development of the themes within the data. The feedback involved two-way communication that encouraged the emergence of different views for consideration prior to moving to intercoder agreement on the interpretation of the data. This process offered a “reality check” (Saldana, 2013, p. 35) for analysis of the data as it introduced alternative perspectives and interpretations.

The qualitative data analysis was driven by both a top-down and bottom-up approach. The top-down analysis results from certain assumptions drawn from both the empirical literature and the findings of Study 1. This is to be anticipated given that Study 2 questions were developed to explain or illuminate Study 1 findings. The data analysis was also driven bottom-up as participants were not constrained by the interview questions and the researcher was alert to the detection of any new findings that contributed to or challenged existing knowledge. Conceptual interpretations were referenced with direct quotations obtained from the raw data (Padgett, 2009). The researcher adopted a reflexive role when generating interpretations from the data to minimise the imposition of preconceptions (Fossey et al., 2002) and this topic is discussed next.

4.9 Reflexivity

As mentioned, the researcher was employed by the organisation where the research was located. As part of her professional role, the researcher provided and received clinical supervision (see above for Focus Group Exclusion Criteria), and was known to some of the participants. Research being undertaken by practitioners within a study location is not new or unusual (e.g. for discussion, see Ward, 2014), however the process of “insider research” (Humphrey, 2012) does require discussion. Being an insider researcher, there was an increased emphasis on the need to preserve the “pivotal role of researcher-as-instrument” (Padgett, 1998, p. 93), in order to be authentically attentive to the participants’ voices. This meant it was critical for the researcher to be engaged in the process of reflexivity, an activity that involves having an awareness of the “interrelationships between the sets of assumptions, biases and perspectives that underpin different facets of the research” (Weber, 2003, pp. xi). The researcher was afforded a structured opportunity to
actively engage in reflexive processes through regular attendance at supervision and debriefing (Padgett, 1998) with her academic advisory team.

Adopting a reflexive approach entails consideration of the implications of professional power and professional knowledge (D'Cruz, Gillingham, & Melendez, 2007). Being an insider researcher has its benefits and disadvantages. For example, an advantage was that the researcher had current knowledge of the organisational context, including the unfolding events related to state, national and international actions occurring at the time of the study and impacting the health service (discussed in detail in Introduction, Chapter 1). This meant the researcher was well positioned to recognise the imminent introduction of significant changes, including organisational restructuring of services that would have had a major negative impact on recruitment. This knowledge enabled the researcher to implement data collection at an optimum point-in-time for both the research program and the organisation. It is likely that any delay to data collection would have resulted in low recruitment rates or more likely, a significant delay to recruitment as it is unlikely the organisation would have allowed staff to participate in the research during the disruptive period of the restructure.

During the research period, the researcher met regularly with a Queensland Health clinical supervision research advisory group. The purpose of the group was to facilitate processes to allow the research to commence and complete, and provide oversight to prevent any negative impact on organisational activity. As an insider researcher, there were already-established working relationships with many of the advisory group members and an understanding of the organisation’s communication processes and systems. These aspects facilitated the recruitment process and minimised delays. In addition, being an employee in the organisation during the time of the research may have increased the profile of the study and contributed to the satisfactory recruitment rate. D'Cruz and colleagues (2007) point out that professional power and professional knowledge can have the capacity to be utilised for emancipation or oppression. The above examples could be seen as facilitating research processes that may result in giving voice to employees about their supervision experiences and therefore contributing to emancipation. It could also be argued that professional power cannot be easily discarded, creating the potential to be used inappropriately in the process of knowledge generation, hence the value of having opportunity for reflexive analysis.
The receipt of academic oversight was especially useful during the process of focus group facilitation as this was the point when the researcher was face-to-face with research participants. Engaging in reflexive processes served to prevent possible transgressions and provided opportunity and encouragement for the questioning of any underlying assumptions. This space facilitated the juxtaposition of alternative elucidations (Weber, 2003), such as not only being aware of what was being said by participants but also being aware of what was not being said. The researcher was also reminded of the need to remain in the researcher role and refrain from sliding into the practitioner role. When reflecting with her academic advisors, the researcher often referred to these situations as wearing two different hats at distinctive times; a yellow researcher hat and a blue practitioner hat. The challenge was not to be wearing a green hat which would be brought about if one mixed the two roles together at the same time. Sometimes, the biggest struggle was for others (e.g., health service managers) to understand that the hats were not interchangeable within either of the specific roles. To mitigate this risk the researcher consistently clarified her different roles with other staff in the health service.

As an employee within the organisation there is an ongoing challenge to cast off the nuances of a familiar work culture in order to reconstitute meanings in new and crisp ways. Locating the focus groups within the workplace environment may have increased these challenges. Being aware of this prospect, and the need to adopt a “self-critical approach that questions how knowledge is generated” (D’Cruz et al., 2007, p. 75) was facilitated by utilising the researcher persona as a way of thinking and interacting, especially during the focus group interviews and data interpretation processes. Hearing and interpreting participants’ voices unfiltered by ‘work speak’ was critical to ensure their voices were the ones being heard.

As the researcher was previously known to some research participants, it was important to reflect on whether this acquaintance may have influenced how they responded to the study, either positively or negatively. Again, the researcher tried to mitigate this risk by making her role clear prior to important points, such as recruitment and data collection. It may be that participant bias was minimal as surveys were anonymous and the focus groups tended to develop a life of their own, based on their constituency. For example, it
was not unusual for spontaneous discussions about supervision to develop between the focus group participants, as the following example demonstrates,

“I don’t know if it’s the same with you; you’re a physiotherapist, oh, you’re a speech pathologist.” Asha, asks another participant.

“No, it’s not (the same)”. Aria, other participant responds.

Although some (Hein & Austin, 2001) would maintain that it is not possible for the researcher to absolutely put aside their biases and assumptions, Weber (2003 pp.vii) claims that researchers who are “pluralistic” in their selection and application of research methodologies, are less likely to fall captive to a particular world view or paradigm. Weber (2003) argues that this frees the researcher to consider the interplay between the methodological construction/s and the study topic in their analysis and interpretation. Never-the-less, the aforementioned reflexivity processes were employed to minimise the risk of researcher bias and ensure information was viewed with ‘fresh eyes’.

4.10 Mixed Methods Data Analysis

There is ongoing refinement of the various stages involved in mixed methods research, including the final stage of data analysis where the findings from the different strands of methodologies are combined (Creswell & Plano Clark, 2011). This process of mixed method data analysis involves taking the separate data sets that have been independently analysed and submitting them to a process of integration. Integration is “a mixed methods term that denotes making meaningful conclusions on the basis of consistent or inconsistent results” (Bergman, 2008b, pp.22). There are different ways of integrating the data sets and this is usually dependent on the mixed methods research design being employed (Creswell & Plano Clark, 2011).

As this mixed methods study follows an explanatory sequential design, the following steps were taken (Creswell & Plano Clark, 2011). Firstly the two data sets were analysed independently of each other, and interpretations were made based on their independent findings. The two data sets were then connected and compared to discover whether the independent findings from the separate strands of research converged or diverged. For example, themes and direct quotes from Study 2 were matched or contrasted with the statistical results from Study 1. Through this process the qualitative results assisted in
explaining the quantitative results. This was followed by an interpretation of the connected mixed methods findings to form the “meta-inferences”, to respond to the research questions set out in the research program (Creswell & Plano Clark, 2011, pp. 237).

4.11 Ethics

Ethical approval for the study was obtained from the Behavioural and Social Sciences Ethical Review Committee at The University of Queensland (Approval Number: 2011000569; see Appendix J) and from the Human Research Ethics Committee at the Health Service District (see Appendix K). Although respondents of this study were not considered to be a vulnerable group, there were important ethical areas to consider. Firstly, as the researcher was employed by the organisation where the study was located, and also provided clinical supervision within that service, steps were taken to ensure the researcher clarified her research role with colleagues, and received oversight from academic advisors and a Queensland Health clinical supervision research reference group. Secondly, as the survey was implemented through the health district’s internal email system, it was important that respondents received reassurance that their responses would remain confidential. Data was de-identified and maintained on a password protected computer, external to Queensland Health. As four of the allied health professions have a small representation within the overall population, this presents specific problems regarding anonymity and care was required when reporting these groups. Although confidentiality within the focus groups cannot be guaranteed (Patton, 1987) participants were advised of “ground rules’ which included their agreement to confidentiality. Thirdly, although the purpose of the research was to explore broad work practices, not individual’s specific practice, there was a consideration that respondents might choose to disclose professional misconduct issues encountered during clinical supervision. Therefore a clear process of management of any disclosed professional misconduct had been outlined for participants and the health service management. This information was contained in the Participant Information Sheet, Participant Consent Form, and was verbally given at the commencement of all Focus Groups. This process provided opportunities for a mechanism for redress (Padgett, 2009) for any respondent who wished to raise ethical concerns or misconduct issues related to clinical supervision. Participation in the survey was voluntary and included the right to withdraw at any time without penalty.
4.12 Rigour

The earliest rationale for combining quantitative and qualitative methods was to cross-validate findings (Padgett, 2004) however bringing together different methods has challenges, one of which relates to rigour (Creswell & Plano Clark, 2011; Gioia, 2004). Essentially, quantitative and qualitative methods have different principles for determining rigour (Creswell & Plano Clark, 2011; Gioia, 2004). To accommodate these different approaches, these two aspects of this research will be addressed separately.

In quantitative studies, rigour refers to the psychometric properties of reliability and validity (Gioia, 2004). The following aspects of Study 1 seek to ensure that these standards are met. The scales adopted are psychometrically sound and have previously been used in multiple studies and cross-culturally (Kim & Lee, 2009; Nissly et al., 2005; Winstanley & White, 2011). Also, the data collection methods suit this population of allied health staff as they are already familiar with the use of survey questionnaires. The sample in Study 1 comprised the total population, however any attrition was investigated and the data was checked for patterns on the basis of profession, and seniority.

With qualitative methods, rigour is usually considered in terms of whether the study is trustworthy. Trustworthiness refers to whether the research “is carried out ethically and ... findings represent as closely as possible the experiences of the participants” (Lincoln & Guba, 1985, cited in Padgett, 2009, p. 102). To meet this standard, the following strategies were adopted. A note book was maintained to document significant decision-making processes, including reasons for any deviations from the research plan and comprises part of an audit trail (Fossey et al., 2002). Records of the raw data and field notes from the focus groups were included in the audit trail. This process of openness enhances opportunities for the study to be reproduced and for confirmation of the findings (Padgett, 1998). Also, a record was maintained of the breadth of the data collected, to reveal “evidentiary adequacy” (Padgett, 2009). In addition, data relating to the clinical supervision experience were collected from two distinct sources (Rubin & Babbie, 2007); supervisees and supervisors. As this data represents two different types of experience, it provided an opportunity to establish whether participants’ experiences of the clinical supervision implementation converged or varied and the degree to which those experiences showed evidence of, or deviated from, the best practice principles approved for use in this health
service. Negative case analysis was employed for examination of data that appeared to disconfirm emerging interpretations (Rubin & Babbie, 2007).

4.13 Summary

This chapter presented the overall design of this mixed methods study. Firstly, the research questions, hypotheses, mixed methods design, conceptual models, associated paradigms, and study sample were discussed. This was followed by an explication of Study 1, the quantitative component, then Study 2, the qualitative component. The next section described how the quantitative and qualitative data were integrated to inform the research findings. The chapter concluded with a discussion of the ethical considerations and rigour associated with this research. The next chapter will address the results from Study 1.
5 Study 1: Findings and Discussion

5.1 Introduction

This chapter presents findings from Study 1. Allied health professionals were asked to report on their perceptions of the clinical supervision that had been recently introduced by their employing organisation. The research questions are as follows:

1. How do allied health staff who receive clinical supervision rate the effectiveness of that clinical supervision in providing support, professional development and guidance for their professional practice?
2. What factors affect the perceived effectiveness of clinical supervision in providing support, professional development and guidance for supervisees’ professional practice?
3. What is the relationship between perceptions of effectiveness of clinical supervision and supervisees’ reports of levels of intention to leave?
4. What is the relationship between perceptions of effectiveness of clinical supervision and supervisees’ reports of levels of burnout?
5. What are the profession-specific differences in perceived effectiveness of clinical supervision, reports of levels of intention to leave, and reports of levels of burnout?

The research questions relate to the study’s focal hypotheses,

1. Effective clinical supervision will be negatively correlated with intent to leave and with burnout.
2. Those receiving effective clinical supervision will report higher levels of professional development, guidance and support for their professional practice than those receiving ineffective clinical supervision.

In the present survey, the term “supervision” was defined to be consistent with that used in the organisation’s guidelines for individual clinical supervision, which had been based on an existing Queensland Health policy (noted in Chapter 1). Hence, “supervision” was defined as a “working alliance between two employees where the primary intention of the interaction is to enhance the knowledge, skills and attitudes of at least one employee” (Queensland Government, 2008, p. 13).
Effectiveness of clinical supervision was defined as how supervisees rated their clinical supervision for providing support, education and guidance for their professional practice. This definition was chosen because it straddles the core functions of clinical supervision as suggested by several authors (Kadushin, 1976; Proctor, 2001) and also closely parallels the three tasks of the Proctor model - normative, formative and restorative (Proctor, 2011). In addition, the instrument selected for this study to measure clinical supervision effectiveness, the MCSS-26©, aligns with Proctor's model (Winstanley, 2000) as it incorporates the three domains, utilising the subscales: Importance/Value of CS, Finding Time, Trust/Rapport, Supervisor Advice/Support, Improved Care/Skills, Reflection (Winstanley & White, 2011). In the current study there was good internal consistency for this scale and its domains and subscales (α = .83 - .94).

In the current study, a range of terms have been adopted to delineate levels of effectiveness for clinical supervision.

I. Firstly, scores of 73 or above on the MCSS-26© scale indicate that the supervision has been efficacious as this is the suggested efficacy threshold for this measure (Winstanley & White, 2011).

II. Independent to the efficacy threshold, is the published normative mean score for the MCSS-26© for allied health at 74.7 (SD=11.00) (Winstanley & White, 2011). Therefore a new variable titled, “High Efficacy”, was created by including scores of >74.7, to represent those scores reaching or exceeding the normative score for allied health.

III. Finally, the variable, “CS Excellence”, was developed to represent those scores greater than the mean plus one standard deviation for effectiveness of clinical supervision (i.e., being MCSS-26© scores > 85).

These various definitions allow for the discernment of degrees of effectiveness and this provides for a greater sensitivity when determining the relationship between clinical supervision effectiveness and outcome variables.

It should be noted that cell sizes throughout will vary due to missing data.

There were 17 respondents who did not complete the MCSS-26©. Their data was interrogated to see if they were different in any way to the other participants. Overall, the participants with missing MCSS-26© data did not differ in age from those without missing data however there was a significant difference in relation to the years they had worked in...
their current allied health position, \( t (79) = 1.99, p = .05 \). Those who had worked longer in their current allied health position were more likely to have missing MCSS-26© data. At the time of the survey, the structured clinical supervision program was still quite new and not all allied health staff had been formally allocated a clinical supervisor. Therefore, it may be that less experienced staff had been allocated a clinical supervisor as a higher priority, compared with those with more experience in their positions. There was a higher number of occupational therapy respondents (n=7) with missing data than the other allied health disciplines, where between 1 and 3 cases with missing data was evident. As six out of the seven occupational therapy respondents had identified that they were not receiving clinical supervision or were receiving a different type of supervision (e.g., peer supervision), it could reasonably be assumed that their missing data was genuine.

Details of the findings and discussions will be presented next. First, the supervision arrangements are reported, followed by the survey responses which have been written in order of the research questions.

5.2 Survey findings

5.2.1 Supervision arrangements

Participants in the present study had been receiving the new model of clinical supervision for periods of time ranging from 1 to >12 months with 54.8% reporting that they had received supervision for more than 6 months. While the survey was implemented 8.5 months after the formal commencement of structured clinical supervision, it is possible that those with longer response times started to use more structured supervision processes prior to the service’s actual formal introduction of the clinical supervision model. On average, participants had been receiving formalised supervision for a period of 6.60 months prior to the data collection. The number of clinical supervision sessions that supervisees had received ranged from 1 to >12 times with 52.4% reporting that they had received supervision five or more times. The majority of supervisees (n=31, 51.7%) received clinical supervision at their supervisor’s work location, with a third of supervisees receiving clinical supervision at their own work location (n=21, 35%), and a small number (n=8, 13.3%) receiving clinical supervision at a location described as “other”. There is evidence to suggest that supervision is more effective when it occurs somewhere other than at the supervisee’s workplace (Edwards et al., 2005; Hyrkas, 2005).
Participants varied in their experiences of previous exposure to clinical supervision; few participants (n=7, 8.6%) reported never having received clinical supervision while others (n=15, 18.5 %) reported having received clinical supervision for periods of ten years or more. It has been suggested that supervisees require time, perhaps spanning a number of supervisory relationships, to learn how to obtain most benefit from their supervision (Hyrkas, 2005).

The length of time clinicians spent in supervision sessions varied with the largest group (n=25, 29.1%) reporting sessions lasting between 45 and 60 minutes, followed by over a fifth (n=18, 22.8%) reporting sessions of between 60 and 75 minutes. Studies of supervision generally report sessions to be between 45 and 60 minutes in duration (Butterworth et al., 2008; Hyrkas, 2005). In contrast, Edwards et al. (2005) demonstrated that supervision sessions lasting over one hour were evaluated as being more effective, which led the authors to suggest that shorter sessions were of questionable value. Interestingly, in their review of the literature, Butterworth et al. (2008) found that there was little empirical evidence to support recommendations regarding minimum length of time and frequency for clinical supervision.

The majority of supervisees (n=45, 66.2%) reported that they had some choice in the selection of their clinical supervisor. This result is consistent with recommended supervision practice (Edwards et al., 2005; Spence, Cantrell, Christie, & Samet, 2002) however many studies report that supervisees have their clinical supervisor allocated to them rather than supervisees receiving any choice (Bradley & Hojer, 2009; Dawson et al., 2012).

Most supervisees (n=55, 85.9%) accessed all their clinical supervision from one clinical supervisor, with five (7.8%) accessing their clinical supervision from two clinical supervisors, and four (6.3%) accessing three or more clinical supervisors. Some supervisees (n=14, 28.6%) had experienced a change of clinical supervisor since the commencement of the structured clinical supervision program.

The overwhelming majority of supervisees (n=57, 89.1%) received clinical supervision from a supervisor who was of their same professional discipline. For the most part,
supervisees (n=62, 95.4%) received clinical supervision from someone other than their line manager. This is consistent with best practice principles that advise against having dual and hierarchical relationships in clinical supervision (Dawson et al., 2012; Hyrkas et al., 2006; Spence, Wilson, et al., 2001). Avoidance of dual relationships in clinical supervision facilitates the development of a safe learning environment for the supervisee and prevents administrative and managerial functions dominating the process (Beddoe, 2010). The combination of line management and clinical supervision responsibilities can increase the potential for ethical dilemmas to arise for the supervisor (Shaw, 2013). The organisation where the present study was located had sought to reduce the potential for dual relationships through the supervisor selection process (see Introduction, Chapter 1) and through the use of a clinical supervision agreement (see Appendix L) that articulated how dual relationships would be managed if they were to occur.

While this study was primarily concerned with the practice of “individual” clinical supervision, the survey also sought information about whether respondents were exposed to additional forms of clinical supervision. Almost half of the respondents (n=39, 47.6%) reported that they also participated in other forms of supervision; most often described as “peer supervision”, but also as “peer learning”, “mentoring”, or “infrequent peer supervision”. The diverse terminology around different modes of supervision can be problematic and may sometimes be confused with operational or administrative supervision (Roche et al., 2007), hence the value of providing a definition of clinical supervision in the survey prelude.

Apart from receiving clinical supervision, respondents were asked whether they were providing clinical supervision to other staff members in the organisation. Just over one-third of respondents (n=29, 35.4%) reported that they did provide clinical supervision. Four of those supervisors (13.8%) reported receiving regular supervision for this role, however, the majority (n=24, 82.8%) reported that they did not receive any supervision of their supervisory role. Of those 24 participants, 69% (n=20) reported that they thought receipt of supervision for this purpose would be useful.

In summary, the majority of participants in this study had received supervision for at least six months, five or more times, at their supervisor’s location, had sessions between 45 and
60 minutes, had choice in selection of their supervisor, and received supervision from an individual supervisor who was of their same profession.

5.2.1.1 Clinical supervision training
Supervisees were asked whether they had attended the clinical supervision training provided within the organisation. The same training was available to both supervisees and supervisors. Almost three quarters of respondents \((n=58, 73.4\%)\) reported having attended the training, while some \((n=5, 6.3\%)\) were waiting to attend the next available training. It is interesting to note that irrespective of whether participants had or had not attended the organisation’s training, over half of respondents \((n=47, 60.3\%)\) reported having previously attended some type of clinical supervision training. Of the 79 respondents who replied to the training question, only 11 \((13.9\%)\) reported never having attended any clinical supervision training, and four of those reported that they were waiting to attend the next offered clinical supervision training. This indicates that the majority of supervisees and supervisors \((86.1\%)\) had attended some form of clinical supervision training. This high level of training attendance may reflect the increased interest in supervision as historically the majority of supervisees and supervisors did not receive any clinical supervision training \((\text{Crow, 2008; Spence, Wilson, et al., 2001})\). Also, until recent times, clinical supervision training when provided, was frequently only made available to supervisors \((\text{For example, see Collins-Camargo et al., 2009; Hyrkas, 2005; Roche et al., 2007; White & Winstanley, 2010})\). Providing training for both supervisees and supervisors is recommended \((\text{Cutcliffe, 2011; Hyrkas et al., 2006})\) and evidence suggests that providing clinical supervision training to both supervisees and supervisors at the same time is likely to produce better outcomes \((\text{Kavanagh et al., 2008})\).

5.2.1.2 Supervision Procedures
The service where the study was located had in place a Guideline for clinical supervision of allied health. The Guideline described the purpose, principles, expectations, and procedures (including required documentation) for allied health staff in relation to clinical supervision. In line with processes articulated in the Guideline, respondents were asked whether they had a written agreement for the clinical supervision they received. The majority of participants \((n=41, 62.1\%)\) reported that they had completed a written supervision agreement. When asked whether they were aware of the Guideline for clinical
supervision, almost three-quarters of participants (n=57, 73.1%) agreed that they were aware. Having clearly structured policies and processes, which includes clinical supervision documentation, is recommended best practice (Hyrkas, Appelqvist-Schmidlechner, & Paunonen-Ilmonen, 2002; Noblet et al., 2016), yet it is often lacking in organisations and is frequently reported as a barrier to clinical supervision effectiveness (Dawson et al., 2012; Kavanagh et al., 2001; Snowdon et al., 2015).

Participants were asked whether they were “clear about the boundaries of confidentiality” as outlined in the clinical supervision Guideline. The overwhelming majority of participants (n=63, 81.8%) responded yes to this question. This level of familiarity may be partly due to knowledge gained from attendance at supervision training. This high response suggests that most participants were confident about the transparency of processes in relation to the information being shared in clinical supervision sessions. It suggests a firm foundation for the development of trust and safety during supervision processes. Given the centrality that the clinical supervision relationship plays in the perception of effectiveness (Crow, 2008; Ellis, 2010) this degree of certainty about boundaries in supervision is encouraging.

Having discussed the supervision arrangements reported by survey participants, the next section presents the responses to the research questions.

5.3 Research Questions

5.3.1 Research Question 1

How do allied health staff who receive clinical supervision rate the effectiveness of that clinical supervision in providing support, education and guidance for their professional practice?

The group’s overall mean score (M=73.23, SD=14.70) was not significantly different from the MCSS-26© efficacy threshold score of 73, t (64) = 0.127, p=.900, nor the published norms for allied health (M=74.7, SD=11.00), t (64)=0.81, p=.423 (Winstanley & White, 2011). It is worth noting that the normative data for the MCSS-26© originated from samples where clinical supervision had been established for some time (Winstanley & White, 2011) whereas formal clinical supervision was a relatively new practice for the present sample of allied health (45.2% reported that they had received supervision for less
than 6 months). As will be discussed later in this chapter, the amount of time that supervisees have been in receipt of supervision seems important in terms of its perceived efficacy; however the sample in this current study did not differ from the normative data despite the relatively short duration of the implementation of clinical supervision.

While the group's overall mean score met the efficacy threshold, Physiotherapy as a group differed significantly from the normative mean for this measure and this topic is discussed later under Question 5.

5.3.2 Research Question 2

What factors affect the perceived effectiveness of clinical supervision in providing support, professional development and guidance for supervisees' professional practice?

Several variables were identified from theoretical discussions in the clinical supervision literature (Bradley & Hojer, 2009; Clinical Education and Training Queensland, 2010; Clinical Education and Training Institute, 2011; Spence, Wilson, et al., 2001) as being linked with perceived effectiveness of clinical supervision. These variables included length of supervision session, number of supervision sessions received, being both a supervisee and a supervisor, and a combination of procedural tasks that were defined by the researcher as “Best Practice” principles. Analyses were conducted to investigate whether these variables were linked to effectiveness of clinical supervision.

5.3.2.1 Time spent in clinical supervision sessions

The time participants spent in clinical supervision sessions ranged from less than 30 minutes to more than 90 minutes, with 54% of participants having less than 60 minutes in supervision sessions. There was a statistically significant relationship between length of time spent in supervision sessions and evaluations of effectiveness, $r (n=68) = .45, p < .001$, with longer supervision sessions being associated with increased effectiveness of supervision. This was evident for the MCSS-26© total scores, as well as all three MCSS-26© domains (Normative, Restorative and Formative), and for all of the MCSS-26© subscales (Importance/Value of CS, Finding Time, Trust/Rapport, Supervisor Advice/Support, Improved Care/Skills, and Reflection) (see Tables 5.1 and 5.2).
Further analysis was undertaken to identify what period of session time was associated with supervision effectiveness. A session time of more than 60 minutes was selected as Edwards and colleagues’ (2005) study of community mental health nurses reported significantly reduced benefits from clinical supervision when sessions lasted for less than 60 minutes. Findings from the current study indicated that as a whole, participants who spent more than 60 minutes in supervision sessions (n=33, M=80.61, SD=11.81) had significantly higher mean scores for the MCSS-26© total score compared to participants who spent less than 60 minutes in supervision sessions, (n=31, M=65.87, SD=13.75), t (62)=4.61, p<.001. Significant differences, favouring the group who spent more than 60 minutes in supervision sessions, were also found for all of the MCSS-26© domains and subscales (see Table 5.3).

Table 5-1 Descriptive data (means, standard deviations) along with correlations between the MCSS-26© Domains (Winstanley & White, 2011) and “Time Spent in Supervision Sessions” along with internal consistency estimates (Cronbach α) in the main diagonal (N=68)

<table>
<thead>
<tr>
<th>Domain</th>
<th>M</th>
<th>(SD)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Normative</td>
<td>22.97</td>
<td>(5.80)</td>
<td>.84</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Restorative</td>
<td>29.08</td>
<td>(6.37)</td>
<td>.65***</td>
<td>.93</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Formative</td>
<td>20.90</td>
<td>(4.40)</td>
<td>.66***</td>
<td>.76***</td>
<td>.91</td>
<td></td>
</tr>
<tr>
<td>4. Total MCSS-26©</td>
<td>73.25</td>
<td>(14.70)</td>
<td>.87***</td>
<td>.92***</td>
<td>.88***</td>
<td>.95</td>
</tr>
<tr>
<td>5. Time spent in supervision sessions^2</td>
<td>-</td>
<td>-</td>
<td>.45***</td>
<td>.59***</td>
<td>.55***</td>
<td>.60***</td>
</tr>
</tbody>
</table>

(*** p<.001)

1 The following range of score values applied to the MCSS-26© Domains: Normative 0-36, Restorative 0-40, Formative 0-28 (Winstanley & White, 2011). In all cases, higher numbers reflect greater effectiveness of clinical supervision.

2 Means and standard deviations are not included for “Time spent in supervision sessions” as this was an ordinal level of measurement, with response options being: “none”, “less than 30 minutes”, 30 to 45 minutes”, “45 to 60 minutes”, “60 to 75 minutes”, “75 to 90 minutes”, and “more than 90 minutes”.
Table 5-2 Descriptive data (means, standard deviations) along with correlations between the MCSS-26© Subscales (Winstanley & White, 2011) and “Time Spent in Supervision Sessions” along with internal consistency estimates (Cronbach α) in the main diagonal (N=68)

<table>
<thead>
<tr>
<th>MCSS-26© Subscale</th>
<th>M</th>
<th>(SD)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Importance/ Value of Clinical Supervision</td>
<td>15.36</td>
<td>(3.24)</td>
<td>.80</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Finding Time</td>
<td>7.61</td>
<td>(3.52)</td>
<td>.47***</td>
<td>.81</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Trust / Rapport</td>
<td>14.44</td>
<td>(3.50)</td>
<td>.55***</td>
<td>.46***</td>
<td>.88</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Supervisor Advice / Support</td>
<td>14.51</td>
<td>(3.32)</td>
<td>.68***</td>
<td>.41**</td>
<td>.75***</td>
<td>.91</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Improved Care / Skills</td>
<td>11.62</td>
<td>(2.82)</td>
<td>.63***</td>
<td>.38**</td>
<td>.52***</td>
<td>.78***</td>
<td>.87</td>
<td></td>
</tr>
<tr>
<td>6. Reflection</td>
<td>9.28</td>
<td>(1.93)</td>
<td>.75***</td>
<td>.37**</td>
<td>.60***</td>
<td>.80***</td>
<td>.71***</td>
<td>.92</td>
</tr>
<tr>
<td>7. Time spent in supervision sessions</td>
<td>-</td>
<td>-</td>
<td>.50***</td>
<td>.27†</td>
<td>.51***</td>
<td>.58***</td>
<td>.48***</td>
<td>.56***</td>
</tr>
</tbody>
</table>

(*** p<.001  
(**) p<.01  
(*) p<.05

1 The following range of score values applied to the MCSS-26© Subscales: Importance / Value of Clinical Supervision 0-20, Finding Time 0-16, Trust / Rapport 0-20, Supervisor Advice / Support 0-20, Improved Care / Skills 0-16, Reflection 0-12 (Winstanley & White, 2011). In all cases, higher numbers reflect greater effectiveness of clinical supervision.

2 Means and standard deviations are not included for “Time spent in supervision sessions” as this was an ordinal level of measurement, with response options being: “none”, “less than 30 minutes”, 30 to 45 minutes”, “45 to 60 minutes”, “60 to 75 minutes”, “75 to 90 minutes”, and “more than 90 minutes”.
Table 5-3 Descriptive data (means, with standard deviations in brackets) along with session time differences of greater than and less than 60 minutes duration, for the MCSS-26© Total score, Domains and Subscales (Winstanley & White, 2011)

<table>
<thead>
<tr>
<th></th>
<th>Session time</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;60 minutes</td>
<td>&gt;60 minutes</td>
</tr>
<tr>
<td><strong>Total Score</strong>*</td>
<td>65.87(13.75)</td>
<td>80.61 (11.81)</td>
</tr>
<tr>
<td><strong>Domains</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normative ***</td>
<td>20.53 (5.54)</td>
<td>25.50 (5.05)</td>
</tr>
<tr>
<td>Restorative ***</td>
<td>26.26 (5.94)</td>
<td>32.18 (4.82)</td>
</tr>
<tr>
<td>Formative ***</td>
<td>18.91 (4.29)</td>
<td>22.74 (3.71)</td>
</tr>
<tr>
<td><strong>Subscales</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Importance ***</td>
<td>13.97 (3.37)</td>
<td>16.74 (2.53)</td>
</tr>
<tr>
<td>Finding Time **</td>
<td>6.56 (3.24)</td>
<td>8.76 (3.47)</td>
</tr>
<tr>
<td>Trust/Rapport **</td>
<td>13.29 (3.12)</td>
<td>15.79 (2.98)</td>
</tr>
<tr>
<td>Advice/Support ***</td>
<td>12.91 (3.17)</td>
<td>16.24 (2.51)</td>
</tr>
<tr>
<td>Improved Care **</td>
<td>10.55 (2.62)</td>
<td>12.56 (2.65)</td>
</tr>
<tr>
<td>Reflection ***</td>
<td>8.36 (1.93)</td>
<td>10.18 (1.51)</td>
</tr>
</tbody>
</table>

(*** p<.001 for difference on that domain between <60 minutes and >60 minutes session time duration)

(W** p<.01 for difference on that subscale between <60 minutes and >60 minutes session time duration)

Watkins’s (2011) review of the clinical supervision literature prompted him to suggest that insufficient time allocated to supervision may be one reason that studies sometimes fail to reveal outcomes from supervision practice. Based on the current study’s findings, it is reasonable to suggest that clinical supervision sessions of less than 60 minutes duration may be of questionable value for allied health workers.

5.3.2.2 Number of clinical supervision sessions attended

A positive relationship was found between the number of supervision sessions attended and the perceived effectiveness of two of the three MCSS-26© domains. The more times staff received clinical supervision under the structured supervision model the higher they rated the effectiveness of clinical supervision in meeting the Formative domain (knowledge and skill development) and the Restorative domain (support and refreshment of the worker) (Proctor, 2008; Winstanley & White, 2011) of supervision, rs ≥.35, ps <.034. It is interesting that this relationship was not found for the Normative domain (clinical governance and monitoring standards). Possible reasons might include the timing and
location of the study as the health service was about to undergo substantial organisational change. Therefore, during supervision sessions, participants may have chosen to specifically focus on skill development in anticipation of changed models of care delivery, and obtaining support to increase their resourcefulness for adaptation to change. Another explanation may be that the Normative domain tasks were being sufficiently addressed through other avenues, for example through operational oversight and case conferencing, and therefore were not seen as a priority during clinical supervision sessions at this particular time. Alternatively, given the short duration since the commencement of the structured supervision program, this result may instead reflect a developmental process in the supervision relationship. Proctor has noted the importance of establishing the Restorative domain as a priority to ensure that the other domains function effectively (Proctor, 2011). Therefore, data collection at a later point in time may have reflected increased levels of perceived effectiveness for the Normative domain.

5.3.2.3 Period of time clinical supervision received during career
The longer the total period of time that participants received clinical supervision during their career, the more highly they rated the effectiveness of all of the MCSS-26© domains, $rs \geq .42$, $ps < .001$, and all the subscales, $rs \geq .27$, $ps < .025$. These findings are consistent with the empirical literature that suggests supervisees learn over a period of time how to make best use of supervision (Hyrkas et al., 2006). It has been suggested that participation in clinical supervision requires the development of specific skills and knowledge, including how to provide and receive feedback (Dawson et al., 2013b; Health Workforce Australia, 2010), undertaking adult teaching, and awareness of the ethical and legal considerations associated with supervision (Health Workforce Australia, 2011c). If expertise in a different skill set is required to enable competent clinical supervision practice, this may explain why length of clinical supervision experience affects the efficacy of clinical supervision.

5.3.2.4 Supervisor role
Of the 77 respondents, 27 identified that they provided clinical supervision to other allied health staff within the organisation. Of those 27, 15 reported that they both received and provided clinical supervision. There were no statistically significant differences in MCSS-26© mean scores between those who both provided and received clinical supervision.
(M=74.92, SD=11.79) and those solely receiving clinical supervision (M=72.81, SD=15.42) t (63)=0.46, p=.646. Similarly there were no statistically significant differences found between the two groups on any of the MCSS-26© domains or the subscales. These findings contradict other studies that report supervisors as being more likely than non-supervising supervisees to positively evaluate supervision (Hyrkas, 2005; White & Winstanley, 2010).

5.3.2.5 Procedural Infrastructure

Analyses was undertaken to determine whether certain factors related to the procedural infrastructure around clinical supervision delivery, as identified in the clinical supervision empirical literature, were associated with clinical supervision efficacy. This focus was adopted because the empirical literature has largely concentrated on links between the clinical supervision relationship and outcomes (Bambling, 2000; Kilminster & Jolly, 2000), even though some (Dawson et al., 2012; Livni et al., 2012) have suggested that the contextual elements of clinical supervision, such as processes and procedures, may be associated with outcomes. The procedural principles as identified from the clinical supervision literature included meeting all of the following five criteria:

- receiving clinical supervision (Clinical Education and Training Queensland, 2010),
- having some choice in the allocation of clinical supervisor (Dawson et al., 2012; Edwards et al., 2005),
- attendance at clinical supervision training (Bradley & Hojer, 2009; Kavanagh et al., 2008),
- having a completed clinical supervision agreement (Clinical Education and Training Institute, 2011; Fleming, 2012),
- having a clear understanding about the boundaries of confidentiality in the clinical supervision relationship (Clinical Education and Training Institute, 2011; Dawson et al., 2012).

These criteria formed a new variable which was defined as “Best Practice” and those participants who responded “yes” to all of the above variables were considered to be implementing “Best Practice” principles. The “Best Practice” group (n=24) was then compared with the “Less than Best Practice” Group (n=54) with a significant difference evident on total MCSS-26© mean scores, t (63) =2.17, p=.033. Those in the “Best
Practice” group ($M=78.81$, $SD=12.34$) rated the overall effectiveness of the clinical supervision significantly more highly than did the “Less than Best Practice” group ($M=70.57$, $SD=15.12$). Significant differences were also found for the Restorative domain and three of the six subscales (see Table 5.4).

### Table 5-4 Descriptive data (means, with standard deviations in brackets) along with “Best” and “Less than Best” Group differences for the MCSS-26© Total score, Domains and Subscales (Winstanley & White, 2011)

<table>
<thead>
<tr>
<th>MCSS-26©</th>
<th>Groups</th>
<th>&quot;Best Practice&quot;</th>
<th>&quot;Less than Best Practice&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Score</td>
<td></td>
<td>78.81 (12.34)</td>
<td>70.57 (15.12)</td>
</tr>
<tr>
<td>Domains</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normative</td>
<td></td>
<td>24.50 (5.72)</td>
<td>22.26 (5.75)</td>
</tr>
<tr>
<td>Restorative</td>
<td>**</td>
<td>32.00 (5.11)</td>
<td>27.68 (6.48)</td>
</tr>
<tr>
<td>Formative</td>
<td></td>
<td>22.09 (3.52)</td>
<td>20.33 (4.70)</td>
</tr>
<tr>
<td>Subscales</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Importance</td>
<td></td>
<td>16.32 (2.93)</td>
<td>14.91 (3.32)</td>
</tr>
<tr>
<td>Finding Time</td>
<td></td>
<td>8.18 (3.63)</td>
<td>7.34 (3.47)</td>
</tr>
<tr>
<td>Trust/Rapport</td>
<td>*</td>
<td>15.82 (2.68)</td>
<td>13.75 (3.67)</td>
</tr>
<tr>
<td>Advice/Support</td>
<td>*</td>
<td>15.95 (2.92)</td>
<td>13.85 (3.31)</td>
</tr>
<tr>
<td>Improved Care</td>
<td></td>
<td>12.09 (2.43)</td>
<td>11.39 (2.98)</td>
</tr>
<tr>
<td>Reflection</td>
<td>*</td>
<td>10.00 (1.41)</td>
<td>8.93 (2.06)</td>
</tr>
</tbody>
</table>

(\*) $p<.01$ for differences on that MCSS© score between the “Best practice” and “Less than best practice groups”.

(*) $p<.05$ for differences on that MCSS© score between the “Best practice” and “Less than best practice groups”.

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While the total MCSS-26© mean score for the “Best Practice” group, was not significantly different from the published norms (i.e., 78.81 compared to 74.70), the means were in the anticipated direction. The “Best Practice” group also had a higher mean for the Restorative domain ($M=32.00$, $SD=5.11$) than the published benchmark ($M=29.7$, $SD=5.10$, $t(20)=2.06$, $p=.052$) (See Figure 5.1). Although not statistically significant, the difference represented a trend towards significance. This result is especially noteworthy as the MCSS-26© benchmark relates to allied health staff where clinical supervision has been established for some time (Winstanley & White, 2011).

![Figure 5-1 Mean data for "Best Practice" group and "Less than Best Practice" group related to the MCSS-26© Domains normative data (Winstanley & White, 2011)](image_url)
Further analyses revealed that two other variables, length of supervision session and being a clinical supervisor, were each linked with being identified in the “Best Practice” group. As can be seen in Table 5.5, those in the “Best Practice” group had more supervision sessions lasting greater than 60 minutes than supervision sessions for less than 60 minutes. For the “Less than Best Practice” group, the opposite prevailed. Although the difference between the groups was not significant at .05, there was a trend that is worthy of note, $\chi^2(1, n=78)=3.73, p=.084$, and it does strengthen the case for recommending supervision sessions of greater than 60 minutes.

Findings from the current study also revealed 87.5% (n=49) of the “Less than Best Practice” group compared to 66.7% (n=16) of the “Best Practice” group did not provide supervision to others. The differences between these two groups were significant, $\chi^2(1, n=80) =4.79, p=.029$ (see Table 5.6).

### Table 5-5 Length of supervision sessions by "Best Practice" and "Less than Best Practice" groups

<table>
<thead>
<tr>
<th>Time spent in supervision sessions</th>
<th>“Less than Best Practice” group N</th>
<th>“Best Practice” group N</th>
<th>Total N</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 60 mins</td>
<td>33 (61.1%)</td>
<td>9 (37.5%)</td>
<td>42</td>
</tr>
<tr>
<td>&gt;60 mins</td>
<td>21 (38.9)</td>
<td>15 (62.5%)</td>
<td>36</td>
</tr>
<tr>
<td>Total</td>
<td>54 (100.0%)</td>
<td>24 (100.0%)</td>
<td>78</td>
</tr>
</tbody>
</table>

### Table 5-6 Providing/receiving supervision groups by "Best Practice" and "Less than Best Practice" groups

<table>
<thead>
<tr>
<th>Providing/receiving supervision</th>
<th>“Less than Best Practice” group N</th>
<th>“Best Practice” group N</th>
<th>Total N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both provide and receive</td>
<td>7 (12.5%)</td>
<td>8 (33.3%)</td>
<td>15</td>
</tr>
<tr>
<td>Receive only</td>
<td>49 (87.5%)</td>
<td>16 (66.7%)</td>
<td>65</td>
</tr>
<tr>
<td>Total</td>
<td>56 (100.0%)</td>
<td>24 (100.0%)</td>
<td>80</td>
</tr>
</tbody>
</table>
The literature reports that supervisors generally perceive benefits from providing supervision to others (Dawson et al., 2013b; Hyrkas, 2005; Hyrkas et al., 2006). It therefore follows that supervisors were possibly more motivated, than non-supervising supervisees, to complete the procedural tasks associated with supervision delivery and hence why more supervisors were in the “Best Practice” group than not.

Independent sample t-tests were conducted to determine any associations between the individual “Best Practice” variables and clinical supervision efficacy. Three individual variables, “receiving clinical supervision”, “having some choice in the allocation of clinical supervisor”, and “having a completed clinical supervision agreement”, were significantly associated with higher total MCSS-26© (Winstanley & White, 2011) scores, $p < .014$. Neither of the remaining two variables, “attendance at clinical supervision training”, or “having a clear understanding about the boundaries of confidentiality in the clinical supervision relationship”, were significantly associated with higher clinical supervision efficacy as measured by the MCSS-26©. The variables “having some choice in the allocation of clinical supervisor”, and “having a completed clinical supervision agreement”, were also significantly associated with higher scores for all of the domains, $p < .033$. See Table 5.7 for the descriptive data (means, with standard deviations in brackets) along with all individual Best Practice Variable differences for the MCSS-26© total score and domains.
Table 5-7 Descriptive data (means, with standard deviations in brackets) along with individual Best Practice Variable differences for the MCSS-26© Total score and Domains (Winstanley & White, 2011)

<table>
<thead>
<tr>
<th>Best Practice Variables</th>
<th>N=</th>
<th>Normative</th>
<th>Restorative</th>
<th>Formative</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Receive clinical supervision</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>44</td>
<td>23.77 (5.75)</td>
<td><strong>30.93 (5.88)</strong></td>
<td>21.30 (4.31)</td>
<td><strong>76.61 (13.89)</strong></td>
</tr>
<tr>
<td>No</td>
<td>25</td>
<td>21.56 (5.73)</td>
<td><strong>25.92 (6.01)</strong></td>
<td>20.17 (4.57)</td>
<td><strong>67.46 (14.53)</strong></td>
</tr>
<tr>
<td><strong>Attended Training</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>49</td>
<td>22.71 (5.88)</td>
<td>29.24 (6.28)</td>
<td>20.96 (4.14)</td>
<td>73.28 (13.90)</td>
</tr>
<tr>
<td>No</td>
<td>20</td>
<td>23.60 (5.70)</td>
<td>28.68 (6.73)</td>
<td>20.75 (5.10)</td>
<td>73.11 (16.90)</td>
</tr>
<tr>
<td><strong>Choice in supervisor</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>43</td>
<td><strong>24.09 (5.37)</strong></td>
<td><strong>30.49 (5.34)</strong></td>
<td>21.91 (3.83)</td>
<td><strong>76.66 (12.90)</strong></td>
</tr>
<tr>
<td>No</td>
<td>26</td>
<td><strong>21.12 (6.11)</strong></td>
<td><strong>26.67 (7.32)</strong></td>
<td>19.16 (4.84)</td>
<td><strong>67.38 (15.98)</strong></td>
</tr>
<tr>
<td><strong>Completed agreement</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>39</td>
<td><strong>24.53 (6.24)</strong></td>
<td><strong>31.46 (5.54)</strong></td>
<td>21.87 (4.08)</td>
<td><strong>78.57 (13.56)</strong></td>
</tr>
<tr>
<td>No</td>
<td>30</td>
<td><strong>20.93 (4.49)</strong></td>
<td><strong>25.93 (6.10)</strong></td>
<td>19.59 (4.55)</td>
<td><strong>66.18 (13.29)</strong></td>
</tr>
<tr>
<td><strong>Understanding of confidentiality</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>56</td>
<td>23.18 (5.95)</td>
<td>29.17 (6.57)</td>
<td>21.11 (4.46)</td>
<td>73.81 (14.79)</td>
</tr>
<tr>
<td>No</td>
<td>13</td>
<td>22.08 (5.22)</td>
<td>28.67 (5.61)</td>
<td>20.00 (4.20)</td>
<td>70.67 (14.66)</td>
</tr>
</tbody>
</table>

**Bolded** = significant differences at $p < .05$

It is perhaps not surprising that participants who reported “having some choice in the allocation of clinical supervisor”, had significantly higher MCSS-26© scores. Providing supervisees with choice in the selection of their clinical supervisor is well established as being best practice as it facilitates the development of a strong supervisory working alliance (Dawson et al., 2012; Hyrkas, 2005; Spence et al., 2002). These findings support the study by Edwards et al. (2005) which found that supervisees who were given a choice of supervisor, perceived the quality of that supervision to be higher than did supervisees without choice. The finding that participants with “a completed clinical supervision agreement”, had significantly higher total MCSS-26© scores than those without an agreement, is consistent with recommendations in the clinical supervision literature (Dawson et al., 2012; Fleming, 2012).
The above findings indicate support for three out of the five processes that are currently identified as being important for effective clinical supervision practice (Bradley & Hojer, 2009; Clinical Education and Training Institute, 2011; Queensland Health, 2009). Based on these findings clinical supervision would be effectively supported by providing supervisees with some choice in the selection of their supervisor and ensuring that supervisors and supervisees complete formal supervision agreements at the commencement of the supervision relationship. It is interesting to note that the findings did not link “attendance at clinical supervision training” or “having a clear understanding about the boundaries of confidentiality in the clinical supervision relationship” with clinical supervision efficacy. This finding diverges from the recommendations in the clinical supervision literature (Dawson et al., 2012; Fitzpatrick et al., 2012), however studies have struggled to conclusively demonstrate outcome benefits from supervision training (Kavanagh et al., 2008; Milne et al., 2011).

5.3.3 Research Question 3

What is the relationship between perceptions of effectiveness of clinical supervision and supervisees’ reports of levels of intention to leave?

The Intention to Leave Scale (Abrams et al., 1998) measures a worker’s intention to leave their employer, with greater intention to leave indicated by higher scores. In the current study, respondents’ scores ranged from 1.00 to 5.00 with a mean of 2.75 (SD=0.87).

Two subscales on the MCSS-26© were found to be negatively correlated with lower intention to leave. The higher that staff rated the effectiveness of “Importance/Value of CS”, the lower the score for intention to leave the organization, \( r = -0.32, p = 0.008 \). Higher ratings of “Reflection”, were also associated with lower scores of intention to leave, \( r = -0.28, p=0.022 \). These findings indicate that valuing and receiving clinical supervision, as well as feeling supported to reflect on complex cases during clinical supervision, may be factors that increase retention of allied health workers.

Comparisons on intention to leave were made between the “High Efficacy” group (MCSS-26© total scores >74.7) and the “Low Efficacy” group (MCSS-26© total scores <74.7).
There was a statistically significant difference between the groups for the Intention to Leave scores, $t(63) = 2.13$, $p = .037$. Those in the “High Efficacy” group ($n=28$, $M=2.52$, $SD=.84$) were significantly more likely to report a lower intention to leave than those in the “Low Efficacy” group ($n=37$, $M=2.97$, $SD=.83$). There were no significant differences found between the “Excellence” group ($M=2.56$, $SD=0.74$) and the “below Excellence” group ($M=2.84$, $SD=0.89$), $t(63) = 1.14$, $p = .258$.

The findings from the current study indicate that efficacious clinical supervision is associated with lower intention to leave in allied health workers. These findings support the empirical literature in signaling that strategies that reduce professional isolation and increase supports through mechanisms (including clinical supervision), are important for retaining allied health staff (Lloyd & King, 2001; Scanlan et al., 2010; Stagnitti, Schoo, Dunbar, & Reid, 2006).

5.3.4 Research Question 4

What is the relationship between perceptions of effectiveness of clinical supervision and supervisees’ reports of levels of burnout?

As noted in Chapter 4, the Maslach Burnout Inventory – Human Services Survey (MBI - HSS) was used to operationalise burnout. This scale identifies three components of burnout: Emotional Exhaustion, Depersonalization, and reduced Personal Accomplishment (Maslach & Jackson, 1986; Maslach et al., 1997). Participants’ scores for the MBI – HSS burnout subscales are reported in Table 5.8. Each subscale will be discussed individually below. Also, as noted previously, clinical supervision effectiveness was measured using the MCSS-26© (Winstanley & White, 2011).
### 5.3.4.1 Emotional Exhaustion

The MBI - HSS Emotional Exhaustion subscale measures depletion of psychological resources with higher mean scores indicating higher levels of experienced burnout (Maslach et al., 1997). The range for the Emotional Exhaustion subscale is categorised as, Low: 0 - 16; Moderate: 17 – 26; High: > 27 (Maslach, Jackson, Leiter, Schaufeli, & Schwab, 1986).

In the current study the scores ranged from 0 to 54, with a mean of 22.92 ($SD = 11.93$). The largest group of participants ($n=29$, 40.3%) in this sample of allied health workers, scored in the high range for Emotional Exhaustion. The remainder of participants fell within the moderate range ($n=18$, 25%) and the low range ($n=25$, 34.7%).

The Emotional Exhaustion subscale of the MBI - HSS is considered by many to be the core component of burnout (Houkes, Janssen, de Jonge, & Bakker, 2003; Koeske & Koeske, 1998; Stalker et al., 2007) therefore it is of note that the majority of the total sample ($n=47$, 65.3%) fell within either the moderate or high categories. This level of Emotional Exhaustion is an important finding given that burnout of workers has been consistently linked with worker absenteeism, reduced job satisfaction, low employee morale, intention to leave, reduced effectiveness of treatments, lower quality of care and risk to service sustainability (Edwards & Burnard, 2003; Edwards, Hannigan, Fothergill, & Burnard, 2002; Maslach et al., 1996).

Two associations were identified between effectiveness of clinical supervision and the MBI - HSS Emotional Exhaustion subscale of burnout. Firstly, there was a significant negative
correlation between Emotional Exhaustion and the MCSS-26© subscale of “Finding Time” (a measure of the time available for the supervisee to attend clinical supervision sessions) (Winstanley & White, 2011). Higher scores of Finding Time were correlated with lower scores of Emotional Exhaustion, $r = - .33$, $p=.006$. While this is an interesting finding, it is difficult to draw inferences as a causal determination cannot be made. The finding could mean that supervisees who are granted sufficient time to attend supervision sessions feel more supported and therefore less emotionally exhausted. Instead, the reason for this finding could be that workers who have less demanding workloads feel less emotionally exhausted and also have sufficient time to attend supervision sessions. Another explanation could be that those who value clinical supervision prioritise their work schedule to enable regular clinical supervision attendance which results in them feeling more supported and less emotionally exhausted. Supervision has been recognised as a strategy to increase resilience and enhance well-being (Howard, 2008), and these supervisees’ scores may reflect this derived benefit.

The second association was found between scores of highly efficacious supervision and Emotional Exhaustion. Identification of those scores that were greater than the mean plus one standard deviation for effectiveness of clinical supervision (i.e., being MCSS-26© scores > 85) allowed the creation of a new variable called “CS Excellence”. This allowed comparison between those who perceived their supervision to be highly efficacious with those who did not. The results showed that those in the “CS Excellence” range (n=16, $M=18.13$, $SD =11.22$) had significantly lower mean scores for Emotional Exhaustion than did those “below CS Excellence” range (n=47, $M=25.11$, $SD=11.17$), $t (61) =2.16$, $p=.035$. This finding would support a threshold level for effectiveness of clinical supervision to be met in order to express a demonstrable reduction in Emotional Exhaustion. It has previously been suggested that “demonstrably efficacious” supervision will show benefits such as enhancement of worker well-being (White & Winstanley, 2010, p. 161), however the threshold proposed by the authors was scores greater than the MCSS-26© normative median score (>136 on the Original MCSS-26©). Findings from the current study would suggest that the score level greater than the mean plus one standard deviation would need to be met before benefits to worker well-being would be evident.
5.3.4.2 Depersonalization

The MBI - HSS Depersonalization subscale measures “negative, cynical attitudes and feelings about one’s clients” (Maslach et al., 1986, p.4.) with higher mean scores reflecting higher levels of experienced burnout (Maslach et al., 1996). The ranges for the Depersonalization subscale categorizations are - Low: 0 - 6; Moderate: 7 – 12; High: > 13 (Maslach et al., 1986). In the current study, the Depersonalization subscale was found to be positively correlated with the Emotional Exhaustion subscale, $r = .38$, $p = .001$, which is consistent with recommendations for this scale (Maslach et al., 1986).

Participants’ scores ranged from 0 to 27, with a mean of 3.58 ($SD=5.16$). The majority of respondents ($n=60, 83.3\%$) scored in the low range, with few participants scoring in the moderate ($n=6, 8.3\%$) and high range ($n=6, 8.3\%$).

A number of associations were identified between effectiveness of clinical supervision and Depersonalization. To begin with, there were significant negative correlations between Depersonalization and two of the MCSS-26© subscales; those being “Importance/Value of clinical supervision”, $r = - .29$, $p = .019$ and “Reflection”, $r = - .33$, $p = .007$, (Winstanley & White, 2011). It is perhaps not surprising that supervisees, who valued supervision for improving clinical care, and who perceived their supervision as being effective for reflecting on complex cases, would be less likely to feel negatively about their clients. Receiving opportunities for support and debriefing about the clinical management of complex clients may have enhanced the capacity of allied health professionals to maintain appropriate and respectful professional relationships with their clients. It is also reasonable to assume that these clinicians provided a higher quality of care as the literature recognises the importance of the therapeutic relationship for the effective delivery of health care (Jones & Cutcliffe, 2009).

Another association was found between scores reflecting highly efficacious supervision and Depersonalization. Results showed that participants in the “CS Excellence” range (i.e., MCSS-26© scores > 85) ($n=16, M=1.63, SD= 1.82$) had significantly lower mean scores for Depersonalization than did those in the “below CS Excellence” range ($n=47, M=4.06, SD=5.70$), $t (61) = 2.57$, $p = .013$, although the mean for both these groups fell within the low range of 0 - 6 for this subscale.
There was also a significant difference found between the “Best Practice” group and the “Less than Best Practice” group for the Depersonalization subscale, \( t(70) = 2.30, p = .025 \). Those in the “Best Practice” group (n=21, \( M=1.48, SD=1.29 \)) had significantly lower scores on Depersonalization than did those in the “Less than Best Practice” group (n=51, \( M=4.45, SD=5.87 \)), although, again, the means for both these groups fell within the low range. Interestingly, there were no significant differences found between the “Best Practice” group and the “Less than Best Practice” group for the other two burnout subscales, Emotional Exhaustion and Personal Accomplishment.

5.3.4.3 Personal Accomplishment

The MBI-HSS Personal Accomplishment subscale measures a human service employee’s competence and personal achievement in their work with lower scores indicating higher levels of experienced burnout (Maslach et al., 1997). The subscale is categorised as – Low PA (i.e., High Burnout): 0 - 31; Moderate PS (i.e., moderate burnout): 32 – 38; High PA (i.e., low burnout): > 39 (Maslach et al., 1986).

Respondents’ scores ranged from 11 to 48, with a mean of 37.06 (SD=8.30). The majority of participants 38 (52.8%) scored in the high range for PA (i.e., low burnout), with 18 (25%) in the moderate and 16 (22.2%) in the low range (i.e., High Burnout).

Several associations were identified between effectiveness of clinical supervision and Personal Accomplishment. Firstly, there was a significant positive correlation between Personal Accomplishment and four of the six MCSS-26© subscales, “Importance/Value of clinical supervision”, \( r = -.38, p = .002 \), Trust/Rapport”, \( r = -.31, p = .014 \), “Supervisor Advice/Support”, \( r = -.26, p = .039 \), “Reflection”, \( r = -.30, p = .015 \). Although the subscale of “Improved Care/Skills” failed to reach significance, there was a trend towards significance, \( r = -.24, p = .051 \). These subscales fall across all three MCSS-26© domains pertaining to the three main tasks of clinical supervision. These findings would indicate that when clinical supervision is effective at meeting its broad functions, the worker is more likely to feel that they are competently fulfilling their work goals.

There was a statistically significant difference found between the High Efficacy group (i.e., MCSS© ≥ 74.7, n=28) and the Low Efficacy group (i.e., MCSS© < 74.7, n=35) for the
Personal Accomplishment scores, $t(61) = 2.68, p = .01$. Those in the High Efficacy group ($M=40.54, SD=5.78$) were significantly more likely to report a higher sense of Personal Accomplishment and therefore fall in the low range for burnout (scores $>39$). Conversely, those in the Low Efficacy group ($M=35.14, SD=9.32$) were significantly more likely to have a moderate sense of Personal Accomplishment and therefore fall in the moderate range for burnout (scores $32-38$) (Maslach et al., 1986).

These findings suggest that effective clinical supervision may enhance worker’s sense of Personal Accomplishment and therefore may act as a buffer against burnout.

### 5.3.5 Research Question 5

What are the profession-specific differences in perceived effectiveness of clinical supervision, burnout, and intention to leave?

To determine any profession-specific differences in effectiveness of clinical supervision, burnout, and intent to leave, a series of one-way analyses of variance (ANOVAs) with professional discipline as the between-subjects factor were performed. The small cell size of the professional groups of dietetics, podiatry, psychology, and speech pathology prevented their inclusion in these analyses. Therefore ANOVAs were undertaken comparing the three largest professional groups of occupational therapy, physiotherapy and social work. These results should be interpreted with caution given the small sample size.

#### 5.3.5.1 Profession and effectiveness of clinical supervision

For the total MCSS-26© scores, physiotherapy as a group ($M=60.63, SD=16.07$), differed significantly from the MCSS-26© published norms for allied health ($M=74.7, SD=11.00$), $t(7) = -2.48, p = .042$). There were no significant differences to the normative data for either the occupational therapy group ($M=72.00, SD=12.88$), $t(15) = -.839, p = .415$), or the social work group ($M=79.58, SD=12.00$), $t(23) = 1.99, p = .058$).

Between-profession significant differences were noted for the MCSS-26© total scores, $F(2.45) = 6.63, p = .003$. Follow-up post hoc analyses indicated that the physiotherapy group reported significantly less effective supervision than did the social work group, $p = .004$. No
other pairwise differences were significant. There were statistically significant differences found between the professions on all three MCSS-26© domains and for four of the six MCSS-26© subscales, “Importance/Value of CS”, “Supervisor Advice/Support”, “Improved Care/Skills” and “Reflection”. Descriptive data for these analyses is presented in Table 5.9.

Of the three largest disciplines, social workers and physiotherapists were equally likely to be in the “Best Practice” group, than in the “Less than Best Practice” group (social workers: n=14, 13 respectively; physiotherapists: n=4, 6 respectively). On the other hand, occupational therapists were more likely to be in the “Less than Best Practice” group (n=18) than in the “Best Practice” group (n=4). The differences between the groups marginally failed to reach significance, $\chi^2(2, n=59) = 5.92, p=.052$.

**Table 5-9 Descriptive data (means, with standard deviations in brackets) along with Professional Group differences and comparisons to normative data for the MCSS-26© Total score, Domains and Subscales (Winstanley & White, 2011)**

<table>
<thead>
<tr>
<th>Professional Group</th>
<th>MCSS-26© Total Score</th>
<th>Occupational Therapy</th>
<th>Physiotherapy</th>
<th>Social Work</th>
<th>Normative Data¹</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Score</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational</td>
<td>72.00 (12.88)a</td>
<td>60.63 (16.07)bd</td>
<td>79.58 (12.00)b</td>
<td>74.7 (11.0)bd</td>
<td></td>
</tr>
<tr>
<td>Physiotherapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Work</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normative</td>
<td>22.46 (5.84) a</td>
<td>19.30 (5.68) b</td>
<td>25.12 (5.13) b</td>
<td>23.5 (4.6)</td>
<td></td>
</tr>
<tr>
<td>Restorative</td>
<td>28.75 (5.95) a</td>
<td>23.63 (6.39) b</td>
<td>31.33 (5.60) b</td>
<td>29.7 (5.1)</td>
<td></td>
</tr>
<tr>
<td>Formative</td>
<td>21.00 (3.86) ab</td>
<td>17.10 (4.56) b</td>
<td>22.88 (3.46) bc</td>
<td>21.4 (3.5)</td>
<td></td>
</tr>
<tr>
<td><strong>Domains</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Subscales</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Importance</td>
<td>15.59 (1.97) a</td>
<td>12.60 (4.14) ab</td>
<td>16.64 (2.68) b</td>
<td>15.5 (2.5)</td>
<td></td>
</tr>
<tr>
<td>Finding Time</td>
<td>6.88 (4.30) a</td>
<td>6.70 (2.87) b</td>
<td>8.48 (3.25) c</td>
<td>8.0 (3.1)</td>
<td></td>
</tr>
<tr>
<td>Trust/Rapport</td>
<td>14.13 (3.38) a</td>
<td>11.75 (2.92) b</td>
<td>15.24 (3.67) c</td>
<td>14.7 (3.0)</td>
<td></td>
</tr>
<tr>
<td>Advice/Support</td>
<td>11.90 (3.60) a</td>
<td>11.90 (3.60) b</td>
<td>15.92 (2.65) b</td>
<td>15.1 (2.7)</td>
<td></td>
</tr>
<tr>
<td>Improved Care</td>
<td>11.63 (2.75) a</td>
<td>9.70 (2.67) b</td>
<td>12.72 (2.32) b</td>
<td>12.2 (2.2)</td>
<td></td>
</tr>
<tr>
<td>Reflection</td>
<td>9.38 (1.41) a</td>
<td>7.40 (2.07) ab</td>
<td>10.16 (1.57) b</td>
<td>9.3 (1.8)</td>
<td></td>
</tr>
</tbody>
</table>

Within each row, values with the same superscript are significantly different at p<.05

¹ (Winstanley & White, 2011)
Investigation revealed further differences between the three professions in relation to the variable ‘time’. In a paper published on this research, the following was reported.

“There were significant differences found between the three professions (i.e. social work, occupational therapy and physiotherapy) for the duration of time spent in supervision sessions, ($\chi^2(2) = 16.80; P = .001; n=58$). More social workers attended supervision sessions lasting > 60 min ($n=20$), than <60 min ($n=6$). Conversely, more occupational therapists attended supervision sessions < 60 min ($n=15$), than >60 min ($n=7$), as did physiotherapists ($ns=9$ and 1, respectively). More social workers attended supervision sessions lasting >60 minutes ($n=20$), than <60 minutes ($n=6$). Conversely, more occupational therapists attended supervision sessions of < 60 minutes ($n=15$), than >60 minutes ($n=7$) as did physiotherapists ($ns=9$ and 1, respectively). In relation to the number of supervision sessions attended, there were no significant professional group differences found, ($\chi^2(2)= 3.57; P = .168; n=34$). There were significant differences found between the three professions for total period of time supervision received during career ($\chi^2(2) = 9.44; P = .009; n=60$). More social workers had received supervision for >2 years ($n=18$) than <2 years ($n=9$). Conversely, more occupational therapists had received supervision for <2 years ($n=12$) than >2 years ($n=11$) as did physiotherapists ($ns=9$ and 1, respectively).”

(Saxby, Wilson, & Newcombe, 2015, pp. 478-479)

As mentioned earlier in this chapter, findings from the current study suggest that clinical supervision sessions of at least 60 minutes contribute to higher supervision effectiveness scores, as does greater period of time supervision is received during a career.

Authors have reported that clinical supervision practices vary between the individual allied health professional groups (Bogo et al., 2011; Dawson et al., 2012). For example, Dawson and colleagues (2012) suggest that certain professions, such as social workers and psychologists, may as a result of their specific undergraduate training, have greater capability for managing the support function within the supervision relationship. Given the broad acceptance that operating as a competent clinical supervisor requires a specific set
of skills (e.g., Health Workforce Australia, 2010; Siggins Miller Consultants, 2012), this view, in combination with the generally longer duration sessions, may explain the higher effectiveness score responses from the profession of social work.

To further explore the between-profession significant differences for MCSS-26© scores, the data was subjected to analysis of covariance (ANCOVA) with time spent in supervision sessions (< 60 minutes compared with > 60 minutes) as the covariate. This was included to investigate whether the group differences could be accounted for by time differences rather than by profession. With time as a covariate, the professional differences on MCSS-26© scores were now not significant, $F(2, 43) = 2.37, p = .106$. That is, the previously found significant differences on MCSS-26© scores appear to be more related to time rather than being discipline specific. This result does reduce the influence of the professional group and underscores the importance of ensuring clinicians have a minimum time of sixty minutes available to attend clinical supervision sessions.

The professions did not differ significantly on their scores on the three MBI-HSS subscales (Maslach et al., 1986). There were also no profession-specific differences found for intention to leave.

### 5.4 Summary

This chapter has discussed the findings from allied health workers’ responses to the online survey. It described the supervision arrangements and procedures, as well as attendance at supervision training. The majority of participants in this study had received supervision for at least six months, more than five times, at their supervisor’s location, had sessions between 45 and 60 minutes, and had choice in selection of their supervisor. Most participants reported receiving supervision from a same-profession supervisor, having attended supervision training, and having completed supervision agreements.

The findings revealed that, overall, participants perceived their clinical supervision to be effective with the total mean score meeting the published efficacy threshold (Winstanley & White, 2011). Even so, variations in the MCSS-26© scores indicated the need for further analyses to determine whether specific aspects of clinical supervision practice were linked to higher levels of effectiveness. The variable “time” was found to be significantly and
positively associated with effectiveness in relation to length of supervision session, number of sessions and total period supervision had been received. In addition, three procedural tasks, identified as “receiving clinical supervision”, “having some choice in the allocation of clinical supervisor”, and “having a completed clinical supervision agreement”, were established as being linked to increased supervision effectiveness. An unexpected finding was the lack of association between training and clinical supervision efficacy. There were significant differences between the professional groups in terms of clinical supervision effectiveness and length of supervision sessions. However, subsequent analysis indicated that length of supervision session had a stronger association with clinical supervision efficacy, than did professional group differences. Lower levels of burnout and lower levels of intention to leave were found to be the associated with higher MCSS-26© total scores and selected MCSS-26© subscales.

These findings support the study’s hypotheses. That is, effective clinical supervision was negatively correlated with intent to leave and with burnout. Also, those receiving effective clinical supervision, as identified by those in the “Best practice group”, did report higher levels of professional development, guidance and support for their professional practice, as measured by the MCSS-26© total scores, than those receiving ineffective clinical supervision, as identified by those in the “Less that best practice group”.

These results from Study 1 are important as they highlight enablers for effective clinical supervision practice. However, on their own, they do not explain the unexpected findings, such as why supervision training was not linked to effectiveness, or why some professional groups were more likely to attend supervision sessions lasting more than one hour. The paper now moves on to describe the findings from Study 2, the focus groups. The purpose of the focus groups is to help further explain the findings from Study 1, through exploration of individual participant’s experiences of clinical supervision.
6 Focus Group Findings: Supervisors

6.1 Introduction

As noted in the Methodology, focus groups were the selected method of data collection for Study 2 of this mixed methods research (Chapter 4). Five focus groups were convened, with separate sessions held for supervisors and supervisees. This current chapter presents findings from the two supervisor focus groups, which comprised eleven participants, across six different allied health professions. The two focus groups were held on different dates, a few days apart, and across different locations within the health service. As discussed (Chapter 4), data were recorded via the use of paper-based field notes and audio recordings.

The researcher facilitated the focus groups and had an assistant attend as an additional note taker. Each group was mapped out regarding participant’s seating locations. Participants were allocated a pseudonym to identify where quotes had originated. All data was stored separately in password protected files. A referencing style was used for the reporting of responses. The first letter of the name identifies the participant’s focus group. Names beginning with “A” indicate that those participants originated from focus group one, and names beginning with “B” originate from focus group two.

As this chapter presents supervisor focus group responses, questions 1, 2 and 5 will be addressed in turn. The next chapter, which addresses findings from the three supervisee focus groups, will attend to all five questions. This chapter details the supervisors’ perceptions of their supervisory experiences. Supervisors’ views are provided first as they provide a useful lens through which to consider the experience of supervisees (see Chapter 7).

As mentioned, participants in the two supervisor focus groups derived from six different professional groups. As the numbers representing some professional groups were quite small, it was important to consider the protection of participant’s confidentiality. Therefore professional groups are only named if they occur in participant’s direct quotes, where participants have specifically identified their profession, or where the discussion relates to professional differences and the change would result in a loss of meaning. This decision
has been taken as it is not considered to compromise anonymity and has been made in order to preserve the integrity of the participant’s voices.

Most supervisor participants were born in Australia and three derived from Canada, Serbia and Zimbabwe. There were no participants who reported that they identified as Aboriginal or as Torres Strait Islander Australian. Participants’ ages ranged between 33 and 61 years with the majority (n=7, 63.64%) being more than 41 years. The majority were employed at HP5 level (n=6, 54.55%) with the remainder being HP4⁵. Their years of experience in their current health profession ranged between 7 and 30 with the majority having more than 15 years (n=6, 54.55%). Participants’ years of experience in providing clinical supervision ranged between 6 months and 12 years with the majority (n=7, 63.64%) having five or more years experience.

Different group dynamics and processes were observed in the two supervisor focus groups. Focus group one was the smaller group, comprising four participants from three different professions. Overall, this group provided very positive responses about the supervision process (for example, “It gives some validation to supervision by the organization actually rolling out this program”, Asha) and the perceived outcomes from supervision (for example, “My experience is that it does make a difference”, Amelia). The participants of focus group one also spoke about their satisfaction with the focus group process itself, especially the opportunity it provided for them to hear from other supervisors and to be able to express their thoughts, feelings and experiences around supervision (for example, “It’s good that it encompasses all of us.”, Amelia). Focus group two comprised seven participants from four different professions, with two members being more outspoken than the rest. While all participants described a high level of commitment to supervision, a number of supervisors were critical of the organisation’s lack of investment in the supervision process (for example, “If they want us to be providing this supervision, they really need to provide the structure and support to enable this to happen”, Baqir) and other aspects relating to difficulties providing supervision (for example, “The clinical

⁵ Allied health clinicians working in Queensland public health services are usually employed under the Health Practitioner’s Certified Agreement (Queensland Industrial Relations Commission, 2011) which details various Health Practitioner (HP) levels. The majority of allied health practitioners employed in the study location were working at the HP 4 level, which indicates a “High” level practitioner.
demands are so great that we just don’t have the hours” Brionne). Despite this, all participants were keen to provide examples of perceived supervision outcomes (for example, “I think there are some big positives and I’m really enjoying providing supervision” Bibi). Even though strong emotions were expressed by some participants during the focus groups, this did not appear to prevent other participants from providing their unique individual experiences.

6.2 Context

In order for the participants’ comments to convey the fullest meaning, it is useful to reflect on the work context (see Introduction, Chapter 1, for details of the study location context). In brief, community allied health professionals, while members of a multi-disciplinary team, frequently visit clients on their own, without the presence of another health care worker. Most visits occur in the client’s homes which comprise a variety of living situations. Prior to the home visit, the clinician may have limited information about the person’s health and social circumstances, and little or no knowledge of other people who might be sharing the accommodation. Unlike their hospital counterparts, community allied health professionals constantly operate in an unpredictable environment, with no immediate backup present.

Contextual factors in the study location may have influenced the operation of the clinical supervision practice. The most striking contextual factor was the major transformation that was occurring in the workplace at the time of the study. To sum up, health care workers were being affected by changes linked to the Commonwealth health reforms (Commonwealth of Australia, 2010; Council of Australian Governments, 2008) which led to a transformation of models of service delivery, governance structures and funding arrangements. These significant and rapid changes were amplified by events occurring at the State Government level, which resulted in a high degree of job insecurity within the public sector workforce (ABC Local Radio Brisbane, 2012; Brace, 2013). Supervisors described allied health workers as being change-weary as a result of the broader organisational context at the time. A supervisor described the general state of the workforce, as follows,
“There were lots of changes and people were really caught up trying to adjust to the new system…It was an interesting time for it all (clinical supervision) to begin with the changes.” Alice

It is against this backdrop that the following quotes resonate.

6.3 Findings

The focus groups began with supervisors being asked to describe their experiences of clinical supervision, be they positive or negative experiences. Supervisors were also asked to identify any factors that impacted the effectiveness of their supervision, including any profession-specific differences. The following results have been organised under the themes emerging from each research question.

6.3.1 Research Question 1

1. How do allied health staff who receive clinical supervision rate the effectiveness of that clinical supervision in providing support, professional development and guidance for their professional practice?

Overall, supervisors spoke positively about the outcomes of supervision. Supervisors were of the view that clinical supervision had led to improved professional growth in supervisees, resulting in increased supervisee confidence and competence with clinical decision-making. Supervisees were seen as feeling less isolation and having increased capacity to adapt to the changing work environment, as a result of supervision. In addition, supervisors reported supervision had led to supervisees having increased morale and increased job satisfaction. However, a small number of supervisors, who were new to supervision practice, expressed doubts about their capacity to deliver effective supervision (discussed under Question 2). Despite some expressing a lack of confidence, overall, supervisors reported that providing supervision had led to a greater sense of satisfaction in their own roles.

“I think being able to support someone who is less experienced to be able to develop the skills and see them grow is a rewarding thing to be part of.” Bibi
Several themes emerged from the responses, including improved knowledge, clinical governance, enhanced well-being and adaptation to stress. These themes are discussed next.

6.3.1.1 Improved knowledge and skills for clinical practice

Supervisors assisted supervisee learning through the provision of advice about clinical case management, as well as guidance about professional roles and responsibilities. Responses indicated that supervisors taught supervisees new clinical skills, including technical skills, and sought feedback about their subsequent application to practice. Supervisors described a range of strategies they used including critical reflection, problem-based learning, case consultation and client record review.

Participants’ responses illustrated that first and foremost supervision was utilised by supervisees for case consultation. The examples supervisors provided demonstrated that this consultation was sought for complex and challenging casework. Supervisors described assisting their supervisees to plan and implement individualised therapeutic solutions to support vulnerable clients. They also spoke about how the receipt of supervision assisted to reduce the practice isolation experienced by allied health workers. Supervisors understood the importance of being available to provide guidance and expertise to supervisees seeking advice about clinical decision-making.

“The feeling that you have a reference point when you’re dealing with a really complex situation, that you can actually go to someone to discuss it, that’s a big thing”. Amelia

Feedback from supervisors illustrated their use of critical reflective processes for more in-depth case discussion which facilitated practice improvement through consideration of alternative perspectives on assessments and interventions. This process was seen as particularly valuable in situations when the worker had reached a point where they were feeling stuck, not knowing which way to proceed.

“It’s an opportunity just to put it out there isn’t it, for two people then to take a look at it and be a bit more objective, rather than have that dialogue.”
within yourself which gets you nowhere sometimes, especially as you say (names previous speaker), with really complex situations, and complex personalities, where you get to the point that you can’t see it for yourself, you get caught up in it all, you get absorbed in it all, that’s where it’s very valuable.” Alice

Supervisors’ responses indicated that supervisee learning routinely occurred in supervision sessions. This is consistent with Kadushin’s conceptualisation of supervision as having an educational function, as well as administrative and support functions. Empirical findings have provided support for the educational outcomes associated with supervision practice (Bogo et al., 2011; Mor Barak et al., 2009). Supervision provided the place and expertise for allied health workers to develop and extend their skills to address real time clinical problems.

“The kind of problem solving that in supervision, you know, is needed, hearing about interesting clinical cases and like helping to brain storm and problem solve and find solutions to try for those people”. Bella

Many reported that supervision afforded opportunities for reassurance about individual’s practice. Comments such as the one below suggest that supervision led to increased competence for this supervised allied health workforce.

“For the staff that are accessing supervision, their level of confidence in terms of making decisions has increased because they have the opportunity to bring things to supervision to discuss them and reflect on them and look at a whole range of options”. Amelia

Supervisors’ comments suggested that they understood that clinical supervision was more than facilitating learning and that being a supervisor included fulfilling the role of providing clinical governance and this is discussed next.
6.3.1.2 Clinical governance

Supervisors were aware that they had a responsibility to appraise and monitor the standard of their supervisees’ clinical practice to ensure that the practices were safe. For example, one supervisor stated that the services being provided had the potential to impact health service recipients’ lives in both positive and negative ways. This supervisor was of the view that professional supervision provided a mechanism to minimise the risk of harm to health service recipients and described how she explained the need for supervision to her supervisees.

“Yes, you’re a professional and as a professional you need to continue to do this …It’s not like you’re doing some sort of job that really doesn’t have a lot of impact out there.” Asha

Some supervisors described tasks they included in supervision sessions to appraise their supervisees’ interventions and determine whether professional and ethical standards were being met. Supervisors described reviewing client records and case presentations for their assessments about professional standards of practice.

“I’ve made it really clear that because it is clinical supervision, I expect them to bring a case each time to discuss”. Babette

Direct observation of supervisees’ clinical interventions was not reported by supervisors. It is generally recommended that clinical supervision encompass a range of activities including direct observation of clinical practice or use of role plays, (Queensland Government, 2008; Roche et al., 2007). This omission of direct observation may indicate a potential clinical risk for the organisation as appraisal appeared to largely rely on supervisee self-report.

The above examples show how supervision provided a valuable contribution to the professional development of supervisees. However a few supervisors reported that, initially, not all supervisees perceived that supervision would be beneficial. They said that, when supervision first commenced, a small number of supervisees had not understood the need for clinical supervision. These supervisees exhibited reluctance to engage in the supervision process. Supervisors reiterated that these views were in the minority and
changed over time as supervisees came to recognise how supervision could lead to improved practice.

“I think with some people who aren’t used to supervision, I think that when the penny drops for them, when they have a valued experience in supervision, where they go ‘Oh! that’s really useful, I’m going to try that’ and then it works and they go ‘Wow’, and that’s what supervision is about.”

Asha

As well as the maintenance of practice standards and improvement in clinical knowledge and skills, supervisors described other benefits they believed that supervisees derived from supervision. Supervisors spoke about supervisees obtaining support during supervision sessions to enable them to effectively adapt to the changing work environment.

6.3.1.3 Enhanced well-being and adaption to work stress

The support function of supervision came to the fore in this study, perhaps reflecting the specific organisational context and the challenging day-to-day environment faced by allied health workers. Responses from supervisors demonstrated that they understood the impact of the workplace context on their supervisees and responded with the provision of support. Supervisors’ feedback illustrated the role played by supervision in enhancing supervisees’ capacity to adapt to their changing workplace.

“At the moment there is massive change and stress and certain sections of the service in particular are really struggling. You know, there are lots of issues. In a way I don’t think it’s surprising that supervisees would be needing a high level of support at the moment, particularly the way the organization is.” Baqir

Supervisors offered encouragement, reassurance and affirmation about the worker’s capacity to provide high quality clinical services while constantly negotiating the changing occupational milieu. A supervisor’s sensitive description provided below, paints a picture
of the level of stress in the workplace during this period of time and how supervisors could be seen as being effective role models of ‘survival’.

“It’s almost a feeling of crisis when people first hear about the enormous changes and how are we going to cope and I think it can be helpful to look at people who are a bit down the track in that and think well you can survive and just be able to put that in some sort of perspective”. Alice

There was broad agreement from supervisors that the provision of clinical supervision contributed to clinician well-being by reducing stress. Supervisors’ comments demonstrated an understanding of how debriefing, support and attention to self-care were helpful for supervisees. They described how supervisees had sought support to stay intact and maintain their integrity and sense of wholeness and this allowed them to continue to work effectively in very demanding roles.

“and not being destroyed by some of this, and it really can happen, I mean we have some really complex clients … constantly presenting with chronic suicidality and managing them effectively and, you know, we have really experienced, all our discipline are HP4s ⁶, but still you get enough of them or you get one who is really difficult or a complaint is made, that’s when supervision … really comes to the fore then I think”. Asha

Not all examples of support sought by supervisees related directly to clinical practice. Supervisors provided advice and support to supervisees for improved management of their workload, and for difficulties they experienced within their teams or with other employees. Having access to a supervisor for consultation and brainstorming solutions to workplace issues assisted in reducing the associated stress experienced by allied health workers. One of the supervisors recalled providing support and advocacy to a clinician who had disclosed experiences of workplace bullying by a senior staff member. The supervisor reported that she thought her advocacy for the supervisee had led to the satisfactory

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⁶ Allied health clinicians working in Queensland public health services are usually employed under the Health Practitioner’s Certified Agreement (Queensland Industrial Relations Commission, 2011) which details various Health Practitioner (HP) levels. The majority of allied health practitioners employed in the study location were working at the HP 4 level, which indicates a “High” level practitioner.
resolution of this complex matter. At the same time, the supervisor recalled difficulties she experienced due to the lack of formalised support and communication pathways for clinical supervisors.

“\textit{I had one situation where the issue my supervisee brought to supervision was that she was being bullied by her team leader. Without the help of … (names senior staff member), how stuck was I going to be with that?}”

\textit{Baqir}

By effectively decreasing supervisee stress and increasing supervisee sense of well-being, supervisors reported that supervision contributed to increased supervisee moral and job satisfaction. In the example below, the supervisor linked the concept of reduced worker stress with reduced intention to leave.

“\textit{Giving that supervisee the confidence to either decline further services if need be, to refer on, to talk to the team, to be assertive with other health practitioners who may be getting caught up in all this angst about the client. I think that’s a very valuable part in keeping that morale within a team. Keeping your … (profession named), you know, still wanting to do the job”}. \textit{Asha}

As well as providing direct support to supervisees, there was evidence that supervisors attempted to mitigate the potential negative flow-on effects of worker stress to clients. A supervisor suggested that improved worker morale contributed to a higher quality of service delivery. This observation is consistent with findings in the empirical literature that link job satisfaction with quality of care and patient satisfaction (Hawes, 2009; Koivu et al., 2012b). Responses indicated that supervisors helped supervisees to refocus on the core business of delivering quality health care services during this time of organisational upheaval.

“\textit{It takes up a lot of your thinking and it did around that time and the clinical work, yes, at that time, it kind of took a sideways roll at different times}
when people were feeling the changes were so enormous in their working lives. And that can get a bit lost really, can’t it. I mean it’s the real work, it’s the reason we are all here.” Alice

Despite several identified barriers to the provision of effective supervision (discussed later in this chapter), participants offered unsolicited feedback about how their supervisor role had increased their job satisfaction. Through the provision of supervision, they had gained a rich and gratifying experience that enhanced their sense of purpose in the workplace. Supervisors also identified the learning opportunities that came with providing supervision to their work colleagues.

“I’ve found it a really positive experience. When you leave after you have spent time with someone, you both come out feeling really positive and you have both learnt something from that experience.” Aria

In a review of studies of care-giving professions, Stalker et al (2007) found that workers can have high job satisfaction from providing services even when experiencing work stress and work overload. The authors suggested that workers who have a commitment to the overall purpose of their work, and feel they are contributing to assist others, may experience a buffering effect from the work stress, allowing them to maintain high job satisfaction. Supervisors’ responses in the current study would appear to support this finding.

6.3.1.4 Summary

To sum up, supervisors were overwhelming positive about the introduction of supervision. Their statements indicated that overall, the supervision they were providing to supervisees afforded guidance, professional development and support for supervisees’ professional practice. Supervisors’ responses described observation of professional growth and learning in supervisees, and increased supervisee confidence and competence with clinical decision-making. They also reported observing supervisees’ enhanced capacity to adapt to the changing work environment. Other changes that supervisors described as being an effect of clinical supervision included reduced isolation and increased morale. Supervisors also perceived that supervision had led to increased job satisfaction and
decreased intention to leave in supervisees. Supervisors were committed to the supervision process and reported that supervision had made their roles more interesting and satisfying. In all, responses from these supervisors indicated that, in large part, effective delivery of clinical supervision had occurred. At the same time, supervisors were able to identify barriers that they felt impacted the effectiveness of clinical supervision and these will be discussed under Question Two.

6.3.2 Research Question 2

What factors affect the perceived effectiveness of clinical supervision in providing support, professional development and guidance for supervisees’ professional practice?

Overall, supervisors were united in what they saw as the key factors that impacted both positively and negatively on the effectiveness of clinical supervision. Two major elements were perceived to have had a positive impact. First, supervisors spoke about the importance of facilitating a supervisory relationship that was experienced as being “safe” for supervisees. Supervisors reported that, within a safe supervision relationship, supervisees were more open to disclosing areas of their practice that required development, and more open to receiving feedback. Secondly, supervisors reported that the structured clinical supervision processes and documents provided by the organisation had afforded a framework that supported effective clinical supervision practice. Supervisors said that supervision templates guided supervision content, kept participants on task and assisted with making sessions time-efficient. These areas will be discussed in more detail below. Attention will then be directed to the factors perceived to have had a negative influence on the effectiveness of clinical supervision.

6.3.2.1 Positive Factors

6.3.2.2 “Safe” Supervision Relationship

Supervisors described the importance of establishing a safe supervision relationship based on trust. They explained that the supervision relationship took time to establish and allowing supervisee choice in the selection of their supervisor facilitated a trusting environment. Supervisors understood that effective supervision required supervisors to
demonstrate to their supervisees that they were approachable, non-judgmental, and flexible in their style. In particular, supervisors recognised the need to reassure supervisees that the information shared in supervision sessions would not be disclosed outside of that sphere, apart from exceptional circumstances that both parties clearly understood. Trust between the supervisor and supervisee was considered to be of paramount importance for learning to take place.

“If they feel safe, with what you’re talking about, it stays inside that room and also feels safe with you, that they can talk about these things and they’re not being judged …. I guess that’s the biggest issue.” Aria

The importance of safety and trust was a consistent theme expressed by supervisors. They reported that a minimum period of time was required to create a climate of trust. This was the case even when the supervisor and supervisee had previously known each other prior to the commencement of supervision. Supervisors said that this was because the supervisory relationship was a different type of relationship to negotiate. When trust was established, supervisees felt secure and able to ask for support. In this environment supervisees also felt safe enough to identify their learning needs and try new ways of practicing. This meant that supervisory relationships took time to reach an optimal level of functioning. In the example below, a supervisor reflected on the supervisory relationships that had commenced six months earlier.

“I think we were only getting to that really safe space now. Where I think everyone’s being a lot more open than initially because it’s difficult when you’re working with your peers and if you feel like your work is being judged or being potentially criticized, so that’s been the difficult thing for us.” Aria

The same supervisor described the sense of vulnerability associated with exposing one’s practice, especially if this was not a familiar task. This supervisor was of a professional discipline where supervision had not generally taken place outside of their undergraduate training and therefore it was a relatively new workplace experience for them.
“I think that if I had to bring my chart in and put it down on the table in front of somebody, I’d be really nervous about it too. It would take me a while to feel okay, that’s okay.” Aria

As well as allowing time for the supervisory relationship to become established, supervisors noted the importance of being flexible in order to cater for individual needs. Staff required different ways of engaging in supervision depending upon their experience and developmental levels.

“I think that each individual will have a different approach. With senior staff you can’t just say bring me a case because it doesn’t always work.” Barbara

Supervisors’ comments indicated that the majority invested time, energy and enthusiasm into their supervisory roles. By and large, supervisors were not in management positions and were providing supervision to their frontline colleagues. Perhaps the sensitivity and flexibility with which they approached this task reflected their location in the workforce and ability to be able to relate to the struggles and situations of their supervisees.

“I’ve written a very first session, even before we have the supervision, so we’ve gotten to know each other, and really established who I am, where I’ve come from, all my experiences and found out what their experiences are because I believe both these people are on the same HP level as me but different years of experience.” Babette

Participants’ reports about the importance of an effective supervisory relationship are in concert with findings in the empirical clinical supervision literature. It is widely accepted that the quality of the supervision relationship is critical for supervision to be effective (e.g. Bambling, 2000; Ellis, 2010; Kilminster & Jolly, 2000). As reported in previous studies, being approachable and respectful, in the context of providing a safe place for reflection on practice, are all elements found to contribute to effective supervision relationships (Bradley & Hojer, 2009; Kavanagh et al., 2003; Knudsen et al., 2008). There is also agreement that a period of time is required for the development of an effective supervisory relationship (Dawson et al., 2012; Kavanagh et al., 2008), however it is unclear about the duration of
time required. For example, some suggest a minimum of three to five sessions (Hytkas et al., 2006), while others suggest that six sessions are necessary prior to data collection (Edwards et al., 2005). Responses from supervisors in this study would indicate that six sessions are required before attempting to measure effectiveness. The period of time may vary depending on the supervisee’s level of familiarity with clinical supervision, with those who are new to the practice requiring more time (detailed under Question 5).

6.3.2.3 Structured Clinical Supervision Framework

Within the study location, the organisation had developed a framework to support the clinical supervision practice for allied health staff. In brief, the framework comprised a clinical supervision procedure, a suite of templates including supervision agreement, supervision training, supervisor recruitment and selection process, supervisor and supervisee matching process, and on-line data collection of supervision activity (detailed in the Introduction, Chapter 1).

Formal structured supervision documents were described as useful for clarifying the supervision tasks, particularly for those supervisors and supervisees who were new to supervision practice. In particular, supervisors spoke favourably about the supervision agreement which was used for documenting supervision expectations, roles and responsibilities. The agreement operated as a working document that could be modified to adapt to supervisee’s changing learning needs.

“We negotiated it in the first session when we met to do the initial agreement and the agreement is really flexible, so you can build in additional supports, other people that they might need to go to for expertise in certain areas.” Amelia

Supervisors’ responses demonstrated how supervision documents assisted to make supervision practice more efficient and effective by providing structure, purpose and flow to the supervision activity. A structured process enabled sessions to be goal-focused and time-efficient. Supervision agreements also provided delineation between operational and clinical supervision responsibilities, by clearly articulating the goals of clinical supervision.
A few supervisors found the completed agreement particularly helpful when operational managers tried to influence what was occurring in clinical supervision sessions.

“I think having that written agreement has been very helpful in those situations in terms of referring back to the learning goals and trying to separate that. That has been a challenge in one situation.” Aria

The finding that written clinical supervision agreements enhanced effectiveness is consistent with recommendations in the clinical supervision empirical literature (Heath, Ward, Littledale, & Poole, 2013; Strong et al., 2004). Providing supervision training for supervisees and supervisors is also recommended practice (Kavanagh et al., 2008), however, within the focus groups, there was little comment about the value of the supervision training that had been provided by the organisation. Those few supervisors who did express a view were of mixed opinions. One supervisor saw that training provided a framework for understanding the different supervisory roles and responsibilities in the supervision relationship.

“I think that having a training program around supervision for supervisees and supervisors is really important, really important, because it sets a framework. This is what supervision is about, these are the expectations, all of those concerns around confidentiality, they’re all addressed.” Asha

This supervisor further illustrated this point by contrasting her experience of supervising staff who had attended supervision training, with those who had not.

“They (supervisees who have attended supervision training) have an idea of structure around supervision, they know what to bring in supervision, they know how the process works. Those supervision sessions I find are a lot more structured, easier and more productive than supervision with someone who hasn’t (attended training).” Asha

In contrast, another supervisor thought she had gained little through attending the training, explaining that the content had focused on the model of supervision and what supervisees needed to know but did not teach supervision skills.
“It doesn’t really teach people how to be a clinical supervisor:” Brionne

Despite the lack of consensus about the training component, some were of the view that there were less effective outcomes from supervision sessions with supervisees who had little knowledge of the structure and process of supervision.

“It’s more challenging because what is brought to supervision is very vague. It’s very difficult to tease out what is going on ….. Supervisees who have had the training, they know what supervision is about, they know the purpose of supervision.” Asha

In relation to the supervision framework, some supervisors had expressed praise for the way the organisation had implemented the process for matching supervisees with supervisors. The organisation had adopted a formal process for interviewing and selecting supervisors and matching supervisors and supervisees (detailed in Chapter 1). The purpose of this process was to facilitate supervisee choice in the selection of their clinical supervisor. A supervisor noted that the minimum number of breakdowns in supervisory arrangements was evidence of the effectiveness of the matching process.

Although there were positive comments about the matching process, responses also indicated that characteristics of the organisation’s allied health workforce presented specific dilemmas. The allied health workforce had a relatively flat structure and this introduced challenges for those involved in the matching of supervisors and supervisees.

“I think that when we were matching people; that was a big challenge for our discipline. We have a lot of people that work on HP4 level that are highly experienced and quite closely matched in terms of their capabilities and things, so that’s been a huge challenge for us as a discipline.” Amelia

Another difficulty that emerged from the focus group discussions was the issue of having a sufficient pool of clinical supervisors to meet ongoing needs. The shortage of clinical supervisors was most evident in the professions with small numbers and less senior allied
health staff. This difficulty had led to some staff being left without access to clinical supervisors. A supervisor from one of the smaller professions explained,

“"It’s still a bit of an issue for us because there’s not that big a pool to choose from .... For myself, I don’t have a clinical supervisor now because she’s left for maternity leave and we haven’t had a replacement. They’re the kind of difficulties that come up. And if I left, for example, I don’t know what other options would be out there either (for her supervisees).” Aria

The organisation provided health services to a large geographical area covering both metropolitan and regional areas. Consequently, allied health workers were geographically dispersed amongst the service facilities to meet the needs of this population. This characteristic led to additional challenges as practical logistics needed to be taken into account when matching supervisors and supervisees.

“"That’s one of the big challenges for us as well. You really need to prioritise supervision but there’s travel times and other barriers and negotiating central meeting points and those sorts of things. I think it’s more the logistical things that get in the way in terms of the geography of our district.” Amelia

Despite the challenges presented by the workforce structure and the service’s geographical spread, supervisors supported the organisation’s process for supervisee choice in the selection of their supervisor. The empirical clinical supervision literature notes the importance of supervisee choice as it is thought to contribute to the quality of the supervisory alliance (Dawson et al., 2013b; Spence et al., 2002).

In addition to the geographical challenges and supervisor shortages noted above, supervisors identified key factors that they perceived had a negative impact on clinical supervision effectiveness. These factors are presented next.
6.3.2.4 Barriers to Effective Supervision

As previously mentioned, there was consensus from supervisors about what constituted as barriers to clinical supervision effectiveness. They identified three key elements that they believed were impediments. First, although supervisors were committed to providing supervision, they struggled to find the time, in their already busy schedules, to provide supervision. Second, supervisors lacked access to professional support and further supervision training. Third, these challenges led some supervisors to question the organisation’s approach and level of overall commitment to supervision. These key barriers to clinical supervision effectiveness are detailed next.

6.3.2.5 Lack of dedicated supervision time

Time was consistently raised by supervisors as a significant barrier to providing effective clinical supervision. Despite organisational guidelines stating recommended frequencies for clinical supervision, it seemed that supervision generally ended up well down the list of priorities when there were competing agendas. In the context of a time-poor environment, supervisors, with their own busy caseloads and other work commitments struggled to find the time to provide supervision. This created tension and frustration for supervisors, trying to appropriately balance their work responsibilities. Several supervisors voiced discontent that the organisation had added the supervisor role to their positions, without any apparent reduction in their existing workloads. Many supervisors said they simply couldn’t provide supervision as frequently as was prescribed (usually one hour a month per supervisee) and were unable to comply with the time commitment being asked of them.

“I’m not able to provide the required time, I don’t even quite remember how often we are meant to supervise but it’s not happening…. (General discussion in the group about required supervision frequency)...It depends on the individual, some are needing more and some are needing less. Because I’ve got four (supervisees) and we are flat out and I don’t. Sometimes it’s three months, sometimes it’s not three months”. Brionne

Due to time pressures, some supervisors reported having to prioritise which supervisees most needed supervision. Supervisors, who worked part-time, experienced additional challenges.
“I tend to prioritise. I’ll be supervising some with similar levels of experience and they’re the ones that I sort of leave it up to, to determine. I’ll kind of touch base and we’ll have more informal chats about specific issues rather than the formal but I’ll save the formal supervision time for new grads or less experienced staff who tend to be the ones I approach. And I’m also part-time so that adds another dimension.” Bibi

In general, more experienced clinicians were receiving less frequent supervision than was prescribed, with some facing large gaps of time between sessions. Other supervisors managed the time deficit by providing ‘ad hoc’ supervision, that is, they only provided it when requested by supervisees. This means that rather than supervision being a proactive regular professional support strategy, supervision occurred as a reactive response to emergent needs. Examples suggested that these times usually occurred when supervisees were seeking urgent advice to address active clinical problems.

During further discussion about time pressures, it emerged that many supervisors had received confusing and inconsistent messages from the organisation’s management about how they were to prioritise time to provide supervision. For example, some supervisors said that they were subtly discouraged from attending to their supervision tasks by their operational managers. For instance, one supervisor reported that, when she was about to head out to provide supervision, her manager told her that her clinical activity was below the anticipated level. It appeared that the frequency of supervision practice was partly dependent on the varied approaches taken by operational managers. In most cases, clinical supervision appeared to be on the losing end when time was scarce.

“I think there has been acceptance that it is important but not going that step further. Like you should do it, but see all these clients.” Bibi

A few supervisors had developed strategies to deliver supervision within existing time pressures; however the focus was on meeting the more pressing needs of new graduates.
“We have a share arrangement for our new grads. Myself and one of the other senior occupational therapists share the supervision to provide the weekly support to new supervisees.” Bibi

One supervisor from a smaller professional group described a contrasting experience where supervision practice seemed independent of time pressures. The supervisor described a culture where supervision was an expected activity and one which was monitored for compliance.

“We might be a bit unique. Ours is mandated by Queensland Health, that is it has to be completed, it’s part of our PAD (Performance and Appraisal Plan)”. Brooklyn

This community supervisor was atypical as her profession received oversight from a hospital discipline director who had clear governance processes in place for clinical supervision practices. Despite this exception, the vast majority of supervisors reported that they struggled to find the time to provide supervision within their existing workloads. The challenge of finding time for supervision is well documented as being a major barrier to effective clinical supervision practice (Dawson et al., 2012; Lloyd et al., 2014; White & Winstanley, 2006) and the current study reflects this frequent finding.

6.3.2.6 Lack of professional support for Supervisors

Although clinical supervisors were providing supervision to staff members, the vast majority did not receive their own supervision of their supervisory responsibilities. Out of the total eleven supervisors only three regularly received supervision. Supervisors reported the need for their own professional support, including access to clinical supervision and supervisor training. Many supervisors were new to the task and lacked confidence in their ability to provide quality supervision. They felt isolated in the role and most were unable to identify a position in the organisation where they could seek advice when faced with supervision dilemmas. Without their own supervisor, many expressed a sense of powerlessness about what do when presented with challenging situations in supervision. A supervisor who had not previously provided clinical supervision commented,
“Sometimes I do need advice, and they’re not appropriate things to go to management about and you don’t want to have to go to your discipline director about that but you’d just like a little bit of advice, like have I done this appropriately, is there a better way”. Aria

The situation was complicated by the confidential nature of clinical supervision arrangements. Generally, information provided in supervision sessions was kept confidential to facilitate a relationship of trust and open communication between the supervisor and the supervisee. Supervisors spoke of their supervisory relationships with high regard and were keen to maintain the trust and confidentiality they had established. The commitment to confidentiality of information disclosed in supervision sessions was also documented in the supervision agreement. Therefore many of those without their own supervisors felt they had nowhere to go for advice, except if there was a clear breach of the code of conduct where disclosure was expected. This meant that many supervisors managed difficult situations on their own.

“It’s really difficult for me to go to someone about issues that come up within a session because you might know who I’m talking about or you might know what I’m talking about and I don’t know how to get around that….To have someone as a sounding board because you know if an issue came up, someone that you can safely talk to”. Aria

Hence, supervisors often felt they had to manage complex and potentially contentious matters on their own. Some supervisors expressed the view that they had been placed in supervisory roles without adequate support and were tentatively holding together the whole supervision program. Their comments portrayed a heavy weight of responsibility as well as a sense of abandonment by the organisation’s management.

“I guess the fact that we do not have a supervisor for ourselves. The buck stops with us at the moment. So that is a very big problem…… the word disorganization springs to mind. And lack of back up. It’s been spawned but there’s nothing behind that. It’s like we’ve been cast on the winds but
there’s nothing behind that. It’s up to us as individuals to make it happen rather than the organization supporting us.” Brionne

As supervisors were often operating independently and without support, they encountered other challenges. Several supervisors said that they felt a huge sense of responsibility in providing advice to their supervisees. A supervisor identified a particular situation where an urgent response was needed from a supervisee and yet there was insufficient time available for the supervisor to obtain all the relevant information on which to base her decision-making. The supervisor said that, at the time, she had been unsure of whether she had provided the most appropriate advice, as explained below,

“In the spur of the moment, having that situation plonked in front of me, with no knowledge of it and no knowledge of the people involved, really tricky to give advice and she (the supervisee) rushed off and implemented it. And there were a lot of other things going on and it’s a huge responsibility but it went really well and when we met up again, I said, “Look I’m really sorry I didn’t have time to think it all through. Have you thought about this, this and that?” Brionne

Also adding,

“There were time pressures. In that situation, she (the supervisee) had to make a decision right now. We couldn’t waffle around. It was about something that needed to be decided fairly smartly. It really made me freak, I needed to think about it more and give it a bit more time.” Brionne

This supervisor’s comments raised further discussion in the focus group about supervisor accountability. This appeared to be a “grey area” area with supervisors expressing their uncertainty and vulnerability in this area of their supervision practice.

“It does raise issues of accountability in supervisors … Like if, as a supervisor, we’ve given incorrect direction, how responsible or how accountable are we for that? …. So where is that line of accountability in this organization? Where is the support for the supervisors if we do get ourselves into a tricky situation in terms of accountability?” Baqir
No one in the focus groups seemed to have an answer to these types of questions or even an idea of how they might find the answers. This topic led to a broader discussion about clinical governance and risk management. The supervisors reported that there was no defined communication pathway for them to flag trends or patterns being raised in supervision that might affect service delivery. Indeed, it seemed that these supervisors represented a potentially valuable resource for the early detection of clinician-identified matters that could negatively or positively affect the quality or delivery of services. Unfortunately the organisation had no formalised communication process for management to tap into this prospective wealth of knowledge. Yet, supervisors were keen to have a formalised communication pathway in place.

“I would like more access to our team leaders to discuss certain issues that come up or have a regular catch up with my managers about things that come up in supervision that would be service related so I could feed back.” Bella

A number of supervisors spoke about another area of concern where they felt their supervisory role was potentially exposing them to risks to their well-being. By providing clinical supervision some supervisors expressed concern that they were being exposed to potential negative psychological and emotional consequences. At the time of this study, supervisors were providing reassurance and support to supervisees for the same dramatic changes that they themselves were being affected by. Without their own formal support mechanisms, such as having access to their own supervision, supervisors felt vulnerable due to the repeated exposure to the events occurring at that time. Some wondered where they could seek out an appropriate avenue for debriefing, where they could make sense of their own experiences, and those that were impacting on their supervisees. A supervisor expressed it this way,

“The changes have a big impact I think, the system changes, it’s had a big impact on how secure people feel, about their whole working life…. just coping with that myself but also hearing the supervisees, how they were impacted by that. It takes up a lot of your thinking….It’s a bit of a balancing act sometimes, coping with your own feelings about what it’s all going to mean and then hearing, hearing that, in supervision”. Alice
A couple of supervisors spoke about their awareness of how their own responses could negatively impact on their interactions with their supervisees. For example, a supervisor spoke about the difficulties of providing the most appropriate advice while being caught up in the same dilemmas as her supervisees.

“We are all in the same boat and it kind of makes it hard to act as an impartial advisor. It’s sort of difficult”. Brionne

It is widely recognised that being exposed to recurring indirect trauma experiences can be detrimental to worker well-being (Tosone, Nuttman-Shwartz, & Stephens, 2012). Supervision is one mechanism considered to be appropriate for lessening this impact (Ling et al., 2014; Tosone et al., 2012), however it was not generally available to the supervisors in the study location. All supervisors expressed a strong need to have access to their own supervisor for support with their supervisory responsibilities. Some felt so concerned that they had considered purchasing their own external supervision.

“I think it makes a big difference. I’ve previously had a little bit of supervision but that was better than what I’m having now, which is nothing. I’ve even been trying to source external supervision but the cost is just beyond me and I just can’t afford it. So that is really annoying, that I should have to even be thinking of that, because really it’s something that the organization should be providing.” Baqir

Another supervisor had attempted to access peer supervision,

“When we started out and I felt that I was sinking, even as a stopgap I did try to have peer supervision but because of time pressures, that didn’t eventuate but I thought that even that would have helped.” Barbara

The provision of professional support for supervisors was identified as a critical issue, not only for the wellbeing of the supervisors themselves but for the sustainability of the whole supervision program. Many felt that it was the supervisors themselves who were tentatively holding the whole supervision program together, rather than it being driven by
management. Enabling support for supervisors was viewed as a key determinant in the ongoing success or failure of the supervision program.

In contrast to all other supervisors, two supervisors described very structured processes for their clinical supervision which was monitored and driven by discipline directors located within the hospital.

“You have to do it (receive supervision) every month. You have to get it ticked off as a supervisor and a supervisee and it goes to the Discipline Director every month…. I feel that we have it so different in (profession named) because it does work.” Brooklyn

Notwithstanding the above, the vast majority of supervisors in the focus groups did not receive any supervision of their supervisory role and they perceived this to be a barrier to their capacity to deliver effective clinical supervision. The provision of supervision for supervisor’s supervisory responsibilities is considered to be best practice as supervisor’s advice can shape the care that is delivered to clients (Butterworth et al., 2008; Cassedy, Epling, Williamson, & Harvey, 2011). Therefore, supervisors’ expressed need for the receipt of this professional support is consistent with recommended clinical supervision practice.

As well as access to supervision, supervisors said they needed more supervisor training to enhance their level of knowledge and skills. This topic is addressed next.

6.3.2.7 Lack of Supervisor training

Supervisors had attended a two-day clinical supervision training workshop prior to the implementation of supervision practice. The training had been targeted at an introductory level of knowledge and skills and had been simultaneously delivered to supervisors and supervisees alike. One supervisor reported that the training had not taught her any skills to prepare her for the supervisor role, saying that it had been targeted at providing knowledge about the supervision model and procedures. Many supervisors, who were very experienced clinicians, reported that providing clinical supervision was a new role for them and they did not feel confident that they had sufficient knowledge and skills to
competently fulfil the role. Some supervisors had not experienced supervision previously in their working careers, either as supervisors or supervisees, and this contributed to their lack of knowledge in this area. Supervisors said that supervisor education needed to be provided at regular intervals, not just once, especially given their newness to the role. In addition, comments from physiotherapy and occupational therapy supervisors suggested that some profession-specific educational needs existed. (This topic will be discussed under Question 5.). Several supervisors reported that the lack of supervisor training had been detrimental to the quality of the supervision they could provide.

“A lot of people have said, ‘not all of us have come into this role as supervisor feeling totally confident, educated, informed, experienced at it and often supervisors need ongoing education.” Baqir

It is broadly acknowledged in the clinical supervision literature that providing clinical supervision requires a different skill-set to those of the health practitioner role (Health Workforce Australia, 2010; Siggins Miller Consultants, 2012), therefore the identified need for clinical supervision training is not a surprising finding. The lack of time to provide supervision and lack of access to supervisor professional support and training led many supervisors to question the organisation’s approach and level of overall commitment to clinical supervision. This topic is discussed next.

6.3.2.8 Lack of consistent organisational approach and commitment to clinical supervision

Supervisors were of the view that there was a lack of ongoing commitment to clinical supervision by the organisation. While there appeared to have been an initial investment of resources leading up to the implementation of clinical supervision for allied health staff, Supervisors’ comments suggested that there was a reduced focus on its ongoing delivery. This left many supervisors feeling abandoned by the organisation and questioning the sincerity of managers’ commitment to the principles of clinical supervision. Supervisors also wondered how this loss of momentum would impact the ongoing sustainability of the clinical supervision practice.
Supervisors consistently spoke about fragmented and inconsistent supervision practices occurring within the health service. These practices included infrequent supervision, lack of support for supervisors and the absence of a clear process for the ongoing recruitment of supervisors. Supervisors also described how some managers and staff did not comprehend the purpose of supervision, nor did they have an understanding or full knowledge of supervision processes. In many cases, allied health workers were managed by nurses who were not familiar with clinical supervision practice and did not understand how it differed from operational supervision. Several supervisors described having to negotiate awkward circumstances with supervisees’ operational managers, as the example below shows,

“I’ve had one situation with a supervisee, where I felt the operational manager from the program area where this person belonged, had not really understood the process of supervision very well and had actually asked to be a part of some of the sessions and had tried to influence the agenda of the supervisee”. Amelia

In this environment, supervisors struggled to negotiate their way between the requirements of the clinical supervision procedures and the varied managerial perspectives of clinical supervision.

“I’ve had a few cases where other staff have come to me about someone that I am supervising, with an issue and that is then tricky. Well, you’re kind of thinking, well it’s not my job, I’m not their Line Manager.” Baqir

The examples presented above indicated a general lack of shared consensus within the organisation about the clinical supervision purpose, process, roles, responsibilities and its relationship to operational management. Some supervisors believed that part of the problem was that the organisation had failed to appoint a dedicated position to lead and oversee the ongoing implementation of clinical supervision, resulting in the breakdown and fragmentation of processes. This topic drew strong discussion, including condemnation from a number of supervisors.
“At the moment there is no one to do the recruitment of supervisors, the ongoing education, training and support of supervisors… and well yes, “how can you get a supervisor?” There is no process in place and there is no one to drive it and direct it.” Baqir

While systemic modifications had taken place within the organisation, including the introduction of a clinical supervision procedure, documentation, data capture and supervision education, consistent clinical supervision practices for allied health workers had not been realised. It seemed that there had been commitment and support from some areas of management for the introduction of clinical supervision but this commitment had not been shared by all. Perhaps one explanation may have been that formalised clinical supervision had been introduced for allied health workers but had not been adopted by other clinical staff, such as nursing. In order for supervision to be embedded as part of standard practice for allied health professionals, it needed to be valued by the whole organisation in order for managers and staff to fully support the implemented practice. Supervisors’ responses would indicate that this had not been accomplished. Previous studies have shown that lack of organisational support impedes activities including clinical supervision (Kavanagh et al., 2003; Lloyd et al., 2014). The lack of an organisation-wide commitment to supervision for allied health workers appears to have been a significant feature within the current study and served as a barrier to effective clinical supervision practice.

In summary, supervisors were united in their reports of what factors they perceived to impact the effectiveness of clinical supervision. These factors included the establishment of a safe supervision relationship, facilitated by allowing sufficient time for its development, as well as supervisee choice in the selection of their supervisor. The other major element was having a structured clinical supervision framework that included a supervision agreement. There were mixed views about the value of attendance at clinical supervision training. The factors supervisors perceived to have had a negative influence on clinical supervision effectiveness comprised lack of dedicated time to provide supervision, lack of available experienced clinical supervisors, lack of professional support and education for supervisors, and lack of a shared organisational commitment to clinical supervision. Despite these identified barriers to effective supervision, it was apparent from supervisors’ feedback that they had worked hard to continue to deliver supervision to their supervisees.
Their comments suggested that it was their enthusiasm and commitment that had been the critical component driving the supervision practice forward in the health service.

“We know that supervision is important and that’s why we are all committed to it and it’s whether the organisation shows that commitment.”

Baqir

6.3.3 Research Question 5

What are the profession-specific differences in the perceived effectiveness of clinical supervision, reports of levels of intention to leave, and reports of levels of burnout?

By and large, supervisors’ responses indicated that there were many more commonalities than differences between the various professional groups and this is consistent with findings in the empirical literature (Bogo et al., 2011; Crow, 2008). A few differences emerged early in the supervisor focus group discussions and these differences were evident, not only to the researcher, but also to the focus group participants. One such difference was the concept of supervision being seen as “Owned” or “Alien” by the profession and this perspective seemed to parallel with whether supervision was viewed as integral, or separate, to clinical practice. Another area of divergence related to supervisors’ levels of confidence in providing emotional support to their supervisees during supervision sessions. Some participants suggested that there may be additional supervision training requirements for this professional group. This topic is discussed next.

6.3.3.1 Clinical Supervision: Owned or Alien

Certain professions within the focus groups tended to be clumped together around either end of a polarized position between, on one hand, having a proud sense of ownership of clinical supervision practice within their professional history and culture, and on the other hand, perceiving clinical supervision as new and somewhat alien to their professional identity. It has previously been noted in the clinical supervision literature that professions place different values on supervision depending on their professional traditions (Bogo et al., 2011). In the supervisor focus groups, participants from the professions of psychology
and social work proudly described clinical supervision as being “embedded” within their education and professional history.

“With psychology, it’s always been part and parcel of what we do”. Asha

And,

“I think that supervision is very heavily embedded in our education and in the social work culture, it really is”. Alice

Participants from other professional groups did not embrace supervision with the same sense of ownership or familiarity. In some cases, it was portrayed as a novel practice.

“For us it’s quite a new concept because we didn’t have it.” Aria

These differences between the professions were picked up by the participants themselves. For example, a psychologist commented on this distinction quite early in the group session, saying,

“It’s (clinical supervision) embedded in the culture”. (later adding) “I don’t know if it’s the same with you; you’re a physiotherapist, oh, you’re a speech pathologist.” Asha

The other participant responded,

“No, it’s not (the same)”. Aria

A social worker followed up with the comment,

“Yes, I think it definitely is a cultural thing, with our discipline certainly.”

Amelia

The professions that did not see clinical supervision as being a usual part of their culture sometimes found it more difficult to grasp the supervision principles and required a longer lead-in time to establish supervision processes, as the following comment conveys.

“We’ve only been going for a bit over six months so it’s not very long at all” (and) “knowing what the process is too, because it’s really weird for us.” Aria
Another difference between supervisors of different professional groups regarded the location of clinical supervision in relation to their clinical practice. Again, the professions of psychology and social work had similar perceptions and viewed clinical supervision as an essential component of the therapeutic intervention, not aside from it, as the following comments show.

“For social work, we see it as part of our clinical time and I guess that’s always been the culture of our profession” and “it’s a very intricate and necessary part of how we provide a service”. Amelia

For these supervisors, clinical supervision was woven into the very fabric of the clinical intervention, with the clinical supervisor playing an active, but invisible role in their modus operandi. This view was in contrast to a supervisor from one of the other professional groups who described the practice of clinical supervision as sitting outside of the clinical transaction.

“Making people feel okay, that it’s okay to take time out from your clinical work to come to supervision”. Aria

Therefore, for some supervisors, supervision was seen as being separate to clinical work, almost as an extra-curriculum undertaking, but a task that had become sanctioned as legitimate work activity. This dichotomy of viewing supervision as either central or external to core clinical services has also been found amongst mental health nurses (White & Winstanley, 2010). It could be argued that clinical supervision is central to clinical practice as it is recognised as playing a key role in enabling the provision of quality health care services (Australian Commission on Safety and Quality in Health Care, September, 2011; Fitzpatrick et al., 2012).

6.3.3.2 Profession-specific training needs

Feedback from supervisors indicated that most felt comfortable in their ability to provide effective supervision although they were keen to obtain additional skills to support their supervisory role. However, a small number of supervisors reported that they did not feel confident in their capacity to provide the emotional support aspect of supervision for their
supervisees. These supervisors came from professions traditionally tasked with providing practical therapy interventions. Despite their desire to assist, they identified this skill deficit and seemed unable to draw from any theory or evidence-driven knowledge base in their response to identified support needs from supervisees. For example, an occupational therapy supervisor said that when her supervisees identified problems related to work stress, she was unsure whether her responses had been helpful and she had difficulty coming up with strategies to enhance supervisee coping.

“We talk about it for that hour but I don’t know how it would help them, other than for that hour that we talk about it.” Bella

Likewise, physiotherapy supervisors reported struggling to provide their supervisees with emotional support.

“I get some really tricky things and a lot of it is not clinical. I won’t say political but professional coping with what’s going on, with the changes and a lot of it is emotional support and that’s not something that we are trained in as such.” Brionne

Interestingly, physiotherapy supervisors were aware that these skills were present in some of their supervisor colleagues and that this difference represented an educational need for their profession.

“Well physios aren’t necessarily like that so right from the very beginning, I was like, oh my God, what I am going to do in these sessions…..As a physio, I’m not into counselling greatly so if they are wanting to come to me with cry baby problems, it’s going to be really hard for me to deal with that as opposed to straight on clinical things so maybe that depends on the discipline. Maybe there’s going to have to be upskilling in some areas.” Barbara

In contrast, psychology and social work supervisors described being proactive in accessing the support needs of their supervisees and responding confidently in these situations. Profession-specific training needs have not been identified in clinical
supervision training studies (Fleming, 2012; Kavanagh et al., 2008), although authors have suggested that certain professions, such as social workers and psychologists, may be better equipped to manage the support aspects of the supervision role, due to their undergraduate training style and discipline knowledge (Dawson et al., 2012). The supervisors in the current study recognised clear differences between the professions regarding the capacity to meet this supervision function.

“I’m wondering, is it a discipline specific thing here. Certainly from a social work point of view… It’s not at all unexpected to me that the support function would be used.” Babette

As previously stated, overall there were many more similarities than differences between the professional groups. One area of difference that emerged was that focus group participants that derived from social work and psychology professions viewed supervision as being embedded within their professional traditional and integral to clinical practice. Participants from other professions represented within the groups saw supervision as a new and less familiar activity that sat outside of clinical practice. Professions where clinical supervision was a new practice may have required a longer lead-in time to become familiar and comfortable with supervision practice. Another area of divergence related to supervisors’ level of competency in providing emotional support to supervisees during supervision. While participants from social work and psychology professions did not view this task as being any more challenging than the other supervision tasks, some participants from other professions reported a lack of confidence in this area and suggested this was a skill deficit for their professional group. This would suggest that providing additional targeted supervisor training may be of benefit to some professional groups to ensure optimal standards of clinical supervision practice.

The professional differences outlined in this section may have had an influence on the effectiveness of clinical supervision. Due to the small participant numbers of some professions, there is no attempt to claim that these differences are representative of particular professional groups in the study population; however the differences highlight patterns that deserve consideration in future supervision studies of allied health workers. As noted earlier, overwhelmingly, there were many more similarities than differences between the professional groups.
6.4 Conclusion

This chapter has presented the findings from the two supervisor focus groups. Overall, responses indicated that clinical supervision provided supervisees with support, professional development and guidance for their professional practice. In the main, supervisors viewed the implementation of clinical supervision positively, highlighting aspects they thought worked for and against clinical supervision effectiveness. Effective clinical supervision was associated with qualities of respect and trust in the supervision relationship, having a process whereby supervisees were involved in the selection of their supervisor and having a structured framework of guidelines and documents. Some supervisors spoke passionately about their connection with supervision, with the practice being embedded in their professional cultures and histories. For a small number of supervisors, the practice of supervision was new and a less familiar part of their professional tradition. Still, even these supervisors had come to see the value in clinical supervision practice and were supportive of its ongoing delivery.

Nonetheless, supervisors expressed their frustration with the barriers to effective clinical supervision. These areas included the lack of time for providing supervision, lack of sufficient pool of clinical supervisors, and lack of support and education for supervisors. In large part, these difficulties seemed to stem from the organisation’s absence of a shared commitment to clinical supervision. Allied health managers had attempted to implement a supervision model, guided by evidence-based practice, for the allied health workforce. The organisation had adopted a clinical supervision framework comprising procedure, processes and templates to support the implementation. Somehow, allied health management had failed to achieve organisation-wide buy-in for clinical supervision practice. Consequently there was inconsistency of implementation, including lack of sufficient endorsement from all areas of management and lack of governance to monitor and drive supervision practice within the organisation. This presented problems for supervisors trying to deliver clinical supervision in a best-practice and standardised way.

Despite the shortcomings noted above, clinical supervision was seen to be a valuable activity for providing professional development, support and clinical governance for allied health workers. Supervisors reported that supervisees had increased confidence in clinical
decision-making, increased skills and knowledge, increased morale and decreased intention to leave. At the same time, supervisors reported that supervision served as a mechanism to reduce clinical risk, maintain professional standards of practice and maintain and sustain the workforce. Supervisors reported that providing supervision made their roles more satisfying. To sum up, it is likely that the resounding commitment from clinical supervisors played a significant role in the success of the clinical supervision within this health service organisation.

As previously mentioned, supervisors’ views provide a useful lens through which to consider the experience of supervisees. In the next chapter, the findings from the supervisee focus groups will be presented.
7 Focus Group Findings:

7.1 Introduction

The previous chapter presented the findings from the supervisor focus groups which provided a backdrop against which to consider the experience of supervisees. This current chapter presents the findings from the three supervisee focus groups, which comprised fifteen participants, across five different allied health professions. Two of the three focus groups were held on different dates, a few days apart, and across two different locations within the health service. As discussed (Chapter 4), data were recorded via the use of paper-based field notes and audio recordings. The researcher facilitated the focus groups and had an assistant attend as an additional note taker.

Most supervisee participants were born in Australia and one derived from India. One participant identified as Aboriginal and/or Torres Strait Islander Australian. Participants’ ages ranged between 27 and 62 years with the majority (n=8, 53.33%) being more than 37 years. The majority were employed at HP4\(^7\) level (n=9, 60%) with the remainder being HP3 (n=5, 33.33%) and HP5 (n=1, 6.66%). Their years of experience in their current health profession ranged between 1 and 27, with the majority having more than 10 (n=8, 53.33%). Participants had received clinical supervision between 1 and 12 times under the structured model, with the majority (n=9, 60%) receiving four or more sessions. Most reported (n=13, 86.67%) that they had been given choice in the selection of their supervisor.

The focus groups have been numbered continuously; therefore the groups presented in this chapter are groups 3, 4 and 5. Consistent with the supervisor focus group findings, a referencing style has been adopted to identify where quotes have originated. Pseudonyms have been used; the first letter of the name identifies the participant’s focus group. For

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\(^7\) Allied health clinicians working in Queensland public health services are usually employed under the Health Practitioner’s Certified Agreement (Queensland Industrial Relations Commission, 2011) which details various Health Practitioner (HP) levels. The majority of allied health practitioners employed in the study location were working at the HP 4 level, which indicates a “High” level practitioner.
example, names beginning with “C” indicate that those participants originated from the third focus group, and names beginning with “D” originate from the fourth focus group.

As mentioned in the previous chapter, since the numbers representing some professional groups were quite small, it has been important to consider the protection of participant’s anonymity. Therefore, in most cases, professional groups have not been specified. Exceptions have been made in some direct quotes, where participants have specifically identified their profession, and the change would have resulted in a loss of meaning. This decision has been taken as it is not considered to compromise anonymity and has been made in order to preserve the integrity of the participants’ voices.

Different group dynamics and processes were observed in the supervisee focus groups. Focus Group Three was the most diverse professionally of all the groups, with four participants from four professions; however they engaged equably in the discussion. The prevailing atmosphere in this group was one of general consensus about the positive benefits of clinical supervision for supervisees, yet there was room for participants to highlight particular areas of interest or concern. For example, one participant was keen to emphasize the role that supervision played in risk minimisation for clients (“a supervisor might see some signs there and follow up if they see some danger signs” Caitlin). Focus Group Four was the smallest and quietest group with three participants from two professions. Nevertheless, the participants were keen to express their views and the discussion was equally spread between them. Individual differences emerged that demonstrated variations in the application of clinical supervision practice (e.g., “It would help if we did talk about the stressors in the job and the strategies and how I’m coping. I think that would help, it’s just that we don’t seem to have the time” Dahlia). Focus Group Five was the largest group with eight participants, yet it was the most professionally homogenous group with six of the eight attendees being from one discipline. Two participants of different professions dominated the early part of the session, describing positive outcomes from their clinical supervision experiences. However as the session progressed, the discussion broadened and alternative views emerged (for example, “I would have to say I don’t feel better because I feel like I’ve used all that time which has now put me behind” Eleanor). The broad range of opinions and areas raised in the focus groups indicated that participants felt comfortable enough to express their individual views.
7.2 Context

As highlighted in the previous chapter, the context of the study location is of particular significance due to the rapid and considerable changes that occurred in the organisation at the time of data collection. This dominant background of change permeated the focus group discussions. A supervisee described her experience of the situation this way, “Holy hell, we’ve got to basically buckle up and hold on because it’s just going so fast and it’s a roller coaster ride”. Daisy

As in the supervisor focus groups, the supervisee focus groups began with the researcher asking the supervisees to describe their experiences of clinical supervision, be they positive or negative. Supervisees were also asked to identify any factors that impacted the effectiveness of supervision. Finally, supervisees were asked whether they thought supervision made any difference to how they coped with stress in their job or how they felt about where they worked. The results have been organised under the themes emerging from each of the five research questions.

7.3 Findings

7.3.1 Research Question 1

How do allied health staff who receive clinical supervision rate the effectiveness of that clinical supervision in providing support, professional development and guidance for their professional practice?

In the main, supervisees were overwhelmingly positive about their supervision experiences. They identified supervision sessions as a place to seek advice about complex casework. Supervisees reported that supervision sessions provided a rare opportunity to receive feedback about their practice. They perceived that supervision had led to improved clinical practice through opportunities for reflection on their interventions. Supervisees also described using supervision sessions to debrief, obtain support and process the emotional responses to their client interactions. At times, supervisees utilised supervision to seek support and strategies to adjust to the rapidly changing work environment. These areas are detailed in the following sections under the themes of Improved Knowledge, Quality Assurance, and Professional Support.
7.3.1.1 Improved knowledge, skills and use of self

Supervisees frequently sought consultation during supervision. They described the use of problem-based learning to explore and find solutions for real-time clinical and work related issues. In this way, it seemed that supervision facilitated just-in-time learning by providing access to expertise and knowledge that was immediately relevant and transferable to the practice setting. Through supervision, supervisees were enabled to effectively extend their existing knowledge and skill base. As a result, supervisees reported having increased confidence in their clinical competence to meet the needs of their clients.

“I think that probably it changes what you do with the next client and from a clinical point of view, and for future outcomes, and from a business point of view, it improves our efficiency next time around.” Chloe

Supervisees reported that supervision assisted with the management of complex clinical casework. They described how advice gained during supervision enabled them to work more effectively with clients who had challenging and multifaceted needs. At times this led to the adoption of novel solutions for the specific context. Some supervisees articulated how the change in their practice translated into improved clinical outcomes.

“I sought supervision because there were a lot of behavioural issues emerging from a gentleman who had had a stroke and … he was becoming quite aggressive physically and verbally towards his main carer at home … the supervisor helped me to construct and put in place with the client and family a really formal behaviour management plan and I was really surprised because it actually really worked.” Dakota

Several supervisees described how supervision provided a space to explore their assessments and interventions using reflective practice. This process enabled clinicians to review their clinical reasoning and decision-making and consider the theoretical underpinnings driving their interventions.
“It helps me … really conceptualizing why I’m going to do what I’m going to do. It makes you think more about the theories that you are using rather than kind of just being rote responses. You have more of a chance to think about, no that’s not just something that I’ve made up, it’s based on my skills and my knowledge.” Ella

Supervision facilitated increased understanding of the dynamics operating in the client-worker interaction. Some supervisees reported that reflective practice facilitated awareness-raising about their own role in the health care transaction including individual strengths and challenges. This way they developed an understanding of any factors negatively impacting clinical decision-making and actions.

“My current supervisor has… that excellent ability to be reflective but gently challenge and help me feel safe to explore new territory and also to look at my own weaknesses”. Emma

Supervisees saw this aspect of supervision as particularly useful in complex clinical scenarios. The process enabled new meaning-making which they said led to improved clinical assessments and interventions.

“(My supervisor) was able to identify with me, what might be happening with that client and particularly in reference to some of her challenging behaviours. So I found that very helpful for me because it helped me to put into context things that I was experiencing with that person.” Charlotte

While most supervisees commented favourably about the professional skills they acquired in supervision, one supervisee, Dahlia, saw this aspect as an omission in her supervision sessions. Dahlia said that her supervision was focused on the management of casework, with very little time devoted to facilitating broader learning opportunities such as knowledge and skill development.

“Education wise I don’t think we are covering too much, in terms of looking at different theories or different information about particular aspects of the work.” Dahlia
Bradley and Hojer’s study (2009) noted that some areas have experienced a shift from professional to managerial supervision, with an emphasis on ensuring worker compliance with agency protocols and outcome targets. Despite the current study being located in a large organisation, this was the only example in the focus groups that indicated a slide towards a managerial style supervision. In addition to supervision enhancing their knowledge and skills, supervisees perceived that supervisory review of their practice facilitated the delivery of safe quality care.

7.3.1.2 Quality Assurance – safe practice

Supervisees referred to the value of receiving professional oversight of their practice. Rather than feeling deterred by this aspect of supervision, as has been reported (Lynch & Happell, 2008), supervisees viewed it as an opportunity to properly examine their interventions. They understood that working in their isolated roles in the community increased their level of risk as often there was no other worker available for immediate consultation. Although case review provided some oversight and guidance, supervisees reported that clinical supervision provided them with added reassurance that the services they were providing were safe and effective. In this way, clinical supervision operated as a risk mitigation strategy.

“You can get reassurance about something that you are doing and the way you may be handling things because we are such lone practitioners, we could be doing anything out there and it would take a little while before the problem would catch up with us. (Chuckles) But it’s true. Often you need reassurance about how you are operating….. hopefully a supervisor might see some signs there and follow up if they see some danger signs.” Caitlin

The changing circumstances of the workplace and worker’s roles, plus worker’s isolation, meant that some supervisees were not as confident about their level of knowledge and skills as they would have otherwise been. Receiving feedback in supervision reassured workers that they were performing at the anticipated level. For some, lack of confidence
meant they had to garner courage just to attend supervision. Auspiciously, supervision helped with restoration of allied health workers’ confidence.

“I think it’s really easy to lose that confidence, especially in the current context …. I know that I often would turn up to supervision feeling anxious to an extent about my cases and perhaps that I hadn’t done certain things, or feeling that I had knowledge gaps and so I actually would turn up feeling quite anxious but by the end, would feel a lot better and reaffirmed and supported. I always feel a lot better after I go, even when I don’t want to go.” Eva

Supervisees also believed that having access to supervisory review and reflection on their practice facilitated the delivery of quality care to their clients.

“To be able to have that time to reflect on what you are doing is very important because you are working so fast now and you don’t really have time to do that reflection even though it’s really important. It’s important for the quality of the work.” Daisy

In the community context, health care workers sometimes provided clinical services for the same clients over a period of time; for example, when clients experienced multiple hospital discharges. In these instances, supervision was perceived to be particularly valuable for reducing the risk of overlooking critical elements of care provision.

“Sometimes you can’t see the wood for the trees if you see someone for a really long time. …. You know the client and you tend to dismiss sometimes, some of the things that are going on, but there might be a message there that you’re not picking up on because you’ve got history with them, so I think it is good to talk to someone else” Caitlin

Within the large health bureaucracy supervision sessions were seen as providing a useful reference point for ensuring practice was evidence-based and tailored to meeting client’s needs. Accordingly, it was recognised that supervision kept clinical practice anchored to patient-centred care and prevented bureaucratic priorities detracting from this focus.
“I think it might also prevent you from being too prescriptive in your interventions and starting to see people as not an individual and instead, a pathway.” Ella

In addition to improved quality of care for clients, supervisees perceived supervision as a place to obtain support and advice for work-related matters.

7.3.1.3 Professional Support

Supervisees overwhelmingly experienced supervision as supportive (this topic is discussed further under Question 4). Supervisees described being able to utilise supervision sessions for “debriefing”, to process the emotional responses to their work. This process allowed supervisees to express their feelings and concerns through reflection on any critical events that had left them feeling unsettled. As well as providing a sounding board, supervisors offered advice about effective coping strategies and this enabled supervisees to maintain their effective delivery of health care services.

“Even if it’s just debriefing about something that’s happened and been resolved, it’s just your chance to get it all right in your mind about how maybe you should have done it and what you could have done differently.” Caitlin

Supervisees reported that supervision made a difference to how they coped with workplace challenges. Sometimes this related to team dynamics while other times it was related to the workforce more generally. Supervision was portrayed as effective for buffering workers from the workplace tensions and assisting them to continue to function effectively.

“Morale is really down and things like that so I kind of was finding I was just like sucking all the negativity up really while I was sitting there trying to remain focused on doing a good job … I got some really good strategies from them to just try and just keep my boundaries better and remove myself from that situation.” Dakota
At times, supervision provided opportunity for problem identification and awareness-raising of underlying issues for the allied health worker. Strategies were offered to assist the worker to reduce their stress and better manage the situation and thus prevent disruption to effective service delivery.

“I’ve found it helps me relax, with that issue, for me it’s about teasing apart, what am I stressed about, you know that self awareness stuff so it’s not leaking over into the way I’m managing things and the way I’m responding to people on the phone” Emma.

Support was also sought for a range of workplace matters, including team disharmony, boundary-setting and workload management. Supervisors offered useful guidance and ideas to assist workers to manage these situations

“I had double the caseload and at that particular time (and) my supervisor did give me some strategies to help me cope…. I needed some support in that particular situation. She gave me some strategies which was really helpful.” Edith

In contrast to most, one supervisee, Dahlia, indicated that her supervision sessions were almost entirely devoted to case management. Dahlia said she was left with little time to focus on her own support needs and saw this as a deficit in her supervision.

“I don’t see the supervisor very often, we prioritise the casework and we do talk sometimes about how I emotionally cope with some of the cases but in relation to the casework, rather than any change that is happening within the work environment…. It would help if we did talk about the stressors in the job and the strategies and how I’m coping. I think that would help”. Dahlia

One supervisee’s views on supervision presented a significant divergence to all others. Eleanor reported that she had not found supervision to be a helpful experience; instead,
attributing supervision as a source of increased stress. Eleanor viewed supervision sessions as a loss of productive time in her busy work schedule.

“I would have to say I don’t feel better because I feel like I’ve used all that time which has now put me behind … I would want to get something really good out of it to make up for what I’ve got to do now to juggle.” Eleanor

Another supervisee, Emma, then suggested to Eleanor,

“I can think of other experiences when it hasn’t felt worthwhile, it’s probably because of not getting any need met.” Emma

Eleanor responded with a subtle shift in her position,

“I still have to figure out the need, I’m sure it’s there; I’ve just got to work it all out.” Eleanor

Eleanor had only recently started receiving formal clinical supervision for the first time during a long working career. Managing clinical service delivery for so long without clinical supervision may have explained Eleanor’s struggle to see the need for this activity. It is also possible that Eleanor’s supervisor lacked the expertise to “value-add” to her learning and development, or perhaps the supervision style did not match the Eleanor’s developmental level. While there are a range of possible explanations for this response, further details were not provided in the focus group. However, clearly Eleanor did not find the practice useful and she had been courageous enough to put this opinion forward despite being the only one in her focus group to hold this view.

In summary, the majority of supervisees described supervision as being a positive experience. They perceived that supervision facilitated the development of increased knowledge and skills and, at the same time, supported them to maintain or increase their sense of well-being in the work environment. Responses illustrated that supervision served as a sounding board to communicate concerns and seek strategies to reduce work stress. There were exceptions, for example one supervisor was described as adopting a casework focus without adequately addressing the supervisee’s support needs. In another situation, supervision was not found to be helpful and the supervisee reported that it
increased her level of stress due to the time taken away from casework. Even so, overall responses indicated that supervision enhanced supervisee well-being and increased worker capacity to negotiate the changing work environment, while increasing worker knowledge, skills and confidence and contributing to quality clinical service delivery.

The next section addresses responses to Question 2, about the areas that supervisees saw influencing clinical supervision effectiveness. The factors perceived to have contributed positively to clinical supervision effectiveness will be discussed first.

7.3.2 Research Question 2

What factors affect the perceived effectiveness of clinical supervision in providing support, professional development and guidance for supervisees' professional practice?

Supervisees reported a number of factors that impacted positively on the effectiveness of clinical supervision. These factors comprised three themes, having a safe and trusting supervision relationship with their supervisor, receiving supervision from a same-profession supervisor, and having structured standardised clinical supervision processes.

7.3.2.1 Trust

Supervisees spoke about the importance of having a safe supervisory relationship in order for supervision to be effective. “Trust” was an important ingredient in ensuring the relationship felt safe for the supervisee. While supervisee choice in the selection of their supervisor was not raised, a participant explained the importance of having a trusted supervisor in order to effectively engage in self-reflective processes.

“When talking about what is going on for me personally, that could be impacting on what I am doing professionally …. that’s not always something that feels safe to do with the wrong supervisor. …that willingness to maybe look at what is impacting is always, I think, great, but you’ve got to have that relationship to feel safe.” Emma
In common with supervisor responses, supervisees reported that a period of time was required for the establishment of trust in the supervision relationship. Hence, effectiveness increased when the relationship had become more established and developed to the point where supervisees felt safe enough to ask for advice, sometimes about sensitive matters, and receive feedback without the fear of negative consequences.

“I’m on to my fourth session with my new supervisor and it’s getting there. I’m starting ….. to feel a little more comfortable to talk about specific issues.” Emma

The “fit” between supervisee and supervisor was noted as important, not only for skill level but also for learning and working style. Supervisees added that it was necessary to feel confident with the supervisor’s level of clinical expertise.

“Also you need to respect their practice and if it was someone you didn’t think was actually, you didn’t have a high opinion of their practice, I don’t know what you picked up, that wouldn’t be so good.” Caitlin

7.3.2.2 Same-profession supervisor

There was broad agreement from supervisees that they perceived greater benefits from clinical supervision when their supervisor was of their same profession, rather than from a different profession. This was a widely held view, irrespective of professional group. Reflecting on their experiences, supervisees described how they often utilised clinical supervision to obtain profession-specific expertise. Conversely, when they consulted outside their own profession, supervisees reported being unable to obtain the required clarity of clinical decision-making or the high level of clinical expertise they needed for complex case management.

“I have a lot of respect for my team leader but the reality is, he does not know what to do. … in terms of actually providing clinical supervision, he would be completely ineffective most of the time. Most definitely, I need that discipline-specific supervision.” Daisy
Same-profession supervision was reported to be important for reducing professional isolation that was frequently experienced in the community. It was not unusual for an allied health worker to be the only one of their profession in their service or work location and there were few opportunities to discuss their practice with another worker of their own profession. Within the multidisciplinary teams, same-profession supervision was also reported to be particularly valuable for consolidation of professional identity and clarification of professional boundaries. Some supervisees noted that they had struggled to define their roles prior to receiving guidance in supervision.

“For a long time being the only social worker on my team it was quite easy for me to slip into being a general clinician and I found clinical supervision has made me more accountable to my profession and got me to reflect on why I’m doing it and attaching it back to social work process rather than nursing or psychology.” Elizabeth

Being aware of the changing nature of health service delivery, a supervisee commented that having same-profession clinical supervision would be crucial going into the future because it enabled the identification of distinctive contributions that individual professionals within a multidisciplinary team make to patient outcomes.

“I think that will probably become potentially more important to have that discipline-specific supervision if things like the Calderdale Framework are rolled out in Community, where you’re looking at transdisciplinary skills as well as discipline specific. That recognition of our key areas and our strengths will be really important.” Chloe

While the majority of participants emphasized the importance of having access to same-profession clinical supervisors, a small number also recognised that there was a role for other professions to be intermittent secondary supervisors. This related to ad hoc situations where the nature of the clinical practice required clinicians to have specific knowledge and skills that generally fell outside of those traditionally held by that profession.
“And while it’s (clinical supervision) discipline specific for me, there’s been areas that I’ve raised in my sessions that I would like to work on where’s it’s been identified that there are clinicians in the district who are other disciplines who are highly skilled in those areas.” Chloe

One participant belonging to a very small profession had no option but to access clinical supervision from a different, but related, allied health professional. The supervisee described finding supervision “helpful”, but noted that this arrangement worked because her supervisor had a thorough understanding of her role and functions within the work setting.

As well as having access to a same-profession supervisor, supervisees reported significant benefits from utilising the standardised supervision documents and processes provided within the organisation. These documents and processes formed part of the clinical supervision framework developed by the organisation to support supervisory practice for allied health staff (detailed in Chapter 1). This aspect is discussed next.

7.3.2.3 Structured Clinical Supervision Framework

The clinical supervision framework comprised a number of formalised processes which included:

- Organisational guideline prescribing clinical supervision principles, frequency and duration
- Suite of supervision documents (e.g., Agreement to document roles, responsibilities, learning goals; Log to record supervision activity)
- On-line activity data reporting for time spent in clinical supervision
- Training for both supervisees and supervisors
- Supervisor selection process
- Matching process for allocation of supervisors to supervisees

Participants spoke positively about having a structured approach to clinical supervision as it provided guidance for their practice. They perceived benefits from supervisors and supervisees having clear processes to follow regarding tasks, responsibilities and expectations. The supervision guidelines sanctioned the activity as a valid component of
professional development and quality assurance meaning that time could be allocated to attend supervision sessions.

“You know you’re going to have an opportunity to talk something through, it’s good because with our time pressures it’s actually hard to …. whereas this time is set aside so you know you can do that.” Caitlin

Supervisees commented highly on the benefits they perceived from having standardised supervision templates to document aspects of their supervision arrangements. They highlighted how the supervision agreements contributed to making supervision sessions intention-driven which enabled more effective use of the time.

“I found the fact that there was actually a structure and a policy around supervision, to be very refreshing …. so there’s purpose and structure to what you’re doing, there’s outcomes and there’s goals, timeframes. So you’re not just there having a chat, you’re actually going there with a goal and it’s purposeful.” Emma

One of the principles in the clinical supervision model was that the supervisee took a lead role in articulating their supervision goals, based on their learning needs. Although this process occurred in consultation with the clinical supervisor, with agreement from the discipline director and operational manager, it provided supervisees with a sense of control and ownership within the supervision process.

“I find under the current model that I draft the agenda …... I think that the current Model is driven to a great degree by the supervisee whereas historically maybe it wasn’t. It was more supervisor led.” Chloe

Having a structured supervision process and documented actions contributed to keeping all participants prepared and on task with their supervision responsibilities.

“I’ve learnt over the years that I have to take ownership of that process if I expect to improve my learning experiences …. If I haven’t thought about it
In contrast to the enabling aspects discussed above, supervisees highlighted a number of factors that impacted negatively on the effectiveness of clinical supervision. These factors included lack of time for supervision, lack of access to clinical supervisors and lack of a consistent organisational approach and commitment to clinical supervision. Difficulty finding time to attend supervision sessions was the most frequently highlighted barrier to supervision and this factor, as well as the other individual factors, will be discussed next.

7.3.2.4 Lack of time for supervision

Despite organisational guidelines stating recommended frequencies for supervision (usually monthly), supervision time was not systematically allocated, or protected from the intrusion of other activities. Planned supervision sessions were often slotted in between tightly packed work schedules. Most supervisees reported that lack of time prevented them from accessing supervision as frequently as the guidelines advised.

“I found clinical supervision was very difficult … because of the time constraints ….it is not happening frequently or in a timely manner. It is expected that it should occur every month but that’s not happening ….. In the past year I could do my supervision for four times which is not enough, it was supposed to be for at least 8 to 10 (times).” Edith

Supervisees described the challenge of trying to juggle their need to attend supervision with other competing work commitments. Consequently, supervision activity was often postponed as supervisees struggled to manage their workload within an efficiency driven context. Sometimes supervisees felt obliged to reduce their supervision frequency due to their competing clinical demands. Reducing supervision frequency was done reluctantly as supervisees recognised the valuable outcomes they derived from supervision.

“I’ve just cut it back to bi-monthly because I just don’t think I can afford the time once a month. It’s a shame because I would like to develop my skills
at being supervised. I’m sure I could get a lot out of it but I just can’t really give it the time.” Elizabeth

Supervisees were not only concerned about how to fit supervision in with their own workload; they were also concerned about how their supervisor would manage to take the time out to provide the supervision.

“I still find it quite difficult as a supervisee to allocate that time knowing that my supervisor has her own caseload to deal with and multiple supervisees.” Cadence

Infrequent supervision did not work when supervisees were seeking timely advice, especially when input was required for urgent clinical situations. Sometimes workers sought informal methods of supervision, such as consultation with peers, to fill the void between infrequent supervision sessions.

“I’ve found that informal stuff more beneficial sometimes than the clinical one-on-one because of time constraints, not always available, and when I need assistance, it’s actually right now.” Daisy

A few supervisees questioned whether there was real commitment by management to the provision of supervision, given the competing agenda of service transformation occurring at the time.

“With the changes that are going on …. the focus has been on service delivery and efficiency and productivity of staff and that doesn’t really include time to have one-on-one supervision ….. at the moment there’s no priority set by upper management really to allow time for supervision.” Dakota

Despite the busy work environment, three supervisees reported that they had developed successful strategies to safeguard their supervision time. In these examples, there was evidence of real commitment from both the supervisor and the supervisee to prioritise supervision sessions and ensure they went ahead as planned.
“We (supervisee and supervisor) sit down at the beginning of the year and plot out the twelve months for supervision and book out the rooms.” Adding, “So it’s a commitment, this is the time, we don’t let anything else get in the way”. Emily

“I was worried that it was going to become a lesser priority so I make sure I have it 9 o’clock Monday morning. For me, that’s how I cope, you know, once a month, straight up”. Emma

Although a few supervisees had managed to maintain the frequency of their supervision sessions, overall, most supervisees reported lack of time as a consistent barrier. Another significant barrier to clinical supervision effectiveness was the limited availability of clinical supervisors to meet the need of the number of supervisees.

7.3.2.5 Lack of access to clinical supervisors

Several supervisees spoke about difficulties they had experienced in trying to obtain a clinical supervisor which indicated an overall lack of available experienced clinical supervisors. There appeared to be a number of factors contributing to this shortage, such as the gendered composition of the allied health workforce resulting in work absences for maternity and family leave (Health Professions Council of Australia, 2005), as well as the instability of the workforce around the time of the study (Brace, 2013). The problem appeared to be exacerbated for those in the smaller professional groups due to reduced pool of experienced workers.

“I nominated several people from their bios but the one I was allocated, I had her for three months then she was off on maternity leave, then another one on my list was already on maternity leave and then another one on my list left the position so I haven’t really chased it to be honest.” Dakota

The practice environment introduced another complexity because many supervisees viewed community practice as a specialized area. They believed that clinical supervisors
required community-based experience due to the specific knowledge and skills involved in practicing in this complex and challenging environment. For instance, a supervisee compared her current experience of being supervised by a community supervisor, to a previous time when she had a hospital-based clinical supervisor.

“I was in a community position years ago and they were trying to set up cross supervision between hospital and community OTs and I didn’t have a lot of faith in that process ….. I think the strengths in the current model are you are getting someone who’s experienced in the community which is what I really want”. Chloe

Another supervisee in Chloe’s focus group supported her view about the need for access to skilled community-experienced supervisors and was despondent about the lack of availability.

“Yes, completely different but there isn’t choice out…. there is no one in community who you could approach to be a clinical supervisor….. My ….. (hospital supervisor) doesn’t have as much experience as I do. …. that’s where my confidence in the supervision is that this is someone who’s not had community experience.” Cadence

In contrast to most, a supervisee had intentionally sought supervision from a senior hospital clinician because she needed clinical expertise that was not readily available in the community. This example may have been associated with the service’s changing models of care, with community clinicians being called upon to manage increased acuity of clinical cases that would have previously been resolved within the acute setting and not commonly encountered in the community setting.

“The senior (hospital) clinician, she had really up to date information …..about what I needed to be doing at this end of the community, so the service that that person is now going to receive is more focused and appropriate.” Dakota
Having insufficient time for clinical supervision and lack of available supervisors led some supervisees to query the organisation’s approach to supervision. This topic is addressed next.

7.3.2.6 Lack of a shared organisational approach to clinical supervision

Although supervisees reported benefits from utilising the service’s structured supervision framework and despite the existence of a supervision organisational guideline, supervision processes varied across the organisation. These variations occurred irrespective of the professional discipline of the supervisee. Access to supervision was one noticeable area of variation. For example, some supervisees did not have ongoing supervisor arrangements and there did not appear to be a formal system for the identification or remedy of these gaps.

“Someone who I job share with hasn’t had any because her allocated person, well it didn’t start up straight away and then that person got another position … She hasn't done it at all. So, I've had a year of supervision and she’s had none, so perhaps, that could be a bit more consistent so everyone has the opportunity.” Caitlin

Supervisee’s individual supervision experiences tended to be shaped by the support, or lack thereof, provided by their direct line manager to the supervision process. For this reason, local manager’s actions played a significant role in either driving or stalling critical components of the supervision practice. This indicated that not all managers were equally committed to the introduction of clinical supervision. For example, several supervisees compared and contrasted how their supervision experiences were influenced by different team leaders.

“It depends on the team leader at the time. Like I have had different stages where I've had a really supportive team leader encouraging me ..... That's really the only thing that's made me get into gear to do it.” Chloe

“I agree and I’ve had three team leaders in the time that this first was mentioned to me about becoming a clinical supervisor and yes there was
drive but then that team leader moved on and I’ve had two team leaders since then and it’s just fallen by the wayside.” Cadence

Some supervisees expressed uncertainty about whether there was an identifiable position responsible for leading and coordinating the supervision process. The lack of clear coordination and governance processes for supervision resulted in inefficiencies, such as the organisation’s underutilization of the full pool of potentially available clinical supervisors. Several supervisees expressed disillusionment about the lack of consistency. Cadence’s comments below convey her frustration about the mixed messages and lack of direction she had received regarding supervisor selection procedures.

“The push was, ok we should have some clinical supervisors put in their expression of interest. I did that and then the talk was around, oh yes, we would need to interview you. A year later and I have still not been contacted about an interview, so that whole lack of who’s coordinating it in Community… There is not really anybody driving it.” Cadence

The variations in supervision practices led some focus group respondents to question whether there was genuine commitment from management to advance supervision. As mentioned, clinical supervision had been implemented at the same time that the health service had been engulfed within a transformational climate of rapid change. The massive changes meant that clinical supervision was one among multiple competing agendas. This context may partially explain the lack of managerial commitment to clinical supervision, as the following comment alludes.

“I think it’s not everyone that’s getting clinical supervision... because there’s just so many other priorities and things coming down from upper management at the moment. Supervision just isn’t even in their language.” Dakota

In contrast to many, a small number of supervisees had not experienced inconsistent supervision processes. They welcomed the organisation’s implementation of supervision, viewing it as a genuine attempt to improve the professional support available to staff.
“This particular model … has the support of management and did have from the word go …. so I think that’s a positive, that it’s part of our working culture now.” Charlotte

Another supervisee highlighted how the arrival of clinical supervision seemed paradoxical and incongruent with all the other events that had been occurring within the health care environment.

“I would say it’s the most exciting thing that’s happened in Queensland Health to be honest. The change that it’s made; well everything else is a bit doom and gloom. There’s cuts here and there, and it’s shorter and faster and lesser and this is kind of flying in the face of that pull.” Elizabeth

Supervisees’ differing views about the organisation’s management of supervision mirrored the inconsistencies evident in the supervision processes. In the main, responses indicated an absence of an overall cohesive approach for supervision by both middle and senior management levels. This meant that not all allied health staff had the same access to supervision and potential clinical supervisors were not being utilised. All in all, this deficit resulted in less effective supervision being available to allied health professionals.

7.3.2.7 Supervision Training

In general, supervisees did not actively pursue the topic of supervision training. It was only when training was specifically inquired about that supervisees made any comment. While their views were mixed about the value of training, there was no clear trend evident within the discussions. A couple of supervisees had found the training useful for clarifying the purpose of supervision, as well as the types of activities undertaken in supervision.

“I thought it was very useful the training…..I went there going, ‘I’ll have to train to be a supervisee!’ But I found it really helpful to help me conceptualize other ways for using supervision”. Emma

For others, the training had not been useful. For example, some had experienced a lapse of time between attending the training and the commencement of their clinical supervision.
“I think it was probably too far removed from when it actually started, to put it together for me. It’s hard to really remember the details of the training even.” Elizabeth

As a topic, training did not rate as being important, either in a positive or a negative way for supervisees. The training had been provided prior to the implementation of clinical supervision practice and some allied health workers had experienced a time delay between attending the training and the commencement of their supervision. Information had not been sought from participants about when they had attended training however it is possible that any interval of time may have reduced the perceived impact of the training (Kavanagh et al., 2008).

Unexpectedly, a different topic emerged during the focus groups that had not been anticipated. Several participants drew from their prior experiences of supervision, derived from both within and external to the health service, to compare and contrast with their current supervision experiences. Earlier supervision experiences seemed to provide a measuring stick for participants to determine the value of their present supervision practice. Supervisees also described how their former supervision experiences were used to inform and shape the way they interacted in supervision.

7.3.2.8 Prior experience

A number of supervisees had previously received supervision prior to the formal implementation process. Reflecting on these experiences, they described them as less effective. In general, their earlier supervision experiences lacked clear structure, were not focused on the supervisee’s learning needs and weren’t always experienced as being safe places of learning. Supervisees indicated that these deficits had negatively affected the quality of the previous supervision they had received.

“Coming from a previous role where supervision wasn’t really a priority and it didn’t happen frankly, and also when it did happen, I didn’t find it very helpful”. Emma
In reflecting on their previous experiences, supervisees contrasted their new experiences of clinical supervision as being more effective.

“Sometimes the supervisor actually brought to the supervision session the things that they thought they wanted to talk about… we have an understanding now of how supervision works... in this new model.”

Charlotte

The central role of safety in the supervisory relationship was underscored in the following comment from Emma, as she compared her current experience with a previous supervisory experience.

“I have to say; given the experience I had years ago …. that left me feeling very unsafe so the difference is amazing when you’ve got a really developed practitioner.” Emma

Supervisees’ responses indicated that those who had previous experiences of supervision, both positive and negative, used this historical information to inform their current supervision practice. Supervisees with exposure to a range of supervision experiences learnt what worked best for them and they gained the confidence to take a greater command of the process.

“I think it’s also having had different experiences. If you’ve had some that haven’t worked and some that have. It’s again another skill, what doesn’t work for you and what does work and you can direct it a bit more then as well. Take a bit more ownership of where you want it to go.” Ella

These examples demonstrate how supervisees drew from their previous experiences of supervision to positively influence their current experience. While there were no instances of previous experience having a negative impact on current supervision practice, this could conceivably occur. For example, if the supervisee had encountered a former breach of trust in the supervision relationship, this might delay the formation of an effective supervisory alliance. Past supervision behaviours have been found to be predictive of
present supervision behaviours, such as reflective practice and skills acquisition (Crow, 2008).

Having discussed the barriers and enhancers to clinical supervision effectiveness, the next section addresses the relationship between perceptions of effectiveness of clinical supervision and supervisees’ reports of levels of intention to leave.

7.3.3 Question 3

What is the relationship between perceptions of effectiveness of clinical supervision and supervisees’ reports of levels of intention to leave?

Supervisees were asked whether clinical supervision made a difference to how they felt about their jobs. Supervision experiences were described as encouraging, supportive and valuing and supervisees associated these aspects of supervision with improving job satisfaction. Supervisees also reported that supervision provided feedback and recognition about the importance of the roles that they were fulfilling. This reaffirmed worker’s beliefs that their work was purposeful and beneficial to the service’s recipients. In this way, supervision kept workers motivated, interested and engaged in their roles of delivering health care services. These features of supervision increased allied health workers’ sense of connection to the employing organisation and decreased their intention to leave.

“It’s made such a difference to me as a practitioner. It helps you stay really focused on why am I here and it helps you stay focused on the positives that you are getting all the time because they are easy to forget about.”

Ella

Supervision sessions were reported as providing rare opportunities for clinicians to receive feedback about their practice. Apart from supervision, it seemed that the receipt of feedback was scarce during the usual course of their work.

“I think because everyone’s so busy that (encouragement) doesn’t happen very much. …. I’ve certainly had positive comments from my supervisor and that has been huge, meant a lot.” Charlotte
Receiving positive feedback was particularly valuable for workers at the time of data collection as they were experiencing high uncertainty in many areas including changes to their roles and the focus of the service. For some, the climate of rapid change and job insecurity had led to an erosion of their sense of professional competence. It was important for them to know that they, as individual clinicians, were practicing effectively. Feedback from supervisors provided this reassurance, as well as a sense of stability amid the evolving occupational landscape.

“It’s quite a supportive relationship, so your skills and your experience are recognised and that’s quite important in the current environment when everything else is being questioned and changed all the time.” Chloe

One supervisee, Caitlin, recounted examples of how her supervisor played an active role in encouraging her to undertake career developing activities. Her comments illustrate the positive effect this had, when her supervisor communicated confidence in Caitlin’s capacity to undertake higher duties. Discussion and plans about career development would generally be a common function of supervision; however this aspect was not highlighted as much as other functions that were directly supportive. At the time of the study there may have been a greater need for restoration and maintenance of the workforce then extension of capacity. Encouragement to undertake higher duties is important for job satisfaction as lack of career opportunities is one reason that employees leave their workplace (Belbin, 2011).

“I guess, encouragement, being encouraged to do something, maybe something that you didn’t think you were capable of …. Yes, my supervisor …she’s suggested I become a supervisor, so I’ve done that and I’m going to start doing that. Yes, she makes suggestions like that from a professional development point of view.” Caitlin

The implementation of clinical supervision appeared to provide workers with hope and optimism about the future. Having supervision was something real that workers could count on as a sanctum of safety, in an otherwise uncertain and evolving landscape. This increased sense of hope was linked to a feeling of attachment to the health service.
“One of the things that I just wanted to say as a positive about supervision is that I felt it provided a sense of belonging to an organization. Particularly in an otherwise demanding, challenging workplace. It gives you a sense that all is not lost.” Charlotte

Several supervisees indicated that supervision increased their sense of connection to the employing organisation. It was as if the supervisor personified the bureaucracy, enabling supervisees to feel that they individually had a place within the organisation and therefore a sense of belonging to something greater than their immediate and often atomized local environment.

“What it does bring is a sense of being connected to the broader organisation. To feel connected, it’s just to feel connected to, that somebody has a clue what I do, that somebody thinks it’s ok, that it’s not just me floating around here hoping like crazy, I’m doing something useful….. like I’m out there and nobody knows where I am or what I’m doing and that total sense of no one having you back almost ….. That feeling for me, the word is connected, to something bigger.” Ella

One supervisee, Caitlin, saw the implementation of clinical supervision as evidence that the health service management ‘cared about’ her and her colleagues and valued and wished to retain their workers.

“Yeah, it’s supportive and I guess it’s an indication the organization does care about us enough to push that….. and they want to keep their staff.” Caitlin

Caitlin’s viewpoint was not challenged directly within her focus group however other perceptions emerged. For example, a supervisee questioned the organisation’s motive, wondering whether the implementation was more about meeting governance or accreditation benchmarks than being a genuine commitment to valuing and supporting staff.
“I think that experienced clinical staff are valued and supervision is valued but I think ….. there’s a bit of back peddling to demonstrate that this model is in place and we comply with it.” Chloe

Overall, supervisees’ responses illustrated that supervision did enhance job satisfaction and reduce workers' intention to leave. As well as assist to retain workers, supervision facilitated increased morale and improved sense of well-being, as illustrated below,

“Now I feel like I can still cope with what’s going on and that to me was worth it because otherwise I would probably be packing shelves at Coles or something. So it’s given me back my self worth, just from supervision.” Emily

The above example demonstrates the link between the provision of supportive supervision and the retention of workers. This leads to discussion of the next question about the relationship between clinical supervision and worker burnout.

7.3.4 Question 4

What is the relationship between perceptions of effectiveness of clinical supervision and supervisees’ reports of levels of burnout?

Supervisees reported experiencing stress and anxiety related to high workloads, complex casework, and the enormous organisational changes. In general, work morale was described as being low, with workers feeling a high level of uncertainty about the future. Amidst the context of the multiple changes that workers were negotiating, the supervision relationship provided supervisees with a tangible source of support within the health service. Despite their challenging work environment at that time, most supervisees held strong views that supervision assisted them to manage the workplace stress and hence, reduce their risk of burnout. For example, some supervisees reported considerable benefits after several supervision sessions. These benefits included reduced stress and a return to a higher level of functioning in their roles.
“When I first started with my supervisor I was in a really bad place .... and I was sort of at the point of no return, so getting my clinical supervision organized and constantly every month, that gave me back my confidence.”
Emily

Supervisees were familiar with the risk that stress and burnout posed to their well-being and they also understood that stress and burnout could negatively affect their capacity to effectively function within their health care roles.

“Yes, I’m going to supervision and that might mean those people never get seen ever, but at least the ones I do come into contact with, won’t get harmed. If I continue to work at that pace, eventually I’m going to say to someone, ‘You know, I don’t care, that doesn’t sound so bad to me’. And that’s burnout, yeah, certainly.” Ella

Sometimes work stress was associated with the interactions occurring between the worker and the person for whom they were providing services. Clients frequently presented with complex backgrounds and challenging behaviours. Supervision was helpful for the worker to gain a greater understanding of the dynamics operating in the client interaction to ensure there were no negative impacts for the worker or the client.

“We’re exploring .... the impact of that particular case on myself as a worker..... it seems to make it clearer and give me insight into different ways of looking at that particular person.” Daisy

Supervision represented something constant in the changing workplace landscape and could also offer a different perspective on the experience of organisational change. Opportunity to debrief challenging events provided supervisees with validation of their feelings and consideration of different management strategies to reduce their distress.

“I was absolutely gob-smacked with this new reform that could be coming in and potentially what could happen to me in terms of where I’m going to be going or that type of thing, you know, it’s quite unsettling ....... but just
having that opportunity to debrief and face my concerns has been helpful”.

Daisy

There was one exception where supervision had not been experienced as helpful. Instead the supervisee attributed supervision as a source of increased stress as it was viewed as a loss of productive time in her busy work schedule. This example was mentioned earlier in this chapter, along with possible explanations for this lone divergence. Still, overall, the dominant perception was that supervision reduced worker stress and burnout.

Overwhelmingly, these examples demonstrate how supervision functioned as an effective workforce resource for mitigating the risk of worker burnout. As well as maintaining their capacity to do their job, a number of supervisees noted the important link between their sense of well-being and their perception of the quality of the interventions they were able to deliver to recipients of the service. In this way, clinical supervision was seen to make a positive contribution to the maintenance and improvement of quality of care.

“It’s made a huge impact. As soon as you feel, ah, yes, all right, it flows off and you’re not tired, burnt out, stressed; of course you’re going to provide a better service.” Ella

In summary, overall, supervisees viewed supervision as being effective for reducing their level of stress and reducing their susceptibility to burnout. Supervision was also seen to indirectly contribute to improved quality of care. This discussion now moves to the final section of this chapter which is the identification of any profession-specific differences in supervision.

7.3.5 Research Question 5

What are the profession-specific differences in perceived effectiveness of clinical supervision, reports of levels of intention to leave, and reports of levels of burnout?
7.3.5.1 Professional differences and similarities

Overall, there were many more similarities than differences between the professional groups. There were no apparent profession-specific differences for perceived intention to leave or burnout. A theme emerged in relation to differing levels of familiarity with supervision practices between professional groups. This aspect may have had an influence on clinical supervision effectiveness and these professional differences are discussed next.

7.3.5.2 Clinical Supervision: Owned or Alien

Within the supervisee focus groups, a number of participants pointed out that for some of their professions, such as social work and podiatry, clinical supervision was an accepted and owned part of their culture and was embraced within everyday practice. This was in contrast to other professions represented within the supervisee focus groups, where clinical supervision was viewed as something unfamiliar and not yet part of usual practice. A podiatrist illustrated how supervision was seen as routine practice.

“In podiatry, you have to do it every month. You have to get it ticked off as a supervisor and a supervisee”. Brooklynn

In contrast, a physiotherapist explains that clinical supervision is still being accepted and integrated into their practice.

“Still, it’s not a priority for people, like even though we know that it is important”. Edith

For social workers, supervision was embedded within their professional identity and undergraduate training. A few social workers had noticed how some other professions had curiously viewed their willingness to participate in supervision. They recognised that supervision was not customary for these professions.

“A lot of allied health in our team are still looking at us social workers …They’re watching us very closely to get feedback on what it’s like. Because when we did the training, I went, ‘yes, finally’, because it’s so much a part of our degree.” Ella
Another social worker reflected on these perceived professional differences and offered an explanation.

“It's new, they're not used to it and it's unusual going from nothing, unless you've sorted it out yourself, to being an incredible priority. I think it takes time for a cultural shift amongst a professional body … it takes a while to embrace change.” Eleanor

Social workers, more so than other professions in the focus groups, tended to have received supervision prior to the formal implementation and they used that experience to inform their current supervision practice.

“Having learnt from previous different types of supervision ….. I knew what I wanted from the supervisor, what was important to me to get out of supervision but I wouldn't have known that if I hadn't had those prior experiences.” Emma

The above examples highlight how the focus group participants deriving from social work and podiatry professions were more familiar with the practice of supervision than other professions represented within the groups. At the time of implementation within the service, these professions had already experienced a period of exposure to supervision practice and it seemed that the introduction of supervision generally presented less adaptation to their existing practice. Other professions, where clinical supervision was a new practice, may have required a longer lead-in time to become familiar and comfortable with supervision practice. The professional differences outlined in this section may have had an influence on the effectiveness of clinical supervision. Due to the small participant numbers of some professions, there is no attempt to claim that these differences are representative of particular professional groups in the study population; however the differences highlight patterns that deserve consideration in future supervision studies of allied health workers. As noted earlier, overwhelmingly, there were many more similarities than differences between the professional groups.
7.4 Conclusion

In summary, the vast majority of supervisees’ responses provided evidence that supervision effectively met the three overarching clinical supervision functions of support, professional development and guidance. Supervisees indicated that supervision increased worker knowledge, skills and confidence and contributed to quality health service delivery. There were two responses where supervision had not been considered helpful. One situation related to the lack of perceived benefit, plus supervisee stress about lost clinical time while attending supervision. The other situation concerned the supervisor’s overemphasis on casework and inadequate attention to the supervisee’s support and professional development needs. The detrimental effects of adopting a managerial style of supervision have been previously reported (Engelbrecht, 2013). These two examples are important to note however they were atypical relative to other responses.

Supervisees were largely in agreement about the factors that impacted positively or negatively on clinical supervision effectiveness. The positive factors included having regular access to a trusted clinical supervisor who was preferably of the same-profession with community experience. Supervisees valued having supervisors of their own profession as it improved clinical interventions and management, strengthened professional identity, provided role clarity and reduced professional isolation. A small number of participants described benefits from having access to supplementary supervision from other professions when they required access to specific knowledge. Most supervisees preferred supervision from a community-experienced supervisor but at times the knowledge sought resided with hospital-based clinicians and this type of supervision was occasionally selected. Other positive supervision factors comprised utilising a structured clinical supervision framework. A structured framework facilitated goal-directed and purposeful use of supervision sessions.

The factors perceived to have had a negative impact on clinical supervision effectiveness were primarily linked to organisational issues and included the lack of dedicated time for supervision, lack of access to clinical supervisors and lack of a shared organisational commitment and approach to supervision. Lack of access to clinical supervisors and lack to time to attend supervision affected the frequency and availability of supervision which was perceived to negatively affect supervision quality and effectiveness. Lack of
organisational commitment to supervision was linked with inequitable access to supervision, inconsistent processes, and underutilization of the much-needed supervisor resource pool. Supervision training was not considered to be significant in relation to supervision effectiveness. Supervisees with previous supervision experiences drew upon that knowledge to inform their current supervision practice.

In relation to clinical supervision effectiveness and intention to leave, supervisees’ responses illustrated that when supervision provided feedback that was experienced as informative, encouraging, supportive and valuing, it enhanced job satisfaction. Supervision also reaffirmed the importance of the health care role that supervisees were fulfilling. These aspects of supervision were reported to be associated with allied health workers having an increased sense of connection to the employing organisation, as well as decreased intention to leave.

With regard to clinical supervision and burnout, the supervision relationship was perceived to provide allied health workers with a notable source of support which protected and buffered them in the context of their rapidly changing workplace. Supervisees were familiar with the risk that stress and burnout posed to their well-being and their capacity to effectively function within their health care roles. Overall, supervisees’ responses illustrated that they believed the supervision they had received had facilitated their well-being, assisted them to adapt to the changing work environment, reduced their stress and their risk of burnout. Supervisees also highlighted how their sense of well-being influenced their capacity to fulfil their roles. Therefore effective clinical supervision was also viewed as having important implications for quality of care.

Overwhelmingly, there were many more similarities than differences in the findings between the different professional groups. This finding is consistent with the empirical clinical supervision literature (Bogo et al., 2011; Crow, 2008). However, two areas of professional difference emerged. Firstly, the professions of podiatry and social work saw supervision as embedded within their practice and part of their professional tradition whereas other professions represented within the focus groups tended to view supervision as an unfamiliar and new practice. Secondly, supervisees with prior supervision experiences tended to derive from the profession of social work. These supervisees used the learnings from their earlier exposure to supervision to add value to
their current supervision experiences. While these professional differences were small relative to the areas of commonality, they may have had an influence on the effectiveness of clinical supervision.

Having described the supervisee focus group findings, it is useful to compare these findings with the results from the supervisor focus groups (reported in Chapter 6) to ascertain any similarities or differences. A review reveals many converging themes between the focus group findings. In the main, both supervisor and supervisee focus group participants perceived that supervision had been effective at providing education, guidance and support for allied health workers. Findings from the two focus group types also indicated similarities in their views about the barriers and enhancers of clinical supervision effectiveness. Of particular note, the supervisor and supervisee groups both linked clinical supervision effectiveness with having a structured supervision framework. Both the supervisor and the supervisee groups perceived that the structured supervision framework served to set up, guide and facilitate effective supervision practice. Although the use of documentation such as supervision agreements is commonly recommended in the clinical supervision literature (Dawson et al., 2013b; Nancarrow et al., 2014), only one study could be located that linked increased supervision effectiveness with structured processes (Kuipers et al., 2013). Kuipers and colleague’s (2013) study of peer group supervision reported positive outcomes associated with the use of tools adopted from supervision training and when peer groups “reviewed their activities at some level” (Kuipers et al., p. 395), however, notably, in their study positive outcomes were not linked with the use of supervision agreements.

Another major area of convergence between the supervisor and supervisee groups’ findings was the significance of having a safe supervision relationship to build an effective supervisory alliance. A few aspects regarding the supervision relationship differed between the supervisor and supervisee groups. For example, supervisors considered that allowing the supervisee choice in the selection of their supervisor enhanced the effectiveness of the supervisory relationship. Although supervisees did not raise this topic, some emphasized that genuine self-reflection would not be possible “with the wrong supervisor”. In addition, supervisees underscored the importance of having a same-profession supervisor with community experience. These findings support previous outcomes in the clinical supervision literature regarding the importance of the quality of
the supervision relationship (Falender, Shafranske, & Ofek, 2014; Paice & Hamilton-Fairley, 2013), providing supervisee choice in selection of supervisor (Dawson et al., 2012) and the benefits of having a same-profession supervisor (Beddoe & Howard, 2012; Bogo et al., 2011; Kavanagh et al., 2003).

Both supervisors and supervisees emphasised that lack of time for supervision and lack of access to experienced clinical supervisors were barriers to clinical supervision effectiveness. Having insufficient time is consistently reported as a challenge to effective supervision (Bradley & Hojer, 2009; Snowdon et al., 2015). Supervisors and supervisees perceived a lack of consistent commitment and approach to clinical supervision by the service’s management. These inconsistencies were blamed for reported inequities in clinical supervision practice and lapses in supervisor recruitment. White and Winstanley (2010) have previously reported on the detrimental consequences for clinical supervision outcomes in the context of insufficient management support.

There was one notable area of divergence between the supervisor and supervisee groups. Supervisors expressed a lack of confidence in their own supervisory abilities and competence. This was most prominent with physiotherapy supervisors who said they lacked the skills to respond effectively when supervisees sought emotional support in supervision. Most supervisors believed they would benefit from receiving additional supervisor education as well as receiving clinical supervision in their own right. In contrast, the overwhelming majority of supervisees spoke highly of their supervision experience and valued the input from their supervisors. Despite the above exception, the convergence between the major findings from both supervisor and supervisee focus groups indicated that, although they had different supervision roles, supervisors and supervisees had made sense of their clinical supervision experiences in similar ways. In addition, the convergence of results adds corroboration to the overall focus group findings.

In summary, the supervisor and supervisee focus group findings indicated that clinical supervision had been perceived to be effective at providing education, guidance and support for allied health workers. Supervision was also associated with reducing intention to leave and burnout. Both groups identified similar enhancers and barriers to clinical supervision effectiveness. The next chapter will consider the combined findings of the
qualitative and quantitative studies to reach a final analysis in addressing the research questions.
8 Integrating the findings

The previous chapter presented findings from the supervisee focus groups and concluded with a discussion of the similarities and differences between the findings of the supervisee focus groups and the supervisor focus groups. The current chapter will commence with an interpretation of the mixed methods findings resulting from Study 1 (surveys) and Study 2 (focus groups), including discussion on how the findings respond to the central research questions and their connection with the empirical clinical supervision literature. The discussion will include a commentary on the fit between the conceptual framework and this research study. The chapter will conclude with a summary of the overall findings.

8.1 Meta-analysis: Interpretation of Mixed Methods Findings

As discussed in the Methodology (see Chapter 4), a mixed methods approach was selected as the optimum design to address the aims of this research program. Described as an explanatory sequential design, the quantitative study was followed by a qualitative study with the purpose of shedding light on the findings from the initial quantitative study (Creswell & Plano Clark, 2011). Following a process suggested by Creswell and Plano Clark (2011), the major findings from Study 1 and Study 2 will now be connected and compared through the identification and selection of data that converges and data that conflicts. The discussion will begin with a focus on the major areas of convergence and divergence.

Findings from Study 1 and Study 2 converged in all major areas. Tables have been used to assist in the representation of this information (See Tables 8.1 and 8.2). As noted in the previous chapter, there was one area where different perspectives emerged and this occurred only within Study 2, between the supervisor and supervisee focus groups. Some supervisors expressed a low level of confidence in their supervisory skills and knowledge. In contrast, most supervisees expressed satisfaction with their supervision. It was not possible in Study 1 to statistically determine whether supervisor competence was associated with supervision effectiveness as surveys were anonymous and responses to the survey were not linked to focus group responses. All other areas in this mixed methods research converged, with the major areas of convergence listed below.
• Overall, clinical supervision was perceived to be effective at providing supervisees with professional support, education and guidance.

• Effective supervision (total MCSS-26© scores > 74.7) was significantly associated with reduced Intent to Leave and with increased Personal Accomplishment.

• Highly effective supervision (total MCSS-26© scores > 85) was significantly associated with reduced Emotional Exhaustion and reduced Depersonalization.

• Enhancers to supervision effectiveness included: time (length of supervision session, number of supervision sessions and longer experience of supervision over one’s career), and utilising a structured supervision framework (especially receiving supervision, completing a supervision agreement and choice of clinical supervisor). Having time available to attend supervision was significantly associated with reduced Emotional Exhaustion.

• Barriers to supervision effectiveness included lack of time for supervision practice and lack of a consistent whole-of-service approach to clinical supervision.

• Profession-specific differences were significantly associated with increased and decreased supervision efficacy
Table 8-1 Convergence of findings between Study 1 and Study 2 and between focus group types

<table>
<thead>
<tr>
<th></th>
<th>Study 1</th>
<th>Study 2</th>
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<tbody>
<tr>
<td><strong>Method</strong></td>
<td>Quantitative</td>
<td>Qualitative</td>
</tr>
<tr>
<td></td>
<td>Surveys</td>
<td>Supervisor Focus Groups</td>
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<tr>
<td></td>
<td>Supervisee Focus Groups</td>
<td>Supervisee Focus Groups</td>
</tr>
<tr>
<td><strong>Research Question</strong></td>
<td>1. How do allied health staff who receive clinical supervision rate the effectiveness of that clinical supervision in providing support, education and guidance for their professional practice?</td>
<td></td>
</tr>
<tr>
<td><strong>Finding</strong></td>
<td>Overall, clinical supervision efficacy was achieved with the group's mean score attaining the efficacy threshold. Therefore, as a whole, clinical supervision was effective at providing supervisees with professional support, education and guidance.</td>
<td>Supervisors’ statements suggested that overall, supervision provided effective guidance, professional development and professional support to supervisees.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“I think that all three functions are represented in every supervision session…… and I try and engineer it that way so there is a balance in the three functions.” Babette</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The vast majority of supervisees’ responses portrayed positive supervision experiences that illustrated effective provision of professional support, education and guidance for their professional practice.</td>
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<tr>
<td></td>
<td></td>
<td>“I think its confidence building; at least it has been for me….I find that getting advice and ideas on the interventions and ways to manage clients is very helpful.” Charlotte</td>
</tr>
<tr>
<td>Research Question</td>
<td>2. What factors affect the perceived effectiveness of clinical supervision in providing support, professional development and guidance for supervisees’ professional practice?</td>
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<tr>
<td>-------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
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<tr>
<td>Finding</td>
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</tbody>
</table>
|                   | **Time: frequency and duration**  
|                   | Time was a variable significantly associated with increased effectiveness of clinical supervision.  
|                   | The more times supervision was received, the higher supervisees rated the effectiveness of the Formative and Restorative domains. |
|                   | **Time: frequency and duration**  
|                   | A number of supervisors stated that a minimum period of time was required to create a climate of trust in supervision. This meant that supervisory relationships took time to reach an optimal level of functioning.  
|                   | “I think we were only getting to that really safe space now where I think everyone’s being a lot more open than initially” Aria |
|                   | **Time: frequency and duration**  
|                   | Supervisees reported that a period of time was required for the establishment of trust and safety in the supervision relationship, hence effectiveness increased when the relationship had become more established.  
|                   | “I’m on to my fourth session with my new supervisor and its getting there. I’m starting ..... to feel a little more comfortable to talk about specific issues.” Emma |
|                   | **Session duration** was not specifically addressed by supervisors.  
|                   | While session duration was not specifically addressed, supervisees referred to the concept of time as an |
Longer supervision sessions were associated with increased effectiveness. Participants who spent more than 60 minutes in supervision sessions rated the effectiveness of all of the domains and subscales significantly higher than did those who spent less than 60 minutes in sessions.

The longer the total period that supervision was received during career, the higher supervisees rated the effectiveness of all of the domains.

Supervisors indicated that outcomes improved over time.

“I've seen that in some of the supervisees I have supervised for 12 months, their confidence in making decisions has increased “. Amelia

important aspect of having an effective supervision experience. Having time to reflect on practice was linked to the quality of service provision.

“To be able to have that time to reflect on what you are doing is very important because you are working so fast now…. It’s important for the quality of the work.” Daisy

Supervisees learnt over time, through exposure to a range of supervision experiences, what worked best for them in supervision and this increased their confidence to take a greater command of the process.

“I think it’s also having had different experiences. If you’ve had some that haven’t worked and some that have. It’s
<table>
<thead>
<tr>
<th>Time available for supervision</th>
<th>Time available for supervision</th>
<th>Time available for supervision</th>
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<tbody>
<tr>
<td>Higher scores of the subscale “Finding Time” were significantly correlated with lower scores of Emotional Exhaustion.</td>
<td>Most supervisors reported that lack of dedicated time to provide supervision was a major barrier to effectiveness. Supervisors felt stress and frustration as they struggled to fit supervision in alongside their other duties.</td>
<td>Most supervisees reported that lack of time made it difficult to access supervision. Sometimes supervision occurred less frequently than required which was believed to result in reduced supervision outcomes.</td>
</tr>
<tr>
<td>“It is not possible under the current environment to provide that level of time ….. The clinical demands are so great that we just don’t have the hours. It needs to be made a priority. We are trying to fit it in amongst everything.” Brionne</td>
<td></td>
<td>“I've just cut it back to bi-monthly because I just don’t think I can afford the time once a month. It’s a shame because I would like to develop my skills at being supervised. I’m sure I could get a lot out of it but I just can't really give it the time.” Elizabeth</td>
</tr>
</tbody>
</table>
Structured processes for supervision practice
The utilisation of structured supervision processes was significantly associated with higher supervision effectiveness.

Those in the “Best Practice” group (receiving supervision, choice of supervisor, attended supervision training, completed supervision agreement, understanding of confidentiality boundaries in supervision) rated the overall effectiveness of clinical supervision significantly more highly than did others.

Those in the “Best Practice” group rated the overall effectiveness of the Restorative domain more highly.

Structured processes for supervision practice
Many supervisors noted that having formal structured processes assisted to make supervision more effective. Supervisory arrangements that lacked structure were not seen to be as efficient.

“With one of mine there is no structure to anything. I listen and try and direct it but it is hard to get it to work.” Barbara

Support function of supervision
A number of supervisors’ responses illustrated that they understood the impact of the workplace context on supervisees and they provided

Structured processes for supervision practice
Many supervisees described how the service’s structured framework for supervision, with standardised documents and processes, contributed to making supervision sessions purpose-driven and therefore more effective.

“Following the structured templates, I think is helpful so that keeps you to time and also the outcomes and actions and follow ups.” Cadence

Support function of supervision
Many supervisees reported that supervision provided practical and
than the normative data (but just failing to reach level of significance). This indicated that these supervisees felt well supported and could seek advice.

Receiving supervision
Specifically, the ‘best practice’ variables: “receiving clinical supervision”, “having some choice in the allocation of clinical supervisor”, and “having a completed clinical supervision agreement”, were significantly associated with higher supervision effectiveness.

Receiving clinical supervision
Supervisors expressed a strong need to have access to their own supervisor for guidance and support of their supervisory responsibilities. Despite this, the vast majority of supervisors did not receive supervision and this was seen to negatively affect their ability to be effective supervisors and provide sound supervision to supervisees.

“Supportive strategies to mitigate workplace stress.

“At the moment there is massive change and stress .... I don't think it's surprising that supervisees would be needing a high level of support at the moment.” Baqir

Receiving clinical supervision
Several supervisees spoke about difficulties they had experienced in obtaining a clinical supervisor. This was seen as a barrier to effectiveness as it prevented their access to supervision.

“I nominated several people from their bios but the one I was allocated, I had her for three months then she was off on maternity leave, then another one on my list was already on maternity leave and...
The majority of supervisees (n = 45, 66.2%) reported that they had some choice in the selection of their clinical supervisor.

**Choice in allocation of clinical supervisor**

The low number of breakdowns in supervisory arrangements was put forward as evidence that providing supervisees with choice in the selection of their individual supervisor had been an effective process.

“*The way the program has been rolled out in terms of nominating your three preferences … we haven’t had too many arrangements that haven’t gone well.*”  
Amelia

Choice was limited within the

then another one on my list left the position.”  
Dakota

Supervisees were clear that the supervision relationship needed to be one of trust as supervision would not be as effective with the “wrong supervisor”.

*“When talking about what is going on for me personally …. that’s not always something that feels safe to do with the wrong supervisor.”*  
Emma

Choice in the selection of a supervisor was limited by the number of available supervisors and this was reported as a barrier to effectiveness because it
The majority of participants (n = 41, 62.1%) reported that they had completed a written clinical supervision agreement.

Smaller professions due to a shortage of supervisors. A supervisor expressed concern for her current supervisees if she wasn’t available to provide supervision.

“If I left, for example, I don’t know what other options would be out there.” Aria

Clinical supervision agreement

Supervisors spoke favourably about the usefulness of the supervision agreement, especially for documenting expectations, roles, responsibilities and learning goals.

“I think having that written agreement has been very helpful in those situations in terms of referring decreased access to supervisors with community expertise.

“There isn’t any choice … there is no one in community who you could approach to be a clinical supervisor.” Cadence

Clinical supervision agreement

Supervisees valued the supervision agreement as it kept them on task with their learning goals.

“We will actually go back to that agreement … just to check that we are on track with where we need to go.” Emma
Variances in supervision processes

Participants’ responses indicated a lack of whole-of-management commitment to supervision which contributed to inconsistent supervision processes. For example, 24 participants were utilising “Best Practice” principles, compared with 54 participants who were not utilising all of these principles.

Many supervisors spoke about the organisation’s lack of an overall commitment to clinical supervision. This resulted in inconsistent supervision processes that presented problems for supervisors trying to implement supervision practice. “If they want us to be providing this supervision, they really need to provide the structure and support to enable this to happen and at the moment there is no one to do the recruitment of supervisors …… There is no process in place and there is no one to drive it and direct it.” Baqir

Variances in supervision processes

Many supervisees’ responses indicated there was inconsistent management and coordination of the uptake and compliance of supervision processes.

“Someone who I job share with hasn’t had any because her allocated person, well it didn’t start up straight away and then that person got another position … She hasn’t done it at all. So, I’ve had a year of supervision and she’s had none, so perhaps, that could be a bit more consistent so everyone has the opportunity.” Caitlin
<table>
<thead>
<tr>
<th>Research Question</th>
<th>Finding</th>
<th>Finding</th>
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<tbody>
<tr>
<td>3. What is the relationship between perceptions of effectiveness of clinical supervision and supervisees’ reports of levels of intention to leave?</td>
<td><strong>Personal Accomplishment</strong>&lt;br&gt;Effective supervision (total MCSS-26© scores &gt; 74.7) was significantly associated with higher personal accomplishment.</td>
<td><strong>Personal Accomplishment</strong>&lt;br&gt;While this research question related to supervisees, many supervisors said that providing supervision added interest to their role and increased their sense of job satisfaction.&lt;br&gt;“I’d just like to say that doing supervision has been a valuable part of my role, it’s provided more challenges for me and it’s doing something that I do believe in.” Alice</td>
<td><strong>Personal Accomplishment</strong>&lt;br&gt;Several supervisees reported that supervision increased their morale at work as they felt supported, valued and that their work was purposeful.&lt;br&gt;“I’ve found since I’ve been having supervision….I feel what we are doing in the program is worthwhile.” Emily</td>
</tr>
<tr>
<td><strong>Intention to Leave</strong>&lt;br&gt;Effective supervision (total MCSS-26© scores &gt; 74.7) was significantly associated with higher personal accomplishment.</td>
<td><strong>Intention to Leave</strong>&lt;br&gt;Skilled supervisors were aware of</td>
<td><strong>Intention to Leave</strong>&lt;br&gt;A number of supervisees reported that</td>
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26© scores > 74.7) was significantly associated with lower intention to leave.

the potential negative effects of occupational stress on supervisees, and were able to minimise the impact and enhance morale.

“I think that's a very valuable part in keeping that morale within a team. Keeping your … (profession named), you know, still wanting to do the job”. Asha

supervision provided a feeling of connection to the organisation.

“A positive about supervision is that I felt it provided a sense of belonging to an organization, particularly in an otherwise demanding, challenging workplace.” Charlotte
<table>
<thead>
<tr>
<th>Research Question</th>
<th>4. What is the relationship between perceptions of effectiveness of clinical supervision and supervisees’ reports of levels of burnout?</th>
</tr>
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<tbody>
<tr>
<td><strong>Finding</strong></td>
<td><strong>Emotional Exhaustion</strong></td>
</tr>
<tr>
<td></td>
<td>Highly effective supervision (total MCSS-26© scores &gt; 85) was significantly associated with lower Emotional Exhaustion.</td>
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</table>
Depersonalization

Highly effective supervision (total MCSS-26© scores > 85) was significantly associated with lower Depersonalization.

| Alice | Depersonalization | Supervision provided opportunities for supervisees to access support and debrief stressful work events, enabling them to be emotionally available to continue to provide high quality care.
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<tbody>
<tr>
<td>“It's almost a feeling of crisis when people first hear about the enormous changes and how are we going to cope .... and just be able to put that in some sort of perspective”.</td>
<td>Amelia</td>
<td>“What I am seeing in my supervisees is the real client focused approach to their work so that’s been really refreshing”.</td>
</tr>
<tr>
<td>Ella</td>
<td>Depersonalization</td>
<td>“It’s made a huge impact. As soon as you feel, ah, yes, all right, it flows off and you’re not tired, burnt out, stressed; of course you’re going to provide a better service.”</td>
</tr>
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</table>

Some supervisees described how supervision offered opportunities to debrief stressful work events which enabled them to remain patient-focused in their practice.
<table>
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<th>Personal Accomplishment</th>
<th>Personal Accomplishment</th>
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</table>
| Effective supervision (total MCSS-26© scores > 74.7) was significantly associated with higher personal accomplishment. | Supervisors described how they offered encouragement, reassurance and affirmation to their supervisees and this had a flow-on effect to worker morale.  

“I certainly think from a morale/staff satisfaction point of view it makes a big difference.” Amelia | Through the supervision experience, many supervisees felt supported and valued and that their work was purposeful.  

“It’s made such a difference to me as a practitioner. It helps you stay really focused on why am I here and it helps you stay focused on the positives that you are getting all the time because they are easy to forget about.” Ella |
| Research Question | Profession-specific differences in perceived effectiveness of clinical supervision, intention to leave, and burnout?  
8 |
| --- | --- |
| Finding | Effectiveness  
Physiotherapists as a group had a significantly lower mean score for the MCSS-26© (Winstanley & White, 2011) than the published norms for allied health. There were no significant differences to the normative data for either the occupational therapy group or the social work group.  
Supervisors’ comments suggested that some profession-specific educational needs existed. Physiotherapists, in particular, identified gaps in their knowledge and skills in addressing supervisees’ support needs.  
“A lot of it (supervision) is emotional”  
“Having learnt from previous different experience” |
| Profession-specific differences in perceived effectiveness of clinical supervision, intention to leave, and burnout?  
8 |
| Finding | Effectiveness  
The professions differed in the length of time they had been receiving supervision. Those participants with previous experience of supervision, predominantly social workers, said that they had drawn from that experience to inform their current experience.  
“The small cell size of the professional groups of Dietetics, Podiatry, Psychology, and Speech Pathology prevented their inclusion in the survey analyses. Likewise, these professional groups were represented in very small numbers within the focus groups. Therefore discussion of profession-specific differences has been limited to the three largest professional groups of Occupational Therapy, Physiotherapy and Social Work. These results should be interpreted with caution given the small sample size.” |

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8 The small cell size of the professional groups of Dietetics, Podiatry, Psychology, and Speech Pathology prevented their inclusion in the survey analyses. Likewise, these professional groups were represented in very small numbers within the focus groups. Therefore discussion of profession-specific differences has been limited to the three largest professional groups of Occupational Therapy, Physiotherapy and Social Work. These results should be interpreted with caution given the small sample size.
<p>| Session duration | support and that’s not something that we are trained in as such”. Brionne | types of supervision …… I knew what I wanted from the supervisor, what was important to me to get out of supervision but I wouldn’t have known that if I hadn’t had those prior experiences.” Emma |
| Session duration | Although there were no specific comments about session times, some professions found it more difficult to grasp the supervision principles and processes. For example, a speech pathologist commented,  “We’ve only been going for a bit over six months so it’s not very long at all” (and) “knowing what the process is too, because it’s really weird for us.” Aria | Session duration |
| There were no specific comments about session times; however those professions less familiar with supervision may have struggled to prioritise the time for supervision. A social worker describes her observations of another profession, “Its new, they’re not used to it and its unusual going from nothing, unless you’ve sorted it out yourself, to being an incredible priority. I think it takes time for a cultural shift amongst a professional body.” Eleanor |</p>
<table>
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<tr>
<th>Total period supervision received during career</th>
</tr>
</thead>
<tbody>
<tr>
<td>More social workers had received supervision for &gt; 2 years, than &lt; 2 years. Conversely, more occupational therapists had received supervision for &lt; 2 years, than &gt; 2 years as did physiotherapists.</td>
</tr>
</tbody>
</table>

**Burnout and Intention to Leave**

There were no profession-specific differences found for burnout or intention to leave.

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<thead>
<tr>
<th>Total period supervision received during career</th>
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<tr>
<td>Supervisors from the professions of psychology and social work described clinical supervision as a familiar and ongoing practice, “embedded” in their professional identity, whereas the practice was a new experience for some of the other professions.</td>
</tr>
</tbody>
</table>

“For social work …. it’s a very intricate and necessary part of how we provide a service”. Amelia

**Burnout and Intention to Leave**

There were no profession-specific differences found for burnout or intention to leave.

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<table>
<thead>
<tr>
<th>Total period supervision received during career</th>
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<tbody>
<tr>
<td>Professional differences regarding familiarity with supervision were pointed out by participants. For some, such as social work, the practice of supervision was embraced as part of their professional culture but for other professions, it was a relatively new experience.</td>
</tr>
</tbody>
</table>

“A lot of allied health in our team are still looking at us social workers … They’re watching us very closely to get feedback on what it (supervision) is like.” Ella

**Burnout and Intention to Leave**

There were no profession-specific differences found for burnout or intention to leave.
Table 8-2 Divergence of findings between Study 1 and Study 2

<table>
<thead>
<tr>
<th>Study 1</th>
<th>Study 2</th>
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</thead>
<tbody>
<tr>
<td><strong>Method</strong></td>
<td><strong>Method</strong></td>
</tr>
<tr>
<td>Quantitative</td>
<td>Qualitative</td>
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<tr>
<td>Surveys</td>
<td>Supervisor Focus Groups</td>
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<td>Supervisor Focus Groups</td>
<td>Supervisee Focus Groups</td>
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<table>
<thead>
<tr>
<th>Research Question</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td><strong>Nil divergence found</strong></td>
</tr>
<tr>
<td>2.</td>
<td>Supervisor competence&lt;br&gt;Unable to statistically determine whether supervisor competence was associated with</td>
</tr>
</tbody>
</table>

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9 The small cell size of the professional groups of Dietetics, Podiatry, Psychology, and Speech Pathology prevented their inclusion in the survey analyses. Likewise, these professional groups were represented in very small numbers within the focus groups. Therefore discussion of profession-specific differences has been limited to the three largest professional groups of Occupational Therapy, Physiotherapy and Social Work. These results should be interpreted with caution given the small sample size.
effectiveness as surveys were anonymous and responses to the survey were not linked to focus group responses.

“I feel that I need a lot more education and support and I think my learning curve needs to be a lot steeper about the process so that I know I’m more confident.”  Aria

As well as a lack of access to supervisor-specific training, most supervisors did not have their own supervisor. This left them without formal support mechanisms for their supervisory responsibilities.

“Yes, we’re very isolated. We’re all just doing our own thing. You know, you’re out there and who can you go to?”  Brionne

skills.

“My current supervisor has….. that excellent ability to be reflective but gently challenge and help me feel safe to explore new territory”.  Emma
<table>
<thead>
<tr>
<th>Research Question</th>
<th>Finding</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. What is the relationship between perceptions of effectiveness of clinical supervision and supervisees’ reports of levels of job satisfaction?</td>
<td>Nil divergence found</td>
</tr>
<tr>
<td>4. What is the relationship between perceptions of effectiveness of clinical supervision and supervisees’ reports of levels of burnout?</td>
<td>Nil divergence found</td>
</tr>
<tr>
<td>5. What are the profession-specific differences in perceived effectiveness of clinical supervision, intention to leave, and burnout?</td>
<td>Nil divergence found</td>
</tr>
</tbody>
</table>

3 The small cell size of the professional groups of Dietetics, Podiatry, Psychology, and Speech Pathology prevented their inclusion in the survey analyses. Likewise, these professional groups were represented in very small numbers within the focus groups. Therefore discussion of profession-specific differences has been limited to the three largest professional groups of Occupational Therapy, Physiotherapy and Social Work. These results should be interpreted with caution given the small sample size.
8.1.1 Revisiting the Conceptual Framework

Having outlined the major findings, it is timely to reflect on the relevance of the conceptual framework selected for this research. In brief, as discussed in Chapter 3, the social ecological model views the ecological environment as a nested arrangement of multiple systems that include physical, social, institutional and cultural factors (Bronfenbrenner, 1977; Goodman, 2000). It is within this dynamic environment that human behaviour is both modified by, and modifies, external systems. Utilising this approach, it was proposed that the effectiveness of clinical supervision would be influenced by both near and broader systems. In light of the findings it is suggested that Social Ecological Theory has proved to be a useful approach for the examination of the study’s research questions, as described below.

First, although trust in the supervisory relationship was found to be an important element for effectiveness, other aspects also featured as being significant in relation to positive outcomes. Those aspects included duration of supervision session as well as specific procedural factors including receiving supervision, having supervision agreements and choice of supervisor. Despite these procedural aspects being part of the service’s supervision guidelines, they were not applied consistently across the organisation. Participants reported that lack of shared organisational commitment to supervision was a barrier to having a consistent approach because not all managers valued and supported supervision practice. Lack of managerial support was perceived to reduce access to supervision and reduce supervisor recruitment opportunities. Therefore systems external to the immediate supervisory relationship were perceived to negatively impact the effectiveness of clinical supervision. Utilising a social ecological lens suggests that having an understanding of the different systems, and their sub-cultures, across the breadth of the organisation may have promoted a more consistent approach to clinical supervision implementation.

The second component of the conceptual framework is the Job Demands-Resources Model (JD-R), as described in Chapter 3. The study’s findings did support the link between effective clinical supervision and reduced burnout and reduced intention to leave. Supervisees reported benefits from receiving supervision including support and advice for the management of stress and mitigation of burnout. At times, supervision was utilised for
debriefing distressing events and for advocacy. Supervisees also reported that supervision increased their morale and connection to the health service. Supervisees described how supervision led them to feel supported and valued in their roles. Supervisees' reports of benefits from supervision are consistent with the JD-R Model's assertion that increased job resources, as described by supervisees, can buffer the effects of job demands, even in the face of occupational stress including adjustment to organisational change, and thereby protect workers from burnout (Bakker et al., 2005; Prins et al., 2007).

Both Social Ecological Theory and the Job Demands-Resources Model are useful for explaining the existence of professional differences. As mentioned, the Social Ecological approach understands humans to be influenced by factors within their immediate and more distant environments (Goodman, 2000; Stockols, 2000). In this instance, the professional groups were influenced by their historical and cultural traditions in relation to supervision and this in turn, influenced their current supervision practice, confidence as supervisors and levels of effectiveness. Also, the study’s findings indicate that physiotherapists, as a group, had reduced job resources available to them (e.g., supervisor knowledge and skills), in the face of high job demands (balancing clinical duties and finding time to provide and receive supervision) that contributed to supervision ineffectiveness.

Having considered the application of the conceptual framework in this research, the discussion now moves to a detailed interpretation of how the connected findings respond to the central research questions. The discussion also addresses how findings from Study 2, the qualitative study, explain or expand on the findings from Study 1, the quantitative study.

8.1.2 Question 1

How do allied health staff who receive clinical supervision rate the effectiveness of that clinical supervision in providing support, education and guidance for their professional practice?

“I find that getting advice and ideas on the interventions and ways to manage clients is very helpful.” Charlotte
There was consensus between the mixed methods findings that, as a whole, supervision had been effective at providing supervisees with professional support, education and guidance. In Study 1, overall, the group’s mean score attained the efficacy threshold. However supervision effectiveness scores varied with the Physiotherapy profession group scoring significantly lower than this efficacy threshold. Responses from Physiotherapy supervisors in the focus groups provided possible explanations and this is discussed further in this chapter under Question Five. Even so, the vast majority of allied health staff perceived the supervision they received as being effective for providing support, education and guidance for their professional practice.

8.1.3 Question 2

What factors affect the perceived effectiveness of clinical supervision in providing support, education and guidance for supervisees’ professional practice?

A number of variables that enhanced the effectiveness of supervision were identified from the mixed methods findings. Longer individual supervision session times, greater number of sessions and longer experience of supervision over one’s career were significantly and positively associated with supervision effectiveness. Aspects of the structured supervision framework, especially supervisee choice in the selection of their supervisor, and having completed a supervision agreement were also found to enhance the effectiveness of supervision. Conversely, lack of time for supervision participation and lack of access to experienced same-profession supervisors were found to be major barriers to supervision effectiveness. In addition, lack of overall management commitment to supervision was blamed for variations in supervision practices and this was perceived as negatively affecting supervision efficacy. The association between time and supervision effectiveness will be discussed next, including possible explanations contributed from the qualitative findings.

Time and supervision effectiveness

“To be able to have that time to reflect on what you are doing is very important because you are working so fast now”. Daisy
Time was a strong theme across Study 1 and Study 2. The quantitative findings revealed that the variable “time” was significantly and positively associated with clinical supervision effectiveness in relation to length of supervision session, greater number of sessions and longer experience of supervision over one’s career.

Supervision sessions of more than 60 minutes were rated significantly higher for effectiveness than sessions of less than 60 minutes. Although focus group responses did not specifically address the length of supervision session time, responses did afford a greater understanding of the importance of having adequate time in sessions. Both supervisors and supervisees linked having sufficient supervision session time with greater capacity to provide an increased quality of clinical intervention. Supervisees reported that sufficient session time permitted the careful reflection and examination of clinical practice. This opportunity facilitated the connection between practice and evidence and allowed a space for debriefing critical events. The finding that supervision session times of 60 minutes or longer was significantly more effective than sessions of less than 60 minutes is consistent with findings from clinical supervision studies. For example, Edwards and colleague’s study (2005) of community mental health nurses reported significantly reduced benefits from supervision when sessions lasted for less than 60 minutes. Similarly Watkins’s (2011) review of the clinical supervision literature for psychotherapist populations prompted him to suggest that insufficient time allocated to supervision may be one reason that studies sometimes fail to reveal outcomes from supervision practice. Based on these results it seems that supervision sessions <60 minutes duration may also be of questionable value for allied health workers.

The qualitative findings offer possible explanations for the significant associations found between clinical supervision effectiveness and greater number of supervision sessions. Both supervisors and supervisees reported that a number of sessions were required to allow time for the supervision relationship to establish a foundation of trust that was conducive to open discussion and learning. Even when supervisors and supervisees had previously known each other as peers, time was required for the negotiation and development of this different type of relationship. Trust has previously been recognised as an important element of the supervision relationship as it facilitates a context for learning (Bradley & Hojer, 2009) and contributes to the relational bond component of the
Supervisory Working Alliance (Wood, 2005). This explanation is also consistent with the supervision literature which underscores the importance of allocating adequate time for the development of quality supervision (Siggins Miller Consultants, 2012).

Results showing a significant positive link between supervision effectiveness and longer experience of supervision over one’s career can be understood in light of the focus group findings. Supervisees reported learning from their earlier supervision experiences and then applying those learnings to inform and direct their current supervision practice. This finding supports previous evidence (Hyrkas et al., 2006) that supervisees learn over a period of time how to make best use of supervision. Crow’s (2008) research findings indicate that supervisees are not passive participants and the pre-existing skills and self-efficacy they bring are significant factors in determining the content and initiation of future supervision. While consistent with this literature, the current study adds to this body of work as the research findings also indicate that experienced supervisees intentionally took a proactive approach in supervision to optimise their learning experience. This finding underscores the importance of the supervisor having the expertise to recognise and appropriately respond to the supervisee’s evolving role within the supervision relationship so that supervision outcomes can be maximised.

*I’m sure I could get a lot out of it but I just can’t really give it the time.*” Elizabeth

In contrast, lack of time was seen by supervisors and supervisees as having a detrimental effect on the quality of the supervision. Due to time pressures, a number of supervisors reported being unable to provide supervision as frequently as prescribed. Lack of supervision time was blamed for reduced opportunities for supervisees to receive support, professional development, and refreshment in their roles. Supervisees sometimes needed more guidance than was being provided and sought additional advice from informal sources (e.g., peers) to address their unmet supervision needs. Whereas formal supervisors had been identified as competent by a management-staffed interview panel, these quality control measures were not applicable to informal supervisors. Also, as unofficial supervision was various and occurred “on the run”, their activity was not bound by the usual supervision requirements (e.g., use of supervision agreements and session records). This is concerning as the current study showed that structured supervision processes were associated with increased overall supervision effectiveness. In addition,
some supervisors reported that, due to time constraints, they left it to their more experienced supervisees to initiate supervision for when they required guidance. This usually occurred in situations where supervisory oversight was intermittent. Without regular supervisory oversight and a sound knowledge of a supervisee’s skills and knowledge, it would be difficult to determine whether advice was always sought when needed. This also resulted in some supervisors being caught in a cycle of providing reactive problem-solving responses rather than having opportunity to proactively access and address supervisee ongoing learning needs.

Having time available to attend supervision sessions was significantly associated with lower levels of emotional depletion in Study 1, however having insufficient time to participate in supervision was linked to supervisor stress in Study 2. Several supervisors described feeling continually under pressure having to balance their clinical caseload commitments as well as meet supervision provision requirements. They reported that supervision had been implemented without the provision of additional resources or reduction in their clinical loads. Some supervisors also reported that insufficient time occasionally prevented them from providing carefully considered advice to supervisees as there wasn’t time to consider all aspects of the situation. Supervisors were concerned that time constraints could result in the provision of incorrect advice, especially when urgent matters arose necessitating a rapid response. Fears were voiced about the accountability for such actions, should the advice lead to negative consequences.

These findings suggest that insufficient time for supervision represents a possible risk to the delivery of safe clinical practice. For example, the receipt of infrequent supervision reduces the prospect of ensuring that clinical practice is anchored to contemporary evidence. In addition, the quality and safety of the informal, unmonitored and unsanctioned supervision being provided was unknown. Without the ‘paper trail’ detailing supervision activities, it would be difficult to assess whether the informal advice had been followed and if so, whether the outcomes had been beneficial or detrimental. Finally, it is disquieting that supervisors themselves raised concerns about the possible negative impact of lack of time on the quality of advice provided. Infrequent supervisory oversight, supervisors feeling pushed to provide clinical advice in rushed supervision sessions, supervision
delivered by unofficial supervisors, and leaving supervision sessions to be initiated by supervisees, could all result in less than best practice interventions.

The finding that lack of time caused stress for supervisors is consistent with reports from a study of community mental health nurses. Edward’s study (2005) found that nurses grappling to find time for supervision scored higher levels for Emotional Exhaustion than those with time for supervision. Lack of time is consistently reported as a formidable barrier to supervision effectiveness in the clinical supervision literature (Cummins, 2009; Hair, 2008; White & Winstanley, 2010). Therefore the findings noted above are not unique to the study location although they do provide additional information about the potential negative impact on the effectiveness of clinical practice when there is insufficient time available for supervision.

Structures supporting best practice principles and supervision effectiveness

“Following the structured templates, I think is helpful so that keeps you to time and also the outcomes and actions and follow ups.” Cadence

Findings from Study 1 revealed that supervisees who utilised a structured supervision framework based on best practice principles were significantly more likely to perceive their supervision to be effective, than did others. These findings were mirrored in the focus groups. The best practice principles as identified from the clinical supervision literature included meeting all of the following five criteria: receiving clinical supervision (Clinical Education and Training Queensland, 2010), having some choice in the allocation of clinical supervisor (Dawson et al., 2012; Edwards et al., 2005), attendance at clinical supervision training (Bradley & Hojer, 2009; Dawson et al., 2013b), having a completed clinical supervision agreement (Clinical Education and Training Institute, 2011; Spence, Wilson, et al., 2001) and having a clear understanding about the boundaries of confidentiality in the clinical supervision relationship (Clinical Education and Training Institute, 2011; Dawson et al., 2012). As well as having higher overall scores for supervision effectiveness, those who employed all five best practice principles rated the overall effectiveness of the Restorative domain more highly than the published benchmark.
Although not statistically significant, the difference was noteworthy as the MCSS-26© benchmark relates to allied health staff where clinical supervision has been well-established (Winstanley & White, 2011). As mentioned, formalised supervision practice had only commenced six months prior to the data collection. The Restorative domain measures the level of trust and rapport with the supervisor, the ability to discuss sensitive matters, and the extent of support and guidance afforded (Winstanley & White, 2011).

Specifically, the variables ‘receiving clinical supervision’, ‘having choice of clinical supervisor’, and ‘having a supervision agreement’, were significantly associated with higher overall supervision effectiveness scores. Further, ‘having choice of clinical supervisor’, and ‘having a supervision agreement’ were significantly associated with higher scores for all three supervision domains, being the Normative, Formative and Restorative. The importance of these components was echoed in both the supervisor and supervisee Focus Groups.

Supervisors and supervisees regarded the use of structured processes such as a completed supervision agreement as important for the efficient and effective use of supervision time. Supervisees reported that the supervision agreement enabled them to negotiate their learning goals, remain outcome-focused and stay on track during supervision sessions. The standardised agreement was considered by supervisors to be a useful tool for delineating the different roles of the clinical supervisor from the operational supervisor. The use of documentation such as supervision agreements is commonly recommended in the clinical supervision literature (Clinical Education and Training Institute, 2011; Dawson et al., 2013b; Nancarrow et al., 2014), however no other study could be located that decisively linked increased supervision effectiveness with supervision agreements. For example, Kuipers and colleague’s (2013) study of peer group supervision reported greater impact was associated with structured arrangements however the use of supervision agreements was not linked with positive outcomes. In another example, Andersson and colleagues’ (2013) qualitative study of nurse preceptors claimed that a “contract” contributed to a safe and trusting environment, however the results were not convincing as this conflicted with participants’ reported concerns about the “breaking of rules” and “difficulties in reaching a climate of openness and trust” (p. 268). In support of the current study’s findings, a recent study of clinical supervision outcomes for
physiotherapists suggested that the effectiveness of the supervision may have been hindered by the absence of a structured supervision framework (Snowdon et al., 2015).

A number of supervisors saw the process of allowing supervisee choice of supervisor as the reason that there had been a minimal the number of breakdowns in supervision relationships. Supervisees confirmed the importance of this process though their comments that they would not disclose sensitive matters to the ‘wrong supervisor’. In contrast, supervisees and supervisors from the smaller professional groups experienced a limited choice of supervisor due to the reduced supervisor pool and they reported that this was a barrier to supervision effectiveness. The significant positive association found between choice of clinical supervisor and supervision effectiveness is consistent with recommendations in the clinical supervision literature (Dawson et al., 2013b). Edwards et al (2005) found that supervisees who were given a choice of supervisor perceived the quality of the supervision to be higher than for supervisees without a choice. Interestingly, Dawson et al. (2012) in their study of allied health supervisees suggested that, for many, the lack of choice of supervisor may have had a detrimental effect on the quality of the supervision relationship. They argue that this may explain the low effectiveness scores supervisees attributed to the support subscale “personal issues” in their study, as supervisees may have been unwilling to disclose problems of a sensitive nature to their allocated supervisors. Participants in the present study emphasized that, for supervision to be effective, the supervision relationship needed to be built on a foundation of trust and this appears to be one reason for the finding of the significant association between supervision effectiveness and choice of clinical supervisor.

The above findings indicate that implementing supervision that includes providing a choice of supervisor and providing supervision agreements for use in supervision is likely to promote the delivery of supervision that meets the three broad functions of providing supervisees with professional support, education and guidance for their practice. Although the health service had sought to implement clinical supervision based on best practice as was articulated in the organisation’s supervision guidelines, findings revealed significant variations occurred across the service. Results indicate that these variations detracted from the overall effectiveness of the supervision and this area is discussed next.
Inconsistency and supervision effectiveness

“Someone who I job share with … she hasn’t done it at all. So, I’ve had a year of supervision and she’s had none, so perhaps, that could be a bit more consistent so everyone has the opportunity.” Caitlin

Lack of consistency in supervision practice and processes was evident in both Study 1 and Study 2 findings and was confirmed by supervisors and supervisees alike. For example, 30% of respondents were utilising all five best practice principles, as outlined in the service’s supervision guidelines, leaving 70% not adhering. Irregularities also existed in allied health worker’s access to supervision, supervisor recruitment processes and level of support for supervisors, operational managers’ understanding of supervision and their support for staff to attend supervision. These variations were viewed as a significant barrier to the overall effectiveness of the supervision. The service’s lack of a consistent approach to clinical supervision across the organisation was blamed for the fragmentation of supervision practices. Supervisors perceived a lack of interest and support for supervision from some areas of upper and middle management and this made it difficult for them to remain committed to the supervision program. Some supervisors blamed the inconsistencies on the absence of a position, or positions, with dedicated responsibility for providing supervision governance and “driving” the supervision program.

Findings indicated that there had been a broader failure to obtain a consistent and committed whole-of-service approach to clinical supervision. It may that allied health management was unable to achieve service-wide “buy in” regarding the value of implementing supervision for allied health staff. This might partially explain the challenges in obtaining consistency of implementation as many allied health professionals were operationally managed by nurses. Interestingly, clinical supervision practice was not adopted by the dominant section of the organisation, the nursing workforce. Authors have noted a determined resistance to the introduction of supervision by the nursing profession in Australia (Stein-Parbury, 2013; White, 2016; Yegdich, 2001).

The dominant workplace culture can play a major role in determining whether a new practice is successfully implemented. It is claimed that organisational culture, and indeed
subcultures within organisations, often determine what is important and how members ought to respond to new requests (Taylor, 2014). Taylor (2014) points out that innovations can fail due to an absence of alignment between the cultures within an organisation. Butterworth and colleagues’ (2008) review of the clinical supervision literature led them to state that organisational culture was consistently reported to play an important role in the success or otherwise of supervision implementation. Similarly, in White and Winstanley’s (2010) large study of Queensland nurses, the researchers stated that the views of middle managers significantly influenced the study’s supervision outcomes, with their lack of support being a major barrier. Hall and Bell (2013, p. 565), in their discussion of professional support for allied health professionals state that “Provision of training and resources alone does not necessarily result in uptake or implementation of professional support” and they stress that success requires the involvement of the whole workforce. With the study location being swept up in so many organisational, state and national changes (see Chapter 1), it would have been a challenging time to direct sufficient attention and resources to the implementation of a new practice without an organisational culture of shared commitment to its success. Even with the above challenges, it is striking that overall clinical supervision effectiveness was achieved; a credit to the actions of supervisees, supervisors, and those managers who guided and supported the implementation of clinical supervision.

In summary, the mixed methods findings showed that longer supervision session times, greater number of sessions and longer experience of supervision over one’s career were all significantly positively associated with supervision effectiveness. Having structured supervision processes, and specifically supervisee choice of supervisor and supervision agreements, were also significantly positively associated with supervision effectiveness. Conversely, lack of time for supervision participation and lack of a consistent organisation-wide supervision approach were found to be major barriers to supervision effectiveness.

The above findings support the adoption of a Social Ecological lens as the overarching theory in the study’s conceptual framework (see Conceptual Framework, Chapter 3). Derived from systems theory, this model emphasises the importance of interrelationships between multi-layered features in the environment (Stockols, 2000). The model highlights how various tiers in the context can influence individual’s actions and vice versa. It has
been suggested that principles of Social Ecology can usefully guide the implementation of complex programs, especially when multiple interventions are required, as the approach encourages consideration of the existing context (Goodman, 2000). Contextual aspects can prevent necessary interventions occurring concurrently, thereby limiting success. In this study, change was required at several key areas of the organisation, in particular, within policy, practice, and culture. For example, the study’s findings indicate that the contexts of varying levels of management commitment, National and State events, and the significant organisational changes, directly and indirectly impacted the supervision implementation process. Hence the prevailing Exosystem (International, National and State events) and Macrosystem (health service management) environments impacted the effectiveness of supervision outcomes at the Meso (within supervisory relationships) and Micro levels (intrapersonal). Thus, multiple near and far (but interconnected) elements in the context flowed on to those who were operating at the coal-face of service delivery. Embracing a Social Ecological lens has facilitated a comprehensive analysis of these complex phenomena.

8.1.4 Question 3

What is the relationship between perceptions of effectiveness of clinical supervision and supervisees’ reports of levels of intention to leave?

“A positive about supervision is that I felt it provided a sense of belonging to an organization, particularly in an otherwise demanding, challenging workplace.”

Charlotte

In Study 1, effective supervision was significantly associated with reduced intention to leave. Focus group findings resonated with survey findings, indicating that effective supervision increased supervisee morale and reduced their intention to leave. When supervisees experienced supervision as encouraging and valuing, this increased their sense of connectedness to the employing organisation. Therefore, in the context of the supervisory relationship, supervisees felt a greater attachment to the organisation, even though the service was in the midst of undergoing major structural reform. These findings suggest that the supervisor had somehow come to personify the bureaucracy in that the
supervisee’s connection with their supervisor seemed to translate into a stronger overall connection with the organisation.

The finding that supervisees felt an increased connection with the organisation is consistent with previous evidence that supervisees may generalize their perceptions of their supervisor to the employing organisation. (Eisenberger, Stinglhamber, Vandenberghhe, Sucharski, & Rhodes, 2002). For example, Knudsen and colleague’s study (2008) of substance abuse counsellors showed that supervisees’ perceptions of the fairness of the organisation were moderated through supportive relationships with their supervisors. This led the authors to suggest that quality supervision could act to bond employees to the organisation and reduce worker turnover. Similarly, Maertz et al (2007) revealed that supervisees in their study viewed their supervisors as representatives of the organisation and therefore the supervisors had the capacity to shape the supervisee’s views about elements of the organisation, such as justice and fairness. The researchers also found that high support from supervisors mitigated low support from the organisation; however when supervisor support was low, supervisees looked directly to the organisation to meet their support needs. Others have recognised that clinical supervision can be a strategy for increasing attachment to the employing organisation when the supervision being provided is of high quality and there is a positive supervisory relationship (Ellett et al., 2007; Kim, 2008). Also supervisees’ perceptions of their relationship with the employing organisation have been shown to influence both their well-being and job satisfaction (Mihail & Kloutsiniotis, 2016). The current study’s results confirm these earlier findings that supportive supervisor relationships can facilitate greater supervisee attachment and commitment to their employing institution.

“It’s made such a difference to me as a practitioner. It helps you stay really focused on why am I here and it helps you stay focused on the positives that you are getting all the time because they are easy to forget about.” Ella

Study 1 findings showed a significant association between effective supervision and increased Personal Accomplishment. Supervisees reported that having a safe, trusting supervision relationship where they felt recognised and that their work was worthwhile,
increased their sense of job satisfaction. In addition, many supervisors said that providing supervision was challenging but also deeply satisfying, making their job more interesting.

Although the Personal Accomplishment subscale is a measure of burnout, Carson (2009) suggested, following his review of evaluation instruments, that this subscale of the Maslach Burnout Inventory was a proxy measure for job satisfaction. This view seems to have been confirmed by others who have excluded the Personal Accomplishment subscale from the burnout measurement model (Kim & Lee, 2009), noting that the Emotional Exhaustion subscale is the core component of burnout (Koeske & Koeske, 1989). If Personal Accomplishment equates with job satisfaction then the findings demonstrate that effective supervision was not only associated with reduced intention to leave, but also with increased job satisfaction. Research has previously demonstrated that employees enjoy higher job satisfaction when they feel that their work is “making a difference” (Stalker et al., 2007, p. 182). While effective supervision has been linked to increased job satisfaction, studies have also demonstrated associations between ineffective supervision and lack of access to supervision to decreased job satisfaction (Hyrkas, 2005; Lloyd & King, 2001; Wilson, 2015). This may partially explain the variations in levels of intention to leave and personal accomplishment found in this study.

The above findings are consistent with the adoption of a Job Demands-Resources Model as part of the study’s conceptual framework (see Chapter 3). This model proposes that certain activities in the workplace, such as supportive and constructive feedback and enhancement of competence, can increase the level of job resources that are available to workers. By providing sufficient job resources, the model claims that the burden of job demands can be reduced, assisting workers to achieve their work goals and thereby reduce turnover intention (Bakker et al., 2005).

8.1.5 Question 4

What is the relationship between perceptions of effectiveness of clinical supervision and supervisees’ reports of levels of burnout?
“I was in a really bad place .... so getting my clinical supervision organized and constantly every month ....I regained my confidence, so that now I feel like I can still cope.” Emily

Health care workers are considered to be at high risk of burnout due to the caring aspects of their role (Lloyd & King, 2001; Sawbridge & Hewison, 2011). The current research findings would confirm this view as over 40% of Study 1 participants had scores indicating high levels of Emotional Exhaustion, the core component of burnout. Even so, the findings demonstrated that highly effective supervision (i.e. total MCSS-26© scores > 85) was significantly associated with lower levels of emotional depletion in supervisees. Study 2 findings provided insight into ways supervision was perceived to reduce burnout. Supervisees reported that supervision provided a safe place to communicate their concerns, seek advice and gain strategies to manage stress related to critical incidents, workplace conflict and organisational change. Although a higher threshold of supervision efficacy had to be met to demonstrate this relationship, the finding shows that highly effective supervision can act as a resource to protect worker well-being and mitigate the risk of worker burnout. Studies have previously linked effective supervision with lower levels of burnout (Edwards et al., 2006; Hyrkas, 2005) while others have suggested that ineffective supervision may cause harm to supervisees (Dawson et al., 2012; Ellis, 2010). To add to the empirical complexity, other studies have had mixed findings, such as for White and Winstanley (2010), where effective supervision was linked with lower Emotional Exhaustion in supervisors but not supervisees. This led the authors to suggest that only “demonstrably efficacious” supervision may promote the supervisee’s well-being (p. 161) and this perspective would align with the findings of this research program.

“It's made a huge impact. As soon as you feel, ah, yes, all right, it flows off and you’re not tired, burnt out, stressed; of course you’re going to provide a better service.” Ella

Study 1 findings showed a significant association between highly effective supervision (i.e. total MCSS-26© scores > 85) and lower levels of negative attitudes towards clients. Correspondingly, Study 2 findings illustrated that supervision provided supervisees with
opportunities to debrief distressing events, therefore providing refreshment of the worker. Supervisees reported that this allowed them to work effectively with challenging client populations, and yet still preserve their sense of well-being. These findings suggest that highly effective supervision can assist health practitioners to effectively manage the emotional aspects of their caring role and continue to be sensitively available to continue to provide high quality care.

These results support previous research that demonstrated links between effective supervision and reduced Depersonalisation in a study of community mental health nurses (Edwards et al., 2006). It has been suggested that health care workers without opportunity to reflect, process and make meaning of distressing experiences, may unconsciously shift their unresolved feelings to patients; adversely affecting the quality of their care (Jones & Cutcliffe, 2009).

While patient outcomes were not the focus of this research, previous studies have linked burnout to lower patient satisfaction and poorer patient outcomes (Garman et al., 2002; Hawes, 2009), prompting the suggestion that burnout is “antithesis to quality health care” (Thanacoody et al., 2009, p. 54). Given that almost two-thirds (65.3%) of respondents in Study 1 had scores within the high to moderate range for Emotional Exhaustion, the current research findings have important implications as supervision was successfully employed to mitigate worker burnout. Based on these findings, it also seems reasonable to suggest that supervision may be one way to maintain high quality health care standards and, thus, indirectly contribute to positive patient outcomes.

The above findings provide further support for the Job Demands-Resources Model as part of the study’s conceptual framework (see Chapter 3). Burnout is considered to result from chronic stress in workers who have frequent and intense interactions with other people (Maslach et al., 1996) and is known to occur in the health care workforce (Sawbridge & Hewison, 2011) . The current research findings indicate that effective supervision can provide job resources for supervisees in the health care workforce to debrief distressing events and thus offset job demands. Therefore it is suggested that effective supervision can mediate the effects of job demands by providing a buffer to stress and burnout (Howard, 2008).
8.1.6 Question 5

What are the discipline-specific differences\textsuperscript{11} in: perceived effectiveness of clinical supervision, intention to leave, and burnout?

\textit{“A lot of it (supervision) is emotional support and that’s not something that we are trained in as such”}. Brionne

Profession-specific differences were not detected in Study 1 for burnout or intention to leave associated with supervision, however significant profession-specific differences were found for clinical supervision efficacy. As mentioned previously (under Question 1 in this Chapter), physiotherapy as a group, scored significantly lower than the efficacy threshold, which was in contrast to the groups of occupational therapy and social work. Study 2 findings showed that supervision was not a familiar practice for physiotherapists and therefore practices and processes were new for that profession. Physiotherapy supervisors identified that supervision required a specific skill set; in particular skills associated with providing emotional support, which they reported were not part of their undergraduate training. Hence this skills deficit was cited by physiotherapy supervisors as reducing their level of supervisory confidence and competence and this may partially explain the low efficacy rating given by physiotherapy supervisees. This finding is similar to another Australian study of supervision effectiveness in physiotherapy supervisees, where over half of those surveyed, reported that supervision had been ineffective (Snowdon et al., 2015). However unlike Snowden and colleague’s study, participants’ responses from the current research showed that the reduced level of efficacy for the group could be due to the profession’s undergraduate training. More specifically, the findings suggest that this group’s reduced efficacy may be related to an identified skills deficit in physiotherapy

\textsuperscript{11} The professional groups of Dietetics, Podiatry, Psychology, and Speech Pathology were represented in very small numbers in the focus groups. Therefore discussion of profession-specific differences has mostly been limited to the three largest professional groups of Occupational Therapy, Physiotherapy and Social Work. These results should be interpreted with caution given the small sample size.
supervisors. Therefore to facilitate supervisor competency across professions, it is recommended that supervision training be tailored to ensure the content addresses any profession-specific learning needs.

“For social work .... it's a very intricate and necessary part of how we provide a service”. Amelia

Significant differences were also found between the three largest professional groups for the variable of time. In contrast to the groups of occupational therapy and physiotherapy, social workers as a group were more likely than not to be attending supervision sessions of 60 minutes or longer and more likely than not to have been receiving supervision for over two years. The professions of social work and psychology have traditionally embedded supervision within their professional learning cultures and are therefore more likely to embrace supervision as part of ongoing practice (Bogo et al., 2011; Dawson et al., 2012). This acceptance and valuing of supervision was reflected in the qualitative findings and may explain why social workers as a group tended to have longer supervision sessions and to have been receiving supervision over a longer period of time than had those in occupational therapy and physiotherapy. In contrast, some of the other allied health professions saw supervision as an activity that sat outside of clinical practice. Although there did not appear to be resistance to supervision, as has been described in the nursing professions (Cleary et al., 2010; Fletcher, 2008), supervision practice and processes were seen as new and alien for these professional groups, and the practice required more time to become established. Despite these differences, those professional groups less familiar with supervision indicated that there had been progress and supervision had become more accepted as part of standard practices.

While there were areas of clear difference in supervision effectiveness between the disciplines, subsequent analysis indicated that length of supervision session had a stronger association with clinical supervision efficacy, than did professional group differences. That is, the scores appear to be more related to time rather than anything that was discipline-specific. This result does not reduce the influence of professional group and underscores the importance of ensuring clinicians have a minimum time of sixty
minutes available to attend clinical supervision sessions and have access to supervision training that takes into account profession-specific learning needs.

8.2 Recommendations

Based on the research findings, effective clinical supervision is significantly associated with increased job satisfaction, reduced intention to leave, reduced burnout and reduced depersonalisation. In light of the above significant associations, effective clinical supervision may also indirectly contribute to high quality patient care. The following recommendations are offered.

1. Clinical supervision needs to be effective if the practice is to deliver positive outcomes.

2. Given the reported high levels of stress in allied health workers, the high costs of worker turnover, and the critical role that allied health staff have in the delivery of health care, the implementation of effective clinical supervision is recommended to facilitate workforce sustainability and enhance patient outcomes.

3. The implementation of effective clinical supervision requires resources including a structured framework of supervision guidelines (outlining supervision frequency, roles and responsibilities and boundaries of confidentiality), standardised supervision agreements, supervision sessions of more than 60 minutes duration, processes for supervisee choice of supervisor, and supervision training for all participants. The content of supervision training needs to address any profession-specific learning needs, such as interpersonal communication skills associated with support-giving.

4. Implementation of effective clinical supervision requires shared commitment from all levels of organisational management and a culture that values and supports clinical supervision practice. A prerequisite to implementation may include awareness-raising for managers and leaders about the potential benefits of effective supervision.

5. The supervision framework incorporates a formal communication process between clinical supervisors and health service managers. This would enable managers to effectively utilise the valuable resource provided by supervisors’ connection to the
coalface of practice and facilitate the early identification of emerging clinical and service issues to ensure an appropriate and timely response.

6. Time for supervision to be protected by embedding into standard work practices. Strategies may include timetabling allocated supervision sessions into work schedules and ensuring the clinician’s workload is reasonable and allows adequate time for supervision. Time away from direct clinical duties to attend supervision to be viewed as an intervention to ensure the safety and quality of clinical practice, the rapid translation of evidence into routine practice, and continued sustainability of the workforce. Supervision sessions to allocate a minimum time of sixty minutes in order to be effective. Time for supervision preparation and follow-up would be additional to the sixty minutes.

7. Supervision practice to continue during the clinician’s work career given that supervision benefits increase over time.

8. Supervisors maximise learning outcomes by adapting the supervision content and style to correspond with the developmental needs of supervisees and be responsive to the supervisee’s evolving role and developing expertise within the supervision relationship.

9. Supervisors receive professional support to carry out their roles, including the receipt of supervision for their supervisory responsibilities and supervisor training.

10. Evaluation of supervision outcomes be measured no sooner than 12 months post-implementation of supervision practice as the time-frame of six months duration may be premature for the optimum measurement of outcomes.

8.3 Summary

In summary, the following conclusions were drawn based on interpretation of the integrated mixed methods findings. Overall, allied health staff perceived the supervision they received as being effective for providing support, education and guidance for their professional practice. An exception was found for the professional group of Physiotherapy where as a whole, the group’s mean was significantly lower than the published normative data (Winstanley & White, 2011). Even so, the overwhelming majority of allied health staff perceived the supervision they received as being effective.
A number of variables that enhanced the effectiveness of supervision were identified. Supervision session times of 60 minutes or longer, greater number of supervision sessions and longer experience of supervision over one’s career were all significantly and positively associated with supervision efficacy. Conversely, lack of time for supervision was found to be a major barrier to effectiveness. Whereas having time available to attend supervision was associated with significantly lower levels of Emotional Exhaustion, lack of time was reported to cause stress for supervisors and reduce opportunities for support, professional development, and refreshment of supervisees. The qualitative findings help to explain the important role of having adequate time for supervision and the significant positive association found between longer supervision session time and overall supervision efficacy.

Having a structured supervision framework incorporating best practice principles was also associated with increased supervision effectiveness. Specifically, the variables “receiving clinical supervision”, “having some choice in the allocation of clinical supervisor”, and “having a completed clinical supervision agreement”, were significantly associated with higher supervision effectiveness. As well, those who employed all five best practice principles (receiving supervision, choice of supervisor, attended supervision training, completed supervision agreement, understanding of confidentiality boundaries in supervision) scored more highly for the Restorative domain than the published benchmark. Although not attaining statistical significant, there was a strong trend and the difference was noteworthy as the MCSS-26© benchmark relates to allied health staff where clinical supervision has been well-established (Winstanley & White, 2011), whereas formalised supervision practice had only commenced in the study location six months prior to the data collection. Although the health service had sought to implement a common model of clinical supervision based on best practice, findings revealed significant variations across the service. The reported failure to achieve a consistent and committed whole-of-organisation approach to clinical supervision for allied health had led to a negative impact on the effectiveness of supervision.

Despite over 40% of Study 1 participants indicating high levels of Emotional Exhaustion, the present findings demonstrated that highly effective supervision was significantly associated with lower levels of emotional depletion and lower levels of negative attitudes
towards clients. Supervisees reported that supervision was a place where they could safely communicate their concerns and seek advice. The study’s findings also demonstrated a significant negative relationship between clinical supervision effectiveness and intention to leave. That is, those who perceived they were receiving effective supervision had increased sense of work accomplishment and lower levels of intention to leave.

The professional discipline groups shared many commonalities across their clinical supervision practice, however there were important significant differences associated with differing levels of perceived clinical supervision efficacy. Physiotherapy as a group perceived supervision to be ineffective, in contrast to the groups of occupational therapy and social work. Study 2 findings suggested that a skills deficit in physiotherapy supervisors may have contributed to this professional difference. Profession-specific differences were also found in relation to the variable time. Social workers as a group were more likely than not to be attending supervision sessions of 60 minutes or longer and to have been receiving supervision for over two years than not, in contrast to the groups of occupational therapy and physiotherapy.

8.4 Conclusion

This chapter began with a discussion of the study’s limitations and strengths. It then presented an interpretation of the mixed methods findings, showing links between the findings and the empirical clinical supervision literature. Also included, was a discussion of the Conceptual Framework and its relevance in light of the study’s findings. The chapter conclude with recommendations drawn from the study’s findings. The final chapter builds on these findings as it presents the major conclusions to the research program’s central questions and concludes with a discussion of the implications for future clinical supervision research.
9 Conclusion

This final chapter builds on the integrated findings that were presented in the previous chapter. The presentation commences with a brief introduction, followed by a discussion detailing the study’s limitations and strengths. This is followed by a response to the study’s hypothesis. A summary of the major conclusions to the research program’s central questions are then presented. The chapter concludes with a discussion of the implications for future directions in clinical supervision research.

9.1 Introduction

The majority of published empirical clinical supervision literature to date has addressed nursing populations (Carson, 2007). There have been limited studies to determine whether clinical supervision is effective for allied health professionals and fewer studies have been conducted within Australia (Dawson et al., 2013a). Current approaches to clinical supervision for allied health within the Australian health context are fragmented and poorly coordinated (Fitzpatrick et al., 2012). In addition, there is a paucity of research comparing the experiences of Australian allied health professionals utilising a common model of clinical supervision (Dawson et al., 2012). The context for the present study offered a unique opportunity to extend knowledge and understanding about the outcomes of clinical supervision for allied health professionals across several discipline groups. The intervention (clinical supervision) was shaped by the organisation’s guidelines which were framed by principles drawn from the clinical supervision literature. The clinical supervision approach was applied across multiple sites within the one community health service. This provided the opportunity for some consistency of application in the clinical supervision practice across the allied health disciplines. In contrast, many studies have paid little attention to the detailed practices that underlie the supervision being evaluated (Watkins & Milne, 2014).

9.2 Limitations and Strengths

The study has a number of limitations and strengths. As this research design did not incorporate a randomized control trial (RCT) for Study 1, it was not possible to compare
the outcomes with a no-treatment group. Although some have criticized the RCT method “as a reductionist approach to understanding the nature of causality in the social world” (Creswell & Plano Clark, 2011, p. 359), its omission does mean that a limitation of the research design is the reliance on correlational data. Consequently it is not possible to establish causal relationships from the research findings. Also, the research findings cannot be generalized beyond the community health service study site. While the total sample for this study was of sufficient size, some professional groups were small, meaning the small cell sizes prevented their inclusion in analyses specific to determining profession-specific differences. Total recruitment for the focus groups was 26 out of a potential sample of 60. A greater number of focus group participants may have resulted in the materialisation of different themes. The timing of the implementation of the focus groups, four months after the survey, was not sufficient to allow for completion of the analysis and interpretation of the survey findings. This meant that focus group questions were not targeted as specifically as they could have been. The focus groups were implemented at that time because the service was about to undergo significant change processes that would have had a negative impact on recruitment.

The strengths of the study include the use of validated scales for measuring clinical supervision effectiveness, burnout and intent to leave. Two of the three scales have published normative benchmarks based on large sample sizes across health professions. The data collection methods were familiar to allied health professionals. The intervention was applied under optimum conditions as the organisation’s model of supervision was based on best practice principles. The study location, being one health service, meant the intervention, a standardised model of clinical supervision, was implemented for the whole allied health workforce located across several community health sites. This increased opportunity for the variables to be held constant during the duration of the research although not all respondents adhered to the clinical supervision model. The researcher was able to sample the total population of allied health staff within the service, and the survey was completed by more than half of the staff, which strengthened the degree of internal validity. Another strength of the study was the mixed methods design which allowed the investigation of outcomes and processes (Aarons et al., 2012). Adopting more than one method for the inquiry and explanation of a study’s findings increases the integrity and credibility of the study’s results (Creswell & Plano Clark, 2011) and increases
the relevance and ecological validity of the findings (Bryman, 2008; Padgett, 1998). Indeed, the convergence of the major findings in Study 1 and Study 2 adds corroboration to the research’s overall findings.

During the period of the study the researcher was employed as a social worker at the research location. This “insider” position (Humphrey, 2012) brought both strengths and limitations for the research program (discussed in Chapter 4). As the researcher was aware of the impending implementation of formalised supervision within the service, there was opportunity to approach the management to discuss the possibility of undertaking the research. Being alert to approaching organisational changes within the service meant that the researcher was able to implement data collection at an optimum point-in-time for both the research program and the organisation. A limitation was that the researcher had to regularly reiterate the differences with management and staff, between her role as an employed social worker and her other role as an independent researcher. Also, as an insider researcher there was the constant challenge of ensuring that study participants’ responses were viewed with ‘fresh eyes’, a process assisted through engagement in reflexivity (Weber, 2003, p. xi) during receipt of academic oversight. Whilst the timing of the study presented challenges around recruitment with the service having commenced a period of restructuring, this also provided an opportunity to test the effectiveness of supervision for staff working amidst organisational change.

9.2.1 Hypothesis

The findings support the hypotheses.

1. Effective clinical supervision will be negatively correlated with intent to leave and with burnout.
2. Those receiving effective clinical supervision will report higher levels of professional development, guidance and support for their professional practice than those receiving ineffective clinical supervision.


9.3 Discussion of major conclusions
In response to the research questions, the following conclusions were drawn based on interpretation of the integrated mixed methods findings. These major conclusions have been written to link with the primary points of justification raised in the Introduction, Chapter 1.

9.3.1 Clinical supervision effectiveness - Implications for practice and policy
Clinical supervision is being increasingly adopted as a standard practice within health services (Clinical Education and Training Institute, 2011; Council of Australian Governments, 2008), however uncertainty has remained about the outcomes of clinical supervision (Carpenter et al., 2013) and even less is known about the outcomes for the allied health professions (Dawson et al., 2013a). The current study’s findings demonstrate that clinical supervision was effective for providing support, education and guidance for allied health workers’ professional practice, even though the data collection occurred during a time of rapid organisational change. This is an important finding as the current healthcare landscape is one of expeditious and ongoing transformation as health care systems seek to adapt to changing and increased needs. Having effective workforce strategies such as clinical supervision is an essential component as health systems continue to respond to emerging challenges.

The findings identify specific factors that were linked with clinical supervision effectiveness in this study. These include having a structured clinical supervision framework based on best practice principles (receiving supervision, choice of supervisor, attending supervision training, completing supervision agreement, understanding of confidentiality boundaries in supervision), as well as having supervision sessions of 60 minutes or longer. In addition, characteristics of ineffective supervision included a lack of time to attend supervision and inconsistent organisational supervision processes.

Given the need to make efficient use of the resources required to provide clinical supervision, these research findings have the potential to make a valuable contribution to an effective and stable allied health workforce through their translation into clinical supervision policy and practice.
9.3.2 Implications for profession-specific differences in clinical supervision

Current approaches to the implementation of clinical supervision in Australian health services promote a “united model of clinical supervision” for all allied health workers regardless of their individual profession (Fitzpatrick et al., 2012, p. 464). Others acknowledge the benefits of introducing a universal model of clinical supervision but at the same time raise concerns about the diversity of the disciplines comprising the allied health professions and the need for further research into this area (Kumar et al., 2015). Indeed, some have suggested that the skills required by supervisors differ between the individual allied health professional groups (Dawson et al., 2012; Health Workforce Australia, 2010), yet, thus far, there is a paucity of research comparing the experiences of allied health professionals utilising a common model of clinical supervision. The current study responded to this need by examining the application of a single model of clinical supervision across a range of allied health professionals and the findings add to this developing evidence base.

Findings from the study confirm that the larger professional discipline groups did share many commonalities across their clinical supervision practice, however there were important significant differences associated with clinical supervision effectiveness. There were two major areas of difference. Firstly, physiotherapy supervisors reported that they did not feel competent in providing the support function of clinical supervision. They identified that this aspect of supervision required skills associated with providing emotional support, which they reported as not being part of their undergraduate training. This may partially explain why physiotherapy, as a group, perceived supervision to be ineffective, in contrast to the groups of occupational therapy and social work. Similarly, Dawson et al. (2013b), in their study of Australian allied health supervisors, of which half comprised Physiotherapists, found that the support function was the least frequently articulated and suggested that this may have been the result of a knowledge gap in the supervising professionals. Some have reported that physiotherapists struggle to clearly understand the purpose of clinical supervision, sometimes confusing it with operational supervision, causing them to question the need to participate in supervision practice (Hall & Cox, 2009). However this was not reported by physiotherapists in the current study, perhaps
due to the supervision purpose being clearly outlined in the organisation’s supervision guidelines, supervision agreements and training.

In the second area of professional differences, social work, as a group, was more likely to be having supervision sessions of more than sixty minutes and more likely to have received supervision for more than two years. In contrast, the occupational therapy and physiotherapy groups were more likely to have supervision sessions of less than 60 minutes and to have received supervision for less than two years. This is an important finding given that sessions of more than 60 minutes and longer experience of supervision over one’s career were linked with clinical supervision effectiveness. The social work profession was an early adopter of supervision practice (Lynch et al., 2008) and this may explain why supervision has been embedded within its history, practice and professionalism more broadly (Dawson et al., 2012; Roche et al., 2007).

The study’s findings confirmed that profession-specific differences were evident in supervision practice and these differences related to the distinctive histories, traditions and undergraduate training of the individual allied health professions. Importantly, profession-specific differences were significantly associated with clinical supervision effectiveness. However, subsequent analysis indicated that length of supervision session had a stronger association with clinical supervision efficacy, than did professional group differences. Although this result reduces the influence of professional group, it underscores the importance of ensuring allied health workers have a minimum time of sixty minutes available to attend clinical supervision sessions. Still, findings from the study suggest that clinical supervision may be more effective across a range of allied health disciplines if the content of supervision training addresses profession-specific learning needs, including interpersonal communication skills associated with giving support. Therefore, the study’s findings indicate that a ‘one-size-fits all’ approach applied across the allied health workforce may not be best practice unless it can accommodate the needs and characteristics of all the individual professions.
9.3.3 Implications for workforce retention

There are worldwide shortages in the healthcare workforce industry (Alkorashy & Baddar, 2016), including in the allied health professions (Australian Government, 2014; Health Workforce Australia, 2010). At the same time, the allied health population represents a valuable human service resource as it is well positioned to contribute to health care reform and assist health care systems to address current and future health care challenges (Markham, 2015). In this environment there is an increased expectation that organisations promote human resource strategies that increase staff retention and reduce worker turnover (Davey et al., 2006; Ng & Sim, 2011).

The findings from the study demonstrated that allied health workers who received effective clinical supervision had reduced intention to leave, increased sense of personal accomplishment and a greater sense of connection with the employing organisation. These results suggest that effective clinical supervision has the capacity to make a significant contribution as a strategy for workforce retention in allied health populations.

9.3.4 Implications for workforce well-being and sustainability

Health care workers, including allied health professionals, exhibit high levels of stress and burnout (Barker et al., 2016; Fischer et al., 2013). Burnout carries significant costs for the health care industry (Marine et al., 2009), is negatively associated with patient satisfaction (Fredette-Carragher, 2016), is related to increased absenteeism (Hawes, 2009) and is consistently linked to worker intention to leave (Alkorashy & Baddar, 2016). Hence, workforce sustainability strategies are of interest to organisations seeking to maintain an effective and stable allied health workforce (Belbin, 2011).

This study’s findings demonstrated that allied health workers who received highly effective clinical supervision did have reduced levels of emotional exhaustion, considered to be the core component of burnout (Garman et al., 2002). Furthermore, highly effective clinical supervision was also significantly linked with reduced levels of depersonalisation, a coping response linked to emotional exhaustion that presents as distancing behaviour by the worker when treating patients (Maslach et al., 1996). Given the short duration between the clinical supervision implementation and the data collection (on average, participants had
been receiving clinical supervision for 6.60 months), it may be that a longer period of implementation was required to demonstrate these associations at a lower threshold of clinical supervision efficacy. The variable, ‘having time available to attend supervision’, was significantly associated with reduced emotional exhaustion.

Particularly noteworthy were the high scores for the Restorative domain of clinical supervision for those allied health staff employing all five best practice clinical supervision principles (receiving supervision, choice of supervisor, attended supervision training, completed supervision agreement, understanding of confidentiality boundaries in supervision). Although not statistically significant, the score was higher than the MCSS-26© benchmark which applies to allied health staff where clinical supervision has been well-established (Winstanley & White, 2011). Given that most participants had, on average, only been receiving formalised supervision for a period of 6.60 months prior to the data collection, this is an important finding as the restorative domain aligns with the clinical supervision support function and indicates that staff felt supported and could seek advice about sensitive matters (Winstanley & White, 2011). Proctor (2011) describes the Restorative function as an essential component of the supervision transaction as it enables the effective operation of the other two supervision functions; the Normative and the Formative functions. Therefore the Restorative function is not only important in and of itself, but is also critical for the whole process of supervision, making this an important finding. This finding underscores the importance of implementing clinical supervision that is structured and incorporates best practice principles as previously outlined in this chapter. Overall, the study’s findings suggest that effective clinical supervision can be a valuable professional support strategy even within a short duration of time. This finding has important implications for health service managers wishing to maintain an effective allied health workforce.

9.3.5 Implications for health service management

Health care systems require effective processes for clinical governance and professional support to ensure their workforce is skilled and capable of delivering safe, quality health services. The study’s findings indicate that effective clinical supervision is one such mechanism as associations between effective clinical supervision and the provision of
professional support, education and guidance for allied health worker’s practice are demonstrated. The findings also indicate key characteristics associated with effective clinical supervision practice in an allied health workforce.

In addition, the findings show that allied health workers who received effective clinical supervision did have reduced burnout and reduced intention to leave, even though the organisation was undergoing a period of rapid and considerable change. As health care systems move into the future, more than ever, they require a resilient and sustainable workforce. The study’s findings demonstrate that effective clinical supervision can make a significant contribution in this space by improving workforce retention and reducing levels of staff burnout amongst this population.

Given the resources required to provide clinical supervision to staff (including time away from direct service provision), and the possible harmful effects from ineffective supervision, the study’s findings have important implications for health service management. There are three significant points for consideration. First, the study’s findings indicate that effective clinical supervision outcomes are linked to having a structured clinical supervision framework for allied health professionals. Clinical supervision implementation requires adequate planning, resourcing and ongoing governance to ensure its success. Sufficient resources need to be invested in the start-up and maintenance of the program to maximise the outcomes from clinical supervision and prevent ongoing wastage from ineffective supervision practice. Second, the study’s findings demonstrate that lack of time was a consistent barrier to clinical supervision effectiveness. This is not a new finding as studies indicate that lack of time persists as one of the most unrelenting variables associated with clinical supervision ineffectiveness (White & Winstanley, 2006). For supervision to be effective, time for supervision needs to be protected by embedding supervision into standard work practices and workloads and viewing this time away from direct clinical duties as an intervention to ensure the safety and quality of clinical practice. Third, findings from this study and others (Butterworth et al., 2008), demonstrate the major role that the dominant organisational culture can play in determining the success or otherwise of clinical supervision practice, including its effectiveness and outcomes. Effective implementation of clinical supervision requires commitment from all levels of management and a shared organisational culture that values and supports clinical supervision practice. A prerequisite
to implementation may include awareness-raising and dialogue between managers and leaders about the potential benefits of effective clinical supervision as a means to mitigate potential areas of resistance. Opposition to the introduction of clinical supervision is often related to misinformation about the purpose of clinical supervision practice (Cleary et al., 2010; Hall & Cox, 2009).

The conceptual framework adopted for this research comprised the Social Ecological Theory and the Job Demands-Resources Model. Utilising a social ecological lens facilitated understanding of how different systems across organisations, such as the study location, can promote or hinder effective clinical supervision implementation. The Job Demands-Resources Model was useful for explaining the possible mechanism by which clinical supervision, a job resource, might reduce stress and protect workers from burnout. Both the Social Ecological Theory and the Job Demands-Resources Model were relevant in their application to this research.

9.3.6 Implications for clinical supervision evidence base

The findings from the current research program make a significant contribution to the empirical clinical supervision literature for allied health professionals. Firstly, the findings identify antecedents for effective clinical supervision practice for the allied health workforce. Secondly, the results determine the characteristics of clinical supervision that are linked to clinical supervision ineffectiveness for allied health workers. Thirdly, the findings establish the outcomes that can be expected when effective clinical supervision is implemented across an allied health workforce. Therefore, this research assists to fill a previous gap in the clinical supervision allied health evidence base. It also offers a robust foundation for the instigation of future clinical supervision studies. Further research is warranted to determine whether the variables identified in this research are applicable to other allied health populations.

9.3.7 Implications for future directions in research

It is recommended that future research be undertaken to replicate this study with a similar population, using the same methodology. This would provide opportunity to examine whether the variables identified in the present research program are associated with clinical supervision effectiveness in other similar allied health populations. It is
recommended that evaluation of supervision outcomes be measured no sooner than 12 months post-implementation of supervision practice as the time-frame of six months duration may be premature for the optimum measurement of outcomes.

The current research findings identified patterns of difference between the professional disciplines. While these professional differences were small relative to the areas of commonality, they were significantly associated with the effectiveness of clinical supervision and deserve consideration in future supervision studies of allied health workers. Further investigation of this topic is warranted as authors (Fitzpatrick et al., 2012; Health Workforce Australia, 2013b) have advocated for the development of supervision policies that apply equally to disciplines across the breadth of the allied health professions. The current research program would suggest that a simple ‘one-size-fits-all’ approach may not be best practice as some professions within the allied health workforce may require additional support and training to optimise the outcomes from their supervision practice.

**9.4 Conclusion**

This research program has provided an opportunity to evaluate the effectiveness of clinical supervision across a range of allied health professionals who were utilising a common model of supervision at a time of rapid and disruptive organisational change within a community health service. The study location had developed a supervision framework comprising an organisational guideline, a suite of supervision templates including supervision agreements, training, formalised processes for supervisor recruitment, and supervisee choice of supervisor. Hence, this particular study location provided a unique opportunity to undertake process-outcome research, that is to examine the relationship between the intervention and associated outcomes (Watkins & Milne, 2014).

The findings of this research indicate that when specific supervision procedures are implemented, such as agreement documents, choice of supervisor, and allocated supervision time, clinical supervision is effective at delivering professional development, guidance and support for allied health workers. Furthermore, clinical supervision effectiveness was achieved despite the relatively short time-frame of supervision implementation and in the face of considerable organisational change in the study location.
The findings also identified significant differences associated with supervision effectiveness between the individual allied health professions. These findings challenge current views regarding the merits of adopting a standardised 'one-size-fits all' clinical supervision model for the allied health professions.

The research findings also demonstrated that allied health workers who received effective clinical supervision had significantly reduced burnout and significantly reduced intention to leave. These results show that effective clinical supervision can provide professional support for allied health workers even through periods of rapid organisational change. These findings have important implications for supervision practice and policy, given the need to retain and sustain a skilled workforce that is capable of delivering quality health services into the future.
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11 Appendices
Clinical Supervision

**Project Topic:** Impact of Clinical Supervision: a case study of community allied health staff.

**Researcher:** Christine Saxby, PhD Student, christine.saxby@uqconnect.net.au

Your assistance is sought for a research project concerning allied health worker’s experiences of receiving clinical supervision. This research is being undertaken by Christine Saxby of The University of Queensland as part of her Doctor of Philosophy degree.

**What is the purpose of the study?**

The purpose of this study is to obtain a better understanding about the effectiveness of clinical supervision provided within the Primary and Community Health Services, Metro North Health Service District.

**Who can participate in the research?**

The Researcher seeks the participation of allied health workers within Primary and Community Health services, Metro North Health Service District, who have been receiving clinical supervision.

**What will participants be asked to do?**

As a participant you will be invited to complete an on-line questionnaire package that contains a consent section, demographic questionnaire and surveys that ask questions about your experience of clinical supervision and its impact on your clinical practice and your feelings about your job. Completion of this on-line questionnaire package should take approximately 15-20 minutes.

**Will my privacy be respected?**

Participant’s responses will be collected in anonymous form. Specific identifying data is not being sought. Any data that could potentially be used to identify individual workers (such as discipline, age, and years of experience) will be converted to a group format and stored separately from other data. Data will be maintained on a password protected computer, external to Queensland Health. The only people who will have access to the data are those on the Researcher’s team who are directly involved in the collection and analysis of the data. The data will be securely stored for seven years, as is usual practice, then it will be permanently deleted or destroyed.

When information is analysed and reported back it will be presented in a group format and not as individual data. As some of the allied health disciplines have a smaller representation within the overall population, care will be taken when reporting these groups to protect anonymity. For example, these disciplines may be grouped together rather than presented separately.

Your privacy will be respected and the information you provide will be treated in the strictest confidence by the Researcher. This research seeks to obtain general information about clinical supervision practices. In the event that a participant chooses to disclose specific details related to Code of Conduct breaches, they should be aware that the Researcher will confidentially consult with the Primary and Community Health Services Advisory Group, Metro North Health Service District, for advice about the need for any further action.

https://exp.psy.uq.edu.au/clin/  
27/03/2013
Do I have to take part?

Participation in the research is completely voluntary. Only those who give their informed consent will be included in the project. If you do not wish to take part, you are not obliged to. Whether or not you decide to participate, your decision will not disadvantage you in any way.

Possible Benefits

The findings from the research will be used to make recommendations about improved clinical supervision practices.

Possible Risks

It is not anticipated that your participation will involve any risks or discomforts to you.

Where can I get help if I need it?

Should your participation result in any distress to you, you will be provided with access to psychological support through the Employee Assistance Scheme (Phone: 1300 361 008). Aboriginal and Torres Strait Islander workers may choose access a culturally specific service and this will be arranged in consultation with the Indigenous Health Program (Phone: 3139 4633).

How will the information collected be used?

The data generated by the research will be used as part of a doctoral thesis to be submitted for marking to academic staff at The University of Queensland and other universities. The thesis, once complete is kept in various libraries within the University and can be borrowed by library users. The findings of the research will be published as reports and journal articles, and presented at relevant professional conferences and seminars. Individual participants will not be identified in any reports, journals, or presentations.

Can I get information about what I have said?

Findings from the research will be available in summary form only. The researcher plans to disseminate the findings from the research via professional presentations and publications both within and external to Queensland Health.

What if I am not happy about something?

Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it can be directed to the Researcher (Christine Saxby contactable by email: christine.saxby@uqconnect.net.au) or Academic Advisor Prof. Jill Wilson (contactable by phone 33651254 or email: j.wilson@uq.edu.au) or you may contact the Ethics Officer on 3365 3924.

Any other questions?

All questions are welcome. If there is anything you do not understand, or you have further questions, these can be directed to the Researcher (Christine Saxby contactable by email: christine.saxby@uqconnect.net.au) or Academic Advisor Prof. Jill Wilson, phone 33651254 or email: j.wilson@uq.edu.au.

This study has been cleared by one of the human research ethics committees of the University of Queensland in accordance with the National Health and Medical Research Council's guidelines. You are of course, free to discuss your views.

participation in this study with project staff (Christine Saxby contactable by email: christine.saxby@uqconnect.net.au)
Academic Advisor Prof. Jill Wilson, phone 33651254 or email: j.wilson@uq.edu.au). If you would like to speak to an
officer of the University not involved in the study, you may contact the Ethics Officer on 3365 3924.

What do I need to do to participate?

Please read this Participant Information Sheet and be sure you understand its contents before you consent to
participate. If you wish to participate, please acknowledge that you have read the Participant Information Sheet and
you consent to participate in the study by ticking the consent section. You will then be able to proceed to the survey.
Once you submit the survey, your response cannot be returned or excluded from the analysis, as it cannot be singular
out from the other anonymous surveys.

Thank you for your time in considering this invitation.

Christine Saxby
PhD Student
School of Social Work and Human Services
The University of Queensland

Consent

Please select 'I Agree' below if you consent to participate in this survey, and proceed to the next page.

I Agree

I have read the above information and agree to participate in the study.

I Disagree

I do not agree and/or I do not wish to participate.

https://exp.psy.uq.edu.au/clin/

27/03/2013
Appendix B Demographic questions for on-line survey

The following questions seek information about you as an Allied Health Worker.

**What is your professional discipline?**
Select:
- Dietician
- Podiatrist
- Occupational Therapist
- Physiotherapist
- Psychologist
- Social Worker
- Speech Pathologist

**What is your age in years?**
- 20
- 21
- (consecutive years listed)
- 70
- 70+

**What is your gender?**
- Female
- Male

**What is your country of birth?** (please indicate in the space provided)

**What is your main language spoken at home?** (please indicate in the space provided)

**Do you identify as Aboriginal or Torres Strait Islander Australian?**
Select:
- Yes
- No
- No response

**What is your current HP level?**
Select:

- 3
- 4
- 5
- 6
- 6+
- I am not under the HP stream

How many years experience (or full time equivalent) do you have in your current professional discipline?

Select:

- Less than 1 year
- 1 year
- 2 years
- 3 years
- 4 years
- 5 years
- 6 years
- 7 years
- 8 years
- 9 years
- 10 years
- 10-15 years
- 15-20 years
- 20-25 years
- 25-30 years
- 30-35 years
- 35-40 years
- Over 40 years

How many years experience (or full time equivalent) have you worked in your current allied health position?
Select:
- Less than 1 year
- 1 year
- 2 years
- 3 years
- 4 years
- 5 years
- 6 years
- 7 years
- 8 years
- 9 years
- 10 years
- 10-15 years
- 15-20 years
- 20-25 years
- 25-30 years
- 30-35 years
- 35-40 years
- Over 40 years

How many years total experience (or full time equivalent) do you have working in health positions?
Select:
- Less than 1 year
- 1 year
- 2 years
- 3 years
- 4 years
- 5 years
- 6 years
- 7 years
- 8 years
The following questions are about your experience of receiving clinical supervision.

Supervision has been defined as a “working alliance between two employees where the primary intention of the interaction is to enhance the knowledge, skills and attitudes of at least one employee” (HR Policy G5, April 2008).

Metro North Primary & Community Health Services introduced a structured Model of Individual Clinical Supervision for Allied Health staff in July 2011 and this survey seeks your feedback about the receipt of clinical supervision under the Primary & Community Health Service clinical supervision Model.

Do you receive clinical supervision under the current Metro North Primary & Community Health Services Model?

- Yes
- I have a clinical supervisor allocated but we haven’t commenced yet
- No, I don’t receive any clinical supervision
- No, I receive a different model/type of clinical supervision

How long have you been receiving clinical supervision under the current Metro North Primary & Community Health Services Model?

- 1 to 2 months
- 2 to 3 months
- 3 to 4 months
• 4 to 5 months
• 5 to 6 months
• 6 to 7 months
• 7 to 8 months
• 8 to 9 months
• 9 to 10 months
• 10 to 11 months
• 11 to 12 months
• Over 12 months
• I haven’t started receiving clinical supervision yet
• I receive clinical supervision under a different model

How many times have you received clinical supervision under the current Metro North Primary & Community Health Services Model?

• Not at all
• One time only
• Two times
• Three times
• Four times
• Five times
• Six times
• Seven times
• Eight times
• Nine times
• Ten times
• Eleven times
• Twelve times
• More than twelve times

What is the total time you have you received clinical supervision during your career?
What is the usual length of time you spend in sessions when you receive clinical supervision?

- None
- Less than 30 minutes
- 30 to 45 minutes
- 45 to 60 minutes
- 60 to 75 minutes
- 75 to 90 minutes
- More than 90 minutes

Where does the clinical supervision you receive currently take place?

- At my supervisor’s work location
- At my work location
- Other location

Have you had a change of clinical supervisor since the Primary & Community Health Services Model commenced in July 2011?

- No, I have the same clinical supervisor
- Yes, I have had a change resulting in two different clinical supervisors
- Yes, I have had a change resulting in three or more different clinical supervisors
- I don’t receive clinical supervision under this model.

Do you usually access more than one clinical supervisor at a given point in time?
• No, normally only one
• Yes, I usually access two different clinical supervisors
• Yes, I usually access three or more different clinical supervisors

**Is your usual clinical supervisor the same allied health discipline as you?**
• Yes
• No, my clinical supervisor is from another allied health discipline
• No, my clinical supervisor is neither from my allied health discipline nor from another allied health discipline

**Is your usual clinical supervisor the same person as your line manager?**
• Yes
• No

**Did you have any choice in the selection of your clinical supervisor?**
• Yes
• No

**Have you attended clinical supervision training under the current Primary & Community Health Services Model?**
• Yes
• No
• No, but I have indicated my interest in attending a training session

**Have you attended any other supervision training apart from that provided within the Primary & Community Health Services Model?**
• Yes
• No

**Do you have a written supervision agreement for the clinical supervision that you receive?**
• Yes
• No
Are you aware of the Work Unit Guideline for individual clinical supervision within Metro North Primary & Community Health Services?

- Yes
- No

Are you clear about the boundaries of confidentiality in clinical supervision as outlined within the Metro North Primary & Community Health Services Clinical Supervision Agreement and Work Unit Guideline?

- Yes
- No

Apart from the individual clinical supervision provided within Metro North Primary & Community Health Services, do you participate in any other supervision formats (e.g., peer, external supervision etc.)?

- I don’t participate in any type of supervision
- I receive individual clinical supervision and no other format
- Yes, I participate in peer supervision as well as individual supervision
- If other combination/type, please list or put “no response” in space provided

Do you provide clinical supervision to any other staff as part of the Metro North Primary & Community Health Services clinical supervision Model?

- Yes
- No

If you provide clinical supervision to another staff member, do you receive supervision for the clinical supervision you provide?

- Yes, regularly
- Yes, but it's infrequent
- No, but it would be useful
- No, I don’t think I need it
- Not applicable to me
If you receive supervision for the clinical supervision you provide, do you find it useful?

- Yes
- No
- Somewhat
- Not applicable to me
Appendix C Promotion of study on Service’s intranet page

Primary & Community Health Services

Clinical Supervision - Allied Health

Clinical practice supervision is an integral component of the professional development and support strategy for allied health professionals within the Primary and Community Health Services. Clinical Practice Supervision can be facilitated through individual, group and peer clinical supervision.

Primary and Community Health Services expect all clinical allied health professionals to participate in individual clinical practice supervision.

Clinical Supervision Study

The Clinical Supervision study aims to contribute to the improvement of clinical supervision practices.

The surveys and focus groups for the study have now finished. Thank you to all who participated or expressed their interest in this study.

The next phase of the research study is the data analysis and interpretation. Once this phase is complete, it is anticipated that findings will be presented at professional meetings and conferences.

Further information about the study is available from christine.saxby@uqconnect.edu.au

The Clinical Supervision Home Page will provide details of any forthcoming presentations.

Clinical Practice Supervision Principles

1. Provide an integrated approach to profession specific practice supervision for allied health staff within the Primary and Community Health Services.
2. Promote excellence in clinical work and evidence based practice to ensure the delivery of high quality clinical practices.

Appendix D Participant information sheet for focus groups

Participant Information Sheet for Focus Groups

Project Topic: Impact of Clinical supervision: a case study of community allied health staff.

Researcher: Christine Saxby
PhD Student
Ph: 041 871 3436
Email: christine.saxby@uqconnect.net.au

Your assistance is sought for a research project concerning allied health worker’s experiences of receiving and/or providing clinical supervision. This research is being undertaken by Christine Saxby of The University of Queensland as part of her Doctor of Philosophy degree.

What is the purpose of the study?

The purpose of this study is to obtain an better understanding about the effectiveness of clinical supervision provided within the Community and Primary Health Services, Metro North Health Service District.

Who can participate in the research?

The Researcher seeks the participation of allied health workers within Primary and Community Health Services, Metro North Health Service District, who have been receiving and/or providing clinical supervision.

Who will be doing the focus group interviews?

The interviewer is Christine Saxby, PhD student, School of Social Work and Human Services, The University of Queensland. Christine Saxby’s other role is as a social worker within the Metro North Health Service District. There may also be an assistant interviewer who will be part of the Research Team and external to Metro North Primary and Community Health Services.

What will participants be asked to do?

As a participant you will be invited to take part in a focus group discussion with other allied health staff and answer questions about your experience of clinical supervision.
The focus group will be made up of between 7 to 10 allied health workers. There will be several focus groups held and you will be invited to participate in one focus group. It is anticipated that separate focus groups will be held for supervisees and supervisors. Focus group interviews will be audiotape recorded and transcribed.

The focus group will take about 90 minutes of your time, excluding travel. Focus groups will take place at locations within the Metro North Community Health Services District.

Will my privacy be respected?

Participant's responses will be collected from transcripts of the audiotape recordings. This data will be converted to a de-identified form and maintained on a password protected computer, external to Queensland Health. The audiotape recordings will be stored separately from any identifying data. The only people who will have access to the data are those on the Research Team who are directly involved in the collection and analysis of the data. The data will be securely stored for seven years, as is usual practice, then it will be permanently deleted or destroyed.

When information is reported back it will be presented in a non-identifiable format. As some of the allied health disciplines have a smaller representation within the overall population, care will be taken when reporting these groups to protect anonymity. For example, these disciplines may be grouped together rather than presented separately.

Your privacy will be respected and the importance of maintaining confidentiality will be discussed at the commencement of all focus groups. Focus group participants will be asked to agree to hold confidential any information disclosed within focus groups. While this agreement will be sought by the Researcher, the Researcher cannot make any guarantees about disclosure by focus group participants, should this occur.

Your privacy will be respected and the information you provide will be treated in the strictest confidence by the Researcher. This research seeks to obtain general information about clinical supervision practices. In the event that any participant chooses to disclose specific details related to Code of Conduct breaches, they should be aware that the Researcher will confidentially consult with the Primary and Community Health Services Advisory Group, Metro North Health Service District, for advice about the need for any further action.
Do I have to take part?

Participation in the research is completely voluntary. Only those who give their informed consent will be included in the project. Whether or not you decide to participate, your decision will not disadvantage you in any way. Should you decide to participate and later change your mind, you are free to withdraw from the project at any time without prejudice. Please note that participant’s data will not be able to be withdrawn once that data has been de-identified as it will be unable to be singled out from other de-identified data.

Possible Benefits

The findings from the research will be used to make recommendations about improved clinical supervision practices.

Possible Risks

It is not anticipated that your participation will involve any risks or discomforts to you.

Where can I get help if I need it?

Should your participation result in any distress to you, you will be provided with access to psychological support through the Employee Assistance Scheme (Phone: 1300 361 008). Aboriginal and Torres Strait Islander workers may choose to access a culturally specific service and this will be arranged in consultation with the Indigenous Health Program (Phone: 3139 4633).

How will the information collected be used?

The data generated by the research will be used as part of a doctoral thesis to be submitted for marking to academic staff at The University of Queensland and other universities. The thesis, once complete is kept in various libraries within the University and can be borrowed by library users. The findings of the research will be published as reports and journal articles, and presented at relevant professional conferences and seminars. Individual participants will not be identified in any reports, journals, or presentations.

Can I get information about what I have said?

Findings from the research will be available in summary form only. This is because it will be difficult to single out your responses from other participant’s responses as participants may not be easily identifiable from the audio recordings. The researcher plans to disseminate the findings from the research
via professional presentations and publications both within and external to Queensland Health.

What if I am not happy about something?

Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner the research is conducted, it can be directed to the Researcher (Christine Saxby contactable by email: christine.saxby@uqconnect.net.au) or Academic Advisor Prof. Jill Wilson (contactable by phone 33651245 or email: j.wilson@uq.edu.au) or you may contact the Ethics Officer on 3365 3924.

Any other questions?

All questions are welcome. If there is anything you do not understand, or you have further questions, these can be directed to the Researcher (Christine Saxby contactable by email: christine.saxby@uqconnect.net.au or Academic Advisor Prof. Jill Wilson, phone 33651245 or email: j.wilson@uq.edu.au). This study has been cleared by one of the human research ethics committees of the University of Queensland in accordance with the National Health and Medical Research Council’s guidelines. You are free to discuss your participation in this study with project staff (Christine Saxby contactable by email: christine.saxby@uqconnect.net.au or Academic Advisor Prof. Jill Wilson, phone 33651245 or email: j.wilson@uq.edu.au). If you would like to speak to an officer of the University not involved in the study, you may contact the Ethics Officer on 3365 3924.

What do I need to do to participate?

Please read this Participant Information Sheet and be sure you understand its contents. If you wish to take part in the study by participating in a focus group, you can express your interest by contacting the Researcher via the Researcher’s email address which is external to Queensland Health. Participants will be randomly determined on a consecutive basis, whereby the earliest received responses up to the required number, will be selected. Successful participants will be advised by the Researcher via email.

Thank you for your time in considering this invitation.

Christine Saxby
PhD Student
School of Social Work and Human Services
University of Queensland

Participant Information Sheet: Focus Groups
Research Topic: Impact of Clinical supervision: a case study of community allied health staff.
Version 1.1
15.5.12

Page 4 of 4
Appendix E Participant consent form for focus groups

Participant Consent Form
Focus Groups

Research Topic: Impact of Clinical supervision: a case study of community allied health staff.

I ____________________________ consent to participate in the research project about “Clinical supervision: a case study of community allied health staff”. This research is being undertaken by Christine Saxby of The University of Queensland as part of her Doctor of Philosophy degree. The purpose of the research is to obtain a better understanding of the effectiveness of clinical supervision.

- I have read the participant information sheet about the study and I understand what is required of me.
- I give consent to be interviewed in a focus group as part of the research project on “Clinical supervision: a case study of community allied health staff”.
- I have been given clear information and I am aware that the interview in which I participate will be audiotape recorded and transcribed.
- I understand that my privacy will be respected and any information I provide will be treated in the strictest confidence by the Researcher and all those on the Research Team who are directly involved in the collection and analysis of the data.
- I understand that this research seeks to obtain general information about clinical supervision practices. I am aware that in the event that any participant chooses to disclose specific details related to Code of Conduct breaches, the Researcher will confidentially consult with the Primary and Community Health Services Advisory Group, Metro North Health Service District, for advice about the need for any further action.

- I understand that the importance of maintaining confidentiality will be discussed at the commencement of all focus groups and Focus Group participants will be asked to agree to hold confidential any information disclosed within focus groups. While this agreement will be sought by the Researcher, I understand that the Researcher cannot make any guarantee that disclosure by focus group participants will not occur.

- I understand that all information will be securely stored with all identifying information removed and stored separately in the office of the Researcher for this project.

- I understand that none of the information that I provide will be described or portrayed in any way that will identify me in any report on the study.

- I am aware that I may ask any further questions about the research study at any time.

- I acknowledge that my involvement in the study might not be of direct benefit to me. I understand what to do if I need to seek help.
• I understand that taking part in the study is voluntary and I am free to withdraw at any time without prejudice. I understand that if I decide to participate and later withdraw, my data will not be able to be withdrawn once it has been de-identified as it will be unable to be singled out from other de-identified data.

Participant name............................................................
Participant signature....................................................
Date..............................................................................
Appendix F Demographic questionnaire for focus groups

Clinical Supervision Study – Focus Groups
(Supervisees)

Please respond to the following questions which seek information about you as an Allied Health Worker.

<table>
<thead>
<tr>
<th>What is your professional discipline?</th>
<th>Dietitian</th>
</tr>
</thead>
<tbody>
<tr>
<td>(please indicate)</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td></td>
<td>Physiotherapist</td>
</tr>
<tr>
<td></td>
<td>Podiatrist</td>
</tr>
<tr>
<td></td>
<td>Psychologist</td>
</tr>
<tr>
<td></td>
<td>Social Worker</td>
</tr>
<tr>
<td></td>
<td>Speech Pathologist</td>
</tr>
<tr>
<td>Other: (please write)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What is your country of birth? (please write)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Do you identify as Aboriginal or Torres Strait Islander Australian?</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What is your age in years? (please write in space provided)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>What is your current HP level? (please write in space provided or put N/A if not applicable)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>How many years’ experience (or full time equivalent) do you have in your current professional discipline?</th>
</tr>
</thead>
</table>

| Metro North Primary & Community Health Services introduced a structured Model of Individual Clinical Supervision for Allied Health staff in July 2011. |

Supervision has been defined as a “working alliance between two employees where the primary intention of the interaction is to enhance the knowledge, skills and attitudes of at least one employee” (HR Policy G5, April 2008).

<table>
<thead>
<tr>
<th>Do you receive clinical supervision under the current Metro North Primary &amp; Community Health Services Model?</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>No, I receive a different model/type of clinical supervision (please write type)</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Yes</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-----</td>
</tr>
<tr>
<td>Did you have any choice in the selection of your clinical supervisor?</td>
<td></td>
</tr>
<tr>
<td>How long have you received clinical supervision under the Metro North Primary &amp; Community Health Services Model?</td>
<td></td>
</tr>
<tr>
<td>(Please indicate in months or put N/A if not applicable)</td>
<td></td>
</tr>
<tr>
<td>How many times have you received clinical supervision under the current Metro North Primary &amp; Community Health Services Model?</td>
<td></td>
</tr>
<tr>
<td>(Please indicate how many times or put N/A if not applicable)</td>
<td></td>
</tr>
<tr>
<td>What is the total number of years that you have received clinical supervision during your career?</td>
<td></td>
</tr>
<tr>
<td>(Please indicate in years)</td>
<td></td>
</tr>
<tr>
<td>Have you attended clinical supervision training under Primary &amp; Community Health Services Model?</td>
<td>Yes</td>
</tr>
<tr>
<td>Have you attended any other clinical supervision training apart from that provided under the Primary &amp; Community Health Services Model?</td>
<td>Yes</td>
</tr>
<tr>
<td>Do you receive any other supervision formats (e.g. peer, external supervision etc.)?</td>
<td>I receive individual clinical supervision and no other format</td>
</tr>
<tr>
<td>(Excluding operational)</td>
<td>I participate in peer supervision as well as individual supervision</td>
</tr>
<tr>
<td></td>
<td>I participate in peer supervision only</td>
</tr>
<tr>
<td></td>
<td>If other, please write:</td>
</tr>
<tr>
<td>Do you provide clinical supervision to any other staff as part of the Metro North Primary &amp; Community Health Services clinical supervision Model?</td>
<td>Yes</td>
</tr>
<tr>
<td>Do you receive supervision for the clinical supervision you provide?</td>
<td>Not applicable to me</td>
</tr>
<tr>
<td></td>
<td>Yes, regularly</td>
</tr>
<tr>
<td></td>
<td>Yes, but it’s infrequent</td>
</tr>
<tr>
<td></td>
<td>No, but it would be useful</td>
</tr>
<tr>
<td></td>
<td>No, I don’t think I need it</td>
</tr>
</tbody>
</table>

Thank you,
Christine Saxby,
PhD Student,
School of Social Work and Human Services, University of Queensland

Research Topic: Impact of Clinical supervision: a case study of community allied health staff.

Page 2 of 1
Appendix G Interview Guide for focus groups

Interview Guide for Focus groups

Interviewer introduction:
Thank you for agreeing to participate in this Focus Group interview.
The purpose of this focus group interview is to hear about allied health worker’s experiences of clinical supervision within the Community and Primary Health Services, Metro North Health Service District.

This information is being collected for a research study that is being undertaken by Christine Saxby of The University of Queensland as part of her Doctor of Philosophy degree. The findings from the research will be used to make recommendations about improved clinical supervision practices.

As advised in the Participant Information Sheet, the focus group interviews will be audiotape recorded and later transcribed. This is to ensure that we don’t inadvertently miss anything you have to say.

Focus Group participants are asked to agree to hold confidential any information disclosed within focus groups.

Participants are reminded that this research seeks to obtain general information about clinical supervision practices. Your privacy will be respected and the information you provide will be treated in the strictest confidence by the Researcher. In the event that any participant chooses to disclose specific details related to Code of Conduct breaches, they should be aware that the Researcher will confidentially consult with the Primary and Community Health Services Advisory Group, Metro North Health Service District, for advice about the need for any further action.

The focus group will take about 90 minutes.
Are there any questions before we begin?

Is there anyone who no longer wishes to participate or who does not feel well enough to participate?

Research Topic: Impact of Clinical supervision: a case study of community allied health staff.
Interview Guide for Supervisees and Supervisors

In the past people have described both positive and negative experiences of clinical supervision.

1. How would you describe your experience of clinical supervision?

2. What do you think makes a clinical supervision relationship effective?

3. Can you describe any factors that reduce the effectiveness of clinical supervision? (e.g. competing priorities within workplace)

4. Can you give any examples where clinical supervision has made a difference to:
   - how services are delivered to clients?
   - how workers cope with stresses in their job?
   - how workers feel about where they work?

The culture of an organisation is often reflected in the application of its activities.

5. What does your experience of clinical supervision tell you about the culture of this organisation?

6. Do you have any further comments to make about the clinical supervision program?

Research Topic: Impact of Clinical supervision: a case study of community allied health staff.
Appendix H Coding example

For SW it doesn’t feel new, we probably feel a bit differently to some other disciplines. We see it as part of our clinical time and I guess that’s always been the culture of our profession; that’s okay, we’ve been one of the first disciplines to come on board. We’ve been lucky we’ve had nearly a year to start working in the process. So for me it doesn’t have the newness about it but I guess we’ve probably had the history of having the project of negotiating around the whole program for a long time. For me it feels like a long time coming so that’s been fantastic to have people matched and up and running and things.

Matching, HP4s being very experienced and their acceptance. It’s think that’s gone extremely well because I think what we’ve come to realize, no matter what their level of experience is, if you’re matched appropriately to someone in terms of their skill set and knowledge base, you can always learn and develop. I don’t think it matters so much about the level but I think that was a challenge in the beginning when you’ve got people at that peer level saying just what does this person have to offer me but I think the way the program has been rolled out in terms with the Program’s three preferences and I think that SW is a big discipline. We’ve been able to cater quite well to people’s preferences and things so we haven’t had too many arrangements that haven’t gone well. (SW)

It’s still a bit of an issue for us because there’s not that big a pool to choose from and I guess our experience, the differentiation for our experience would be how many years and what areas you’ve worked in.

For myself, I don’t have a clinical supervisor now because she’s left for maternity leave and we haven’t had a replacement, they’re the kind of difficulties that come up. And if I left, for example, I don’t know what other options would be out there either.

C. Saxby
### Appendix I Coding example

<table>
<thead>
<tr>
<th>Transcriptions</th>
<th>Notes</th>
<th>First Level Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 June 2012, Focus Group Two, Supervisees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People have described both positive and negative experiences of receiving clinical supervision: I'm interested in knowing how you would describe your experience of receiving clinical supervision? (Interviewer)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Only within this model that we have had since July?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No, you can compare and contrast if you wish about how this experience compares with other experiences of supervision that you have had. (Interviewer)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If I can compare, I think that one of the <strong>positives</strong> of this particular model in place is that it has the support of management and staff from the word go, so now there is that expectation that we have supervision, it exists and there's a procedure to follow and documents to use to document what's happened and so on, so I think that's a positive, that is part of our working culture now, social workers and all allied health professionals. I guess prior to this model being implemented I did participate in supervision from the time I graduated, when I was with Metro North. Perhaps the difference is that sometimes it wasn't always that consistent. I couldn't always be sure that it was going to happen on a fortnightly or monthly basis. So there was a commitment but it was a bit loose so I think now we have firmed that up. One of my experiences was that sometimes the supervisor actually brought to the supervision session the things that they thought they wanted to talk about which my experience now is pretty ridiculous</td>
<td>Support from Management</td>
<td>Legitimacy</td>
</tr>
<tr>
<td>There's a procedure to follow</td>
<td></td>
<td>Structure</td>
</tr>
<tr>
<td>Part of the culture (allied health workers/organisation?)</td>
<td></td>
<td>Greater Commitment (from workers and organisation?)</td>
</tr>
<tr>
<td>Participant recalls previous negative experience</td>
<td></td>
<td>Comparison of supervision experiences</td>
</tr>
</tbody>
</table>
Appendix J Ethics approval letter from University of Queensland

THE UNIVERSITY OF QUEENSLAND
Institutional Approval Form For Experiments On Humans
Including Behavioural Research

Chief Investigator: Ms Christine Saxby
Project Title: Clinical Supervision, Burnout And Job Satisfaction: A Case Study Of Community Allied Health Staff
Supervisor: Prof Jill Wilson, A/Prof Peter Newcombe
Co-Investigator(s): None
Department(s): School of Social Work and Human Services
Project Number: 2011000569
Granting Agency/Degree: RHD Student Support Funding
Duration: 30th April 2015

Comments:
Expedited review on the basis of approval from the Prince Charles Hospital HREC, dated 06/04/2010.

Name of responsible Committee:-
Behavioural & Social Sciences Ethical Review Committee
This project complies with the provisions contained in the National Statement on Ethical Conduct in Human Research and complies with the regulations governing experimentation on humans.

Name of Ethics Committee representative:-
Associate Professor John McLean
Chairperson
Behavioural & Social Sciences Ethical Review Committee

Date 15/5/2011 Signature JPMC
Appendix K Ethics approval letter from Queensland Health

Me Christine Saxby
School of Social Work and Human Services
The University of Queensland
St Lucia
Brisbane Qld 4072

6 April 2010

Dear Ms Saxby,

Re: HREC/11/QCH/66: Clinical supervision, burnout and job satisfaction: a case study of community allied health staff. C. Saxby; J. Wilson

I am pleased to advise that The Prince Charles Hospital Human Research Ethics Committee reviewed your submission and upon recommendation, the Chair has granted final approval for your low risk project.

Approval of this project is subject to the same confidentiality and privacy requirements as apply to other research projects and research subjects are not recognisable in publications or oral presentations.

Please complete the Communication Form before starting your study and return to the office of the Human Research Ethics Committee.


If you intend to publish the results of your work, it is advisable to ascertain from prospective journal editors the actual requirements for publication. For example, some journals may require full ethical review of all studies. When results are published, appropriate acknowledgment of the hospital should be included in the article. Please forward copies of all publications resulting from the study for inclusion in the Internet website.

On behalf of the Human Research Ethics Committee, I would like to wish you every success with your research endeavor.

Yours truly,

Dr Russell Doman
Chair
HUMAN RESEARCH ETHICS COMMITTEE
METRO NORTH HEALTH SERVICE DISTRICT

Office
The Prince Charles Hospital
Metro North Health Service District
Rode Road,
Chermside QLD 4032

Dear
(07) 3199 4500
Fax
(07) 3199 4501

Appendix L Clinical supervision agreement and other supervision templates

281
**Individual Clinical Practice Supervision Agreement**

**Section 2**

**Between**

__________________________

**and**

__________________________

**From** / / **to** / /

---

Refer to the following documents before completing this agreement:
- Work Unit Guideline POHS100v1 Clinical practice supervision - individual allied health staff
- Practice Supervision in Allied Mental Health G5 Human Resources Policy

1. **Goals of Supervision**

List the knowledge and skills that the supervisee would like to develop in supervision sessions based on supervisee’s learning needs. Goals to include outcomes identified in supervisee’s PAD. This will require regular review and renegotiation as the needs and skills of the supervisee change over time.

<table>
<thead>
<tr>
<th>Goal 1</th>
<th>Goal 2</th>
<th>Goal 3</th>
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2. **Responsibilities**

Responsibilities of supervisor:

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<tr>
<th>Responsibility 1</th>
<th>Responsibility 2</th>
<th>Responsibility 3</th>
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Adapted from Practice Supervision in Allied Mental Health HR Policy G5
Responsibilities of supervisee

How will dual roles (eg line manager and practice supervisor) be managed? (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)

How will supervisee/supervisor conflict be addressed?

How will confidentiality be maintained in supervision sessions? Outline circumstances under which confidentiality could be broken

Exchange of information between supervisees and supervisors about clinical practice should be as free as possible to build an effective supervision relationship. There are limits to confidentiality and these should be discussed when completing the supervision agreement (eg, Queensland Health Code of Conduct policy, Performance Appraisal and Development policy, Unsatisfactory Performance policy, Grievance Resolution policy, Professional Registration and Professional Association policies and ethics, and other relevant Queensland Health policies and procedures).

In the first instance, any problems that arise in the course of supervision should be addressed between the supervisee and supervisor. If there is a remaining problem, and agreement cannot be reached, the supervisor has a responsibility to inform the supervisee that they are intending to progress the matter as outlined in Practice Supervision in Allied Mental Health (G5 Human Resources Policy 3.19.1)

3. Structure of Supervision

Frequency:

Duration:

Location:

What resources do we require for effective supervision (eg., time, space, absence of interruptions, relevant documentation including reporting of activity)
How will interruptions and/or cancellations of supervision sessions be managed?

__________________________________________________________________________________________________________________________________________________

What preparation will be required prior to each session?

__________________________________________________________________________________________________________________________________________________

How will agendas for each session be set?

__________________________________________________________________________________________________________________________________________________

Supervisor's availability between sessions:

__________________________________________________________________________________________________________________________________________________

Are some elements of the supervision plan better met by other appropriately qualified clinical staff? If so, with whom? How will this be arranged?

__________________________________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________________________________

If yes, how will different forms of supervision be integrated and monitored?

__________________________________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________________________________

4. Methods used for Supervision

This section is to outline the methods by which each objective will be met (e.g., case discussions, work shadowing, file reviews, role plays, and development of specific clinical practices)

__________________________________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________________________________


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Adapted from Practice Supervision in Allied Mental Health HR Policy G3
5. **Evaluating Supervision**

Planned review dates for the Performance Appraisal & Development Plan

6 month review / / 12 month review / /

When will the individual clinical practice supervision agreement be reviewed? ____________


6. **Other information/agreements**


**AGREEMENT COMPLETED**

Supervisee name: ___________________ Supervisor name: ___________________

Signature: ___________________ Signature: ___________________

Date: _______________ Date: _______________

Line Manager Agreement: ___________________ Discipline Director Agreement: ___________________

Name: ___________________ Name: ___________________

Signature: ___________________ Signature: ___________________

Date: _______________ Date: _______________
This form/checklist is to be used to record Individual Clinical Supervision Notes.

<table>
<thead>
<tr>
<th>Date:</th>
<th>Time:</th>
<th>Place:</th>
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**Individual Clinical Practice Supervision Notes**

**Supervisor:**

**Topic(s) of Exchange:**

**Learning That Took Place:**

**Follow Up Expectations:**

**By Whom:**

**When:**

**Signatures:**

**Next Meeting:**

**Date:**

**Time:**

**Place:**

Adapted from Queensland Centre for Mental Health Learning
### PRIMARY AND COMMUNITY HEALTH SERVICES

**RECORD OF INDIVIDUAL CLINICAL PRACTICE SUPERVISION MEETING**

**Metro North Health Services District**

This form/checklist is to be used as a record of individual clinical practice supervision sessions.

<table>
<thead>
<tr>
<th>Supervisee’s Name</th>
<th>Supervisor’s Name</th>
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1. Reflection about practice by supervisee
2. Problem solving about practice issues
3. Review of clinical notes/reports
4. Discussion of additional skills and strategies
5. Demonstration of skills / strategies
6. Demonstration / rehearsal by the supervisee
7. Discussion of secondary practice issues (eg team relationships)
8. Personal or career development

<table>
<thead>
<tr>
<th>Date</th>
<th>Time spent</th>
<th>Content of session (please record as noted noted above)</th>
<th>Action Plan</th>
<th>Initials</th>
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Adapted from Practice Supervision in Allied Mental Health RR Policy G3

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