Clinical supervision: outsider reports of a research-driven implementation programme in Queensland, Australia

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WHITE E. & WINSTANLEY J. (2010) *Journal of Nursing Management* **18**, 689–696
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Aim The aim of the present study was to explore substantive issues related to the implementation of Clinical Supervision (CS).
Background Historically, the treatment of mental illness in Australia has been inadequate. CS has shown promise as a positive contribution to the clinical governance agenda, as a structured staff support mechanism.
Evaluation Within the wider context of a randomized controlled trial (RCT) of CS, semi-structured interviews (n = 17) were conducted with staff who worked alongside colleagues that attempted to implement CS.
Key issues Senior managers embraced CS and were disappointed when junior managerial colleagues did not hold a similar conviction, when tested by the realities of CS implementation. If CS was regarded as an additional activity, it stretched human resources and created inter-staff tensions.
Conclusions The personal testimony of these 'outsiders' spoke about the practicalities of implementing CS and the prevailing culture into which they were introduced. When perceived as a *tour de force* for culture change, CS was polarized as an opportunity by many, but also as a threat by some.
Implications for nursing management A single, cohesive and explicit management position on CS in each Health Service entity may obviate some of the impediments to CS implementation.

Keywords: clinical supervision, implementation, nursing management

Accepted for publication: 17 December 2009

Introduction

In her recent speech to the National Press Club, Canberra, Australia, the Federal Minister for Health and Ageing (Roxon 2008) confirmed that, historically, the treatment of mental illness in Australia has been 'vastly inadequate, inappropriate, or simply not available'. Similar concerns have been expressed in the United Kingdom (Lawton-Smith 2008) where acute mental health inpatient units 'are often, in effect, places of safety masquerading as a therapeutic response'. A litany of critical Australian reports has been catalogued

DOI: 10.1111/j.1365-2834.2010.01071.x
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over time, including the Australian Senate Community Affairs References Committee (2002) which reported the 'added stress on mental health staff, which arose from poor working conditions, heavy workloads and lack of resources, within a culture in which there was a large degree of burnout, low morale, lack of job satisfaction, poor status, insensitivity and indifference'. White (2003) has suggested that this is particularly so for mental health nurses (MHN) whom, above all others, create the ambience in clinical settings and substantially influence, if not determine, the organizational culture within which care is delivered and patients are assisted to recover in the least restrictive environment, safe from harm from themselves and/or others. Major, long-standing, concerns over the recruitment and retention of high-quality mental health nurses in Australia had been comprehensively articulated by Clinton (1999). The tipping point was eventually found by the seminal publication *Not for Service* (Mental Health Council of Australia 2005). Recent commitments made since by all State governments under the 2006–2011 Council of Australian Governments (COAG) National Action Plan on Mental Health 'should go some distance to addressing these priority concerns' (Australian Government 2007). Although the Australian Health Ministers' Advisory Council's National Mental Health Working Group (1997) has long recommended that staff who work in mental health services should have access to formal and informal Clinical Supervision (CS), the concept of CS has remained underdeveloped in Australia (Yegdich 2001) and the implementation of CS has remained patchy (White 2008).

As a discrete contribution to better understanding ways in which mental health service consumers might be assisted to recover, an unique randomized controlled trial (RCT) of nursing clinical supervision (CS) in mental health settings is presently being conducted by the lead authors in Queensland, Australia (White & Winstanley 2009a), focused on the outcomes of the CS model developed by Proctor (1986) for mental health nurses, the quality of care they provide and the effect on patient outcomes. CS has shown promise as a positive contribution to the clinical governance agenda (Butterworth & Woods 1998) and is now found reflected in health policy themes elsewhere in the world (Severinsson & Hallberg 1996, Hyrkas *et al.* 1999, Sirola-Karvinen & Hyrkas 2006). However, a recent review of the international CS literature (Butterworth *et al.* 2008) lamented the 'tired' discussions in the literature that 'offered no new insights', but was 'encouraged that new ideas related to patient outcome and professional development are emerging' and cited the present RCT as an example. For the present purposes, CS was operationally defined (Open University 1998) as follows:

> 'Clinical Supervision provides time out and an opportunity, within the context of an ongoing professional relationship with an experienced practitioner, to engage in guided reflection on current practice in ways designed to develop and enhance that practice in the future'.

The detailed methodological background to the RCT has been fully reported elsewhere (White & Winstanley 2009a). In keeping with contemporary research practice (White 2003, Doyle *et al.* 2009), supplementary qualitative data collection methods were also employed, including diary accounts provided by the 24 trainee Clinical Supervisors from the Intervention Arm of the RCT (White & Winstanley 2009b) and semi-structured interviews. The aim of these was to explore substantive issues related to the implementation of CS, the main themes arising from which are summarized in the present study. These have been drawn from the personal testimonies of key managerial and clinical informants each of whom, although not active participants in the RCT, had first-hand exposure to the implementation of CS by the CS trainees in the clinical facilities in each of the nine Intervention sites. A small number (n = 17) of intensive, semi-structured interviews (Foddy 1993) were conducted by a single researcher (E.W.) towards the end of the RCT quantitive data collection period, in which the observations and the impressions of these so-called 'outsiders' were canvassed. Respondents were purposively identified by the 24 Trainee Supervisors, as key local individuals with telling items of datum in each location. Interviews lasted for between approximetely 45 minutes and approximetely 1 hour and were conducted either in the respondents workplace, or where this was impractical, by telephone. Each respondent agreed to participate in an interview. Prior to commencement, written approvals were received from ten independent Human Research Ethics Committees (HRECs) across Queensland, in which the presently reported component was explicitly conveyed. A semi-structured interview guide (Appendix 2) was modelled on the instrument previously employed by the Joint Chief Investigators in their 1995 CS fieldwork in England and Scotland (White *et al.* 1998). All interviews were recorded, with permission, and yielded approximetely 58 000 words of transcribed text. This was content analysed for substantive patterns within and between study locations. Holsti (1969) described content analysis as 'any technique for making inferences by

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objectively and systematically identifying specified characteristics of messages'. Rigour was applied to the analytic process by carefully scrutinizing the audio-typed transcript, reading and re-reading it several times, to identify and confirm emergent themes. Iteratively, these themes comprised a functional coding frame, to organize and synthesize all the evidence relevant to each theme. Where possible, verbatim data presented here have been allowed to speak for themselves (Brewer 2003).

Key issues

Suspiciousness

The definitions of CS are many and various (Winstanley & White 2002). White *et al.* (1993) undertook an early conceptual analysis and revealed that the definition of CS was caught in a 'tautological maelstrom' and a universally accepted/adopted definition of CS has remained elusive over time. Part of the confusion generated by the lack of a universal operational definition and/or conceptual ignorance, was driven by an innocent concern about an overarching and covert purpose of the endeavour.

> 'Often, with that corporate-driven stuff, sometimes the staff are a bit suspicious of it. There's loads of things [they would be suspicious of], because we have so many new programs rolled-out through Queensland in the last two years. There is a lot more information to come around and there are a lot of people that are feeling overwhelmed. There is loads of stuff coming through all the time and people tend to switch off. And I do hear from nurses, and not particularly the older nurses, who see Clinical Supervision as a form of checking up rather than a form of…' (Team Leader).

> 'I guess a lot of the nursing staff, and a lot of staff generally in Queensland Health, have come from other Districts and other States. So they may have had some experience with the process of supervision before. I guess, if they [nurses] fear the process and all those sort of misconceptions of what it's about, what it means and what they can benefit from it, if that's where their coming from, if they perceive it as something that may be held against them, if things are discovered about their foibles, or their lack of confidence and that's going to be a detrimental thing to them. I think they fear it. I think that's basically right' (Psychologist).

Staff commitment

Some individuals held reservations, therefore, about the ostensible purpose of CS. However, there were also those who were mindful of the paradoxically negative effect that efficacious CS may have on their existing and privileged positions within their organizations. Both conditions may help to explain why a less than fulsome commitment to the CS endeavour was forthcoming. White *et al.* (1998) had previously hypothesized this in relation to the implementation of CS, based on a generic proposition originally put by Machiavelli (1513).

> 'This was one of my strategies [CS]; a great opportunity turns up [RCT], but we've not grasped that and we need to take a really serious hard look at ourselves and where we are going to be going with this. That's dire, absolutely dire. I don't believe it. 'Sabotage'; don't be afraid to say it' (Nursing Director).

> 'I think it was supported when it [CS] was first moved into the Service. It was supported across the Service very well. However, I'm not sure that is the case, as it has progressed. Yeah, I think there's a number of factors that influenced it. One is that we have had a reasonably high turnover of staff, so the groups have been deconstructed, reconstructed and now reconstructed again on the basis of staff attrition and staff losing a little bit of interest because it hasn't been as well supported as it might have been on the roster. That sort of effort seems to have waned…' (Registered Nurse).

> 'More recently, in this workplace, we have employed some new staff. So the Forces of Good are starting to outweigh the Forces of Evil and, in fact, that brings people along' (Acting Team Leader).

Context for non-involvement

A further explanation for non-participation in the establishment of CS arrangements, that did not rely on a suspicion about the true purpose of the endeavour, nor a fear about the possible changes to the established order in the power and prestige relations between clinical and managerial colleagues, was driven by a dispassionate resignation to the actualities of the existing health care system.

> 'No, I don't; I don't buy into it [Clinical Supervision]. It's stuff that **they** do and I chose not to participate in it. I just can't see any point in it. I've

learnt how to deal with the crap we put up with day to day and it's just a culture I feel is never going to change, because it's just the way it is. It's just the way we are. I've been working for Queensland Health for nearly [number] years. I've seen a change from what we used to do, to what we are doing now and you learn to compartmentalise it. But, yeah, I just don't feel the need to participate in a forum like that, I guess. From my personal point of view, I think its flogging a dead horse. No, I don't need to talk about work. If I ever need to talk to someone, I will go home and debrief with my partner. We do it over the coffee table as well. And as much as you work with some that are nuff-nuffs, the majority of staff here are good, solid, people that you look forward to working with. Like, I walk home and its generally gone in the air. Like, I don't think anything to sitting down with my partner and having a beer on the veranda and, just as I said, she is a nurse as well, so we can sort of "Oh God; you should have seen the thing I had to deal with today" and that's that' (Registered Nurse).

Culture

The foregoing claim to realism in the health care system, spoke to a personal impression of the prevailing culture within which the clinical practice development is being attempted. Data collected from a separate aspect of the present RCT and reported elsewhere (White & Winstanley 2009a) revealed that the management and practice of mental health care in Queensland (as it had also been found previously in New South Wales; White & Roche 2006) was widely sub-optimal.

> 'I still hear things like, "We're [nurses] going to cook them [patients] a cake". I still hear things like "Well, if they're well enough, I'll take them for a walk". I don't hear "Let's talk about anger management"; "Let's talk about you interaction with your family and carer"; "Let's talk about where you are going to live when you leave here"; "Let's talk about what are your financial circumstances"; "Do we need to start linking you back into Centrelink, or something else", "Let's talk about how we might be able to talk with your employer about having an out of role experience and, as soon as possible, getting them back into some form of reasonable vocational activity or recreation activity in the community". I don't hear that discussion. I hear the discussion about "Let's make a cake" (Nursing Director).

> 'I was rather disappointed to have moved from [State], less than [time] ago, to find people I worked with in the institutions 20-odd years ago not having changed their practice. What's interesting about [location], is that the ward that was chosen to pilot [CS implementation] has a less custodial flavour about it, than does the other ward which was not a part of the project and yet there are obviously nurses within [location] who are old asylum, or 'Old Bin' nurses, as well. But, I think the ability to roll out the CS, has been enhanced in that [location]. It was chosen because there was less resistance. And I certainly get a strong connection that nurses who maintain a fairly prominent custodial approach and the dominant culture is certainly, from what I see, custodial, safety-driven, more than engaging with the consumers' (Nursing Director).

Burden/costs

In the absence of making appropriate logistical arrangements, the perfunctory introduction of CS was regarded as an additional activity for staff to accommodate. This was reported to stretch human resources to breaking point and created predictable inter-staff tensions. However, as White and Winstanley (2006) had previously posited, where the introduction of CS was regarded as an integral professional nursing activity, especially in settings where the demonstrable buy-in from Managers was apparent, the new enterprise was not burdened by additional costs and also benefitted from the secondary gain of role modelling positive Management practices.

> 'The only thing I notice is that when it [CS] is held, our work load…for the people that aren't in it…it sort of doubles, because they're off. You're taking six or seven people away, cause they plan to work it on the day where everyone is involved, so it leaves you with three on the ward. So you notice that, but.......It's just something you have to put up with and its part of the job. They have agreed to do it, as part of a research thing, for studies to make it better, so I'm quite happy to go down. It's like education, I guess; it's now become a norm. We have that many meetings, we have meetings for meetings now' (Registered Nurse).

> 'No [there is not a material cost consequence for providing CS]. I suppose it's the facilitation that needs to be considered. So, if we were going to

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> have an external facilitator, whether the nurses themselves within the District, the NO4s themselves look at maybe how they sustain their own facilitation, across the District. Yeah, I think [it's important], cause they're not going to be forced to do it and, in that way, there would be no cost implication, because we just do it across the District. I think money is the least of the issues, or least of the obstacles' (Nursing Director).

Roster

White and Winstanley (2009b) have reported that a bellwether for judging how an organization conceptualized the introduction of CS, either as additional to professional nursing practice or as integral to it, might be found in the operational management of the staffing roster. Previous reports have indicated that this was easier to achieve when the Supervisor had personal responsibility for designing the staff duty roster. Often, however, this was not so and Supervisors were required to negotiate synchronized dates with a third party. Here, too, this was easier to achieve when the third party (often their immediate Manager) was sympathetic to the CS endeavour. When this was not so, considerable tensions were created and the roster-setter became the sole *de facto* arbiter of the entire CS implementation enterprise (White & Winstanley 2009b). Even when this was so, and the management of the roster was driven by goodwill, the everyday practicalities of staffing a clinical entity was not without challenge and was exacerbated by staff absences, through intra-Service transfers, illness and injury. Examples of workarounds were founded upon the flexibility and the exceptional commitment of key individuals.

> 'We had a meeting with them, myself, the Nurse Manager and the NUMs [Nurse Unit Managers] and said "We have to make this happen"; "Who's going to cover?" "Where?" I cover the Unit, when they have Supervision. I go clinically down and take a caseload. I think that's good that they have asked me to do that. Some of the 6 o'clock sessions I can't get to, otherwise I'm working fourteen hours a day. But most times, especially for [location] because they have a large number of 1's [nursing staff grade], I'll go down. I have it all in my diary. I go down and work on the Unit, with the NUM' (Nursing Director).

> 'In such a ward as [name] which is quite acute, I think the people who do the rostering have difficulties in rostering on the Clinical Supervisor and/or the ones being supervised. There is no continuity in that and I think that is where it falls down. I think…we just don't have, clinician-wise....its finding that experienced clinician. Cause a lot of guys are getting tired of mental health, or tired of being punched, or kicked, or swore at…it can be quite volatile on [location] at times. So, we end up losing experienced clinicians. [Staffing is] quite unpredictable at times. You don't know who is going to be off, and how long for, with their illness, and how long their going to take to recover from that injury. So there are a lot of factors that, sort of, hinder Clinical Supervision' (Clinical Nurse).

> 'I know of two RN's that went to the Director of the Unit; that went to resignation and went to the Director with issues about the rostering support, the lack of confidentiality, and so on. So, it's well known, it's not by any means a secret in this Service. Yep [two RN's who were disadvantaged by the adverse rostering arrangements offered to resign to the Director]. Did resign, in fact. Yes' (Registered Nurse).

Recruitment and retention

The contribution that well-established and demonstrably efficacious CS arrangements may make to the recruitment and retention agenda of health service providers has long been speculated at an anecdotal level. Not unusually, such a positive relationship has appeared in policy documents (e.g. Queensland Health 2008) and was, again, found in these interviews. One of the objectives of the present trial, however, is to attempt to discover an empirical basis for such claims.

> 'Yes, I suppose we try and give them everything that would attract a staff member to our area. Telling them we have a Clinical Supervision program, we give you time off line every month, and we are very supportive of you to go. It's not just Clinical Supervision; it's whatever we're doing' (Nursing Director).

> 'But, I suppose a lot of people don't have any family here. They don't transfer up here. Whereas, they like cities, or they go into bigger centres, than what we are. Yeah, it is hard to…we just lost a nurse this morning; it's her last day. She left because, one day, she had an absolute crap of a day and she just went home and fired off a resumè to these people and got

> the job and she's gone. But, yeah, she just had an absolute horrid day…I do think if you look after the nurses, they'll look after the patients. This particular nurse, maybe if she had someone to talk to that day, we may not have lost her, but we did. I know people can't be on call 24 hours a day, 7 days a week. But, maybe, if someone had known about it, they could have said 'we'll make a time to sit down and talk about this'. I think she struggled. She doesn't normally struggle, but she definitely struggled that day and sometimes that's all it takes; one day' (Enrolled Nurse).

Discussion

The insights summarized in the present study are contained to, and may be limited by, the purposive selection of the interviewees, the sub-speciality of nursing and the particular geographical locations. However, they were earthed to the personal testimony of nursing managerial and clinical staff whose colleagues were directly involved with a contemporary practice innovation and may resonate with other relevant staff, beyond mental health nursing and Queensland, Australia, respectively. They spoke not only of the practicalities of implementing CS, but also of the prevailing culture into which they were introduced. Multiple examples were reported of an organizational culture across Queensland which owed provenance to a history of reluctance to change and to which previously motivated staff had become reluctantly reconciled. Self-apparently, a policy of public frankness and accountability was indicated in some settings and CS was increasingly widely regarded as the vehicle by which this might be achieved. As potential *tour de force,* therefore, this simultaneously polarized CS, not only as an opportunity by many, but also as a threat by some. The practical endeavour to implement CS, therefore, appeared to create a predictable conundrum; viz, that the success of the CS enterprise relied on support from local management, the conduct and outcomes over which it could exercise little or no control, but was dependent upon feedback from (and possible improvements to) the clinical governance agenda.

At interview Senior Managers (Nursing Directors) revealed themselves to be enthusiastic and optimistic about CS, but concomitantly disappointed and embarrassed when junior managerial colleagues (Nurse Unit Managers) and some other clinical nursing staff, did not hold to a similar conviction when tested by the realities of implementation. The personal disposition of individual middle managers emerged as the central factor which substantially influenced, if not determined, the outcome of the entire CS enterprise. This ranged from enthusiastic, through to unsupportive, to frankly hostile and resistant. Control and management of the staffing roster was found to be the bellwether mechanism by which CS was both facilitated and stymied. It also conveyed how CS was conceptualized; either as extra-curricular, or integral to local nursing practice arrangements (White & Winstanley 2009b). In turn, such conceptualizations framed the mindset for management of the staffing budget.

The substantive themes revealed by the interviewees mapped onto the same themes that had emerged from the analysis of independent diary accounts provided by the Trainee Clinical Supervisor in the RCT and reported elsewhere (White & Winstanley 2009a). Senior managers and clinically-based staff essentially agreed, therefore, about the salient issues which satellited the implementation of sustainable CS arrangements; viz, widespread suspiciousness, staff commitment, context for non-involvement, organizational culture, burden/costs, management of the roster and recruitment and retention. These recurring features comprised a *de facto* rolling agenda of issues for consideration by managers at local levels. A single, cohesive and explicit management position on CS in each Health Service entity, arising from such considerations, may obviate some of the impediments revealed by the foregoing *verbatim* testimonies. The following theoretical propositions may also assist to both conceptualize and operationalize future strategic management decision-making:

- Enthusiasts of CS may be innocent of the prevailing evidence and socio/political drivers; detractors of CS may be fully informed.
- Staff who need CS most, may be those (including middle managers) who are least likely to receive it and/or facilitate it for others.
- The busier and time-poorer staff become, in ever more demanding clinical settings, the stronger an argument to allocate time for CS, not the weaker.
- Revenue costs for budget holders may accrue when CS is not an integrated part of contemporary professional nursing practice and may not accrue when it is.

Conclusion

If health service managers and other key stakeholders, at all levels of an organization, gave full attention to maximizing the factors which appeared to advantage

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the implementation processes and concomitantly minimized those factors that disadvantaged the enterprise, sustainable and demonstrably efficacious CS may impact on some nominated outcomes over time and may help to promote change in health care practices. However, if CS is poorly understood at the conceptual level and is superficially delivered at the level of implementation, it may waste public money and other scarce resources or, worse still, prove ineffectual and/or inadvertently detrimental to Supervisee and health service consumer alike.

Acknowledgements

The authors are indebted to Natalie Stuart, Project Research Officer, for her administrative and data management talents and to Sue O'Sullivan (CS educator), Christine Palmer, Jo Munday and Kerrie Counihan (Area Coordinators), each of whom are experienced Clinical Supervisors and educators. The responsibility for any errors, however, together with matters of interpretation, rest solely with the two authors. The authors are grateful to the Queensland Treasury/Golden Casket Foundation, Brisbane, Australia, for the funding necessary to conduct this study (A$248,000) which, by its nature, is totally dependent on the goodwill and cooperation of respondents. This is readily acknowledged with thanks.

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Appendix 1

Table to show the discipline and grade of interview respondents (*n* = 17).

Discipline	*Grade*	*Count (%)*
Nurse	Nursing Director	6 (35.2)
	Nurse Manager	2 (11.8)
	Team Leader	2 (11.8)
	Nurse Unit Manager	1 (5.9)
	Registered Nurse	2 (11.8)
	Clinical Nurse Consultant	1 (5.9)
	Clinical Nurse	1 (5.9)
	Enrolled Nurse	1 (5.9)
Psychologist	Clinical	1 (5.9)
		17 (100*)

*Rounded.

Appendix 2

Semi-structured interview guide

Definitions

- In this Service, since the research project began, is there a common understanding of what nursing CS is and what it is not?
  - If yes, what is it?
  - If not, what does the range include?
  - What effect does either have upon local CS implementation?

Structure

- What are the local arrangements for nursing CS implementation in this Service?
  - How many staff, in how many groups, meeting at what frequency and where?
  - Who decided these and upon what bases?

Process

- Since the research project began, how do nursing CS groups usually operate in this Service?
  - Who, actually, decided the ground rules?
  - How are confidential matters dealt with?
  - How are risks managed?
  - How are new members inducted?

Outcomes

- Are you optimistic about the future of CS in this Service after the research project has ended?

Concerns

- What are the three most pressing matters that have made it difficult [or impossible] to successfully implement nursing CS in this Service?
  - Are strategic remedies likely? What and when?

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