Clinical supervision in mental health: Toward identifying common elements across professions

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Brief Summary

This fact sheet summarizes the findings presented in two papers on the perceptions of front-line mental health and social work staff regarding interprofessional clinical supervision (ICS) under a program-management administrative model. Data was collected in 2008-2009 at the Centre for Addiction and Mental Health (CAMH), an organization that had recently undergone amalgamation and had subsequently adopted a program management structure. A semi-structured interview guided discussion in 13 focus groups; participants (*n*=77) were clinicians from the facility, representing various professions. Focus group discussions concentrated on clinicians' experiences with and perceptions of clinical supervision, as well as organizational impacts on that supervision. In light of the shift in many healthcare agencies towards a project management model, the research summarized herein is timely: it describes a core set of common elements for ICS, and offers insights into limitations for a common model of supervision.

Context

Restructuring and amalgamation of health organizations has led to new organizational relationships.

1. **Intraprofessional supervision replaced by interprofessional program management.** A typical outcome of restructuring is the replacement of profession-specific departments, run intraprofessionally, with interprofessional programs, run by program managers. Program managers are typically hired based on their overall knowledge and leadership skills, and not based on their particular profession. Additionally, professional practice leaders are appointed to consult with clinicians regarding promotion of profession-specific standards.
2. **Change in practitioners' primary affiliation.** With the creation of interprofessional teams, front-line practitioners' primary affiliation becomes the interprofessional team.

Clinical supervision plays an important role in clinician's professional development.
Theoretical and practice literature from the past three decades suggests that effective supervision positively effects clinicians and their work. This is supported by a growing body of empirical evidence.

1. **Mediation of organizational and professional stress.** Stressors such as mismatched professional values and organizational demands, maintenance of a professional identity in a multidisciplinary environment, and more recently, role ambiguity brought on by restructuring, are mitigated through individual and team support [5, 9, 12].
2. **Cultivation of clinicians' personal/ professional development.** Provision of supportive supervision is associated with numerous personal benefits for clinicians, including increased sense of autonomy, professional competence, and job satisfaction [4, 10, 11].
3. **Distributed benefits of individual professional development.** Supportive clinical supervision is also associated with increased organizational commitment and elevated levels of client care [3, 7, 8].

Mounting research supports ICS

Research over several decades has provided empirical support for various benefits of clinical supervision (cf. above citations). And although extant literature supports ICS in theory [2], there is less clarity regarding healthcare professionals' perceptions of ICS. Some clinicians prefer the traditional model of clinical supervision, and express misgivings about making interprofessional affiliations primary, suggesting that ICS erodes the possibility of comprehensive supervision [1, 5, 6]. However, the qualitative research reviewed here augments findings in favour of ICS.

Summary of Findings

Clinicians discussed the effects of reorganization upon their ability to serve clients, their supervisory arrangements, and their new interprofessional affiliations.

Organizational influences upon clinicians' workplace experience.

1. **Downsizing and cutbacks** have intensified workload and increased stress. Some clinicians feared for their jobs, and avoided asking for help.
2. Many clinicians expressed the desire for more **accountability** to and from the organization. In some cases, participants expressed a lack of structure or clarity of role expectations
3. **Training opportunities** were highly valued by clinicians, especially when related to day-to-day demands of the job.

Challenges of meeting clients' complex needs.

1. **Time constraints**, which are intensified through downsizing and cutbacks, lead to increased workloads, and served to further complicate clinicians' provision of client-centred care.
2. **Updating professional knowledge and skills** is important to clinicians, as they are very committed to increasing their effectiveness organizationally and with clients.
3. Feelings of **professional competence, self-esteem,** and subsequently, **job satisfaction** are highly influenced by the ability to meet clients' often complex needs.
4. **A non-judgemental workspace** was desired by some clinicians, who were unsure that the complexity of their work was understood by interprofessional supervisors.

Negotiating new supervision arrangements.

1. **Decreased frequency of supervisory meetings** resulted for some clinicians, following implementation of ICS.
2. **Mixed reaction to ICS**, among clinicians: *Negative attitudes* were associated with situations where supervisors assumed a more managerial role, and put program goals ahead of professional values. *Positive attitudes* were associated with new supervisory experiences that were clinician-centred, and that honoured the clinician's profession.

Attitudes toward interprofessional teams.

1. The new interprofessional configuration is **generally highly valued**, as it enables team members to learn from each other and provide care comprehensively, together.
2. Working together with others is **seen as supportive**, informative, providing relief from anxiety.
3. However, in some instances, **competing schedules** interfered with regular team meetings.

Nurses' attitudes towards clinical supervision. The opinions of some nurses differed from other professions, and within their own.

1. Some nurses expressed a **sense of professional obligation to work autonomously**, and to be self-reliant. Correspondingly, these nurses expressed fears of being undermined by intra- and interprofessional colleagues, and were therefore hesitant to request help or advice.
2. Among the nurses, there was a common perception (and experience) of **"supervision" as being correctional or punitive**, rather than supportive.

Emerging themes as to common elements of effective supervision.

Components of effective clinical supervision.

1. **Structure:** Effective supervision is readily available, such that ad hoc meetings are a possibility. Meetings take place regularly, and are systematic, reflective, clinical discussions. When supervisors are routinely present, their feedback about job performance is seen as being relevant.
2. **Content:** Effective supervisors are knowledgeable and skillful in terms of serving the client population. They are resourceful, and provide clinicians with the opportunity for sustained professional development. Supervisory meetings are clinician-centred, and address the clinician's specific needs/challenges.
3. **Process:** Clinicians' description of ideal supervision closely mirrored the clinician/client relationship: it takes place in a holding environment that is respectful and safe, and allows for the confidential processing of weaknesses or errors. The discussion features mutual interest and collaboration. The clinician feels accepted and validated, especially when struggling with particularly complex client needs.

Interprofessional Supervision.

1. **Affiliation:** The need for professional affiliation with one's supervisor was less important to clinicians than having a supervisor who had clinical expertise, who could facilitate continual updating of clinical knowledge and skills, and who met with clinicians in a spirit of safety and trust.
2. **Team cohesion:** Effective ICS promotes team unity and support, and facilitates engaged, interdisciplinary problem-solving.
3. **Profession-specific work:** ICS may be limited in its ability to provide guidance that is specific to a particular profession. When supervisor and clinician

share the same professional background, they tend to share the same language and philosophical orientation to providing care. This affinity facilitates discussion of professional values/ethics, of one's professional role on an interprofessional team (or within an organization), and of new trends in profession-specific work.

Caveats to the application of a common model of clinical supervision.

1. **New graduates:** In the early years of a clinician's career, it is best to get support, education, and sinterdisciplinary guidance from a supervisor of like profession. The intraprofessional supervisor becomes a mentor, orienting, socializing, and providing career guidance for the clinician.
2. **Nursing:** Similarly to other professions, nurses generally value supervision that is regular, and process-oriented. As well, they expressed appreciation for the acceptance and support often found within interdisciplinary teams. However, feedback from nurses indicated an unclear relationship between supervision and professional autonomy. The perceived mismatch is not pervasive, but is insufficiently understood. To develop a set of truly common elements of clinical supervision, this relationship needs further examination.

This fact sheet is a summary of the following articles:

Bogo, M., Paterson, J., Tufford, L., & King, R. (2011). Interprofessional clinical supervision in mental health and addiction: Toward identifying common elements. *The Clinical Supervisor, 30*(1), 124–140. doi:10.1080/07325223.2011.564961

Bogo, M., Paterson, J., Tufford, L., & King, R. (2011). Supporting front-line practitioners' professional development and job satisfaction in mental health and addiction. *Journal of Interprofessional Care, 25*(3), 209–14. doi:10.3109/13561820.2011.554240

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