South Australian Mental Health Nursing Workforce

Clinical Supervision Training and State-wide Pilot Program

EVALUATION REPORT

Yvette Pollard
Ann Roche
Chelsea Todd

March 2007

National Centre for Education and Training on Addiction (NCETA)
Flinders University, Adelaide, Australia

CONTENTS

EXECUTIVE SUMMARY

> *"It has provided a long overdue focus on giving back to Mental Health Nurses instead of asking more of them. This is how mental health reform will happen."*
>
> Comment provided by participant of August 2006 workshop

A Clinical Supervision Program for the Mental Health workforce was developed and funded by the South Australian Department of Health Nursing Office in late 2005. The program aimed to introduce a sustainable model for state-wide Clinical Supervision for the Mental Health Nursing Workforce through the implementation of pilot programs, conducted with the support of a training program. The clinical supervision training was facilitated by Mr John Driscoll, a UK-based healthcare consultant. The pilot programs were implemented by Senior Mental Health Clinicians in a variety of mental health facilities across South Australian Department of Health regions from May 2006.

The National Centre for Education and Training on Addiction (NCETA) was contracted to undertake an evaluation of the clinical supervision training and state-wide pilot programs. A 3-stage evaluation was undertaken.

- Stage 1 was a pre-training survey. This survey was completed by 139 Mental Health Professionals in May 2006. Each of the respondents completed a training session of either one or two days duration following the completion of the pre-training survey.

- Stage 2 was a post-training survey. A subset of Stage 1 participants (approximately 40 Senior Mental Health Clinicians) completed two Clinical Supervision training workshops focussing on 'Group' Clinical Supervision processes and 'One-on-One' Clinical Supervision processes. Each workshop was two days in duration and were held in May 2006 and August 2006. The Stage 2 post-training survey was completed by 33 participants who attended both these workshops.

- Stage 3 was a follow-up survey. This survey was distributed in December 2006 to the same group of Senior Mental Health Clinicians who had completed Survey 2. Seventeen useable surveys were collected.

Key Findings

Stage 1 – Pre-training survey

- Over half the respondents were aged 46-55 years.
- Approximately 50% of respondents believed that they had a good understanding of clinical supervision.
- Respondents tended to perceive benefits related to individuals were more likely to occur than benefits related to the organisation.
- Approximately half the respondents agreed that all 10 barriers presented were going to impact on effective clinical supervision implementation.
- Only 17% of respondents believed that their organisation's delivery and implementation of clinical supervision was adequate.

Stage 2 and 3 – Post-training and Follow-up surveys

- Approximately 90% of training participants agreed or strongly agreed that their understanding of clinical supervision and its components had improved as a result of the May and August 2006 training workshops.
- The pilot programs had a significant impact on training participants' understanding of the difference between line management and clinical supervision, and the difference between performance appraisal and clinical supervision.
- "Opportunity for reflection and development of best practice" was agreed to be a benefit of clinical supervision by significantly more training participants at Stage 3 (December 2006) compared with Stage 2 (August 2006).
- Perceptions of barriers to implementing clinical supervision in the workplace had reduced considerably by follow-up.
- Over 71% of training participants reported development or modification of their organisations' clinical supervision policy as a direct result of the training and/or pilot program.
- Fifty percent of respondents believed that their organisation's delivery and implementation of clinical supervision was adequate.

EVALUATION METHODOLOGY

The evaluation methodology was developed in collaboration with the Project Working Group (see Appendix 1).

Data collection

Stage 1: Mental Health Professionals (n=139) completed a Pre-training survey in May 2006.

Stage 2: A Post-training survey was completed by Senior Mental Health Clinicians (n=33) in August 2006 following their attendance at two Clinical Supervision training workshops (each of two-days duration).

Stage 3: A Follow-up survey was distributed in December 2006 to the Senior Mental Health Clinicians who had completed Survey 2. Seventeen useable surveys were completed.

Survey design

The Pre-training survey (see Appendix 2) was designed to measure participants' perceptions of their knowledge and understanding of clinical supervision *prior* to training, expectations of the training workshops, expectations of the pilot programs, perceptions of benefits and barriers to clinical supervision, and organisational responsibilities regarding clinical supervision. The Pre-training survey included a section on participants' demographics including age, gender, occupation, years of experience in the Mental Health field, years employed in their organisation, and geographic location.

The Post-training survey (see Appendix 3) was designed to evaluate the delivery both training programs (May and August 2006), evaluate the immediate impacts of the training programs on skills and knowledge, gather data on preliminary impacts of the workplace pilot programs, identify experienced benefits and barriers to clinical supervision implementation, and examine organisational responsibilities regarding clinical supervision.

The final survey, the Follow-up survey (see Appendix 4), was designed to measure any changes over time regarding the effect of training on skills and knowledge, effect of workplace pilot programs on skills and knowledge, experience of benefits and barriers to clinical supervision implementation, and organisational responsibilities regarding clinical supervision.

The surveys were designed to minimise time use on the part of participants and included objective questions measuring levels of agreement/disagreement. Primarily quantitative data was gathered. All surveys provided space for participants to give written comments (ie, qualitative information) on the training and pilot program.

Data analyses

Quantitative data was analysed using the Statistical Package for Social Sciences (SPSS) software and qualitative data was categorised according to common themes identified among the responses.

Stage 1 – Pre-training survey

Participants

A total of 139 participants completed the Pre-training survey prior to the delivery of five workshops (3 x 1-day duration, 2 x 2-days duration) in May 2006.

Occupation, occupational status and work location

The majority of participants (45%) were employed as Level 1, 2 or 3 Mental Health Nurses (see Figure 1 below).

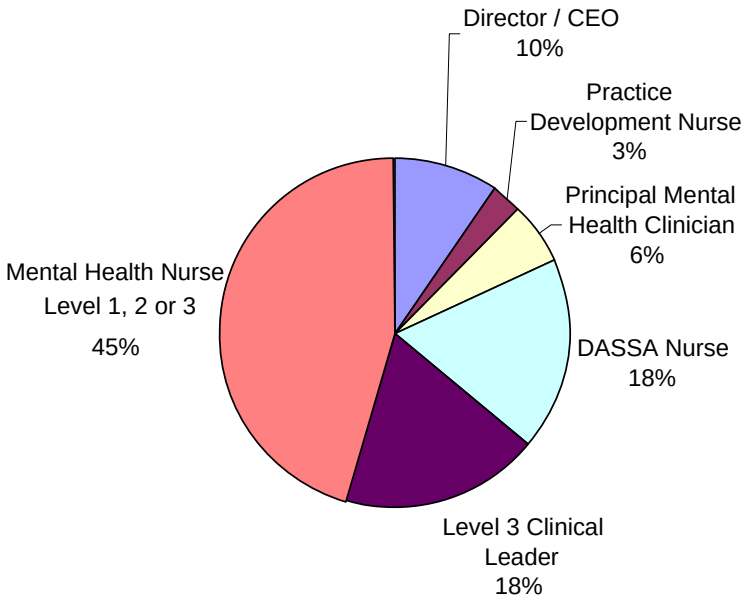

Figure 1: Participants' occupation (n=136)

Overall, the majority of participants were employed full-time (80%).

The categorisation of geographic location of participants is presented in Table 1.

Table 1: Geographic location of participants

Geographic location	*Frequency (n)*	*Percentage (%)*
Urban	84	71%
Regional	20	17%
Rural / Remote	15	12%
Total	**119**	**100%**

Geographic categorisation by Department of Health regions was also undertaken. Figure 2 illustrates the location of participants by departmental mental health region.

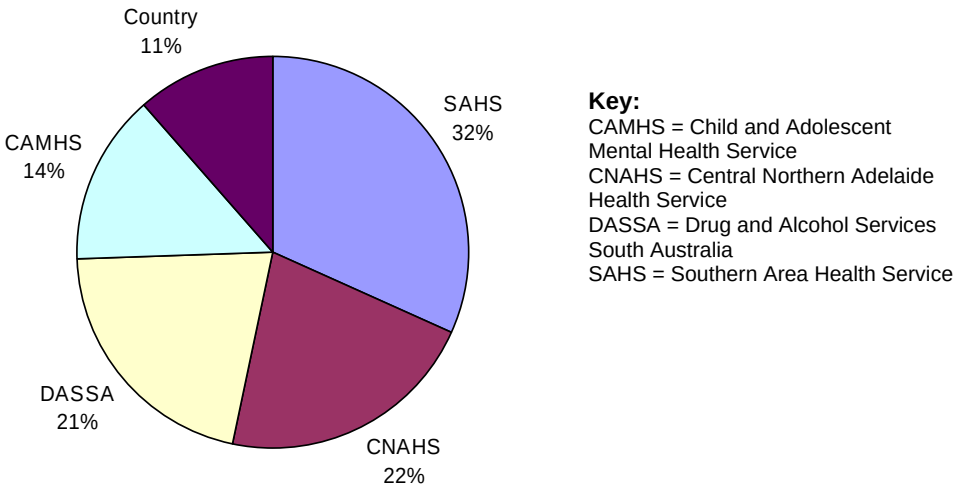

Figure 2: Participants' working location by Department of Health mental health region (n=133)

Gender, age, and length of service

The majority of respondents were female (75%). Table 2 shows proportions of male and female workers employed across occupations. Generally, males were equally represented and comprised approximately half of Principal Mental Health Clinicians (43%) and Level 3 Clinical Leaders (48%), but were underrepresented amongst DASSA Nurses (0% male, 100% female).

Table 2: Occupation by gender

	Gender		
Occupation	***Male***	***Female***	***Total***
Director / CEO	1	8	9
Practice Development Nurse	1	2	3
Principal Mental Health Clinician	3	4	7
DASSA Nurse	0	20	20
Level 3 Clinical Leader	10	11	21
Mental Health Nurse Level 1, 2, or 3	15	41	56
Total	**30**	**86**	**116**

Nearly two-thirds (64%) of participants were aged 46 years and over. Figure 3 provides the age breakdown of participants.

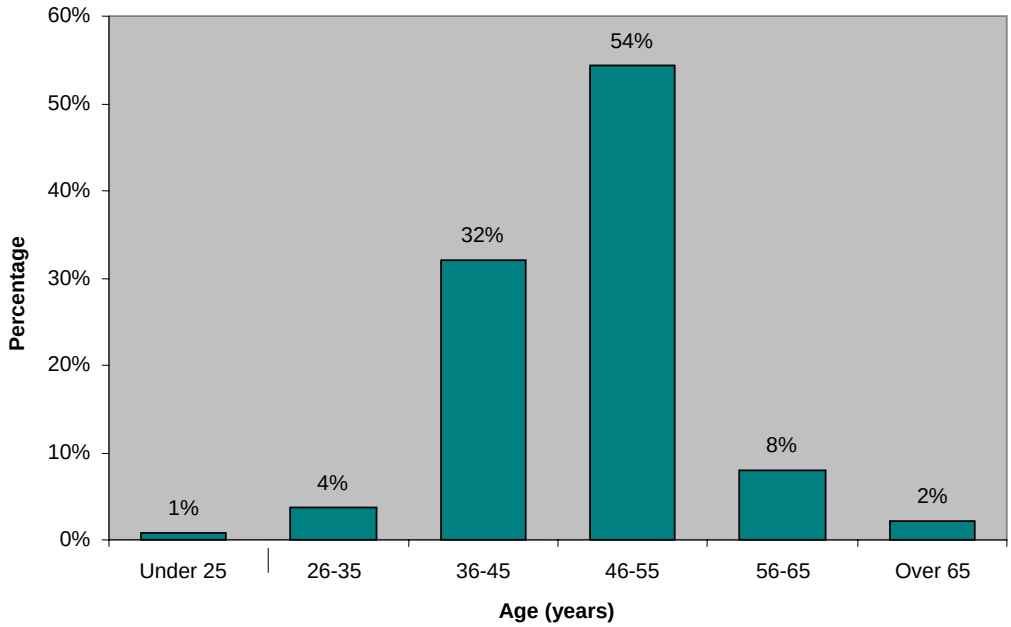

Figure 3: Proportion of participants by age group (n=138)

The mean length of time participants had been working in their current organisation was nine years (range <1-30 years). The mean length of service in the Mental Health/Alcohol and Other Drug field was 17 years (range <1-35 years).

General understanding of clinical supervision

As can be seen from Table 3, 62% of participants reported that they agreed/strongly agreed that they had a good understanding of clinical supervision prior to the training. Fewer respondents (43%) agreed/strongly agreed that they had a good understanding of the various components of clinical supervision, with a further third of participants (33%) undecided, and 24% disagreed or strongly disagreed that they had this understanding.

A high proportion of participants (approximately 70%) agreed or strongly agreed that they had a good understanding of the differences between line management and clinical supervision, as well as a good understanding of the difference between performance appraisal and clinical supervision.

Participants were roughly equally divided with regard to their understanding of the roles and responsibilities of supervisors and supervisees. Approximately half the participants agreed

or strongly agreed that they had a good understanding, and approximately half were undecided or did not agree.

While these figures indicate that the majority of participants perceived their understanding was "generally good" prior to the training, it was anticipated that levels of understanding would improve following the training and again, following pilot program implementation. Results provided below in the Post-training and Follow-up findings and comparisons indicate that such improvement were experienced by participants of the August training sessions and workplace pilot programs.

Table 3: General understanding of clinical supervision prior to training

	Strongly Disagree	*Disagree*	*Undecided*	*Agree*	*Strongly Agree*
I have a good understanding of the general principles of clinical supervision	0%	16%	22%	49%	13%
I have a good understanding of the various components of clinical supervision	1%	23%	33%	34%	9%
I have a good understanding of the difference between line management and clinical supervision	1%	10%	20%	52%	17%
I have a good understanding of the difference between performance appraisal and clinical supervision	0%	9%	20%	53%	18%
I have a good understanding of the role and responsibilities of a clinical supervisor	1%	16%	33%	38%	11%
I have a good understanding of the role and responsibilities of a supervisee	1%	17%	34%	36%	12%

Previous clinical supervision provision and training

Fifty-four percent of participants were currently providing clinical supervision to mental health / AOD nursing staff, however, only 33% had previously received any form of training in clinical supervision prior to the May 2006 workshops.

Perceptions of clinical supervision training

Table 4 below shows approximately half the participants agreed that the May 2006 training would:

(a) enable them to provide effective clinical supervision with great confidence,

(b) be effectively incorporated into their workplace,

(c) be appropriate for their current work needs, and

(d) enable them to engage effectively as a supervisee.

Not surprisingly, an average of half the participants were undecided regarding the impact of the training prior to its delivery and very few disagreed that the training would have potentially positive outcomes.

Table 4: Perceptions of clinical supervision training

	Strongly Disagree	*Disagree*	*Undecided*	*Agree*	*Strongly Agree*	*Total*
This training program will enable me to provide clinical supervision with greater confidence	0%	2%	28%	54%	17%	100%
Skills or knowledge gained from this training program will enable me to provide effective clinical supervision	0%	2%	33%	50%	16%	100%
The knowledge and skills acquired from this training program will be effectively incorporated into the workplace	1%	0%	43%	48%	8%	100%
The content of the training program will be appropriate for my current work needs	0%	1%	58%	34%	7%	100%
This training program will enable me to participate as a supervisee with greater understanding of its purpose	0%	2%	33%	55%	11%	100%
Skills or knowledge gained from this training program will enable me to engage effectively as a supervisee	0%	1%	42%	47%	11%	100%

Perceived benefits of clinical supervision

As can be seen from Table 5, the majority of participants agreed or strongly agreed that staff would experience a range of benefits, with approximately 15% of participants undecided and very few disagreeing. The results are ranked in order of 'strongly agree' responses. Three of the top five benefits in this categorisation related to individual benefits (opportunity for reflection and development of best practice, opportunity for support and debriefing, and improved skills and clinical practice), while the other two related to improved client outcomes and improved client care. Organisational benefits such as improved clinical governance were ranked lower, however, it was anticipated that responses to these items would improve over time following participants' training and pilot program experiences.

Table 5: Perceived benefits of clinical supervision by participants prior to training

	Strongly Disagree	*Disagree*	*Undecided*	*Agree*	*Strongly Agree*	*Total*
Opportunity for reflection and development of best practice	0%	0%	4%	58%	38%	100%
Opportunity for support / debriefing	0%	1%	9%	58%	32%	100%
Improved client care	0%	1%	10%	64%	25%	100%
Improved skills / clinical practice	0%	0%	9%	68%	23%	100%
Improved client outcomes	0%	0%	13%	66%	21%	100%
Improved understanding of ethical issues and accountability	0%	1%	13%	66%	20%	100%
Improved knowledge base	0%	3%	15%	63%	19%	100%
Improved clinical governance and organisational accountability	0%	4%	20%	57%	19%	100%
Consistency of practice	0%	1%	14%	69%	16%	100%
Improved compliance with best practice	0%	2%	18%	64%	16%	100%
Prevention of worker stress and burnout	0%	2%	15%	68%	15%	100%

Perceived barriers to clinical supervision

The survey examined participants' perspectives regarding systematic barriers within the workplace that could impact on the effectiveness of a Clinical Supervision program. Table 6 provides results in order of highest agreement (with the responses categories of 'agree' and 'strongly agree' summed) to the organisational issue participants perceived would be a barrier to implementing effective clinical supervision.

Eighty percent of participants believed lack of training for supervisors would be a barrier prior to the training sessions. Over 75% of participants agreed or strongly agreed that a *workers'* lack of understanding of the benefits of clinical supervision by would be a barrier to effective clinical supervision whereas only 60% agreed or strongly agreed that *managers'* lack of understanding of the benefits of clinical supervision by would be a barrier. Over 60% of respondents disagreed or were unsure as to whether distance or travelling time would be a barrier to clinical supervision.

While the percentages here are relatively high for the "agree" and "strongly agree" responses it should be noted that these perceptions were held by participants *prior* to training and pilot program implementation. The sections below provide comparative data that shows improved changes to perceptions of barriers following delivery of the training and pilot program implementation.

Table 6: Perceived barriers to clinical supervision held by participants prior to training

	Strongly Disagree	*Disagree*	*Undecided*	*Agree*	*Strongly Agree*	*Total*
Lack of training for supervisors	1%	7%	12%	59%	21%	100%
Lack of understanding of the benefits of clinical supervision by workers	1%	10%	12%	59%	18%	100%
Insufficient pool of suitably qualified supervisors	1%	7%	14%	54%	24%	100%
Backfilling difficulties	2%	7%	18%	40%	33%	100%
Different conceptual frameworks among supervisors, supervisees and managers	0%	13%	32%	45%	10%	100%
Lack of understanding of the benefits of clinical supervision by managers	2%	21%	17%	44%	16%	100%
Conflict between clinical and managerial staff (ie blurred administrative & clinical roles)	0%	16%	30%	40%	13%	100%
Funding shortfalls	1%	15%	28%	37%	18%	100%
Lack of commitment by upper management to program implementation	1%	23%	26%	35%	15%	100%
Geographical distance / travelling time between supervisors and supervisees	2%	23%	38%	24%	13%	100%

Organisational responsibilities regarding clinical supervision

With regard to clinical supervision policy in the workplace the majority of participants (44%) reported that their organisation did not have a clinical supervision policy, while 26% were unsure. Thirty percent indicated that their organisation did have a clinical supervision policy in place.

Delivery and implementation of clinical supervision within their organisation was not adequate according to nearly half (48%) of participants, 22% reported they were unsure, 13% believed it to be ‘somewhat’ adequate, and the remaining 17% reported it to be adequate (see Figure 4).

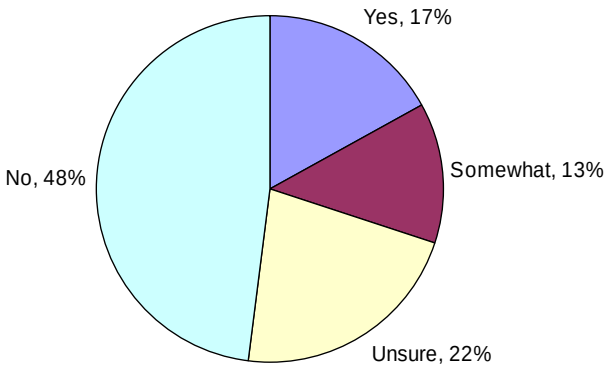

Figure 4: Participants’ responses regarding their organisation’s adequacy in delivering and implementing clinical supervision (n=107)

Regarding organisational culture, nearly half the respondents (48%) reported that the culture did support a clinical supervision policy, with 17% unsure, 15% perceiving their organisation to support a policy 'somewhat', and 19% responded that their organisation did not.

Although these figures suggest a large proportion of respondents were dissatisfied with clinical supervision implementation and/or support in their workplace, this result may be due to the limited implementation of clinical supervision in the workplace at the time of data collection. The implementation of pilot programs throughout the second half of 2006 was expected to impact on these perceptions, and these results can be seen from page 29 – "Follow-up Survey (December 2006) – Findings and Comparisons with Pre- and Post-training Data".

Comments by participants

A section was provided at the end of the Pre-training survey to enable participants to provide qualitative statements regarding the training program. A selection of qualitative statements is provided below.

Qualitative statements from respondents:

"I'm looking forward to this next stage in my self development."

"Through poor management and supervision I have been left very scared. I will not allow this to happen again."

"Thank you for the opportunity to attend."

"I will not be personally involved as a clinical supervisor/supervisee but am very supportive of the introduction in my work area."

"Appreciate opportunity to learn about formal frameworks for supervision."

"New management is supportive of change and new initiatives – this hasn't been so in the past so the cultural shift is slow."

Stage 2 – Post-training survey (August 2006)

Participants

A total of 33 current and future Mental Health Clinical Supervisors completed the Post-training survey at the second round of workshops in August 2006. The survey was completed by participants prior to the final session on the second day of the workshop. As with the May workshops, Mental Health Nurses 1, 2 or 3 were the largest occupational group.

Table 7: Proportion of respondents by profession (n = 33)

Occupation	*Frequency*	*Percentage (%)*
Practice Development Nurse	1	3
Principal Mental Health Clinician	3	9
DASSA Nurse	8	24
Level 3 Clinical Leader	5	15
Mental Health Nurse Level 1, 2, 3	16	49
Total	**33**	**100**

Training impact on understanding of clinical supervision

The majority of participants responded positively to questions regarding improvement in understanding of a range of elements pertaining to clinical supervision as a result of the training workshops. Figures 5 through to 10 provide clear results indicating the training had a positive effect on a large majority of participants' understanding of a range of clinical supervision areas. Only a very small number of participants reported that the training did not impact on their understanding.

The Pre-training survey (Survey 1) respondents generally agreed or strongly agreed that they had an understanding of a variety of areas pertaining to clinical supervision, with between 20% and 35% undecided. Although pre-training perceptions of understanding was relatively high, the following figures show that the workshops did contribute to an improved understanding for most respondents.

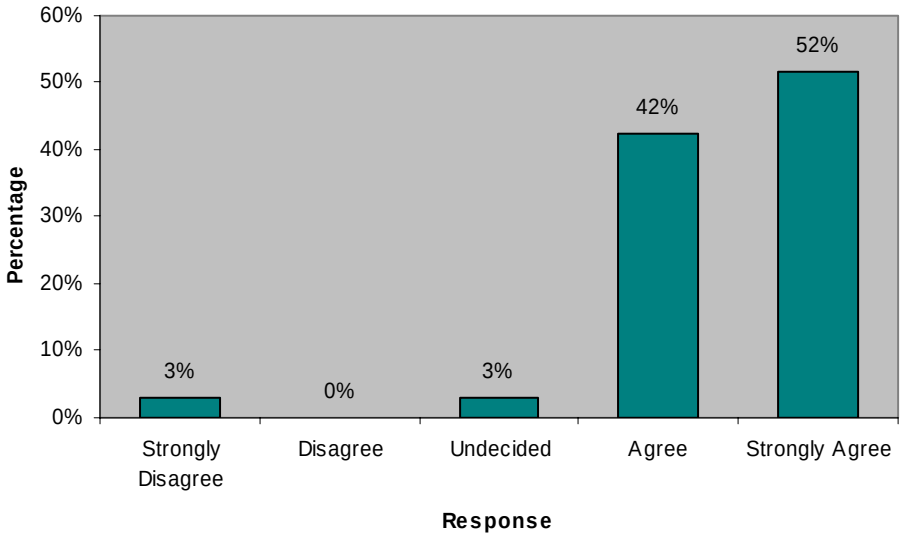

Figure 5: Responses regarding an improved understanding of the general principles of clinical supervision due to the May and August 2006 training

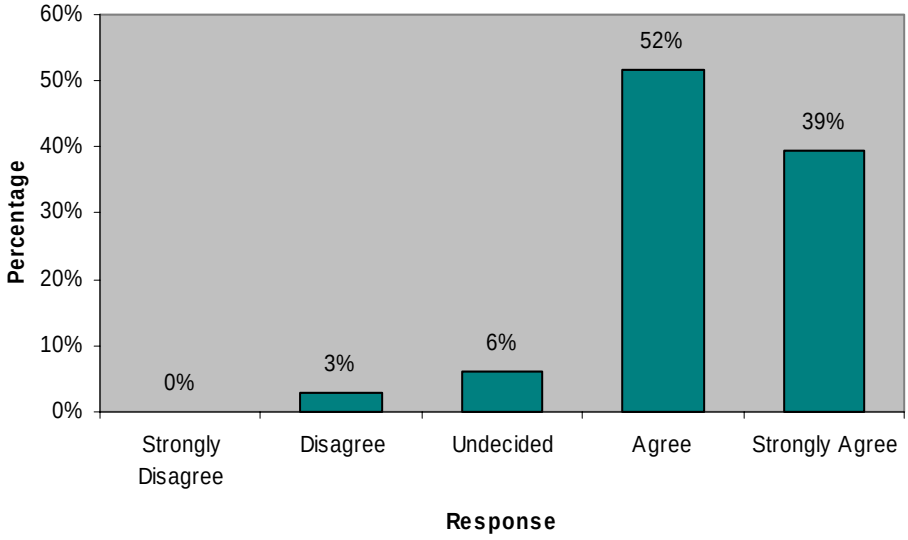

Figure 6: Responses regarding an improved understanding of the various components of clinical supervision due to the May and August 2006 training

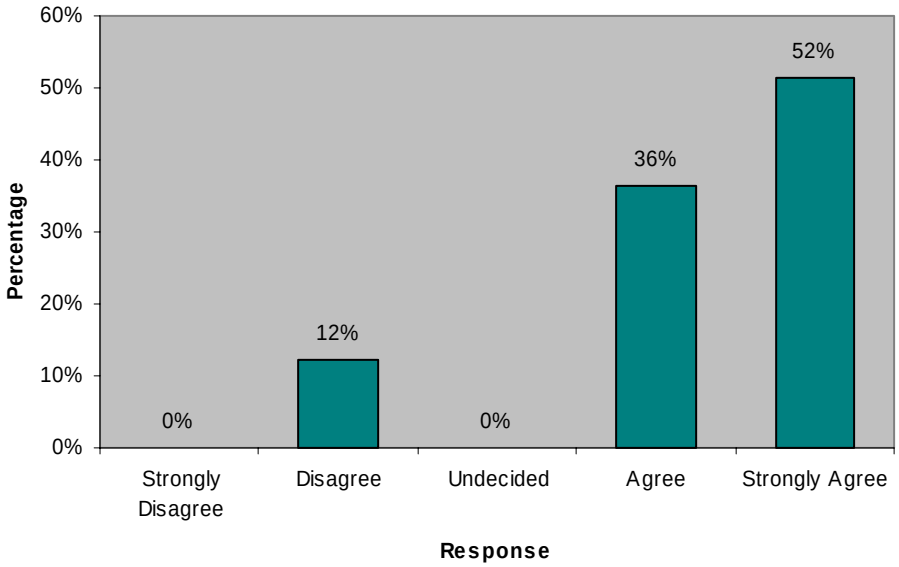

Figure 7: Responses regarding an improved understanding of the difference between line management and clinical supervision due to the May and August 2006 training

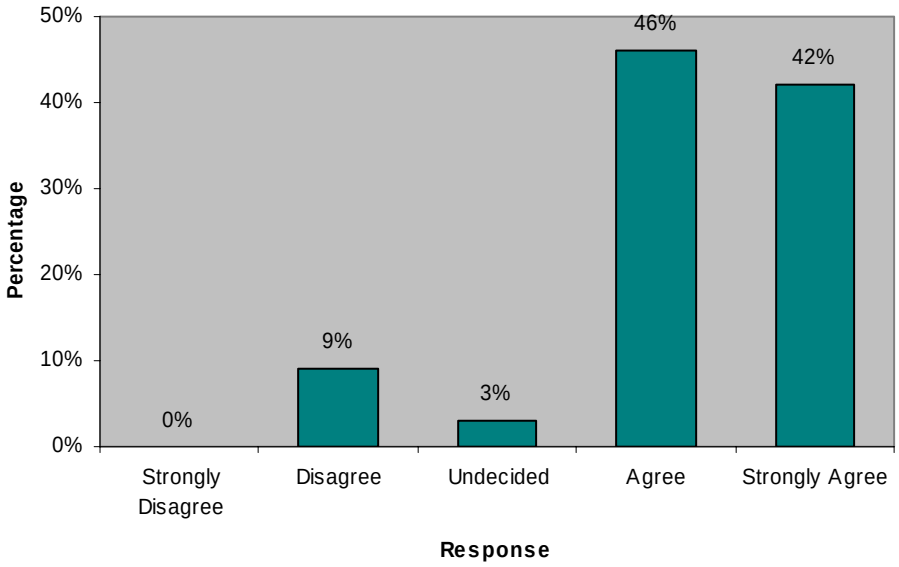

Figure 8: Responses regarding an improved understanding of the difference between performance appraisal and clinical supervision due to the May and August 2006 training

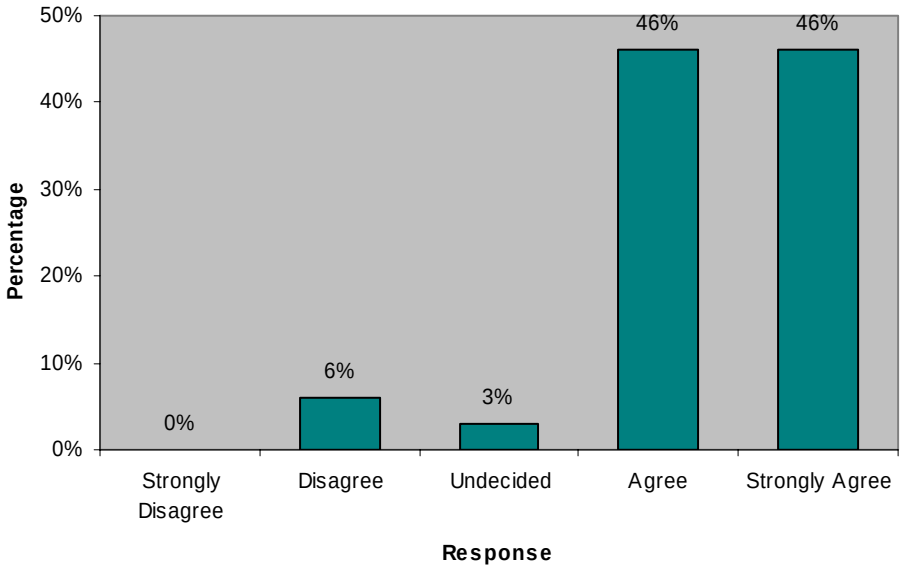

Figure 9: Responses regarding an improved understanding of the role and responsibilities of clinical supervisors due to the May and August 2006 training

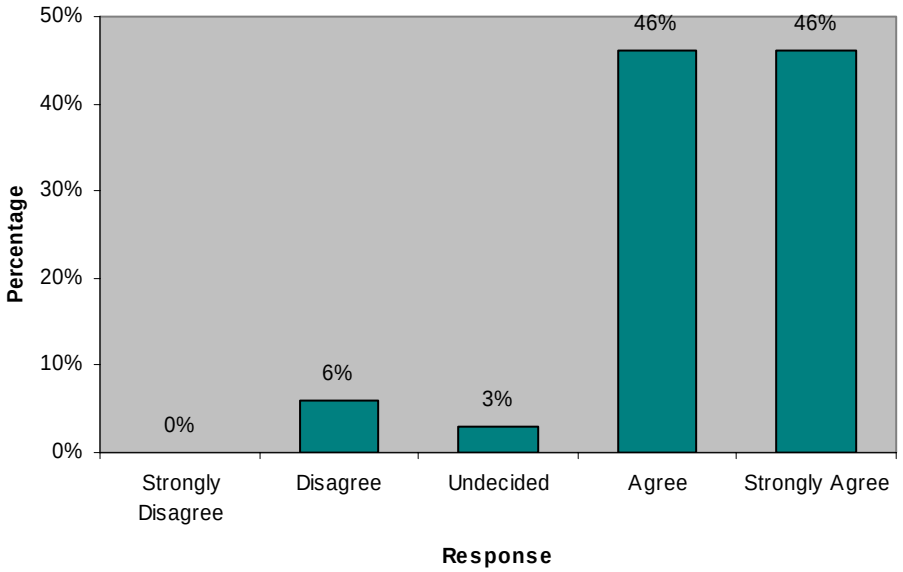

Figure 10: Responses regarding an improved understanding of the role and responsibilities of supervisees due to the May and August 2006 training

Overall, there was satisfaction with the quality of training received. Sixty-eight percent (n=22) of Post-training respondents were satisfied with the training and 19% (n=6) were somewhat satisfied. Thirteen percent (n=5) were not satisfied with the training received.

Figure 11 below provides participants' responses to whether the training would impact on their ability to provide effective clinical supervision.

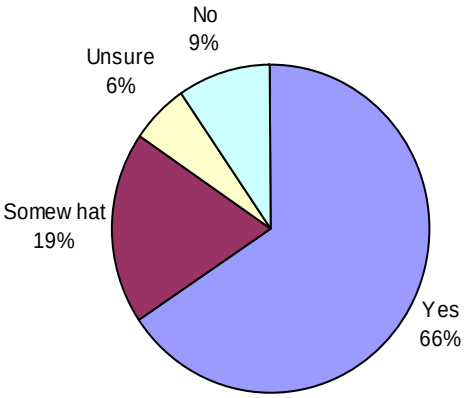

Figure 11: Training impact on respondents' ability to provide effective clinical supervision

In general, there were very positive responses to questions regarding both the applicability of the training to participants' workplace and work role, and personal outcomes (e.g., skill development, knowledge enhancement, role confidence). An average of 84% of respondents agreed or strongly agreed that the training has had, or will have, beneficial outcomes on their clinical supervision practice. The results are provided below in Table 8.

Table 8: Participant responses to training outcomes

	Strongly Disagree	*Disagree*	*Undecided*	*Agree*	*Strongly Agree*
This training program enabled me / will enable me to provide clinical supervision with greater confidence	0%	3%	6%	49%	42%
Skills or knowledge gained from this training program has enabled me / will enable me to provide effective clinical supervision	0%	6%	9%	46%	39%
The knowledge and skills acquired from this training program has been / will be effectively incorporated into the workplace	0%	3%	18%	49%	30%
The content of the training program has been / will be appropriate for my current work needs	3%	3%	18%	49%	27%
This training program has enabled me / will enable me to participate as a *supervisee* with greater understanding of its purpose	3%	0%	9%	39%	49%
Skills or knowledge gained from this training program has enabled me / will enable me to engage effectively as a *supervisee*	3%	0%	12%	36%	49%

Pilot program impact on understanding of clinical supervision

Table 9. provides the responses to perceptions of increased understanding in clinical supervision due to the workplace Pilot Program. It is understood that few pilot programs were fully implemented at the time of this data collection, however the results confirm there was a positive impact on participants' understanding of a range of clinical supervision components at this early stage of implementation. Qualitative statements by participants regarding Pilot Programs are provided below Table 10.

Table 9: Responses regarding improvement of understanding of clinical supervision due to the Pilot Program

	Strongly Disagree	*Disagree*	*Undecided*	*Agree*	*Strongly Agree*	*Total*
The general principles of clinical supervision	0%	13%	6%	50%	31%	100%
The various components of effective clinical supervision	0%	13%	13%	44%	31%	100%
The difference between line management and clinical supervision	0%	13%	6%	41%	41%	100%
The difference between performance appraisal and clinical supervision	0%	13%	6%	41%	41%	100%
The role & responsibilities of a clinical supervisor	0%	13%	6%	44%	38%	100%
The role & responsibilities of a supervisee	0%	13%	6%	44%	38%	100%

Results pertaining to skill and knowledge development as a result of the pilot program were not as conclusive as those for training workshops. Approximately 50% of participants were undecided about the impact of the pilot programs. This was most likely due to the limited time (three months) participants had to implement clinical supervision, or it may have been because pilot programs had not yet been established in their workplace.

Although approximately half the participants were undecided, the remaining tended to agree or strongly agree with the range of pilot program outcomes provided. These results are shown in Table 10 below.

Table 10: Participant responses regarding impact of pilot programs on outcomes

	Strongly Disagree	*Disagree*	*Undecided*	*Agree*	*Strongly Agree*
Increase group skills and dynamics	3%	7%	50%	37%	3%
Improve individual skills and knowledge	0%	10%	47%	37%	7%
Enhance your ability to establish a clinical supervision program in the workplace	0%	7%	43%	37%	13%
Improve negotiation skills	0%	13%	53%	27%	7%
Improve goal setting	0%	13%	43%	40%	3%
Increase ability to design and develop a contract	0%	3%	43%	33%	20%
Increase knowledge of clinical supervision guidelines and policy	3%	3%	43%	33%	17%
Increase knowledge of other organisational work practice guidelines and policies	0%	17%	47%	37%	0%

Qualitative statements from respondents:

"No impact as yet, but very excited re: potential. Will start providing clinical supervision in about six weeks."

"Learnt a lot from others involved – from their great skills and their willingness to share and exchange this knowledge."

"Not yet implemented in my region."

"It's been really difficult to set up – time being the old enemy. As a result I have felt some anxiety and frustration."

"Has not formally commenced in my workplace although all the groundwork has been done in readiness."

"The organisation was very supportive of getting clinical supervision started but then nothing has been followed through in practice."

Experienced benefits of clinical supervision

Participants were asked to indicate the extent to which they or their staff had experienced a range of benefits as a result of the clinical supervision training workshops and the pilot program.

Table 11 provides the listed benefits in order of summed 'Agree' and 'Strongly Agree' responses. The benefit most frequently agreed with was "opportunity for reflection and development of best practice" (63%), followed by "opportunity for support and debriefing" (61%) and "prevention of worker stress and burnout" (48%). These results show that items pertaining to individual factors were those mostly strongly supported. Three organisational

factors with the lowest level of agreement were: "consistency of practice" (42%), "improved compliance with best practice" (39%), and "improved clinical governance and organisational accountability" (36%). This result suggests that as pilot programs were still in their relative infancy during this survey period, individual benefits were likely to be more apparent, whereas benefits at the organisational level may not yet have been experienced or had not taken effect.

Table 11: Participants' experienced benefits following clinical supervision training and pilot program implementation in order of combined 'agree' and 'strongly agree' responses

Benefits	*Strongly Disagree*	*Disagree*	*Undecided*	*Agree*	*Strongly Agree*
Opportunity for reflection and development of best practice	0%	6%	30%	30%	33%
Opportunity for support and debriefing	0%	6%	33%	33%	27%
Prevention of worker stress and burnout	0%	6%	46%	27%	21%
Improved skills and clinical practice	0%	6%	49%	27%	18%
Improved understanding of ethical issues and accountability	0%	12%	42%	33%	12%
Improved knowledge base	0%	15%	39%	33%	12%
Improved client care	0%	12%	46%	18%	24%
Improved client outcomes	0%	12%	46%	21%	21%
Consistency of practice	0%	12%	46%	24%	18%
Improved compliance with best practice	0%	12%	49%	24%	15%
Improved clinical governance and organisational accountability	0%	12%	52%	27%	9%

The relatively high proportion of 'undecided' responses is likely to be due to the limited time between the first round of training (May 2006) and the second round of training (August 2006). Secondly, there were a number of participants whose pilot programs had not yet commenced at the time of survey collection and would, therefore, contribute to high levels of indecision in this area. It was expected that a the Follow-up survey would provide more definitive results in regard to benefits experienced at the individual, client, and organisational levels, and these are provided in the next section of the report.

Experienced barriers to clinical supervision

The Post-training results of barriers to clinical supervision were expected to show a reduction in the number of participants who either agreed or strongly agreed, compared with Pre-training perceptions. In general, this trend occurred.

Table 12 provides results of perceived barriers to clinical supervision prior to (May 2006) and following (August 2006) training. It can be seen that there was a general shift from agreeing

that designated barriers would inhibit supervision implementation toward disagreeing or strongly disagreeing. For example, agreeing or strongly agreeing responses to “lack of training for supervisors” reduced considerably from 83% (Pre-training) to 27% (Post-training). Of note are the two barriers which contravened this trend: “Funding shortfalls” slightly up from 56% to 57%, and "lack of commitment by upper management to program implementation” increasing by 4% overall in the agreeing or strongly agreeing categories but with strongly agree responses doubling from 15% to 30%.

Table 12: Pre-training and Post-training perceptions of barriers to clinical supervision

	Strongly Disagree	*Disagree*	*Undecided*	*Agree*	*Strongly Agree*
Backfilling difficulties					
Pre-training	2%	8%	18%	40%	33%
Post-training & pilot program	6%	15%	9%	33%	36%
Conflict between clinical and managerial staff (ie blurred administrative & clinical roles)					
Pre-training	0%	16%	30%	40%	13%
Post-training & pilot program	3%	27%	42%	21%	6%
Different conceptual frameworks among supervisors, supervisees and managers					
Pre-training	0%	13%	31%	45%	10%
Post-training & pilot program	3%	33%	21%	33%	9%
Funding shortfalls					
Pre-training	1%	15%	28%	38%	18%
Post-training & pilot program	6%	12%	24%	33%	24%
Geographical distance / travelling time between supervisors and supervisees					
Pre-training	2%	23%	38%	24%	13%
Post-training & pilot program	6%	33%	36%	15%	9%
Insufficient pool of suitably qualified supervisors					
Pre-training	2%	7%	14%	54%	23%
Post-training & pilot program	0%	30%	33%	15%	21%
Lack of commitment by upper management to program implementation					
Pre-training	2%	23%	26%	35%	15%
Post-training & pilot program	3%	30%	12%	24%	30%
Lack of training for supervisors					
Pre-training	1%	7%	12%	59%	22%
Post-training & pilot program	9%	49%	15%	24%	3%
Lack of understanding the benefits of clinical supervision by managers					
Pre-training	2%	21%	18%	43%	16%
Post-training & pilot program	3%	27%	18%	36%	15%
Lack of understanding the benefits of clinical supervision by workers					
Pre-training	2%	10%	12%	58%	18%
Post-training & pilot program	3%	18%	9%	52%	18%

Figures 12 through 17 are provided below to further illustrate the magnitude of attitude change in five of the 10 proffered barriers.

Figure12 below shows a large shift in attitude regarding conflict between clinical and managerial staff. Pre-training responses indicated over 50% of participants agreed or strongly agreed that conflict between clinical and managerial staff would be a barrier to effective clinical supervision in the workplace. Following both sets of training and partial implementation of pilot programs in the workplace, this figure had reduced to 27%, with a further 30% disagreeing or strongly disagreeing (up from 16% Pre-training). One reason for this shift may be due to increased communication with managerial staff during implementation of pilot programs. Another reason could be the training workshops attended by managers in May 2006 may have had an influence on their knowledge and understanding of the differences between administrative and clinical supervision and were then accordingly reflected in August attendees' responses.

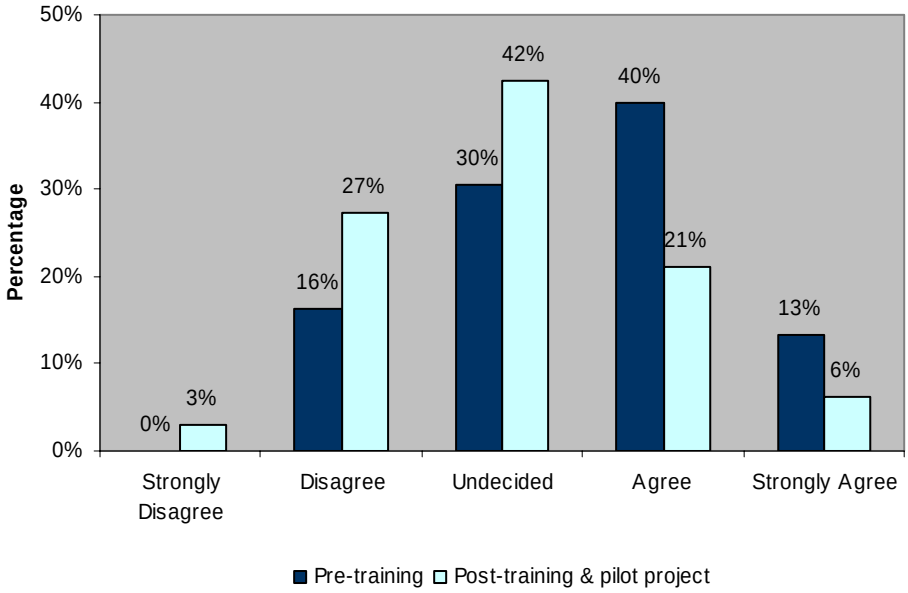

Figure 12: Pre-training and post training participant perceptions of conflict between clinical and managerial staff (ie blurred administrative & clinical roles) as a barrier to clinical supervision

Figure 13 below provides further indication of changes in perception. The Pre-training perceived differences of conceptual frameworks among supervisors, supervisees and managers was very strong, with 55% agreeing or strongly agreeing that differing frameworks would be a barrier to effective clinical supervision. However, this figure was reduced by 13% to 42% following both sets of training and implementation of pilot programs. Importantly, there was a 23% increase in respondents who disagreed or strongly disagreed that differences among supervisors, supervisees and managers would be problematic. It would appear that

dialogue and communication on clinical supervision between these tiers of the workforce may have impacted on their perceived levels of difference.

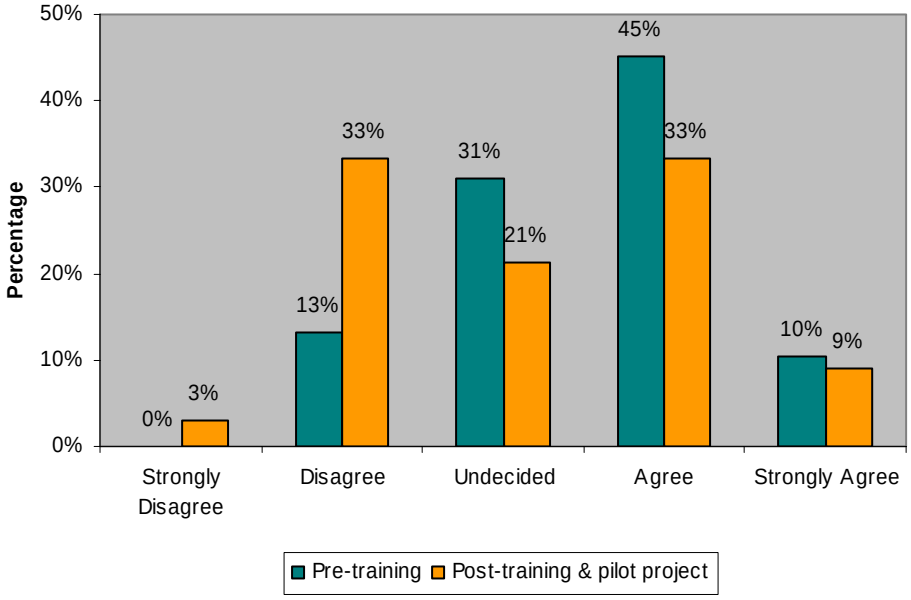

Figure 13: Different conceptual frameworks among supervisors, supervisees and managers

Figure 14 clearly shows a large shift in participants' perceptions of the available pool of suitably qualified supervisors that would enable efficient clinical supervision programs. The majority of Pre-training participants (77%) agreed or strongly agreed that an insufficient pool of suitably qualified supervisors would be a barrier to implementing supervision in the workplace, however, after both training workshops and the (limited) implementation of pilot programs this had reduced to 36%. A further change in perception is the rise from 9% to 30% of participants disagreeing or strongly disagreeing that the pool of supervisors will be a barrier. This result suggests that participants, having received training, altered their perceptions of clinicians' expertise within the mental health sector to adequately support clinical supervision programs.

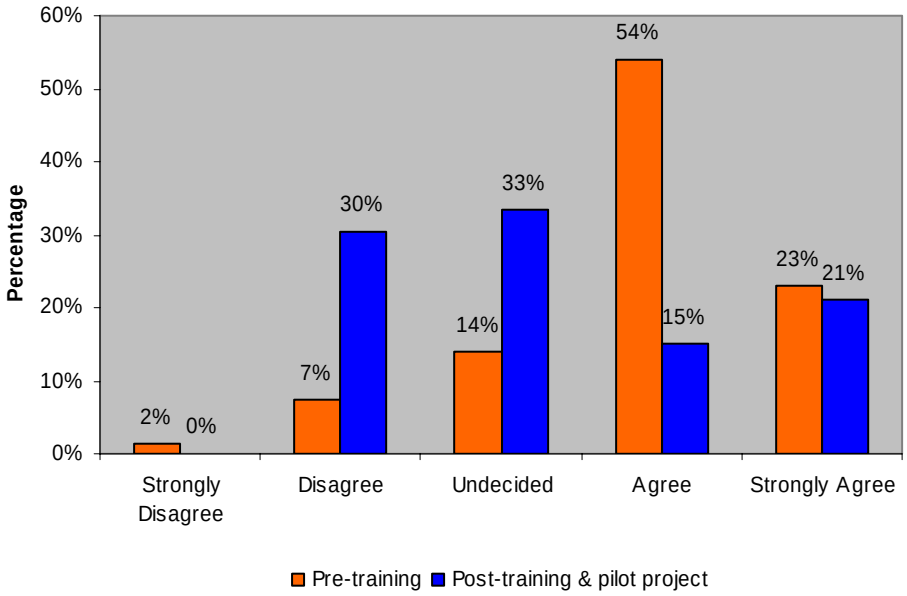

Figure 14: Insufficient pool of suitably qualified supervisors

Figure 15 presents an unexpected result where participant perceptions have gone against the trend of a reduction in agreement with the suggested barrier. In this instance, the perception of a lack of commitment by upper management as a barrier to program implementation has doubled in the 'strongly agree' response category from 15% to 30%. This is of concern and it is recommended that this issue be more closely examined at both Departmental and organisational levels.

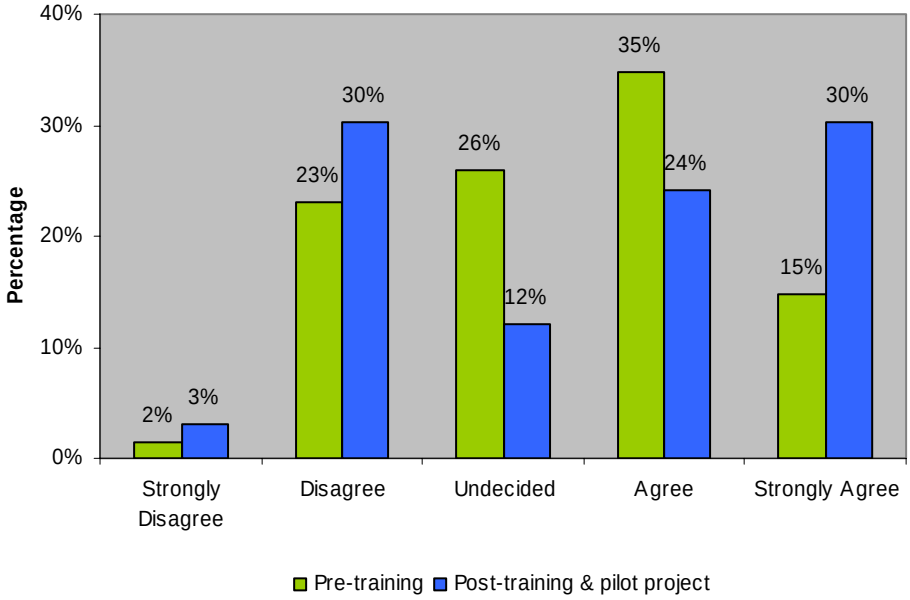

Figure 15: Lack of commitment by upper management to program implementation

In regard to supervision training, a major shift occurred over the three month timeframe between the Pre-training survey and the Post-training survey. Pre-training data showed over 80% of participants agreed or strongly agreed that a lack of training for supervisors would be a barrier to implementing effective clinical supervision. Three months later, following both sessions of training and the early implementation of pilot programs, this figure reduced to 27%, with the strongly agree response making up only 3% of the total result. A substantial increase of 50% (from 8% to 58%) of participants who, Post-training, disagree/strongly disagree with this suggested barrier confirms that the training program and pilot program had an impact on clinicians' perceptions of departmental and/or organisational support mechanisms that enable them to undertake clinical supervision.

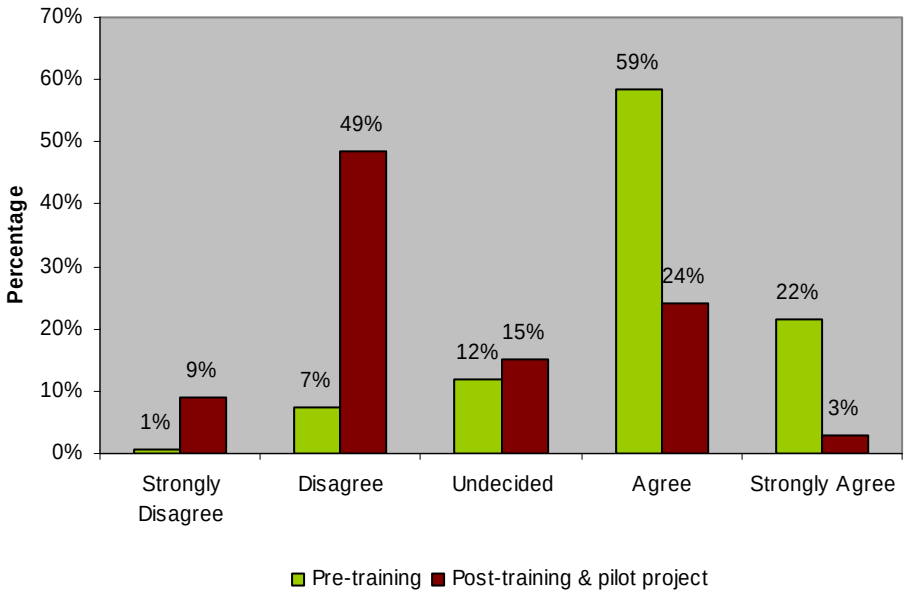

Figure 16: Lack of training for supervisors

Figure 17 shows very little change between Pre-training and Post-training perceptions of the barrier relating to a lack of understanding the benefits of clinical supervision by workers. The high proportion (70%) of participants who remained in agreement that this is an area of concern suggests that appropriate steps (eg, education, training, information dissemination) should be undertaken across mental health organisations to reduce the real or perceived unawareness of benefits such as individual support, debriefing, and improved client outcomes. A strategy of this nature has the potential to impact on the number of clinicians seeking clinical supervision and thus resulting in flow on effects for themselves, their clients, and mental health organisations.

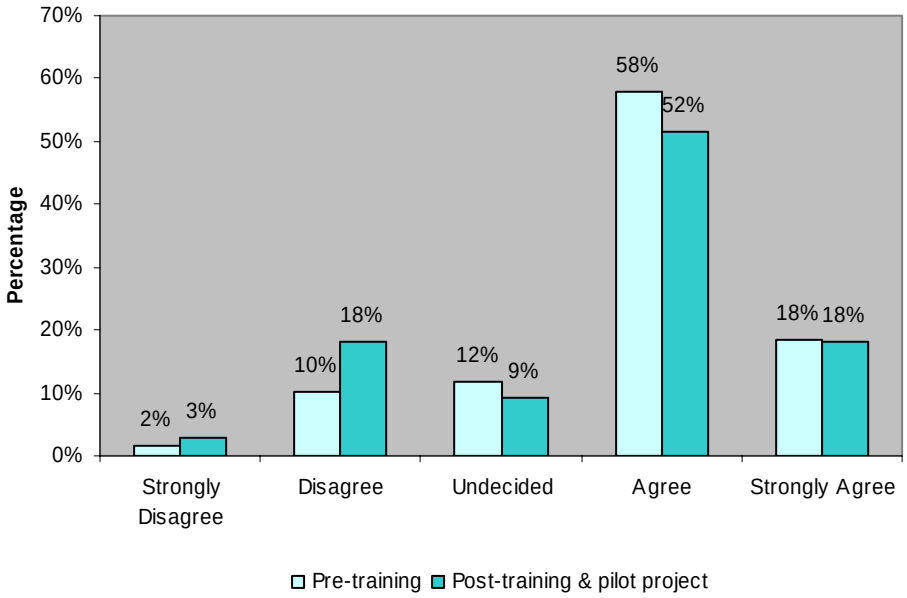

Figure 17: Lack of understanding the benefits of clinical supervision by workers

Organisational responsibilities regarding clinical supervision

A range of questions regarding organisational responsibilities were provided in the Post-training survey. Figure 18 shows that over half the respondents worked in an organisation that developed or modified their Clinical Supervision Policy as a result of the training and/or pilot program.

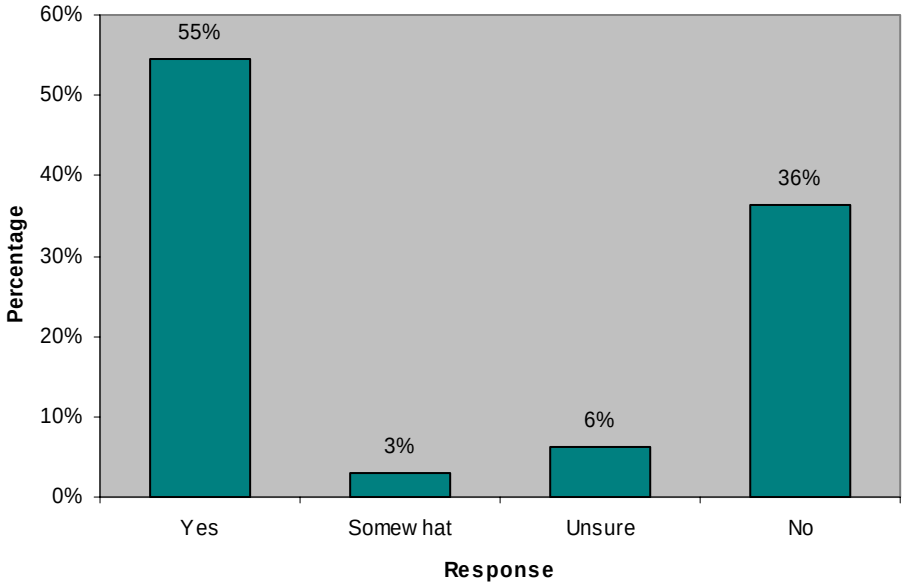

Figure 18: Percentage of respondents' organisations that had developed or modified a Clinical Supervision Policy as a result of the Training and/or Pilot Program (n=33)

Figure 19 provides comparisons between Pre-training and Post-training staff participation in the development/modification of clinical supervision policies in the workplace. Thirty-seven percent of Pre-training respondents reported that staff either were involved or were somewhat involved in the development of their organisation's clinical supervision policy. Following both training and pilot program initiatives this figure had risen to over 80% and is reflective of the positive outcomes of both programs.

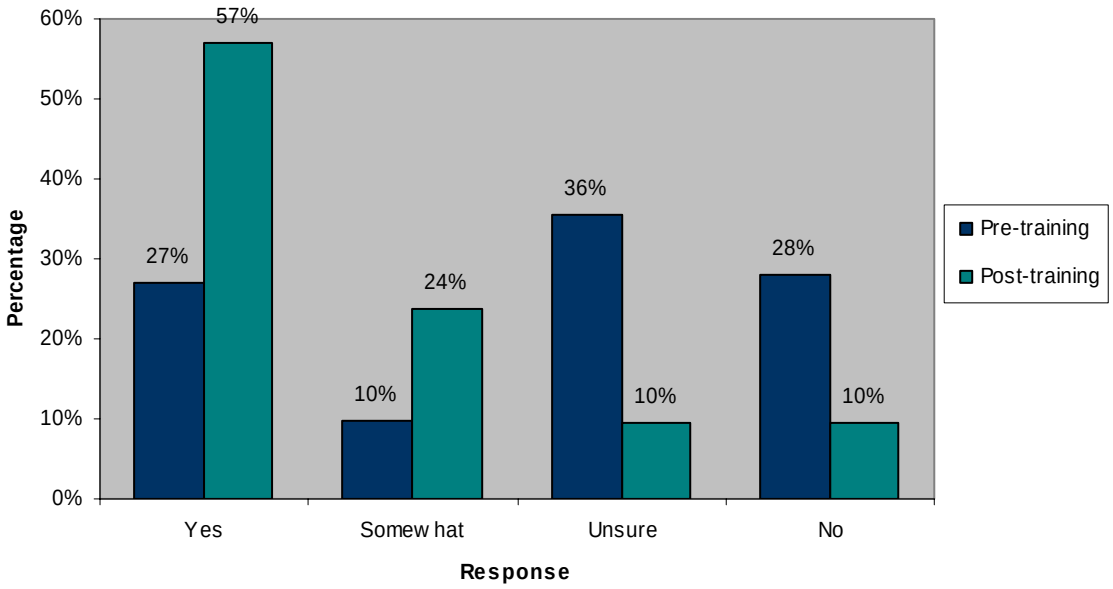

Figure 19: Pre-training and Post-training staff involvement in their organisations' clinical supervision policy development/modification

The Post-training survey asked participants whether the organisational culture (i.e., support for clinical supervision) in their organisation had improved since the clinical supervision training and implementation of pilot programs. Figure 20 below shows a large majority of participants perceived organisational culture to have improved (38%) or somewhat improved (28%) since the training and pilot programs. Seventeen percent were unsure and 17% reported that organisational culture had not improved in this regard. This result, however, should not necessarily be perceived as a negative finding, as 17% of Pre-training participants reported they were satisfied with their organisation's delivery and implementation of clinical supervision and this result may be affirming this level of satisfaction.

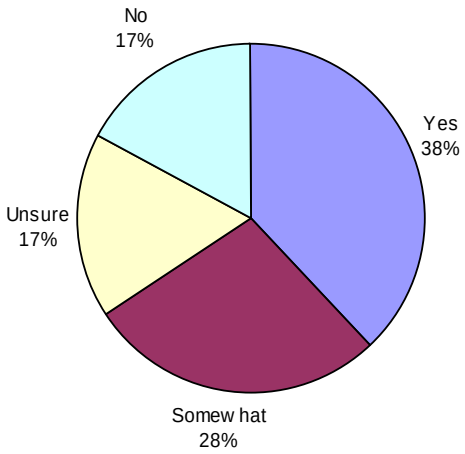

Figure 20: Post-training perceptions regarding improvement of organisational culture (ie, support) since the clinical supervision training and pilot program

The survey also examined participants' perceptions of the adequacy of delivery and implementation of clinical supervision in the workplace. Figure 21 indicates a range of opinion with 28% of reporting adequate delivery and implementation, 28% reporting it as somewhat adequate, and 17% reporting that they were unsure. A relatively high percentage (28%) of respondents reported delivery and implementation was inadequate, however, it is expected as more clinical supervision pilot programs are implemented these perceptions would improve over time. Confirmation of this expectation is provided in the following section.

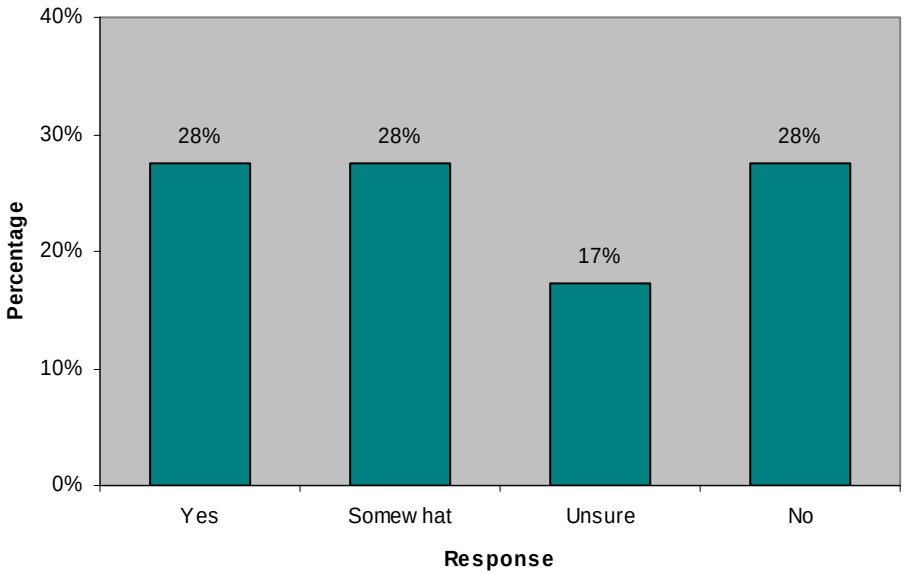

Figure 21: Responses regarding adequacy of organisational delivery and implementation of clinical supervision

Comments by participants

Participants had the opportunity to provide qualitative information on their training and pilot program experiences. The comments provided were diverse and a range of responses is provided below.

Qualitative statements from respondents:

"Pauline Blane has been an extremely effective champion and has maintained energy, commitment and enthusiasm in Southern Mental Health."

"It's very empowering and validating. The work that I am doing to improve my practice will not only benefit me and my work colleagues but will also impact on my interaction with my clients."

"I was not happy with the training – could have been done better."

"Funding not available to backfill. I am presently supervising on days off as are the supervisees. Lots of difficulties with clinical supervision in inpatient unit."

"I have a greater sense of purpose as a Level 2 and much more confidence in the supervisory role."

"My organisation has a long standing supervision program that needs reviewing and improving. This process is presently underway and will be informed by information gathered at these workshops. Thank you."

"Excellent training and networking. Role modelling enabled great ability to anticipate real practice."

Stage 3 – Follow-up survey (December 2006)

The purpose of the Follow-up data collection and analysis was to determine whether perceptions and experiences of the participants of both workshops and the Pilot Program had changed, either positively or negatively, over a longer course of time following the final training workshops.

During the three month timeframe (from August 2006 to December 2006) participants had further opportunities to appraise clinical supervision in their workplace through their own practice and/or provision of clinical supervision during the implementation of Pilot Programs.

Follow-up surveys were distributed to August 2006 workshop participants in their workplaces in December 2006. Surveys were completed by participants 'on-the-job' and were collected by the Department of Health.

Participants

A total of 17 participants completed the Follow-up survey during December 2006 in which matched pairs could be made with the Post-training survey data collected in August 2006. As with the May and August workshops, Mental Health Nurses 1, 2 or 3 were the largest occupational group to complete this survey.

Table 13: Proportion of Follow-up respondents by profession (n = 17)

Occupation	*Frequency*	*Percentage (%)*
Practice Development Nurse	1	6
Principal Mental Health Clinician	2	12
DASSA Nurse	6	35
Level 3 Clinical Leader	1	6
Mental Health Nurse Level 1, 2, 3	7	41
Total	**17**	**100**

Training impact on understanding of clinical supervision

Participants responses regarding an improvement in their understanding of clinical supervision due to the training were relatively consistent with August 2006 data except for the items which related to their understanding of the differences between clinical supervision and line management, and clinical supervision and performance appraisal (see Table 14 below). The percentage of participants agreeing that they had an increased understanding of the difference between line management and clinical supervision decreased from 36% in August 2006 to 24% in December 2006, but the proportion of those who strongly agreed increased from 52% to 71%. Similarly, in the case of increased understanding of the difference between performance appraisal and clinical supervision, the percentage of participants agreeing decreased from 46% in August 2006 to 18% in December 2006, and the strongly agreed response rose sharply from 42% to 76%. A Wilcoxon Signed Ranks Test for matched pairs of Post-training and Follow-up survey participants showed a statistically significant change for this item (z=-2.236, *p=.025*).

Table 14: Responses (%) to items relating to improved understanding of clinical supervision due to clinical supervision training in May and August 2006

	Strongly Disagree	*Disagree*	*Undecided*	*Agree*	*Strongly Agree*
The general principles of clinical supervision	0%	6%	0%	53%	41%
The various components of effective clinical supervision	0%	0%	12%	47%	41%
The difference between line management and clinical supervision	0%	6%	0%	24%	71%
The difference between performance appraisal and clinical supervision	0%	6%	0%	18%	76%*
The role and responsibilities of a clinical supervisor	0%	0%	6%	35%	59%
The role and responsibilities of a supervisee	0%	0%	6%	35%	59%

* significant difference from Post-training responses to Follow-up responses (z=-2.236, *p=.025*)

Pilot Program impact on understanding of clinical supervision

Strong improvements in the understanding of clinical supervision elements were found as a result of the implementation of the Pilot Programs in participants' workplaces. Overall, there were shifts in positive responses from Post-training to Follow-up surveys, including significant results on two items. See Table 15 below for comparison data between Post-training to Follow-up survey results.

Table 15: Responses (%) to items relating to improved understanding of clinical supervision due to involvement in a Pilot Program

	Strongly Disagree		Disagree		Undecided		Agree		Strongly Agree	
	Aug-06	Dec-06	Aug-06	Dec-06	Aug-06	Dec-06	Aug-06	Dec-06	Aug-06	Dec-06
The general principles of clinical supervision	0%	0%	13%	6%	6%	6%	50%	41%	31%	47%
The various components of effective clinical supervision	0%	0%	13%	6%	13%	12%	44%	41%	31%	41%
The difference between line management and clinical supervision	0%	0%	13%	6%	6%	6%	41%	23%	41%	65%*
The difference between performance appraisal and clinical supervision	0%	0%	13%	6%	6%	6%	41%	23%	41%	65%*
The role and responsibilities of a clinical supervisor	0%	0%	13%	6%	6%	12%	44%	29%	38%	53%
The role and responsibilities of a supervisee	0%	0%	13%	6%	6%	12%	44%	29%	38%	53%

* significant difference from Post-training responses to Follow-up responses (z=-2.449, *p=.014*)

These results reveal that the increased time (August to December) participants had in the workplace to implement programs resulted in a greater understanding of many aspects of clinical supervision. Of note are the significant changes in responses relating to the increased understanding of organisational processes of line management and performance appraisal. These results show that education and training, while important components of influencing understanding, should not be the only approach used to change and improve knowledge. It is important that organisations and managers are cognisant of the potential impact that well run and effective programs can have on workers' knowledge-base.

Participants were asked in the Post-training and Follow-up surveys to indicate whether the implementation of the Pilot Program impacted on a range of outcomes. Results are provided below in Table 16.

The results from August 2006 were somewhat difficult to interpret as a large proportion of respondents had answered "undecided". This was most likely because of the limited time participants had actively participated in a program. The four-month time lag between the two surveys has resulted in respondents' being able to provide more definitive responses to the question items. "Undecided" responses reduced by an average of 20%, and importantly, this shift resulted in positive responses to the pilot project outcomes more often than not.

Individual items, such as improvements in individual skills and knowledge, negotiation skills, and goal setting were experienced by 66%, 53% and 60% respectively.

Items relating to organisational knowledge (ie, increased knowledge of clinical supervision guidelines and policy, and increased knowledge of other organisational work practice

guidelines and policies) had very large drops in uncertainty (30% and 34% respectively and encouraging final figures of 80% and 73% of respondents agreeing or strongly agreeing that this was occurring within the workplace.

Table 16: Post-training (August 2006) and Follow-up (December 2006) responses to outcomes of the Clinical Supervision Pilot Program

		Strongly Disagree	*Disagree*	*Undecided*	*Agree*	*Strongly Agree*
Increase group skills and dynamics	Post-training	3%	7%	50%	37%	3%
	Follow-up	0%	7%	40%	40%	13%
	Difference	-3%	0%	-10%	3%	10%
Improve individual skills and knowledge	Post-training	0%	10%	47%	37%	7%
	Follow-up	0%	7%	27%	53%	13%
	Difference	0%	-3%	-20%	16%	6%
Enhance your ability & establish a clinical supervision program in the workplace	Post-training	0%	7%	43%	37%	13%
	Follow-up	0%	7%	13%	60%	20%
	Difference	0%	0%	-30%	23%	7%
Improve negotiation skills	Post-training	0%	13%	53%	27%	7%
	Follow-up	0%	7%	40%	53%	0%
	Difference	0%	-6%	-13%	26%	-7%
Improve goal setting	Post-training	0%	13%	43%	41%	3%
	Follow-up	0%	7%	33%	60%	0%
	Difference	0%	-6%	-10%	19%	-3%
Increase ability & design and develop a contract	Post-training	0%	3%	43%	33%	20%
	Follow-up	0%	13%	20%	40%	27%
	Difference	0%	10%	-23%	7%	7%
Increase knowledge of clinical supervision guidelines and policy	Post-training	3%	3%	43%	33%	17%
	Follow-up	0%	7%	13%	53%	27%
	Difference	-3%	4%	-30%	20%	10%
Increase knowledge of other organisational work practice guidelines and policies	Post-training	0%	17%	47%	37%	0%
	Follow-up	0%	13%	13%	53%	20%
	Difference	0%	-4%	-34%	16%	20%

Experienced benefits of clinical supervision

Participants were asked the same question in the Follow-up survey as the Post-training survey regarding their experienced benefits that were attributable as a result of the Clinical Supervision Training and Clinical Supervision Pilot Program. Table 17 below shows the results from the Follow-up survey.

A substantial shift occurred in regard to the organisational benefit "improved clinical governance and organisational accountability". There was an increase from 27% agreeing as a benefit in August 2006 to 50% in December 2006. The large increase in respondents agreeing that "consistency of practice" is a benefit (24% to 63%) was offset to some extent by a decrease in the percentage strongly agreeing in this category (18% to 6%).

The time between surveys appears to have enabled participants to observe organisational benefits over time and this had an impact on the percentage of participants who had previously reported that they were "undecided". "Improved compliance with best practice" dropped substantially from 49% undecided in August 2006 to 13% in December 2006; "opportunity for support and debriefing" dropped from 33% to 6%; and "opportunity for reflection and development of best practice" dropped from 30% to 6%.

Time between surveys also allowed participants opportunity to reflect on individual benefits to them personally and this was shown in improvements across a range of individual benefit items. A significant difference was found between the Post-training and Follow-up results relating to "opportunity for support and debriefing" ($z=-2.296$, $p=.022$). Other individual benefit results included "improved knowledge base" increasing by 13% in the strongly agree response to 25%, "opportunity for support and debriefing" increasing from 27% strongly agreeing to 50%, and "prevention of worker stress and burnout" increasing in combined agree/strongly agree responses by 15%.

Approximately one-third of participants were still undecided regarding benefits to improvements in client care and client outcomes. It is possible that further time is required for workers to fully evaluate the impact of the clinical supervision program on benefits relating to client outcomes. Furthermore, it may be a difficult task for workers to determine whether the processes and outcomes of clinical supervision result in direct improvements for their clients.

Table 17: Follow-up participant responses to experienced benefits

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Total
Consistency of practice	0%	13%	19%	63%	6%	100%
Improved client care	0%	13%	31%	50%	6%	100%
Improved client outcomes	0%	13%	31%	44%	13%	100%
Improved clinical governance and organisational accountability	0%	13%	31%	50%	6%	100%
Improved compliance with best practice	0%	13%	13%	56%	19%	100%
Improved knowledge base	0%	13%	25%	38%	25%	100%
Improved skills and clinical practice	0%	13%	25%	38%	25%	100%
Improved understanding of ethical issues and accountability	0%	13%	31%	38%	19%	100%
Opportunity for reflection and development of best practice*	0%	13%	6%	31%	50%	100%
Opportunity for support and debriefing	0%	13%	6%	19%	63%	100%
Prevention of worker stress and burnout	0%	13%	25%	50%	13%	100%

* significant differences in Post-training responses to Follow-up responses (z=-2.296, *p=.022*)

Experienced barriers to clinical supervision

Table 18 presents all data relating to participant perceptions and experiences of barriers to effective implementation of clinical supervision in the workplace from the May 2006 Pre-training data to Follow-up data collected in December 2006.

Perceptions from the initial Pre-training survey (May 2006) were negative with the majority of participants (generally greater than 60%) perceiving the 10 listed barriers to effect the implementation of workplace clinical supervision programs. By August 2006 this average had dropped to approximately 45% of participants perceiving or experiencing these barriers. The Follow-up figures reveal that further shifts have occurred during the August-December time period with approximately 35% of participants reporting these barriers are impacting on effective implementation of clinical supervision in the workplace.

“Backfilling difficulties” saw a positive 21% increase in the percentage of participants disagreeing, with this barrier rising from 10% in May to 31% in December 2006. Implementation of clinical supervision in the workplace may have revealed that time commitments required to participate in clinical supervision can be negligible (eg, half to one hour per fortnight) and therefore can be accommodated within workers’ work schedules without the need for backfill.

A large shift occurred in the “different conceptual frameworks among supervisors, supervisee and managers” item increasing by 43% in the “disagree” and “strongly disagree” response

categories and reducing by 25% in “undecided” responses. The seven-month time gap between first and final surveys may have provided respondents with an opportunity to become aware of the clinical supervision frameworks held by a range of staff, and that the frameworks held are not as disparate as originally perceived.

A Wilcoxon Signed Ranks Test analysis of Post-training and Follow-up matched pairs (n=16) provided statistically significant differences regarding the items “lack of commitment by upper management to program implementation” (z=-3.166, *p=.002*) and “funding shortfalls” (z=-2.041, *p=.041*). These are very important results from an organisational perspective as it suggests that clearly supported training and program implementation by the Department of Health and organisational commitment to these programs can result in significant changing of workers’ perceptions over the longer timeframe.

Not all items within the 10 barriers resulted in a positive change. The final item in Table 20, “lack of understanding of the benefits of clinical supervision by workers”, shows minimal shift over the course of the training and pilot program implementation. Participants of the Post-training and Follow-up surveys (who are most current or future supervisors) clearly see this limitation as a barrier to successful project implementation. If their perceptions are indeed correct this will likely have a negative impact on a range of supervisee behaviours including the uptake of clinical supervision, supervisee acceptance of clinical supervision programs, and engagement in clinical supervision, therefore strategies to address this should be given careful consideration by management.

Table 18: Pre-training perceptions, Post-training and Follow-up experiences of barriers to clinical supervision

		Strongly Disagree	*Disagree*	*Undecided*	*Agree*	*Strongly Agree*
Backfilling difficulties	Pre-training	2%	8%	18%	40%	33%
	Post-training	6%	15%	9%	33%	36%
	Follow-up	6%	25%	19%	19%	31%
Pre-training & Follow-up difference		+4%	+17%	+1%	-21%	-2%
Conflict between clinical and managerial staff (i.e., blurred administrative and clinical roles)	Pre-training	0%	16%	30%	40%	13%
	Post-training	3%	27%	42%	21%	6%
	Follow-up	12%	38%	25%	25%	0%
Pre-training & Follow-up difference		+12%	+22%	-5%	-15%	-13%
Different conceptual frameworks among supervisors, supervisees and managers	Pre-training	0%	13%	31%	45%	10%
	Post-training	3%	33%	21%	33%	9%
	Follow-up	6%	50%	6%	38%	0%
Pre-training & Follow-up difference		+6%	+37%	-25%	-7%	-10%
Funding shortfalls*	Pre-training	1%	15%	28%	38%	18%
	Post-training	6%	12%	24%	33%	24%
	Follow-up	12%	25%	25%	19%	19%
Pre-training & Follow-up difference		+11%	+10%	-3%	-19%	1%
Geographical distance / travelling time between supervisors and supervisees	Pre-training	2%	23%	38%	24%	13%
	Post-training	6%	33%	36%	15%	9%
	Follow-up	12%	44%	19%	19%	6%
Pre-training & Follow-up difference		+10%	+21%	-19%	-5%	-7%
Insufficient pool of suitably qualified supervisors	Pre-training	2%	7%	14%	54%	23%
	Post-training	0%	30%	33%	15%	21%
	Follow-up	12%	25%	19%	31%	13%
Pre-training & Follow-up difference		+10%	+18%	+5%	-23%	-10%
Lack of commitment by upper management to program implementation*	Pre-training	2%	23%	26%	35%	15%
	Post-training	3%	30%	12%	24%	30%
	Follow-up	25%	19%	31%	19%	6%
Pre-training & Follow-up difference		+23%	-4%	+5%	-16%	-9%
Lack of training for supervisors	Pre-training	1%	7%	12%	59%	22%
	Post-training	9%	49%	15%	24%	3%
	Follow-up	19%	63%	12%	0%	6%
Pre-training & Follow-up difference		+18%	+56%	0%	-59%	-16%
Lack of understanding of the benefits of clinical supervision by managers	Pre-training	2%	21%	18%	43%	16%
	Post-training	3%	27%	18%	36%	15%
	Follow-up	19%	31%	25%	19%	6%
Pre-training & Follow-up difference		+17%	+10%	+7%	-24%	-10%
Lack of understanding of the benefits of clinical supervision by workers	Pre-training	2%	10%	12%	58%	18%
	Post-training	3%	18%	9%	52%	18%
	Follow-up	6%	13%	6%	56%	19%
Pre-training & Follow-up difference		+4%	+3%	-6%	-2%	+1%

* significant differences in Post-training responses to Follow-up responses (z=-3.166, *p=.002*)
* significant differences in Post-training responses to Follow-up responses (z=-2.041, *p=.041*)

Organisational responsibilities regarding clinical supervision

The figures regarding organisational development and modification of clinical supervision policies due to the training and/or pilot program improved from 55% in August 2006 to 71% of respondents in December 2006 (see Table 19 below). Of note is the reduction in uncertainty responses (ie, "somewhat" and "unsure") from 9% to zero.

Table 19: Percentages from Post-training and Follow-up surveys of respondents where their organisation's clinical supervision policy had been developed or modified a as a result of the clinical supervision training and/or pilot program

	Aug-06	*Dec-06*
Yes	55%	71%
Somewhat	3%	0%
Unsure	6%	0%
No	36%	29%
Total	**100%**	**100%**

Similarly, improvements were found in staff involvement in policy development and modification. Seventy-six percent of respondents were involved in the modification or development of a policy in December 2006, up from 56% in August 2006 (see Table 20 below). Importantly, there was a reduction in the total percentage of respondents being "somewhat" involved, "unsure" of involvement, or not involved, from 44% in August to 24% in December 2006.

Table 20: Post-training and Follow-up participant involvement in organisational policy development/modification

	Aug-06	*Dec-06*
Yes	56%	71%
Somewhat	24%	8%
Unsure	10%	8%
No	10%	8%
Total	**100%**	**100%**

Further improvements were made in terms of improvement of organisational support for clinical supervision (see Table 21 below). Organisational support improving as a result of the clinical supervision training and pilot program increased from 38% in August 2006 to 50% in December 2006. This result, together with the two previous results, demonstrates the substantial progress Mental Health Organisations have made in terms of their capacity to develop, modify, implement and support clinical supervision policies and programs in the workplace during the course of pilot program implementation.

Table 21: Post-training and Follow-up participant perceptions regarding improvement of organisational culture (ie support) since the clinical supervision training and pilot program

	Aug-06	*Dec-06*
Yes	38%	50%
Somewhat	28%	36%
Unsure	17%	0%
No	17%	14%
Total	**100%**	**100%**

Figure 22 below provides a comparison of percentages of participant responses to the adequacy of their organisation's delivery and implementation of clinical supervision. The percentage of respondents satisfied with their organisation rose from 28% to 50%, and there was a reduction in the percentage of uncertain respondents from 17% to zero. A Wilcoxon Signed Ranks Test analysis of Post-training and Follow-up matched pairs (n=14) for this item resulted in statistically significant differences (z=-2.264, *p=.024*).

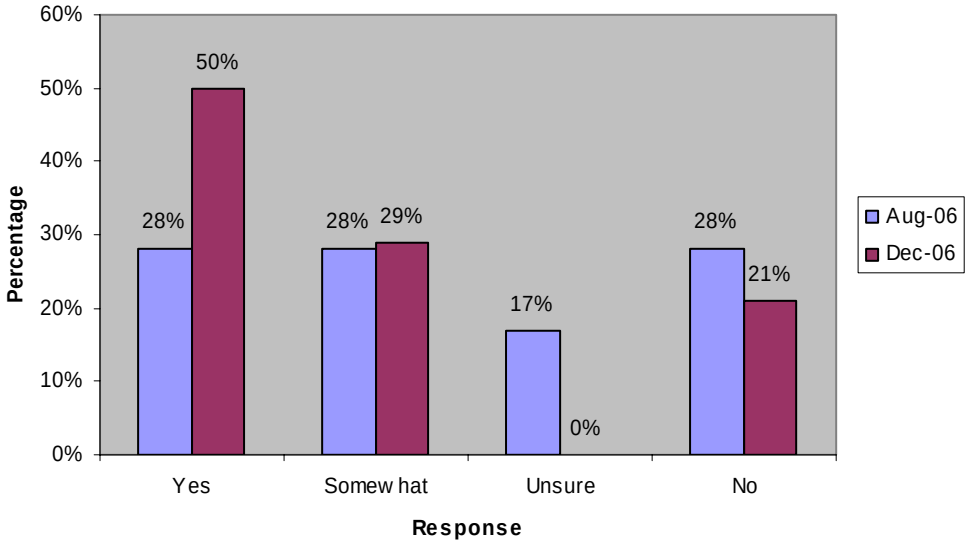

Figure 22: Responses regarding adequacy of organisational delivery and implementation of clinical supervision in August 2006 and December 2006 (z=-2.264, *p=.024*)

Comments by participants

Respondents to the Follow-up survey had the opportunity to provide qualitative information on their training and pilot program experiences. All comments are provided below.

Qualitative statements from respondents:

"We are an inpatient unit. The lack of backfill resources has made it very difficult to implement the program. The group I have started are attending group supervision with me in their days off, which is non-viable in the long term. Enthusiasm in the beginning has begun to fizzle out! It is a great challenge to implement this program by myself in this area."

"Attempted to implement clinical supervision and continued with the support of other participants of the course. The lack of support from the organisation and the lack of experienced and the decision by the organisation to not renew the contract for the Clinical Practice Nurse in the southern area impacted hugely."

"Clinical supervision has provided me the opportunity to discuss clinical issues, gain support from peers and set goals to improve practice."

"The supervision training was not useful – the presenter was not competent in his own field. Conducting supervision myself – I have found rewarding and insightful. It has provided me with new skills and knowledge. I look forward to each session."

"Have just started group supervision in my workplace, due to rostering etc have only had one session so far, plans for regular sessions in 2007. Feedback from staff was positive."

"A second round of supported training would be very beneficial to cement the work begun."

"It has raised my awareness of the importance of clinical supervision and what it can do for Mental Health Nurses. It has enabled me to provide supervision and discuss it with people who are unaware of it with confidence and seeming authority. It is a Pilot Program that has had a hugely positive impact on the Mental Health Nursing workforce. Thank you."

"Challenging time! Has had a positive impact for supervisees that have participated. They feel supported especially sole practitioners."

RECOMMENDATIONS

1. That future strategies such as education, training programs, and information dissemination, target Mental Health Nurses (supervisees) to enable workers' to gain a clear understanding of, for example, the benefits of clinical supervision and the difference between clinical supervision and administrative functions (eg. line management and performance appraisal). These strategies are likely to increase supervisee acceptance of workplace clinical supervision programs, encourage uptake of clinical supervision, and enhance engagement in clinical supervision.

2. That attention be given to the barrier "lack of commitment by upper management" (identified as a barrier to program implementation by one quarter of follow-up participants and nearly one third participants remained unsure at follow-up) through a range of strategies, such as:
   - management involvement in organising, implementing and supporting clinical supervision programs
   - using effective communication strategies to declare support for clinical supervision practice (eg, emails, articles in newsletters, face-to-face meetings and forums) to Mental Health Nurses in both to supervisor and supervisee roles
   - demonstrable commitment to clinical supervision programs (eg, mandatory scheduling of clinical supervision into Nurses' programs of work).

3. That information regarding clinical supervision from upper levels of management within Mental Health facilities is effectively communicated to all levels of the organisation to ensure consistent conceptual frameworks of clinical supervision are held across all levels of workers with the organisation.

4. That evaluation of future programs occurs at least six months following the implemented initiative (eg, training workshop, group clinical supervision sessions) to ensure that sufficient time has elapsed to be able to assess attitudinal change, knowledge improvement and skill development.