PROFESSIONAL SUPERVISION FOR MENTAL HEALTH AND ADDICTION NURSES

A review of current approaches to professional supervision internationally and in the New Zealand mental health and addiction sector.

WORKFORCE
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FOREWORD

Professional Supervision in mental health and addiction services is a key aspect of working with service users and their families. It enables practitioners to engage safely and effectively with a focus on a quality experience for everyone involved.

Professional Supervision establishes boundaries around the relationships between practitioner, service user, family/whanau and support agencies. The result is effective treatment outcomes. Ultimately, supervision enables growth, development and new ways of working that contribute to a positive experience for all people who have contact with mental health and addiction services.

Mental Health Nursing and its Future: A Discussion Framework (Ministry of Health, 2006) recommended that supervision requires further attention to enable practice to be consistent, valued and supported by employees and employers, and to enable interventions with service users to be safe and effective.

I am pleased to introduce this national research project about the professional supervision practices of mental health and addiction nurses working in New Zealand.

This work will inform the future direction of professional supervision training and processes for supervisors, supervisees and organisations who provide mental health and addiction services, and it will link other significant work related to increasing workforce capability such as Let's get real, Talking Therapies and other national training programmes.

Professional Supervision, therefore, is not limited to nurses. It is relevant to everyone who works with mental health service users and their families/whanau.

Above all, leadership underpins all aspects of effective supervision. It is crucial at all levels – from managers, clinical directors and nurse leaders through to supervisors. Without multi-level leadership good supervision can not be put into practice. This document is aimed at ensuring leadership supports the practice of quality supervision in order to deliver quality services.

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EXECUTIVE SUMMARY

Mental Health Nursing and its Future: A Discussion Framework (Ministry of Health, 2006) recommended that the strengthening of the nursing workforce is integral to the provision of services to mental health and addiction service users. It prioritised professional supervision as one of its nine recommendations in order to achieve this goal.

This project was designed to investigate current approaches to professional supervision for mental health and addiction nurses within District Health Boards (DHBs) and Non-Government Organisations (NGOs) across New Zealand and internationally.

The report begins with a literature review of international best practice in relation to professional supervision for mental health and addiction nurses. This is followed by survey research on the provision of professional supervision across DHBs and NGOs. This involved mail and telephone surveys with DHB Directors of Mental Health Nursing, NGO nurse managers and a sample of supervisors currently providing professional supervision.

The information generated from this consultative process of this literature review and the surveys will be used by Te Pou o Te Whakaaro Nui, the National Centre of Mental Health Research, Information and Workforce Development to inform workforce development planning for professional supervision of mental health and addiction nurses.

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1. INTRODUCTION

Nau te raurau,
naku te raurau,
ka ki te kete.

With your input,
and my input,
the basket will be full.
(Mental Health Commission, 2007, p. 55)

This Maori whakatauki (proverb) captures the essence of professional supervision; that through a supportive relationship, clinical practice and the professional role can be explored, understood and improved for the benefit of the supervisee and for the benefit of service users.

Mental Health Nursing and its Future: A Discussion Framework (Ministry of Health, 2006) recommended that the strengthening of the nursing workforce is integral to the provision of services to mental health and addiction service users. It prioritised professional supervision as one of its nine recommendations in order to achieve this aim. Furthermore, the Health Practitioners Competence Assurance Act 2003, with its emphasis on maintaining standards of practice to ensure public safety, requires mental health and addiction nurses to demonstrate that they are "competent and fit" to practice. Professional supervision is a critical component in this regard ("Health Practitioners Competence Assurance Act," 2003).

The framework document highlighted variability and inconsistencies in the provision of professional supervision across both DHBs and NGOs in the mental health and addiction sector. This included variability in the way supervision is provided; variability in the quality of supervisors; lack of knowledge of who to approach for supervision; financial restraints in accessing primarily external supervision; and the identification of some resistance from nurses to engage in the process (Ministry of Health, 2006).

This project is designed to investigate current approaches to professional supervision for mental health and addiction nurses within DHBs and NGOs across New Zealand. The report begins with a literature review of international best practice in relation to professional supervision for mental health and addiction nurses. This is followed by survey research on the provision of professional supervision across DHBs and NGOs. This involved mail and telephone surveys that were distributed to all DHB Directors of Mental Health Nursing, NGO nurse managers, and to a sample of supervisors currently providing professional supervision. This focused on eliciting information on the number of nurses receiving professional supervision, the characteristics of those providing professional supervision, and the respondent's views of the effectiveness of professional supervision that is currently being provided.

The information generated from the literature review and the surveys will be used by Te Pou o Te Whakaaro Nui, the National Centre of Mental Health Research, Information and Workforce Development to inform workforce development planning for professional supervision for mental health and addiction nurses.

2. REVIEW OF MODELS FOR PROFESSIONAL SUPERVISION

2.1 Introduction

This section reviews national and international literature on professional supervision for mental health and addiction nurses. It includes literature from other disciplines such as counselling, social work and psychology. The review begins with an overview of definitions of professional supervision followed by examination of the theoretical models of professional supervision for mental health and addiction nurses. The value of professional supervision and the presumed benefits and limitations of professional supervision are then discussed.

Publications included in this review were accessed through computer searches of a number of medical and nursing databases. The University of Auckland's Philson Medical School Library and General Library were used for all manual searches of PsychInfo, Web of Science, Medline, and CINAHL databases. Articles were also accessed through on-line searches using the internet search engine 'Google' (www.google.co.nz) and manually on the Ministry of Health (www.moh.govt.nz), District Health Board New Zealand (www.dhbnz.org.nz), and World Health Organisation (www.who.int/mental_health) web pages.

2.2 What is professional supervision?

The term professional supervision is often used interchangeably with clinical supervision; which has lead to a degree of confusion within the literature. Clinical supervision is perceived to have a narrow focus on clinical practice, yet nurses may be involved in clinical, academic, management and leadership roles. For this reason, the more inclusive term professional supervision is favoured in order to project the value of supervision beyond clinically specific roles (Ministry of Health, 2006). However, there still remains some confusion in the literature concerning this distinction. Some literature refers to supervision undertaken by a supervisor from a health discipline other than that of the supervisee as being professional supervision, whereas supervision undertaken by supervisors from the same discipline constitutes clinical supervision (Herkt, 2005).

In this report, the more inclusive term is adhered to. We adopt a definition whereby the professional supervision of mental health and addiction nurses is seen as "…a formal process that provides professional support to enable practitioners to develop their knowledge and competence, be responsible for their own practice and promote service users' health outcomes and safety…[this involves] time away from the practice environment to meet with an experienced practitioner of their choice to engage in guided reflection on current ways of practising" (Ministry of Health. 2006, p. 22).

Given this definition, it is clear that the aims of professional supervision are complex. The literature highlights the aims of professional supervision to include: oversight of practice; accountability to the organisation for practice; development of professional skills; reflection

on practice; establishment of a support system; provision of a safety mechanism for the nurse; provision of a safety mechanism for the service; ongoing educational development; professional empowerment; assistance in the application of theory to practice; assistance in understanding practice; role exploration; achievement of job satisfaction; prevention of "burn out"; clarification of the therapeutic relationship; increased beneficial outcomes for service users; practice improvement; and support for the welfare and well-being of the nurse (Herkt, 2005; Yegdich, 1999).

Kadushan (1992, cited in Herkt, 2005) provides a three category simplification of these diverse aims. Table 1 groups the diversity described in accordance with administrative supervision, educative supervision and supportive supervision. Administrative supervision is associated with service management requirements of nursing practice. Educative supervision, in contrast, is focused on the development of the supervisee's knowledge, skills and professional understanding. Lastly, supportive supervision is concerned with the development of "attitudes and feelings that will enable [the supervisee] to work effectively" (Herkt, 2005, p. 21). Supportive supervision is crucial because interpersonal expertise and use of the 'self' is integral to mental health and addiction nursing. Such interactions have emotional consequences (both positive and negative) that benefit from exploration through a supervisory relationship (Peplau, 1952, cited in Winstanley & White, 2003). Furthermore, the nature of the supervision will vary depending on the level of experience or developmental stage of the nurse, for example as they move from novice to expert. For example, dimensions such as level of accountability or responsibility of supervisor, extent of evaluation, and power difference between supervisor and supervisee vary, these being typically high in training (pre-qualification) supervision and lower in supervision or consultancy where supervisees are experienced practitioners. The following table provides a summary of the types of aims according to the three key functions presented above.

Table 1: Categorisation of the aims of supervision

Administrative function	Provision of oversight of and accountability for practice Development and maintenance of competence Safety system for the service
Educative function	Professional and educational development Reflection on practice Application of theory to practice Foster innovative and creative practice Clarification of role and relationships Clarification of the therapeutic relationship Increased beneficial outcome for service users
Supportive function	Empowerment Encouragement Support Management of the emotional effects of the work Provision of a safe place to explore ethical and safety issues

	Management of wider organisational or team issues Promotion of job satisfaction Management of stress and prevention of “burn out” Enhancing the welfare and well-being of the nurse

There are various forms of supervision or consultation to assist in these aims. Cultural competence can be maintained within professional supervision as well as in specifically focussed cultural supervision or cultural advice.

Specific *cultural advice* from a knowledgeable cultural expert must be sought when practitioners are working with service users or on projects whose service users are culturally different to themselves. This is different to supervision for cultural competence in that the consultant would be a member of the service user’s culture and provide more specific advice regarding practice.

There is also now recognition of the importance of *Kaupapa Maori supervision* for ensuring the safety, accountability and professionalism of specifically Maori practitioners. This offers an opportunity to provide cultural safety in addition to service user case discussion regardless of whether they work in a mainstream organisation or a Maori-based organisation (Howard, Burns, & Waitoki, 2007). The purpose of this supervision by Maori for Maori is to: build knowledge of Maori cultural values, attitudes, and behaviours, provide a supportive context to manage complex cultural issues, ensure safe practice and culturally appropriate behaviour (Walsh-Tapiata & Webster, 2004). They define the parameters of cultural supervision as distinct from training and development or professional supervision.

Similarly, where practitioners of other non-dominant ethnic groups are working in mainstream organisations, cultural supervision where there is a matching of supervisee and supervisor ethnic group is recommended. For example, supervision providing support for Pacific workers with the aim of focussing on the personal, family, cultural, community, and professional domains as it relates to the practitioner (Mafile'o & Su'a-Hawkins, 2005).

2.3 The efficacy of professional supervision

Nearly all literature on professional supervision for nurses is supportive of its development and growth as it is widely accepted as an essential prerequisite for high quality nursing care (Edwards et al., 2005). With the advent of the Health Practitioners Competence Assurance Act (Ministry of Health, 2003) many health professions are seeking to enhance the robustness of their services and ensure quality standards are maintained. The emphasis upon the provision of professional supervision as a vehicle to deliver these aims continues despite the relative paucity of empirical evidence to support the effectiveness of specific models of professional supervision (Winstanley & White, 2003, p. 16). This is largely due to the complexity of supervision research and overall poor methodological rigour.

However, where systematic reviews of the literature have been applied some limited conclusions about the impact of supervision can be formed. For example, Wheeler and Richards (2007) reviewed 18 published studies of professional supervision of counsellors or psychotherapists. The results were variable, but they were able to determine some positive impacts on key developmental areas such as skill development, self-awareness and self-efficacy improvements. Furthermore there were studies that demonstrated thematic transference from supervision to therapy, for example the application of cognitive-behavioural methodologies (Milne, Pilkington, Gracie, & James, 2003). Finally, and most importantly, there was some support for the positive impact of supervision on service users. Three studies demonstrated impact in terms of improved competence in cognitive-behavioural methodology; increased confidence, congruence, focus and less emotional distractibility amongst other variables. However the authors caution that the link to improved outcome for service users is tentative as none of their studies showed substantial evidence in this regard.

Qualitative and anecdotal evidence is more positive about the value of supervision and suggests that when models of professional supervision have been implemented, supervision increases nurses' feelings of support and personal wellbeing; enables reflection on knowledge and practice creating an awareness of solutions to clinical problems; and increases staff morale and satisfaction leading to a decrease in staff turnover/absenteeism (Cleary & Freeman, 2006; Winstanley & White, 2003). Bradshaw, Butterworth and Mairs (2007) were able to demonstrate tentative findings regarding the enhancing effects of professional supervision compared to training alone on mental health nurses learning psychosocial interventions. This included effects on reduction of symptomatology in the service users of the supervisees.

2.3.1 The need for professional supervision in New Zealand

Ministry of Health (,2006)acknowledge that there is currently a recruitment and retention crisis for mental health and addiction nurses in New Zealand. Retention of mental health and addiction nurses is dependent on organisations having clear goals that nurses can adhere to. These goals include a "clear understanding of roles and competencies; good management and employee relations; good human resource management systems that allow for performance appraisal and reward; exit interviews to gather information about why staff may be leaving or unable to be recruited; and supervision and support" (Ministry of Health, 2006, p. 55). Professional supervision aims to meet several of these goals and is a potentially important retention strategy.

One of the common claims is that professional supervision can reduce levels of burnout; however there are contradictory findings in the literature. Two studies that supported this claim are noteworthy. In a study of New Zealand nurses, Kalliath and Beck (2001) showed that supervisory support has both direct and mediating effects on job burnout experiences and intention to quit. Butterworth et al, (1997) evaluated the impact of professional supervision on nurses in Britain and found that ratings of emotional exhaustion and

depersonalisation were stabilised once nurses began receiving professional supervision, these measures increasing when there was no supervision. This along with other findings from the study led the authors to conclude that professional supervision and mentorship has a beneficial impact on staff.

In New Zealand there is no national approach to professional supervision or professional supervision training. There is no comprehensive list of qualified staff offering professional supervision to mental health and addiction nurses. Developments have been haphazard across the DHB and NGO sectors and it is envisaged that a co-ordinated approach may increase the ability to maximise the benefits discussed above (Ministry of Health, 2006). New Zealand requires professional supervision for mental health and addiction nurses that is supported by nurses, supervisors and service users and overcomes significant barriers to its successful implementation. It is also essential that such an approach incorporates the specific cultural needs of Maori nurses (Broodkoorn & Wahanui, 2005). With this in mind evaluative and/or research processes aimed at determining effectiveness and utility need to be built into supervision to provide for the ongoing development and refinement of an approach which fits with our culture given that most models of supervision have been developed overseas.

2.4 Professional supervision models

There are a variety of ways in which professional supervision can occur and a number of models have emerged that provide a framework to guide the supervisory process. These models vary in relation to the emphasis they place on administrative, educative and/or supportive supervision. Furthermore they vary in terms of the various elements they address. This may have contributed to some confusion about what constitutes a 'model' or essential ingredients of supervision practice which in turn may contribute to the lack of consistency in approaches to supervision.

A helpful approach is that proposed by Watkins (1997) who proposes a multi-layered conceptualisation of the elements, which make up our understanding of supervisor functioning. The layers begin with the broadest and move to the more detailed. The broadest aspect to examine is the supervisors' *assumptive world*, values, assumption and perspective on life, including work with supervisee and service users. Next is the supervisors' *theory or model* – understanding of and approach to their work with service users and supervisees. Examples of this include whether one follows a biological, social or psychological model(s) or is psychodynamic, systemic, humanistic or cognitive-behavioural. *Supervisory style, the next layer,* will be thus determined, that is the characteristic way in which the supervisor relates to supervisees, for example, be it facilitative, task-oriented, directive, passive, or expert. Then there are a variety of *roles or strategies* supervisors may use according to the task at hand. Roles can include the following; teacher/instructor, counsellor/therapist, consultant, colleague /peer, model and mentor, monitor/evaluator. The next layer down is the *focus of supervision* sessions, meaning the factors or processes that receive primary attention during the session. After this comes the *format* of supervision, which refers to the way in which the supervision is delivered, be individually or in a group, hierarchical or peer-based. Within this category the writer includes different *methods* of supervision, this referring to whether the supervision

involves the use of live or electronically recorded work samples, case-discussion, and review of written materials. Finally the *techniques* (interventions) used will vary, be they prescriptive, conceptual, catalytic or confrontative for example.

This organisation of concepts can be useful when considering the various approaches to supervision practice presented in the literature. In assessing any one approach it can be considered from the vantage point of how comprehensive it is or what elements of supervision it pertains to. Cleary and Freeman (2005) propose the success of models is dependent upon appropriateness to the profession and its speciality and locality. In addition, incorporating approaches that have an evidence base where possible and that fit with the local cultural context is desirable. For the purpose of this review the most frequently adopted and cited models in New Zealand have been selected for discussion.

2.4.1 Models that emphasise the purpose of supervision

Proctor's supervision alliance model

More recently a range of models have evolved that attempt to be inclusive of a broader perspective of administrative, educative and supportive supervision. Proctor's supervision alliance model (Proctor, 2001; Yegdich, 1999) is a one-to-one supervisory process within the context of counselling supervision (Scaife, 2001). The aim of this model is to develop the supervisees' "job identity, competence, skills and ethics" (Severinsson, 2001, p. 36).

This model acknowledges three distinct functions of professional supervision. The 'normative' function is focused on the supervisee aligning him/herself with the institutional framework in which care takes place. Thus, the goal is to assist the nurse to relate their practice to managerial requirements, including policy, ethics and professional standards of competent practice. Here the intent is "quality control of adequate standards of professional practice" (Severinsson, 2001, p. 36), which is achieved through the discussion of examples of practice that highlight aspects of practice needing improvement. This aligns with administrative supervision and might be more prominent in training supervision.

The 'formative' function of this model is focused on learning in order to assist the supervisee to develop nursing knowledge and skills. Its assists the person to understand practice through reflection on the evidence that supports practice; the formative function aligns with educative supervision.

The third function of this model is 'restorative'. The restorative aspect provides support for the supervisee to manage emotional responses arising from clinical practice. This might include managing stress. Restoration of emotional integrity occurs within a supportive relationship whereby the supervisor and supervisee discuss and share experiences and anxieties resulting from therapeutic interactions (Sloan & Watson, 2002).

Proctor describes several features to her model. These include: the formation of contracts and agreements, the development of a working relationship (alliance), the achievement of the

three tasks as above, via a variety of roles executed with flexibility. To practice the model, the supervisor requires comprehensive training to recognise functions as they arise and provide appropriate strategies. Proctor also describes various skills in interpersonal communication and reflection based on Egan's model of exploration, deeper understanding and action. Proctor has developed extensive training courses in the UK from which training materials are available (Inskipp & Proctor, 1995). Sloan and Watson (2002) have suggested that any supervision following this model should be accompanied by detailed documentation of aims and associated interventions.

2.4.2 Models that emphasise a broad range of elements.

Holloway's (1995) systems approach to supervision (SAS) model is one of the broadest models whereby she describes the supervisory relationship as central and embedded within the contextual features of the service user, the trainee, the supervisor and the institution. Holloway suggests that a supervisor considers how to respond to the supervisee depending on the task at hand, i.e. the process of supervision. These tasks include the development of the supervisee's counselling skills, case conceptualisation ability, professional role, emotional awareness or self-evaluation skills. The supervisor has five main supervisory skills to select from depending upon the task of the supervision session. These skills include monitoring/evaluating, instructing/advising, modelling, consulting, or supporting/sharing. For example, if the supervisor were assisting the supervisee to develop emotional awareness she would possibly utilise a supporting/sharing style. Alternatively, a modelling approach might be best to develop counselling skills. As this approach was developed with counsellors in mind there may be aspects of it that are less transferable to nurses. However given its breadth it offers much to those who are engaged in training and preparation for supervision.

2.4.3. Models that emphasise psychotherapeutic approaches

Psychotherapeutic models of supervision evolved within the professions of psychotherapy and counselling and have appeal within nursing because of the perceived limitations of line management supervision along with the acceptance of the centrality of the therapeutic relationship to mental health nursing practice. The utility of psychotherapeutic models lies in their explanations for human functioning and relational processes, these being useful when considering the tasks of supervision. In addition, psychotherapeutic models contribute to the task of the "development of the self as the therapeutic agent" (Consedine, 2000, p. 472). Advocates argue that life experiences may impinge on a nurses' therapeutic ability and that "traumatic experiences that are so much a part of nursing the mentally ill" may first need to be processed developmentally (Consedine, 2000, p. 472). Furthermore where nurses are more engaged in therapeutic interventions these models may gain more popularity in the future. Such models however may not cover the full range of tasks and activities involved in conducting supervision.

There are many varieties of psychotherapeutic models available in the literature. For example, Watkins (1997) handbook on psychotherapy supervision contains a range of models, from psychodynamic, dialectical behaviour therapy, to cognitive and service user-centred. Each emphasises a model for the understanding of service users and supervisees and preferences for

certain styles, strategies and techniques. For example, the psychodynamic supervisor might emphasise the transference and counter transference relationship between service user, supervisor and supervisee and utilise a supportive or insight oriented approach to supervision. The cognitive-behavioural supervisor might emphasise a structured approach to supervision and utilise modelling, role-play and the use of recorded work samples to bring about learning within supervision. As such each model may have something to offer the individual supervisor depending upon their favoured orientation.

There is some criticism in the nursing literature of those models which emphasize the personal growth of the nurse at the expense of the service user (Yegdich, 1999). Indeed, most ethical guidelines present in today's literature agree on a boundary between personal therapy and supervision, with the aim of supervisory interventions as being on the work itself (Howard et al., 2007). If personal therapy is required the task of the supervisor is to assist in the identification of this and recommend appropriate sources of resolution outside the supervision.

2.4.4 Cultural forms of supervision

Cultural competence in its widest sense is considered to be of vital importance to the delivery of culturally safe and appropriate nursing practice (Ministry of Health, 2006). This has implications for the education and ongoing professional development activities for nurses including supervision. Furthermore, a skilled Maori mental health and addiction workforce is crucial to the future development of the sector in meeting the needs of Maori service users and their whanau (New Zealand Health Workforce Advisory Committee, 2001)

It is imperative that Maori nurses who are currently employed are supported, nurtured and encouraged to continue to develop and integrate their clinical and cultural skills. For Maori nurses it is often difficult to differentiate between clinical and cultural dilemmas as both are intertwined. There is little evidence that Maori nurses receive both elements from the same supervisor; however Maori nurses support this need. (Broodkoorn & Wahanui, 2005)

There have been several variations of supervision practice for 'cultural' purposes developed thus far but these are seldom understood or practiced with consistency at a national level. Although these models are still in need of further development the following is an attempt to provide some clarification.

Specific Maori models of supervision – Kaupapa Maori supervision.

Eruera (2005) argues that both cultural and bi-cultural supervision approaches must be included in the development of 'best practice supervision' for Aotearoa when addressing the needs of the social work profession. She defines Kaupapa Maori supervision as 'an agreed supervision relationship by Maori for Maori with the purposes of enabling the supervisee to achieve safe and accountable professional practice, cultural development and self-care

according to the philosophy, principles and practices derived from a Maori worldview' (Eruera, 2007, p.144).

Broodkoorn and Wahanui (2005) have developed such a model for Maori nurses in consultation with Kaumatua and Kuia called He Tohu Matekite, which translates as 'to see beyond'. Aimed at enhancing, not replacing Kaumatua, it aims to assist Maori nurses more to integrate their cultural knowledge with their clinical knowledge. The supervisor is ideally one who has both excellent knowledge of Te Ao Maori and mental health nursing practice. The growth of the supervisee is aligned with Maori cosmology that explains the creation of the earth. The supervisor's role is to facilitate the supervisee's movement from a state of Te Kore (the nothingness) to one of understanding, Te Ao Marama (the world of light) by using a number of roles. These range from Kaiwhakarongo (the listener), Pukenga (the expert), Kaiwhakatara (the challenger), Kaikokiri (the initiator), Kaiwhakamana (the encourager), Kaiarahi (the guide), Kaiwhakamaori (the normaliser) and Kaihohouraongo (the peacemaker). Maori tikanga (such as karakia) are central to the model (Broodkoorn & Wahanui, 2005). The supervisee needs to identify their ongoing learning needs and seek these out from a variety of sources.

Eruera (2005) proposes a model where the supervisor can draw on a range of cultural components such as Te Ao Maori (Maori worldview), Whakapapa (Geneology), whānaungatanga (family and relationship building), in developing a responsive Kaupapa Maori supervision approach. The basis of her approach is to weave traditional Maori concepts and practices together to make a "kete" or "carrier" that can be filled with skills, knowledge, professional and personal experiences, protocols, and values. The components of the "kete" are located within Maori knowledge and cultural values, but can be applied in some instances to other cultural settings as the values associated with each concept are universal.

Although not exhaustive, these approaches represent models from which Maori nurses may draw in the provision of Kaupapa Maori supervision. More development and training would be needed to promote these practices. Cultural consultation or supervision is typically in danger of being considered of lesser significance than general professional supervision (Eruera, 2005). Insufficient recognition and understanding of the importance of these practices present barriers to their organisation and resourcing.

Pasifika cultural supervision

In keeping with the principles above, nurses of other non-dominant ethnic groups working in mainstream organisations also need cultural supervision from a supervisor who matches their ethnic group. For example, Mafile'o & Su'a-Hawkins (2005) present an approach to supervision for Pacific workers with the aim of focussing on the personal, family, cultural, community, and professional domains as it relates to the practitioner. They describe two practices, Pasifika cultural supervision and cultural consultation as practiced within social work. The former they describe as 'broader and deeper than consultation beyond practice to include development of the practitioner' (Mafile'o & Su'a-Hawkins, 2005, p. 120). They aim to promote the cultural development and capacity of the supervisee through reflection, critique, action and support for Pasifika practitioners who work in predominantly non-Pasifika

contexts. Cultural consultation they distinguish as a process used to assist in case management decisions, facilitate access to families or to gain ethnic specific information.

Cultural consultation/advice

Where nurses are working with service users who are of a different culture to themselves, they should seek cultural *consultation*. The consultant would be a knowledgeable cultural expert matched to the service user's culture who can provide more specific advice regarding practice. Cultural consultation typically takes place for a specific purpose with a specific focus, implying much more limited responsibility on the part of the consultant and less regularity of meeting' than supervision (Crockett, 2005). In the example of a pakeha practitioner going to a Maori consultant or Kaumatua for advice about her work with Maori, Crocket questions whose responsibility is the cultural practice of pakeha practitioners' given that the available resource of Maori practitioners is very small (Crockett, 2005). Currently Maori, Pacific and Asian groups are underrepresented in the nursing workforce - Maori 13%, Pacific 2% and Asian 3% (McKenna, Thom, & O'Brien, 2007). Many writers concur that cultural competence in its broadest sense should also remain a central goal of general professional supervision for all practitioners alongside other forms of cultural input as described above (Howard et al., 2007).

2.4.5 Approaches which emphasise roles or strategies

Kolb's experiential learning model of professional supervision

This model emphasises a facilitative approach to educative and supportive supervision. The mutually inclusive and empowering supervisor-supervisee relationship pivots around the principles of adult learning. Adult learning principles acknowledge that each participant brings their unique experiences to the relationship and have the ability to provide their own solutions to the issues identified.

The process of exploration adopts Kolb's (1984) Experiential Learning Cycle of Reflection. In this model reflection is seen as a process of active leaning. The opportunities for learning arise from our experiences. In the learning process there are four phases. The experience first needs to be described. Then there is conscious reflection on the experience, which then becomes the source for deeper analysis. The analysis process may involve the exploration of new knowledge including enquiry into potential theoretical or conceptual explanations to inform the reflection. Finally, the analysis leads to the planning for future actions and experimentation through applying these actions. This experimentation may then initiate further processes. Thereby, the supervisee is engaged in a constant reflection-action cycle, which may occur independent of the supervisory relationship (Nichols, 2007), but is ideally suited to the supervision experience. When the supervisee identifies new perspectives and solutions to dilemmas themselves, deeper learning can take place as opposed to a more directive information giving process, which might occur in training situations for example. Its success lies in the reflective questioning skills of the supervisor in guiding the process.

This approach is popular in the literature and training programmes for professional supervision. However, the success of it relies on the participants having a familiarity with or willingness to adopt a reflective approach to practice. As such it also implies that learning is an integral part of ongoing professional development, an assumption that is not universally embraced. Furthermore supervisees have different learning styles and any approach to learning in supervision requires adaptation accordingly.

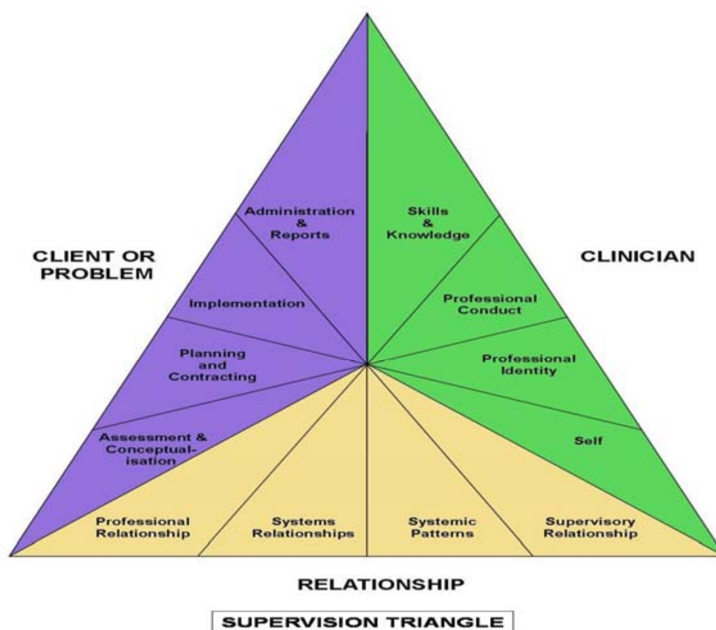
2.4.6 Approaches that emphasise focus in supervision.

The TAPES model (O'Donoghue, 1998) was the first professional supervisory model in New Zealand with an accompanying training package for supervisors. This model was based on the theory of transactional analysis and was taught at the Central Institute of Technology until the early 2000's. The financial cost of the programme to participants was accredited for its demise (Herkt, 2005), but there are indications that training in the model has been established by other educational providers. This model requires the issues arising in supervision to be placed into five categories that align with the acronym in the model's title. The categories are:

T Theory
A Assessment and intervention planning
P Parallel processes
E Ethics and professional practice
S Strategies and intervention techniques.

Categorising the issues this way enables a number of specific actions to be undertaken by the supervisor, which are prescribed in relation to a specific category (Herkt, 2005). The focus of this model is educative with an emphasis on clinical role clarification. However, supportive supervision is also evident with the use of psychotherapeutic techniques, specifically parallel process. Parallel process refers to the "unconscious replication of the therapeutic relationship in the supervision situation" (Morrissey & Tribe, 2001, p. 103). This provides an opportunity to explore the therapeutic relationship and identify areas within the relationship that are in need of improvement.

Hewson (2002) offers another type of focussing device in the form of a template including twelve areas relating to the service user, the practitioner (supervisee) and the process (interactions between service user, practitioner/supervisee and supervisor) (see Fig 1). It can be used in the processes of induction of supervisees into supervision, contracting, case discussion, evaluation of progress, reviewing supervision and re -contracting, self-monitoring and supervision of supervision (Hewson, 2002). For example, in case discussion, the supervisor and supervisee can negotiate which of the twelve areas to focus on as a way of managing the supervision session. Both parties can monitor the balance of focus over time when evaluating the efficacy or breadth of supervision.



Hewson, D (2002) Supervision of psychologists: a supervision triangle. In M.McMahon & W. Patton (eds), *Supervision in the Helping Professions: A Practical Approach*. Pearson Education, Frenchs Forest, Australia.

Hewson has developed this template with a variety of professions including nurses and has presented it in workshops in New Zealand and Australia. One of Hewson's central premises is that power is intrinsic in any supervision relationship. Her aim is to encourage supervisors to openly address structural power and intentionally develop mutual social power (Hewson, 2002).

2.4.7 Approaches which emphasise format

Line management supervision

This model of supervision was prevalent in New Zealand in the 1980's. It involved a didactic directive process primarily undertaken by line managers with supervisees. This model aligns with a management emphasis on determining performance, whereby practice is viewed in relation to the impact it has on organisational function. The focus of this model of supervision is on safe practice required to protect service users and the service. The emphasis lies on the accountability of practice to service requirements. This approach to supervision has been criticised as constituting 'snoopervision', with oversight functions that have little to do with professional growth (Yegdich, 1999).

Peer supervision

Polaschek (2007) describes peer supervision as a supportive supervision process that encourages nurses to take responsibility for their own professional development. Proponents of the model suggest that it is aimed at "maintaining safe practice for nurses and health workers" (Polaschek, 2007). Peer reciprocal supervision is supervisee-centred, in which the

supervisee is seen as having the internal resources to address most issues they bring to supervision (Baltimore & Crutchfield, 2003 cited in Polaschek, 2007). Peers share responsibility for the supervision; negotiate structure, leadership, roles and responsibilities (Scaife, 2001). As the name suggests, it is usual for peers to take turns in the role of supervisee and supervisor in the same supervision session. This process is both informative and supportive. It is also non-hierarchical as peers are not in management relationships to each other. As such it should be termed 'consultation' as it does not involve a supervisor in a position of authority.

The Royal New Zealand Plunket Society has adopted this model of supervision. The goal of the Royal New Zealand Plunket Society was to ensure "the safety of their service users and staff, and to provide a quality assurance measure" (Baldwin, Patuwai, & Hawken, 2002, p. 299). It was brought about also as a response to "increased staff anxiety because of workload pressure" (Baldwin et al., 2002, p. 300). This model was chosen as the proponents believed it encourages co-operative and collegial relationships; installs a belief in the professionalism of staff; acknowledges that the skills for supervision already exist in staff and only need refinement through training; and because financially it is a cost effective option. Training in this model is offered in some DHBs and NGOs.

Advantages include the optimisation of safety and trust between participants and empowerment through taking responsibility for one's own and each others' learning. Disadvantages include the drift toward a more social relationship and the possibility for less challenge to occur where members have a less hierarchical relationship.

Variations of group supervision – Authoritative, participative, co-operative and peer

Although the models stipulate specific modes of delivery, the uses of either one-to-one or group processes are not mutually exclusive. There appears to be flexibility in the mode of delivery based on the expertise of the person facilitating the process and commitment of those involved (Walsh et al., 2003). It is also clear that technology is re-defining the mental health and addictions sector. It is feasible that telecommunications and information technology could be an adjunct to professional supervision given constraints of time and distance. Modes of delivery could include e-mail, audio teleconferencing and video teleconferencing (Stamm, 1998) especially in remote areas where access to supervisors is restricted, or in highly specialised practice where local expertise is limited.

There are variations on the group supervision model with regard to the extent to which the group is supervisor lead (Scaife, 2001). They can be *authoritative* models where the supervisor supervises individuals with other members as a more or less involved audience. Alternatively they might be *participative* where the supervisor supervises but members are taught and encouraged to participate actively. Another variation, *co-operative* group supervision, is similar to this but the supervisor facilitates the group sharing responsibility for the tasks of the supervision. Finally they may be *peer* group based whereby the peers (no identified supervisor) take responsibility for supervision and the members negotiate structure,

leadership, roles and responsibilities. Each has advantages and disadvantages and satisfies different aims.

One model implemented in community mental health nursing in South Australia (Walsh et al., 2003) involved a group of nurses meeting once a month, in which the facilitation of the supervision sessions was rotated at each meeting. The model is akin to the peer consultation model described above. Results of the evaluation of this process were mixed with some nurses reporting that the group was not overtly challenging and focused too much on mutual support at the expense of practice related issues. However, there was almost 100% attendance to the sessions, which implies a strong sense of ownership of the process.

Supervisees receiving group supervision felt that the advice and support was more effective in participative or co-operative group supervision, whereby the supervisor facilitates the discussion within the group, encouraging learning, feedback and the exchange of ideas Winstanley (2000) cited in Edwards et al (2005). An example of the *peer* group supervision approach is the egalitarian consultation model (Stevenson & Jackson, 2000). In this model a group of supervisees come together and undertake supervision. There is no 'one' expert supervisor in the group; rather each individual brings their own experience to encourage collaborative problem solving. Peer supervision groups are particularly good at creating supportive environments for practitioners where they can share things not necessarily shared with other support people (McNiccoll, 2004).

Bassi and Polifroni (2005) have suggested that regular meetings between nurses which involve problem solving and allow them to connect with each other, may reduce isolation and encourage autonomy, collaboration and staff development. Ministry of Health (2006) suggest that collaborative group supervision with joint ownership of supervision between peers may be advantageous. Other benefits include cost effectiveness, with peer group supervision reducing the need for qualified supervisors (Hines-Martin & Robinson, 2006; Stevenson & Jackson, 2000).

This model overtly encourages networking amongst peers. However, this approach relies on the mobilisation of large groups of nurses and the substantial logistical and organisational support from nursing management. It may prove difficult to keep the same group together due to changing schedules, which in turn affects group cohesion and confidentiality. Open group sessions have the potential to lack focus, although a prepared agenda may assist in this regard (Cleary & Freeman, 2006).

For this supervision model to succeed it is necessary that group member roles, motivations, responsibilities and expectations are clear from the outset (Cotrell, 2002). This fosters the desired respectful and encouraging relationship between supervisee peers (Vuorinen, Tarkka, & Meretoja, 2000).

2.4.8 Approaches which emphasise techniques

Heron's six-category intervention model

Heron's (1989b) six-category intervention model is a one-to-one process that originated as a method for examining the therapeutic relationship between practitioners and service users. The model provides six categories for the therapeutic engagement processes. Engagement can be prescriptive, informative, confronting, cathartic, catalytic or supportive (Sloan & Watson, 2001).

The six interventions can be divided into two approaches: authoritative and facilitative. Each of these approaches contains three interventions. The authoritative approach enables the supervisor to maintain control in the relationship. In this regard, the supervisor can be prescriptive in influencing and directing the behaviour of the supervisee by offering advice. Further, an authoritative approach might involve an informative intervention in which the supervisor consciously offers information and instruction. Finally, authoritative supervisor may engage in confronting interventions that directly challenge patterns of behaviour that restrict the practice of the supervisee.

Conversely, the supervisor might offer a facilitative approach to supervision whereby the locus of control in the supervisory relationship is assumed by the supervisee. This approach can consist of cathartic interventions that assist the supervisee in processing and releasing strong emotions. Furthermore, catalytic interventions may be employed to encourage self-exploration, learning and problem-solving by the supervisee. Finally, in the facilitative approach interventions might be supportive in attempting to validate the worth of the supervisee through positive regard for their qualities, attitudes or actions.

There is no hierarchical process of choosing one approach or intervention over another (Heron, 1989a). It is the nature of the content and focus of the issue as well as the developmental stage or needs of the supervisee that influence the use of a particular approach and intervention. The entire six interventions could be theoretically used as a structure in a given supervision session (Fowler, 1996). However, it is acknowledged that interventions can be unsolicited, manipulative, compulsive or unskilled. Care is needed so that a supervisor does not interact with a supervisee without agreement, negotiation or permission (Sloan & Watson, 2002).

Little is understood regarding the impact of socio-cultural variables on intervention choice. In research from the Philippines, nurses who participated (n = 138) tended to perceive their supervisors as primarily authoritative (Paderanga, Pagsuyuin, De Castro, & De Guzman, 2007). Cultural differences need to be taken into account with regard to the style of supervision and techniques selected. It is imperative that the supervisor clearly negotiates this at the outset so that learning is not hindered. Heron's model is strong on interventions but does not emphasize the goal directed nature of their use. Furthermore it does not present other broader elements of the supervision process.

2.5 Evaluation of professional supervision

Given the limited findings regarding supervisions efficacy, and the fact that many of the models of practice have been developed in other countries it is important that supervision practice is evaluated in an ongoing way. One example of an outcome measurement has been developed to assist in this regard. The Manchester Professional supervision Scale is to date the only internationally validated research instrument used to measure the effectiveness of professional supervision. The instrument is based on Proctor's model of professional supervision and operationalises its normative, formative and restorative components (Hyrkäs, 2005; Winstanley & White, 2003). This instrument has not been designed as a 'before and after' tool, so it cannot be used to establish a baseline need for supervision.

There are other rating scales that have been used to evaluate desired outcomes of professional supervision. These include: the Minnesota Job Satisfaction Scale (Weiss, Dawis, England, & Lofquist, 1967) and the Maslach Burnout Inventory (Maslach & Jackson, 1986) designed to measure emotional exhaustion, depersonalisation, and a reduced sense of personal accomplishment. Supervisors should at the very least request regular feedback about their practice in non-defensive or anonymous ways that promote the likelihood of candid comment.

2.6 Barriers to supervision

Models of supervision are important; however pragmatic implementation is required for professional supervision to be successful. Several barriers to the implementation of professional supervision can exist. These include: the availability and quality of supervisors; lack of a databases/access to knowledge of available qualified supervisors; irregular supervision with no formal contracts; financial constraints limiting availability of primarily external supervisors; the potential for supervisors to judge or criticise (Arvidsson, Lofgren, & Fridlund, 2001; Cleary & Freeman, 2006; Ministry of Health, 2006; Scanlon & Weir, 1997).

From a survey of the literature, Gilmore (2000) reports that resistance may arise from lack of knowledge of the purpose of supervision, a lack of understanding by managers as to how professional supervision fits with service priorities and a lack of replacement cover, (an issue in particular for nurses). Nurses may not trust the supervisor, nor perceive it as needed or high enough priority to find the time especially when they view informal peer support or collegial communication as helpful in providing many of the benefits usually ascribed to formal supervision (Cleary & Freeman, 2005). Edwards et al (2005) found that the perceived effectiveness of professional supervision in community mental health nurses in Wales was greatest when session length was over an hour and held at least monthly. Furthermore, having sessions away from the workplace and having choice of supervisor was more positively evaluated. Although some organisations may view professional supervision as expensive, White and Winstanley (2006) found that the cost of one-to-one professional supervision represented about 1% of annual salary.

A crucial perceived barrier to professional supervision is the power dynamic inherent in the process. Professional supervision is determined by the institution and has a degree of administrative purpose through mechanisms such as reporting requirements. Furthermore, social power exists in the supervisor-supervisee relationship with the supervisor holding the power to influence, while the supervisee the power to collaborate or resist. Hewson (1999) advocates addressing this power dynamic through negotiation and challenge. Structural power can be minimised by making the administrative purpose transparent, negotiable and procedurally accountable. Negotiation and transparency in the supervisor-supervisee relationship has the potential to empower rather than disempower. Also, the clear identification of appropriate boundaries for the relationship and extent and limits of confidentiality during contracting can assist. This is even more important where the service has a history of hierarchical, managerial or punitive concepts of supervision and/or supervision as performance management. Communication about the content of professional supervision to a manager by a supervisor should be limited to agreed-upon information or limit itself to a summary of attendance and/or overall goals. All other information about what happens in professional supervision should remain confidential to the parties involved.

One issue not yet discussed is that of internal versus external supervisors. Supervisor led processes can consist of "internal supervision" by a colleague who usually works with the supervisees or "external supervision" where this link does not exist (Walsh et al., 2003, p. 34). Advantages of the supervisor being external include the freedom of the supervisee to take concerns about practice they couldn't take to an internal supervisor and the provision of an alternative perspective by an 'outsider'(Herkt, 2005). However, it has been argued that the external supervisor is not able to offer support and guidance that an 'on-site' supervisor can (Hirst & Lynch, 2005). Being off-site, they cannot provide debriefing or immediate support that an on-site supervisor might. At an organisational level there are more challenges arranging replacement cover or allowing time for travel. The value of internal supervision lies in the knowledge the supervisor has of the clinical context, though it is argued that reflection on the institutional culture can be better explored by a supervisor external to the service.

Given the difficulties outlined above, it is understandable that there appears to be resistance to supervision by some nurses (Hines-Martin & Robinson, 2006; Kelly, Long, & McKenna, 2001; Scanlon & Weir, 1997; G Sloan, 1999; Walsh et al., 2003). Therefore, it is important that this resistance is acknowledged and accommodated in supervision planning. Orientation to supervision or training of supervisors and supervisees to make optimum use of supervision is advocated by many writers, for example, Gilmore (2000). At an organisational level, successful implementation requires the commitment and motivation of one or more individuals within an organisation to lead the supervision project.

2.7 Moving forward: Recommendations from the literature

The aim of this literature review is to assist Te Pou o Te Whakaaro Nui, the National Centre of Mental Health Research, Information and Workforce Development to inform workforce development planning for the professional supervision of mental health and addiction nurses. Various models and modes of delivery allow for flexibility within organisations to tailor

supervision processes to specific organisational and supervisee need. Therefore, it is not possible to devise one model to suit all (Teasdale, Brocklehurst, & Thom, 2001). It may be preferable to pursue a more flexible approach with regard to the choice of approaches or models ensuring these are tailored to individual setting needs.

However, there are essential administrative, educative and supportive functions that should exist in any model adopted. Dissatisfaction with models of supervision are reflected when models favour one function at the expense of others (G Sloan, 1999).

The approach adopted should be operationalised through the development of policies. Supervision should be formalised, with contracts written to clarify the responsibilities of supervisor and supervisee (Chambers & Cutcliffe, 2001; Mahmood, 1994). Most policies on supervision now include a supervision agreement or contract and although not legally binding, it has become recognised as a hallmark of ethical practice in supervision (Falvey, 2002). This represents a process of informed consent whereby all parties negotiate the parameters of supervision. In this way, the frequency, time and venue of meetings; cancellation policy; and method of recording would be formalised beforehand. In addition, the goals of supervision; how the supervision relationship may be terminated; issues of confidentiality; self-disclosure; and unsafe or unprofessional practice should be discussed and made clear from the outset. Howard, Burns and Waitoki (2007) recommend the following areas to be discussed and recorded - the purpose of the supervision; professional disclosure statements; models and frameworks of supervision to be used; goals of supervisee; methods of supervision (e.g. use of live, video- or audio-tapes, and/or case discussion); evaluation of supervision and supervisee and due process procedure (if relevant); accountability and responsibilities of each party; confidentiality of supervision and its limits; dual relationships (what constitutes appropriate boundaries); and problem resolution plan. These authors stress the importance of a negotiation approach to the supervision agreement to build trust and rapport and encourage supervisee ownership, motivation and responsibility for their own learning.

From the information contained within this document, it is clear that the model will need to address the requirements of a number of key stakeholders in the mental health and addiction sector. Importantly because of New Zealand's commitment to Te Tiriti O Waitangi, no 'one' approach should be developed that is not endorsed by Maori as tangata whenua. A skilled Maori mental health and addictions workforce is crucial to the future development of the sector in meeting the needs of Maori service users and their whanau (New Zealand Health Workforce Advisory Committee, 2001). It is imperative that currently employed Maori nurses are supported, nurtured and encouraged to continue to develop their clinical and cultural skills. Maori models of supervision practice should be promoted and developed further.

Professional supervision for mental health and addiction nurses requires a level of commitment from both nurses and the organisations they work for. Organisations need to put in place mechanisms that support the continued sustainability of professional supervision practices including the development and provision of supervision training for supervisors and supervisees as well as the supervision of supervisors. As reported above, there are indications that supervision training has efficacy (Milne & James, 2000) and that it can result in

improving participants' attitudes towards, and level of confidence in providing, professional supervision (Hancox, Lynch, Happell, & Biondo, 2004). Resource allocation and managerial accountability are absolutely necessary to ensure that this happens.

The expectation that nurses receive quality professional supervision needs to be reinforced within the mental health nursing culture. This process needs to begin when students are being socialised into the nursing culture during undergraduate education. This value needs to be reinforced in the first year of practice programmes; and throughout orientation, induction and on-going support structures within mental health and addiction services. Many of these recommendations are supported by the literature. For example, subsequent to a literature review and survey of relevant stakeholders, Rice et al (2007) recommended twelve best practice guidelines for mental health nurses in Northern Ireland. In brief, these included: an agreed upon and visible definition; facilitation to attend supervision by managers; robust operational policies; appropriate time allocation and funding for attendance; sound supervisory skills; supervisors who are trained in supervision, work clinically and demonstrate commitment and reliability; and evaluation of the effectiveness of supervision including attempting service user feedback.

A final point in relation to service user involvement in professional supervision is that no reference to this need was found during this literature search. The Mental Health Commission's *Service-user Workforce Development Strategy for the Mental Health Sector 2005–2010* noted that the workforce in the mental health sector includes workers who have current or previous experience of using mental health services. Furthermore, the Mental Health Commission's vision of future service delivery states "in 2015 the expertise, experience and insights of service users will be valued throughout the mental health and addictions service" (Mental Health Commission, 2007, p. 18). New Zealand mental health and addiction services have a commitment to deliver recovery focused care; any approach to professional supervision that is developed will need to have service user involvement to the extent that service users may need to be part of the delivery of professional supervision.

3. METHODOLOGY

3.1 Research aims

The methodological framework for this project is comprised of three parts that correspond to the stated objectives for the project. The objectives of the project were to:

1. Generate information on the number of nurses within DHBs and NGOs who are/are not receiving professional supervision;

2. Generate information on the number and demographics of nurses who are trained supervisors, what type of training they have received and who provides their training;

3. Investigate the views of DHB Directors of Mental Health Nursing, NGO managers of nurses and supervisors of professional supervision in terms of improving outcomes, professional development and competency requirements;

4. Review the models of professional supervision being provided in DHBs and NGOs across New Zealand;

5. Determine the accountability the supervision programmes have to service users' structures aligning with the organisations;

6. Develop a standardised implementation model(s) of professional supervision and training of supervisors that can be applied nationally.

3.2 Research design

The project was overseen by the cmhr's expert reference group involved in sharing information relevant to the project; helping to identify or address issues of concern; giving input into research designs; and feeding back on drafts of the final report. This expert reference group consisted of representatives of the National Directors of Mental Health Nursing, Te Ao Maramatanga the New Zealand College of Mental Health Nurses, Maori mental health nurses, Pacific Island mental health nurses, mental health nurses in the NGO sector and service users.

The design of the project involved three phases:

3.2.1 Phase One: Literature Review

A review of international best practice in relation to professional supervision for mental health nurses was conducted. The methodology for this literature search was discussed in section 2.1 (page 3).

3.2.2 Phase Two: Scoping of current professional supervision

A scoping exercise of the provision of professional supervision across DHBs and NGOs was conducted in part two. This involved telephone and mail surveys being undertaken with Directors of Mental Health Nursing or their equivalents in DHBs, NGO nurse managers and a sample of supervisors currently providing professional supervision. This process focused on eliciting information on the number of nurses receiving/not receiving professional supervision, the characteristics of those providing professional supervision, and the respondent's views of the effectiveness of professional supervision that is currently being provided.

3.2.3 Phase Three: Development of standardised model of supervision and training

A national standardised structure of professional supervision and training will be developed in part three by Te Pou o Te Whakaaro Nui, the National Centre of Mental Health Research, Information and Workforce Development.

3.3 Scoping of current professional supervision

The following gives an overview of the design, targeted sample, data collection process and analysis process of the anonymous surveys designed to scope the current professional supervision occurring with nurses in mental health and addiction services throughout New Zealand.

3.3.1 Survey design

An anonymous survey to capture an overview of professional supervision being undertaken in New Zealand DHBs and NGOs (see Appendices 5 and 6) was developed. This survey was adapted from an Australian survey designed to provide an overview of professional supervision in New South Wales (White & Roche, 2006). This survey was refined to capture the views of supervisors conducting professional supervision. Both surveys use a cross sectional, independent measures design.

Both adaptations of the study were made with input from the cmhr's expert reference group and Te Pou o Te Whakaaro Nui, the National Centre of Mental Health Research, Information and Workforce Development.

Ethics approval was granted by the University of Auckland Human Ethics Committee (ref: 2007/176).

3.3.2 *Data Collection and sample*

The survey was designed to determine an overview of supervision within services and a participant information sheet (see Appendix 1) was distributed to the Directors of Mental Health Nursing in each of the DHBs (n = 21). Each respondent was requested to return the survey by mail. Filling out and returning the form was indicative of consent to participate.

Te Pou o Te Whakaaro Nui, the National Centre of Mental Health Research, Information and Workforce Development were advised by Platform(NGO support agency) of survey fatigue by mental health and addiction NGO services with mail out surveys. Therefore, the survey was sent to the nurse managers of seven NGOs, with the option of a telephone survey. A separate participant information form and consent form was attached to accommodate this option (see Appendix 2). The telephone survey took place on the receipt of the consent form to participate. The NGOs (n = 7) were purposively selected by the funders of the research to represent a cross section of the variety of mental health and addiction services employing nurses in the NGO sector throughout New Zealand.

An anonymous survey also aimed to capture the views of supervisors undertaking professional supervision in the services outlined above. The nurse leaders already surveyed were requested to distribute the survey to five supervisors currently providing professional supervision in their organisation (n = 140). Separate participant information sheets were sent to the DHBs (see Appendix 3) and to the NGOs (see Appendix 4). The latter was to accommodate the telephone survey option. A consent form also accompanied the participant information sheet sent to supervisors in the NGO sector. Filling out and returning the form was indicative of consent to participate.

Two reminder e-mails were sent out to the DHB Directors with the request for them to forward the reminders to the five supervisors they had selected.

3.3.3 *Analysis and reporting*

Data from the surveys were collated and transferred into relevant software (SPSS, version 14). Qualitative information was entered into NVIVO (version 7). Qualitative data was analysed using thematic analysis (Patton, 2001). This approach involved: close readings of the text and consideration of multiple meanings; the creation of labels for new categories to which the text is assigned; the addition of text segments to the category as appropriate; and the development of categories into a model or framework that summarises the data and conveys key themes. A 'consistency check' involved a parallel process of independent analysis by two members of the research team. Key themes were determined by consensus between researchers.

4. RESULTS FROM SURVEY

This section presents the results of the two surveys that canvassed nurse leaders and professional supervisors from the DHB and NGO mental health and addiction sector.

4.1 *Survey one: DHB Directors of Mental Health Nursing and NGO managers of nursing*

The first survey canvassed the opinions of the Directors of Mental Health Nursing in all 21 DHBs and seven managers of mental health and addiction nurses in NGOs regarding their current provision of professional supervision. The following presents the results of this survey. It begins with an overview of the main factors that characterise DHBs and NGOs, including: management structure, services provided, number of nurses employed and any notable features about the population the organisation serves.

4.1.1 *Sample description*

The Directors of Mental Health Nursing or their equivalents were surveyed in all of New Zealand's DHBs. DHBs are responsible for providing, or funding the provision of health and disability services in their district. There are 21 DHBs in New Zealand and they have existed since 1 January 2001. The statutory objectives of DHBs include: improving, promoting and protecting the health of communities; promoting the integration of health services, especially primary and secondary care services; and promoting effective care or support of those in need of personal health services or disability support (www.moh.govt.nz).

NGOs are independent community and Maori organisations operating on a not-for-profit basis. This means any profits are put back into the organisation, rather than distributed to shareholders (www.moh.govt.nz). They are a vital component of the mental health and addiction sector and a sample were surveyed for this study. The NGOs (n = 7) were recommended by Platform to Te Pou o Te Whakaaro Nui, the National Centre of Mental Health Research, Information and Workforce Development to represent a cross-section of the variety of mental health and addiction services employing nurses in the NGO sector throughout New Zealand. The following information profiling these services has been anonymised.

Four of the services are large NGOs offering a wide range of community based support and rehabilitation to mental health service users. All provide structured supportive accommodation, respite care and mobile teams that aim to support people in their own houses or the communities within which they live. In addition, one organisation extends its services to those people with intellectual and physical disabilities; another service also provides specialist services to those with co-existing mental health and drug and alcohol issues; another service describes itself as a Christian based service; and the other provides community development initiatives alongside service user support. There are differences in

the geographical catchments that each of the NGOs service: One is located in a large urban area in the North Island; another in a large urban area in the South Island; one covers eight regions in both Islands, and the other a variety of regions in the lower North Island.

Two further NGOs target culturally specific service user needs. The first is a small Maori mental health service provider on the west coast of the North Island. This service provides day activities for tangata whai ora, crisis intervention services with an emphasis on cultural assessment, early intervention services and the provision of social services. The second is a service which targets the needs of Pacifica peoples in a large urban area in the South Island. The service emphasises health promotion, cultural assessment, and support and advocacy to mental health and addiction service users. The final NGO is an addictions specialist service meeting the needs of a region in the lower North Island. This organisation provides a full range of specialist services including: interventions targeting youth, adult specific services, detoxification services, methadone treatment and services for problem gambling.

4.1.2 Characteristics of the organisations

The survey began by inquiring into the management structure of the DHBs and NGOs. Directors of Mental Health Nursing (i.e. nurse leaders) were evident in all but three of the DHBs. In these three, responsibility for mental health nurses either rested with the overall Director of Nursing or the manager of mental health services. Three of the seven NGOs also had a Director of Mental Health Nursing, while in the remainder of the NGOs this responsibility was assumed by service managers.

The managers were also asked what definition best describes the location of their DHB or NGO. Most DHBs (62%) and over half the NGOs considered their location to be a mixture of urban and rural.

Managers supplied information on the specialist services provided by their organisation. Table two illustrates the various services provided by DHBs and NGOs. NGOs were more likely to provide specific services; for instance, Maori and Pacific mental health services or alcohol and addiction services. The DHBs provided a range of general and specialist mental health and addictions services.

Table 2: Specialist services provided by DHBs and NGOs

Specialist Service	DHB (n = 21)	NGO (n = 7)
Child and adolescent inpatient services	9	1
Early psychosis	13	4
Mood disorders	7	1
Psychiatric intensive care	18	0
Promotion, prevention and early intervention	12	2
Alcohol and drug services	18	3

Forensic services	13	2
Psychiatry of older age	11	1
Perinatal mental health	15	1
Other services	11	4

The 'other services' category included the various specialist services of dual diagnosis, forensic intellectual disability, psychiatric liaison, eating disorders, anxiety disorders and primary mental health liaison.

The number of nurses employed within the mental health and addiction services differed between DHB and NGO. Registered nurses employed by NGOs ranged from 1 – 36, with an average of 13 nurses. In some NGOs registered nurses are employed as generic workers (for example support workers); these nurses were included in the total. The number of registered nurses employed by DHBs ranged from 10 (in a small rural DHB) to 585; with an average of 184.

4.1.3 Provision of professional supervision

The next part of the survey required the Directors of Mental Health Nursing (DOMHN)/managers to provide information on whether professional supervision is provided in their organisation, the information processes they use to promote supervision, and the numbers of nurses who participate.

Professional supervision for registered nurses employed in mental health and addiction services was provided to 'all nurses' by 17 DHBs and to 'some nurses' by 4 DHBs. Those DHBs that indicated the option was available to "some" tended to be the larger DHBs. Five of the seven NGOs provided access to professional supervision to 'all' nurses. In one case, no supervision was available and in the other a resource was allocated to each nurse to access their own supervision arrangements.

All of the DHB Directors of Mental Health Nursing stated that they provide nurses with information on professional supervision. Five of the NGOs stated they provided information, while two stated they did not. If the DOMHN/manager stated yes to this question, they where then asked to elaborate on what information they provide and how nurses access the information. The most common information offered to nursing staff was a list of possible professional supervisors for both internal and external supervision. This information was most often posted on the intranet or disseminated by a senior nurse allotted that responsibility. Information on professional supervision policies and contracts was also frequently available from the intranet.

One service indicated they reinforce this information during annual performance appraisals and at professional development opportunities, in order to assist in internalising the importance of supervision. A further service indicated providing information to staff on how they could become supervisors through a supervision training programme. Another DHB

indicated that information dissemination is formalised through a service-wide supervision committee.

Sixteen of the managers/DOMHN of (5 = NGOs, 11 = DHBs) were able to give a specific number of registered nurses currently attending supervision, with 11 services not providing the number of those receiving supervision and one service not providing the numbers of those employed as mental health nurses or whether they currently received supervision. This reflected the difficulty in recording the numbers of nurses receiving supervision in the larger organisations. For those who did provide this information, it was possible to calculate how many nurses within the organisation on average received supervision. On average 75% of the nurses employed in both NGOs and DHBs are currently attending professional supervision.

The services that did keep a database of nurses attendance found it helpful for assisting in the auditing requirements of the service, and determining if the existing professional supervision arrangements were sustainable. Some concern was generally expressed about the bureaucratic mechanism required for regular updating and follow up of individuals whose supervision contracts had expired. Others expressed concern for the potential for confidentiality of the database to be compromised, the data used for other purposes; and the short comings of data in that it may say nothing about the quality of professional supervision.

4.1.4 Professional supervisors

Part three of the survey inquired about the details of professional supervisors used by the organisation. The first section of this part of the survey included detail relating to how many fully trained supervisors were used, whether this number was sufficient to meet the need, the professional background of the professional supervisors, whether the supervisors are external or internal to the organisation and the cost-effectiveness of the latter.

In total, 688 trained supervisors were identified. The DHB DOMHN reported using between 6 and 124 trained professional supervisors. The NGOs tended to employ lower numbers of professional supervisors ranging between 0 and 17, which reflected the lower numbers of mental health and addiction nurses.

In regard to whether this number was sufficient to meet the need, the services were equally divided between those who thought the number was sufficient (n = 12) and those that did not (n = 12), with four services having missing data on this item.

For those who did think there were enough, qualifying comments were offered. One service (a DHB) commented on the variable ability of trained supervisors, in that some professional supervisors may only supervise one person and some several. In one service a statement was made that although the numbers were sufficient, they were not used to their capacity in the service (a DHB). One NGO mentioned the ability to access supervisors was enhanced by the local DHB being able to provide this resource.

There was considerable variability across services in terms of the professional discipline of supervisors, with 16 services indicating that they have a mixture of nurses, psychologists, psychiatrists, social workers, Maori mental health workers, psychotherapists, counsellors and occupational therapists practising as professional supervisors. There was a tendency for supervisors external to the service to be from a discipline other than nursing. This may reflect the multi-disciplinary nature of specialist mental health services. Some services had trained registered mental health and addiction nurses to undertake professional supervision with their colleagues (n = 8). This model was confined to larger DHBs who are assumed to have the resources to initiate this training.

As table 3 indicates, a large percentage of services employed a combination of internal and external supervisors (n = 22, 81%). Two NGOs only employed external supervisors. The value of external supervisors was expressed for specialised teams requiring supervisors with specific knowledge that could not be located in the service.

Table 3: DHB and NGO use of internal and external supervisors

	Internal only	External only	Both	Total
DHB	3	0	18	21
NGO	0	2	4	6
Total	3	2	22	27

For organisations using external supervision, it was often hard for them to comment on the cost effectiveness of this option. This information did not appear to be available. DOMHN/managers were more likely to place a subjective value on professional supervision based on the perceived benefits to staff. This included diminished "burn out" and increased staff retention.

4.1.5 Records of those able to undertake supervision

DOMHN/managers were also asked to stipulate whether their organisation kept a record of those able to provide professional supervision and if so, how accessible this information was, how useful record-keeping was, and whether there were any disadvantages of keeping a record.

The service leaders reported that their services predominantly kept a database of supervisors (n = 23, 82%). Only five services did not have such a record (four being NGOs and one DHB). One of the NGO services did not provide the opportunity for professional supervision, one service placed the onus on staff to negotiate supervision on the basis of a resource allocated to the staff member and the other two did not respond to this item.

Eighteen of the 23 respondents who answered this question stated this database was easy for staff to access. Lists were posted on the intranet or dissemination through a co-ordinator or

senior staff member. For those services that train their own supervisors, those who have completed the training automatically went onto this list.

For all the services keeping a list, this process was deemed to be useful in that it assists staff in choosing who their supervisor might be. Having information on the professional qualification and clinical experience of the proposed supervisor further assisted in this choice. One DHB DOMHN talked about the use of this database as a tracking device whereby it helps: "sorting out practical things like travel to supervision. We can record the supervisor's up-dates and send out reminders regarding next up-date sessions"

No consistent disadvantages where expressed regarding the keeping of a data base of supervisors. A small number of respondents indicated privacy concerns but failed to elaborate or expressed frustration that such a list implied availability of access which was not always the case.

4.1.6 Supervision of supervisors and supervisor accreditation

An overview of DHB and NGO practice revealed a commitment to meeting the supervisory needs of those undertaking supervision. In each DHB, 'all' supervisors (n = 13 DHBs) or 'some' supervisors (n = 8 DHBs) received supervision. Four of the NGO managers stated that 'all' of their supervisors received supervision. There was variability as to whether this supervision was provided by a person of the same discipline, or by a person who was internal or external to the organisation.

The DOMHNs/managers were asked if it was a requirement that supervisors used by their organisation were accredited by their service. Most indicated this was the case (n = 17, 68%); fourteen of these being DHBs. However, there was some variability in the understanding as to what constituted "accreditation". For most (n = 13 of 17), evidence of supervision training was enough. Some services required evidence of the quality of supervision and on-going role development demonstrated in a resume or a letter of confirmation from a service manager. For one NGO, DHB endorsement was sufficient accreditation.

Irrespective of this variability there was an overwhelming expectation of clear responsibilities and accountabilities of the supervisors to the organisations concerned. This expectation was often formalised in contracts and policies. However, it was conceded by one respondent that this process was more difficult to enforce on external supervisors.

4.1.7 Consumer input and cultural approaches to professional supervision

In part four of the survey, respondents were asked to comment on whether they include service user involvement in the development of professional supervision, training of professional supervisors, delivery of professional supervision, on-going support of professional supervision programmes, and the monitoring and evaluating of professional supervision. The survey also included the question: 'do you think it would be possible for

service users to become involved in the development and monitoring of professional supervision programmes?' This allowed us to determine whether managers envisaged the involvement of service user groups would be beneficial for the future development of professional supervision programmes.

Table 4 indicates that very few services involve service user groups in any areas of professional supervision. No NGO managers reported that they involve service users, while a small percentage of DHBs use service users in this regard.

Table 4: Involvement of consumer groups in professional supervision

	DHB (N = 21)	NGO (N = 7)
Development of programmes	5	0
Training of supervisors	3	0
Delivery of supervision	2	0
Ongoing-support	4	0
Monitoring and evaluation	2	0

Although, 18 respondents expressed a willingness to explore the possibility of service user involvement some ambivalence was evident. This ambivalence is demonstrated in the following quote from a DHB Director:

> *I have a hesitation [of* service user *involvement] in actual supervision. We need to carefully think about issues of professional development and this is professional supervision with a high degree of trust and openness in order to deal with issues that are very sensitive especially if the person is exploring issues of transference or counter transference. It may be useful to have* service user *supervision which is different from clinical.*

Other respondents were more fervent in their expression of involvement of service users in professional supervision. One DHB Director stated:

> *As this resource is part of providing effective care delivery it is absolutely necessary that* service users *or representatives of are included and consulted on the development and monitoring of these programmes.*

Regarding the need for cultural supervision, only eight DHBs and five NGOs stated that there was an expectation that the cultural needs of their staff were met through supervision. However, most of the DHBs (n = 19) and NGOs (n = 5) reported their nurses received specific cultural supervision.

Organisations expressed a strong desire to initiate appropriate cultural supervision. One respondent stated that:

> *"Supervision is considered a safe supportive relationship between peers. The clinical focus of the session will expose cultural issues or needs and the supervisee will develop a plan to meet the needs."*

The majority of services were able to name individuals or groups in their organisation who could be accessed for this purpose. These included Kaumatua, kuia or staff of kaupapa Maori services. One respondent expressed difficulty in sustaining a critical mass of cultural supervisors. In some other services there was an expectation that those staff requiring cultural supervision would initiate the process.

The qualitative comments suggested that the respondents viewed cultural supervision as a separate process to professional supervision that should be met outside of professional supervision. Cultural supervision was generally not fully integrated into mainstream professional supervision.

4.1.8 Professional supervision content and application

In part five of the survey, respondents were asked to report on the supervision programme's success in their organisation; the models they use to guide supervision processes; the details on the frequency and composition of supervision sessions; and whether supervision occurs in work time. Following this, the DOMHN/managers were asked to describe whether professional supervision is integrated into annual performance reviews and professional development and recognition plans. Additionally, it was requested they indicate whether a formal contract and policy exists, whether professional supervision is mandatory, and whether funding is allocated for professional supervision within their organisation. The existence or not of evaluation processes in regards to the provision of professional supervision in their organisation was also surveyed.

4.1.9 What makes professional supervision successful?

A number of themes emerged from open-ended responses to what makes professional supervision successful. The strongest theme was related to the evolution of a culture that *values* supervision. This culture was reflected in the commitment of both staff and management to professional supervision. Supervision was seen as an integral component of a wider commitment to "a robust quality service which improves outcomes for service users and reduces stress for staff." In this regard, professional supervision was prioritised with institutional time allotted for it to occur effectively.

Another theme attributed the success of professional supervision to the endorsement of a specific philosophical framework that supported professional supervision. This might be in the form of a model of supervision, with associated feedback loops that allowed for the

refinement of this model. However, some responses did not mention a specific model per say but rather the value of a non-threatening process of professional supervision that was adopted by the organisation.

Several respondents also made mention of the importance of the *quality* of supervisors who had been trained in the role. One respondent extended this importance to the need for a service "champion" for professional supervision who took a co-ordinating role to sustain the momentum within their organisation.

Although this question focused on what makes supervision successful, a few respondents discussed why professional supervision was not successful in their organisations. This included poor understanding of the purpose of professional supervision; low attendance by supervisees (despite perceived opportunity); lack of training for supervisors; and ethical and boundary issues not being addressed in the supervisor/supervisee relationship.

4.1.10 Models of supervision and timing of sessions

Respondents were asked to detail whether their organisation used a particular theoretical model to guide the training and/or delivery of professional supervision. Seventy per cent of managers reported that their organisation does use a model, with 17 of these respondents from DHBs and two from NGOs. The most common models identified were the TAPES Model and Proctor's model which were identified by five respondents. Other models mentioned were Heron's model (n = 1), Margaret Morrell's model (n = 2) and Mike Consedine's model (n = 1). An eclectic range of models adopted by supervisors was also endorsed.

The details of the composition (group or one-to-one), frequency, and length of professional supervision session were also reported. Table 5 illustrates that most organisations undertake professional supervision both in groups or one-to-one for an hours duration. The duration of professional supervision sessions ranged from ranged from 30 minutes to no limit on time. The frequency of professional supervision varied considerably; sessions occurred regularly or on an as-required basis. The most popular scheduling of supervision sessions was monthly.

Table 5: Length and composition of supervision

		Composition			
		Groups	One to One	Both	Total
Length (Hours)	0 .5	0	1	0	1
	1	1	8	15	24
	1-1.5	0	0	1	1
	No limit	0	1	0	1
Total		1	10	16	27

4.1.11 *Relationship between professional supervision and performance appraisal*

In the majority of organisations (n = 19, 70%), the outcome of the supervision process was integrated into annual performance reviews. This was done in an ad-hoc manner and often amounted to little more than presenting records of attendance. In only two instances was a more comprehensive process related to performance review. In one case the registered nurse was required to "submit a mutual supervision report with their completed self assessment report" and in another instance the supervisor was a part of the interview to determine performance.

Slightly fewer service configurations (n = 16, 60%) indicated that professional supervision was incorporated into professional development and recognition programmes. This may be a reflection of under-development of these programmes within the NGO sector; with only one NGO stating that they integrated professional supervision into their programme. Again this involved submitting records with no clear indication that professional supervision was instrumental in determining the level of competency or level of expertise of the nurse involved in the professional development and recognition programme.

4.1.12 *Professional supervision contracts, policies, costs and evaluation*

Professional supervision is primarily formalised. In all but one case the supervision took place in work time, as is the case when training staff to be supervisors. In all organisations a formal contract of supervision is required, while all but three organisations had a documented policy to facilitate professional supervision.

However, services differed as to the compulsory nature of supervision. Just over half of the services (n = 16, 64%) had mandatory requirements for professional supervision.

Adequate funding is important in the day-to-day sustainability of professional supervision. Sixteen DOMHN or managers (11 from DHBs, 5 from NGOs) stated that there is adequate funding allocated to support professional supervision in their organisation. One DHB signalled that cultural supervision was not presently funded, while one organisation indicated difficulty in meeting the cost incurred for external supervisors.

Given the commitment to professional supervision it is surprising that only a third of respondents (n = 10, 37%) indicated that there was an evaluation process that fed into the quality refinement of professional supervision. Three services indicated that there was an easily accessible report available for this evaluation.

4.1.13 *National model*

The intent of this supervision project is to consider the benefits of a nationally agreed approach to training, delivery and evaluation of professional supervision. Table 6 indicates that 63% of the leaders from the services surveyed thought it would be beneficial to have a

nationally agreed model and training procedure. Interestingly, all but one NGO agreed that a national approach would be beneficial; the six organisations that disagreed were DHBs.

The most prevalent theme on the benefit of a national approach was the ability to establish a standardised and consistent approach to professional supervision. This would allow monitoring and quality control in order to refine the process. However there was a caveat placed on this consistency. It was expressed that no one model of professional supervision should be adopted as this would potentially negate efforts to establish models to date.

Table 6: Organisations that support a national approach

	Yes	No	Don't know	Total
DHB	12	6	0	18
NGO	5	0	1	6
Total	17	6	1	24

Respondents expressed confidence that standardisation will allow cross linking and cross fertilisation of ideas; further developing best practice between organisations.

Respondents mentioned barriers and resistance to a national initiative. It was recognised that the DHBs and NGOs have no history of working collaboratively and that this might be a barrier to establishing a national initiative. Also of concern is the tendency for national need to usurp local need. As stated by one respondent: "I would hate a national programme to override what we are doing well here."

4.1.14 Other comments

Lastly, managers were invited to make general comments on professional supervision. One theme was frustration with the high turnover of supervisors. Further, a pool of back-up supervisors would avoid delays after supervisors resign. This was related to the absence of local training options.

Some respondents expressed frustration at having to accommodate supervisors who endorse a variety of models; or staff from the UK having their own perspective on what constitutes professional supervision.

Finally one DHB espoused the value of having a supervision co-ordinator:

> *A supervision coordinator was employed for 12 months to raise the supervision profile, set it up for success for the future through arranging training for supervisors and supervisees. This has been very successful I think. The supervision coordinator finished a couple of months ago. The challenge for the service will be sustaining the*

supervision training, database, and profile without having a dedicated person leading it.

4.2 Survey two: Professional Supervisors

We assessed supervisor role-perception by undertaking a separate anonymous survey with five purposely chosen supervisors from each DHB and five from each NGO (n = 140). These supervisors were chosen by the DOMHN or manager of nursing in each organisation.

Although five supervisors could be accessed in each DHB, this was not so in all NGOs. Only one NGO accessed five supervisors; one NGO had no supervisors; three NGOs had one supervisor; one NGO had two supervisors and one had three supervisors. Consequently, the total number of surveys distributed was 123.

From the 123 we had 73 completed surveys returned; giving a response rate of 60%. This is a very satisfactory response rate as data collection methods significantly influence response rates and self-reported postal questionnaires are generally considered to result in lower response rates (Badger & Werrett, 2005). International nursing research, for example, reports rates of between 25 and 30% (Burns & Grove, 1993), 15 and 20% (Skodol-Wilson, 1989) and 20 and 40% (May, 2001; Yammarino, Skinner, & Childers, 1991) to be common for self completion and postal questionnaires. Our high response rate may have been enhanced by offering telephone interviews to the 13 supervisors who provide supervision to the NGOs.

The survey comprised of four parts that sought: personal details, current employment details, current clinical practice, and professional supervision details.

4.2.1 Personal details

The socio-demographic profile of the supervisors surveyed (see table 7) indicates that they were predominantly middle-aged, NZ/European females. They were also highly experienced clinicians with 91 (84%) having over 10 years of nursing experience.

Table 7: Demographics of supervisor respondents

	Gender		Total
	Male	Female	
Age (years)			
20-29	0	1	1
30-39	4	7	11
40-49	11	23	34
50-59	3	17	20

60+	2	5	7
Total	**20**	**53**	**73**
Ethnicity			
Maori	1	3	4
Pakeha	15	37	52
Pacific	0	2	2
Asian	1	0	1
Other	2	11	13
Total	**19***	**53**	**72**

* One missing data

4.2.2 Current employment

The professional supervisors worked in the full spectrum of mental health and addiction services. Of the 73 respondents 19 (26%) worked in community settings. A clear majority (n = 69, 94.5%) worked under permanent contracted employment arrangements. Most were employed full-time (n = 58, 80%). Surprisingly 26% (n = 19) were employed part-time, indicating that supervision might be a significant component of their role. A large percentage (n = 54, 74%) were employed as nurses, six (8%) as generic mental health workers and 13 (18%) in an 'other position'.

Of the professional supervisors who were nurses (n = 54), 30 were in advanced practice roles including nurse specialist, clinical nurse educator, clinical nurse consultant, nursing unit manager and senior nurse manger. Over three quarters also had a post-graduate qualification.

4.2.3 Professional Supervision for the professional supervisor

The majority of the supervisors were committed to supervision arrangements that informed their *own* practice, with 85% (n = 62 of 73) currently in supervisory arrangements themselves. Many had been involved in supervision for more than 5 years (n = 45; 62%). Of those who received supervision, some received it from registered nurses (n = 40 of 62) and others from another mental health professional
(n = 21 of 62).

4.2.4 Characteristics of the professional supervision undertaken

The formalisation of professional supervision mirrors the organisational overview expressed by directors and managers. A clear majority (n = 62, 85%) indicated that they enter into

professional supervision contracts with their supervisees. Most professional supervision sessions occurred monthly or fortnightly (and took an average of one hour). These arrangements usually occurred in work time on an individual one-to-one basis. Most professional supervision occurred in the service the supervisor was aligned with (internal supervision); though many also undertook external professional supervision.

The professional supervisors where asked whether their organisation endorsed a particular theoretical model of professional supervision. Just under half stated that this was the case. They were then asked to comment on whether they used a particular model to guide their professional supervision sessions. Over half (n = 48, 66%) stated they are guided by a particular model. The most popular models used by the supervisors were the TAPES model (n = 18), Proctor's model (n = 6) and the reflective model (n = 5). One supervisor had this to say about such alignment:

> *To be bound by a model would be very limiting and would not enhance the flexible approach I use which has been developed after years of experience working holistically. I am informed by a variety of theoreticians whose opinions are valuable but not useful in their entirety as a model. Most supervision models are drawn from overseas and therefore have restricted relevance when it comes to work being carried out with service users in New Zealand…*

The supervisors were asked to indicate the three most frequently discussed topics in professional supervision sessions. *Reflection on clinical work* was highlighted by 78% (n = 56) of respondents, *professional development* by 51% (n = 37) of respondents, *interpersonal issues* by 38% (n = 28) of respondents and *organisational/management skills* by 33% (n = 24) of respondents.

4.2.5 Perceived barriers to professional supervision

Supervisors were asked about barriers to the provision of professional supervision. The predominant theme for over half of the respondents was the issue of time and/or workload constraints. Some supervisors expressed difficulty balancing their professional supervision role with an existing clinical caseload. This created "time management problems." In some instances caseload and work related requirements meant they could not fulfil their supervisory commitment. Travelling long distances to undertake external professional supervision added to time constraints.

Another theme involved the availability and willingness of some mental health and addiction nurses to engage in professional supervision. A lack of supervisors contributed to this barrier. However reference was made to resistance by some nurses to engage in supervision:

"Nurses do not always come from a culture of supervision. Their attendance is often less regular than counsellors or psychologists."

Professional supervisors also highlighted environmental barriers. Specifically, this involved inappropriate settings in which to hold professional supervision.

4.2.6 Accountability of professional supervisors

Almost a third of the supervisors surveyed indicated that they had been involved in professional supervision relationships in which the registered mental health and addiction nurse had been directed to undertake professional supervision. Directed supervision included the supervision of new graduates in post graduate mental health programmes; management of interpersonal conflict in the clinical setting; mental health issues experienced by the supervisee that required determination of fitness to practice; and the use of professional supervision as a “resolution tool in performance management issues”.

Most supervisors thought this process was useful; however there was some degree of ambivalence expressed in undertaking directed professional supervision. This included a perceived resentfulness on the part of supervisees who lacked the motivation to engage.

Almost two thirds of those surveyed believed that the professional supervision they provided was integrated into performance appraisal reviews. At a rudimentary level this involved the keeping of a record of attendance at professional supervision sessions. However, several respondents mentioned written reports that were submitted for performance appraisal or attendance at the performance appraisal interview.

4.2.7 Quality improvement of professional supervision

The supervisors surveyed indicated that monitoring and evaluation of professional supervision was a standard part of the supervisory relationship. However, it appears this is done in an ad-hoc, informal manner; gaining ‘feedback’ from supervisees on helpful or unhelpful aspects of the relationship. This feedback then becomes the basis for personal reflection and refinement of the role. Some supervisors indicated that this reflection is part of their own supervisory arrangements. Only one supervisor referred to a review of their supervision with a line manager of the organisation.

4.2.8 What motivates professional supervisors and what makes professional supervision successful?

Undertaking the role of professional supervisor requires personal commitment and organisational support. Supervisors were motivated to perform the role by the intrinsic benefit to the supervisee. The supervisee experienced “growth” from sharing the knowledge and experience of the supervisor. Extrinsic motivators were also expressed. Some supervisors felt a professional obligation to support and assist peers in their professional development.

The goal in this regard was to improve the quality of nursing care that was offered to service users. The final theme related to improving the overall culture of the organisation involved *"improving general morale"* or improving multi disciplinary functioning.

A number of predictable themes were expressed in terms of what was perceived to make professional supervision successful in their organisation. These mirrored the themes expressed by DHB and NGO leaders in their overviews of professional supervision within their organisations. Success was attributed to a culture that valued professional supervision and was supported by staff and management. It was indicated that this support allowed professional supervision to become deeply embedded in the institutional culture. Other themes included the quality of supervisors, training opportunity which increased the availability of supervisors, time allocation and "champions" or advocates for professional supervision.

4.2.9 Other Comments

Lastly supervisors were invited to discuss general issues regarding professional supervision. No themes became evident, though in summing up the value of a national training initiative for professional supervisors, one respondent stated:

> *…having one set qualification would be beneficial, especially linked with NZQA. Currently there is a qualification that can be gained … however few (if any) clinical supervisors in mental health and addiction have achieved their qualification via this.*

5. CONCLUSIONS

5.1 *Overview of professional supervision*

It was difficult to assess the exact number of mental health and addiction nurses undertaking professional supervision in the organisations surveyed. From available data approximately 75% of mental health and addiction nurses currently attend professional supervision. Surprisingly, it was the large DHBs that had difficulty meeting the supervisory needs of all staff. This may relate to the complexity of managing a large and diverse nursing workforce across specialty areas, with presumably significant rates of staff turnover.

The literature review indicated a variety of models of professional supervision being used internationally. The surveys of both nurse leaders and supervisors indicated that this diversity is mirrored within the mental health and addictions sector in New Zealand. In some cases an eclectic mix of different models has been developed.

It seems futile to presume that one model could accommodate all services. Kadushan (1992, cited in Herkt, 2005) reports it is more important that the model chosen addresses the administrative, educative and supportive functions of professional supervision. Administrative supervision is associated with service management requirements for nursing practice; education supervision focuses on the development of professional practice; while supportive supervision is concerned with the development of "attitudes and feelings that will enable [the supervisee] to work effectively" (Herkt, 2005, p. 21).

5.2 *Is professional supervision working?*

Although there is scant evidence of the effectiveness of professional supervision in the literature, much is written anecdotally on the value of professional supervision for clinical practice. Winstanley and White (2003, p. 16) report that professional supervision "has received widespread acceptance within the nursing profession and implementation has continued, despite the lack of empirical evidence to link the process of [professional supervision] with real benefits to the delivery of quality care and to patient outcomes." This anecdotal support was evident in the surveys of nurse leaders and supervisors undertaken in this research.

Despite the lack of evidence, expert opinion and indeed commonsense would support continued emphasis on its use. The lack of evidence, however, indicates the need to include measurable evaluation as an integral component of professional supervision programmes. Ideally this evaluation should be framed within a research paradigm that assists in providing much needed evidence.

5.3 *What is needed to improve professional supervision?*

We found scant reference to service user involvement in the development and implementation of professional supervision programmes in either the literature or the surveys. The Mental Health Commission's *Service-user Workforce Development Strategy for the Mental Health Sector 2005–2010* noted that the workforce in the mental health and addiction sector includes workers who have current or previous experience of using mental health services. Furthermore, the Mental Health Commission's vision of future service delivery states "in 2015 the expertise, experience and insights of service users will be valued throughout the mental health and addictions service" (Mental Health Commission, 2007, p. 18). New Zealand mental health and addiction services have a commitment to delivering recovery focused care; therefore professional supervision programmes must reflect service user involvement. This may include service users being involved in providing professional supervision.

A skilled Maori mental health and addiction workforce is crucial to the future development of the sector in meeting the needs of Maori service users and their whanau (New Zealand Health Workforce Advisory Committee, 2001). It is imperative that Maori nurses who are currently employed are supported, nurtured and encouraged to continue to develop their clinical and cultural skills. There is incongruence between the present provision of cultural supervision delivered by services and that desired by Maori nurses. Presently, most services provide cultural supervision and professional supervision separately; yet Maori nurses indicate the need for cultural and professional supervision to occur simultaneously as culture and practice are intertwined (Broodkoorn & Wahanui, 2005). It is necessary that Maori involvement occurs at all stages of any national initiative to improve professional supervision for mental health and addictions nurses.

This research indicates that professional supervision is most successful when its value is embedded within the institution's culture. This is a culture in which professional supervision is seen as part of "*a robust quality service which improves outcomes for service users and reduces stress for staff*" (survey respondent comment). All key stakeholders have an obligation to address barriers for which they have some responsibility.

5.3.1 *Service responsibilities*

The overall development, implementation, co-ordination and evaluation of professional supervision programmes lie with service management. This planning and implementation should be done in conjunction with key stakeholders including staff, supervisors, service users and Maori. This responsibility involves the determination of a model and associated process for professional supervision; the development and maintenance of a pool of supervisors; human resource management that enables the supervision to take place; the marketing of the programme in a manner that engenders enthusiasm and commitment; and refinement of the programme through on-going quality assurance mechanisms.

It is a management responsibility to ensure that a model(s) is chosen that meets the essential functions of professional supervision and that this model is translated into processes and procedures. Furthermore, processes and procedures need to be written into supervision policy and contracts. The survey indicated that this translation is already widely undertaken.

Administrative supervision is about how professional supervision assists in meeting a management responsibility to sustain a competent workforce. Presently supervision is integrated into the annual performance reviews in an ad-hoc manner, usually involving evidence of supervision attendance. More direct input is necessary whereby supervisors submit reports or attend performance appraisal interviews. This involvement is also required to determine the competency and level of expertise of nurses in professional development and recognition programmes. The role of the supervisor in this process would have to be very clear, as there is a danger that the administrative function could override the other functions of professional supervision.

A significant minority of supervisors indicated that they had been involved in supervisory relationships in which the registered mental health and addiction nurse had been directed to undertake professional supervision. Although they felt comfortable with meeting this administrative need, there was an indication that supervision was thwarted by the resentfulness of some supervisees at being compelled to engage. This perception can be minimised by the administrative purpose of supervision being transparent, negotiable and procedurally accountable (Hewson, 1999).

It is a management and professional leadership responsibility to maintain a pool of supervisors. There is indication that there are not enough professional supervisors trained to meet the demand in some regions. This gives support to a national training initiative that increases capacity through a flexible learning package that meets the needs of rural services.

Many supervisors talked of pragmatic improvements required to enhance their role. Foremost was the difficulty expressed by some supervisors in balancing their supervision role with their clinical caseload; this is a human resource need that must be managed.

It is common practice for supervisors who are not nurses to undertake professional supervision. Although some services are focusing on training nurses to be professional supervisors, there is no reason why a multidisciplinary approach should cease. It is important that any national training initiative is not restricted to nurses.

In determining a pool of supervisors, there is a responsibility to determine the competency of those involved. There was little indication in the survey of accreditation processes to achieve this. Completion of training was often the sole determinant of competency. Careful consideration needs to be given to accreditation processes that take into account evidence of competency maintenance.

Information on professional supervision programmes is routinely marketed in orientation programmes, on the intranet or through senior nurse appointments. However, many services

lacked a strategy to market the benefits of professional supervision. One proactive example was the development of a service wide supervision committee.

It is important that professional supervision programmes are monitored and quality improvement supported. This was made difficult in some organisations by the lack of baseline information that tracked the involvement of staff in supervision. Given the commitment to professional supervision, it is also surprising that there was not more evidence of evaluation processes that fed into quality refinement.

Finally, the literature suggests that professional supervision is difficult to maintain on financial grounds (Arvidsson et al., 2001; Johns, 2003). This is refuted by a cost analysis undertaken in Australia which found that the cost of one-to-one professional supervision represented about 1% of annual salary (White & Winstanley, 2006).

5.3.2 Supervisor responsibilities

The supervisors surveyed were well qualified academically, and experienced in both clinical practice and the supervisory role. The majority expressed a sense of obligation to the professional growth of supervisees and improvement of the institutional culture. Supervisors also role modelled commitment by themselves being supervised.

Supervisors tended to evaluate their own role primarily through unstructured feedback from supervisees. In some cases this feedback was used as a point of reflection in their own supervision. There was scant indication of evaluation accountability to line managers from the organisation contracting their services. This further reinforces the need for structured quality monitoring and quality refinement processes.

5.3.3 Responsibilities of supervisees

It was difficult to assess the professional supervision compliancy rates of mental health and addiction nurses due to inadequate records. Further, some nurses were reported to be offering resistance and not engaging in professional supervision. This resistance is well articulated in the literature (Hines-Martin & Robinson, 2006; Kelly et al., 2001; Scanlon & Weir, 1997; G Sloan, 1999; Walsh et al., 2003).

A sense of institutional imposition associated with administrative supervision may fuel this resistance. It may also relate to the power dynamic that is integral in the supervisory relationship. It is important that the supervisee takes some responsibility for monitoring and controlling this dynamic through negotiation and challenge (Hewson, 1999). It is important that this resistance is acknowledged and accommodated in supervision planning.

5.4 A way forward

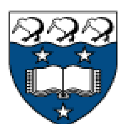
A central aim of this project was to assess support for a nationally endorsed approach to meeting the training needs of professional supervision as per the recommendation in *Mental health nursing framework and its future: A discussion framework* (Ministry of Health, 2006). Professional supervision training is being provided in New Zealand by different learning institutions in accordance with a variety of models. It was outside the brief of this project to scope present educational opportunities. However, it is clear that the opportunities that do exist are not readily accessible geographically.

The majority of services and individuals canvassed were supportive of a nationally endorsed approach. Standardisation was seen as a means of further assisting monitoring, quality refinement and collaborative cross linking between DHB and NGO sectors. As organisations developing professional supervision are at different stages it is important that a national initiative supports individual progress.

5.5 Recommendations

1. Development of National Professional Supervision Guidelines.
2. Development of a national training structure for professional supervision which aligns with Let's get real.
3. Training should not be model-specific but rather focus on the structure (administration, education and support) of professional supervision.
4. Accreditation processes should be developed to recognise and maintain the competency of professional supervision training and ensure alignment with Let's get real and e-learning.
5. A national database of trained and accredited supervisors will be developed.
6. Measurable evaluation must be an integral component of the professional supervision structure. Ideally this evaluation should be framed within a research paradigm.

APPENDIX ONE: DHB DIRECTORS INFORMATION SHEET



THE UNIVERSITY OF AUCKLAND
NEW ZEALAND

Faculty of Medical and Health Sciences
School of Nursing
The University of Auckland
Private Bag 92019
Auckland, New Zealand

PARTICIPANT INFORMATION SHEET

Mental Health & Addiction Nursing Professional Supervision project

To: Associate Directors of Mental Health & Addiction Nurses (or equivalent) in DHBs

Brian McKenna, Valerie Williams and Kate Thom are members of a research team from the University of Auckland undertaking the above titled research project. The research is funded by Te Pou – The National Centre of Mental Health Research and Workforce Development and managed by Auckland UniServices. This project seeks to address the recommendations outlined in the *Mental Health Nursing and its Future* discussion document (Ministry of Health, 2006), which stated that District Health Boards (DHBs) and Non- Government Organisations (NGOs) will implement a national approach to Professional Supervision.

We invite you to take part in the first stage of the project; which includes a national survey of Associate Directors on the current approaches to Professional Supervision in mental health services within DHBs and NGOs in New Zealand, with the purpose of developing a best practice model of Professional Supervision. The findings will be presented to an expert reference group of nurses who along with Te Pou (the funding agency) will decide on a best practice model of supervision for mental health and addictions nurses. The stated intent is to pilot this model and evaluate its effectiveness at a later date.

In addition, we would like you to distribute the five enclosed Participant Information Sheets, and Professional Supervisor Questionnaires to five senior Professional Supervisors who supervise mental health & addiction nurses in your DHB/NGO.

The *Mental Health Nursing and its Future* discussion document (Ministry of Health, 2006) makes recommendations to strengthen mental health nursing as an integral component in the provision of services to mental health service users. This document defines Professional Supervision as "a formal process that provides professional support to enable practitioners to develop their knowledge and competence be responsible for their own practice and promote service users' health outcomes and safety", and prioritises Professional Supervision as one of its nine recommendations. Furthermore, the Health Practitioners Competence Assurance Act 2003, in its emphasis on maintaining standards of practice to ensure public safety, requires mental health and addictions nurses to demonstrate that they are "competent and fit". Professional Supervision is a critical component in this regard.

We are interested to ascertain the number of nurses receiving/not receiving supervision; the theoretical models (if any) of supervision followed; the characteristics of those providing

supervision; views of managers on the effectiveness of supervision, supervision training and any financial/time constraints of supervision as well as the accountability for any Professional Supervision programmes undertaken. We also wish to explore service user involvement in Professional Supervision and the use of specific cultural approaches.

Your participation will involve completing the Associate Director questionnaire attached to this document. The questionnaire will take about 15-30 minutes to complete. Please return the completed questionnaire in the pre-paid envelope provided.

The questionnaires are regionally coded to aid with sampling and response rate calculation; however questionnaires are anonymous and the data within will remain strictly confidential. The research team will ensure questionnaires are stored securely, in a locked location at the University of Auckland and destroyed 6 years after completion of the study. The data will be entered into a computer database and stored on password protected computer files on the University of Auckland server.

Information gathered from the questionnaires will be included in a report submitted to Te Pou; however individual nurses/managers/supervisors will not be identifiable during data collection, distribution or publication and no material that could personally identify you will be used in any reports on this study.

Please understand that your participation is voluntary and you do not have to take part in this research. Completion of this survey is taken to imply consent to participation in the project. Should the research team send out a reminder to non respondents, please ignore if you have already completed the questionnaire.

If you have any questions or wish to know more about the study please contact us using the details below.

Kind Regards,

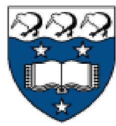
....
Associate Professor Brian McKenna, Valerie Williams & Katey Thom

Principal Investigator	Researcher	Head of School
Brian McKenna Phone: 09 373 7599 Extn 89554 b.mckenna@auckland.ac.nz	Katey Thom Phone: 09 373 7599 Extn 89579 k.thom@auckland.ac.nz	Assoc Prof Judy Kilpatrick Phone: 09 373 7599 Extn 82897 j.kilpatrick@auckland.ac.nz

For ethical concerns contact: The Chair, The University of Auckland Human Participants Ethics Committee, Office of the Vice Chancellor, Private Bag 92019, Auckland. Tel: 09 373 7599 Extn. 87830.

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE 20/08/07 to 20/08/10. Reference number 2007/176

APPENDIX TWO: NGO MANAGERS INFORMATION SHEET



THE UNIVERSITY OF AUCKLAND
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Auckland, New Zealand

PARTICIPANT INFORMATION SHEET

Mental Health & Addiction Nursing Professional Supervision project

To: Associate Directors of Mental Health & Addiction Nurses in NGOs

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In addition, we would like to include five senior Professional Supervisors who supervise mental health & addiction nurses in your NGO in the survey. We would like you to distribute Participation Information Sheets and consent forms to these people on our behalf. On receipt of your consent form we will send these to you.

The *Mental Health Nursing and its Future* discussion document (Ministry of Health, 2006) makes recommendations to strengthen mental health nursing as an integral component in the provision of services to mental health service users. This document defines Professional Supervision as "a formal process that provides professional support to enable practitioners to develop their knowledge and competence be responsible for their own practice and promote service users' health outcomes and safety", and prioritises Professional Supervision as one of its nine recommendations. Furthermore, the Health Practitioners Competence Assurance Act 2003, in its emphasis on maintaining standards of practice to ensure public safety, requires mental health and addictions nurses to demonstrate that they are "competent and fit". Professional Supervision is a critical component in this regard.

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supervision; views of managers on the effectiveness of supervision, supervision training and any financial/time constraints of supervision as well as the accountability for any Professional Supervision programmes undertaken. We also wish to explore service user involvement in Professional Supervision and the use of specific cultural approaches.

Please return your consent form via fax to (09) 367 7158. On receipt of your consent to participate, your participation will involve undertaking the survey via the telephone. The survey questionnaire will take about 15-30 minutes to complete.

The surveys are regionally coded to aid with sampling and response rate calculation; however surveys are anonymous and the data within will remain strictly confidential. The research team will ensure surveys are stored securely, in a locked location at the University of Auckland and destroyed 6 years after completion of the study. The data will be entered into a computer database and stored on password protected computer files on the University of Auckland server.

Information gathered from the surveys will be included in a report submitted to Te Pou; however individual nurses/managers/supervisors will not be identifiable during data collection, distribution or publication and no material that could personally identify you will be used in any reports on this study.

Please understand that your participation is voluntary and you do not have to take part in this research.

If you have any questions or wish to know more about the study please contact us using the details below.

Kind Regards,

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Associate Professor Brian McKenna, Valerie Williams & Katey Thom

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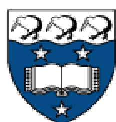
APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE 20/08/07 to 20/08/10 Reference number 2007/176.

APPENDIX THREE: DHB PROFESSIONAL SUPERVISORS



THE UNIVERSITY OF AUCKLAND
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Faculty of Medical and Health Sciences
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The University of Auckland
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Auckland, New Zealand

PARTICIPANT INFORMATION SHEET

Mental Health & Addiction Nursing Professional Supervision project

To: Professional Supervisors of Mental Health & Addiction Nurses (or equivalent) in DHBs

Brian McKenna, Valerie Williams and Kate Thom are members of a research team from the University of Auckland undertaking the above titled research project. The research is funded by Te Pou – The National Centre of Mental Health Research and Workforce Development and managed by Auckland Uniservices. This project seeks to address the recommendations outlined in the *Mental Health Nursing and its Future* discussion document (Ministry of Health, 2006), which stated that District Health Boards (DHBs) and Non- Government Organisations (NGOs) will implement a national approach to Professional Supervision. The findings will be presented to an expert reference group of nurses who along with Te Pou (the funding agency) will decide on a best practice model of supervision for mental health and addictions nurses. The stated intent is to pilot this model and evaluate its effectiveness at a later date.

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Your participation will involve completing the Professional Supervisor questionnaire attached to this document. The questionnaire will take about 15 minutes to complete. Please return the completed questionnaire in the pre-paid envelope provided.

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Kind Regards,

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Associate Professor Brian McKenna, Valerie Williams & Katey Thom

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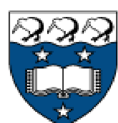
APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE 20/08/07 to 20/08/10. Reference number 2000/176

APPENDIX FOUR: NGO PROFESSIONAL SUPERVISORS



cmhr
CENTRE FOR MENTAL HEALTH RESEARCH

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PARTICIPANT INFORMATION SHEET

Mental Health & Addiction Nursing Professional Supervision project

To: Professional Supervisors of Mental Health & Addiction Nurses in NGOs

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Please return your consent form in the pre paid envelope provided. On receipt of your consent to participate, your participation will involve undertaking the survey via the telephone. The survey questionnaire will take about 15-30 minutes to complete.

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Please understand that your participation is voluntary and you do not have to take part in this research.

If you have any questions or wish to know more about the study please contact us using the details below.

Kind Regards,

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Associate Professor Brian McKenna, Valerie Williams & Katey Thom

Principal Investigator	Researcher	Head of School
Brian McKenna Phone: 09 373 7599 Extn 89554 b.mckenna@auckland.ac.nz	Katey Thom Phone: 09 373 7599 Extn 89579 k.thom@auckland.ac.nz	Assoc Prof Judy Kilpatrick Phone: 09 373 7599 Extn 82897 j.kilpatrick@auckland.ac.nz

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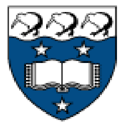
APPENDIX FIVE: DHB/NGO DIRECTOR/MANAGER SURVEY



THE UNIVERSITY OF AUCKLAND
NEW ZEALAND

PROFESSIONAL SUPERVISION SURVEY - ASSOCIATE DIRECTORS OF MENTAL HEALTH & ADDICTION NURSES (or equivalent) IN DHBs & NGOs.

We are a research team from the University of Auckland conducting a national survey on the Professional Supervision of mental health and addiction nurses in NZ.

Professional Supervision for mental health & addiction nurses is important to ensure competency, fitness to practice and gain an Annual Practising Certificate under the Health Practitioners Competence Assurance Act 2003[1]. This survey hopes to ascertain the number of nurses receiving/not receiving supervision; the models of supervision followed; the characteristics of those providing supervision; views of managers on the effectiveness of supervision and the accountability for any Professional Supervision programmes undertaken.

The information collected from this survey will contribute to the design of a nationwide best practice of Professional Supervision for mental health and addiction nurses; therefore we invite you to participate and air any comments/ideas you may have regarding supervision.

The questionnaires are regionally coded to aid with sampling and response rate calculation; however questionnaires are anonymous and the data within will remain strictly confidential. The research team will ensure questionnaires are stored securely and that individual nurses/managers/supervisors will not be identifiable during data collection, distribution or publication.

We advise you to read the accompanying Participant Information Sheet for further explanation of this project. Completion of this survey is taken to imply consent to participation in the project.

Please complete this survey if you are a Mental Health Nursing Manager/Acting Manager for your District Health Board (DHB) or Non Government Organisation (NGO) of mental health and addiction nurses.

Please simply tick the appropriate boxes and write within the dedicated spaces to answer questions. Please complete both sides of each page.

Kind Regards,

…………………………………………
Associate Professor Brian McKenna, Valerie Williams & Katey Thom

[1] Ministry of Health (2006). Mental health nursing framework and its future: A discussion framework. Report from the Expert Reference Group to the Deputy Director-General, Mental Heath Dr Janice Wilson. Wellington: Author. ISBN: 0-478-29923-0 (Internet)

PART ONE: YOUR ORGANISATION

1. Name of DHB or NGO ____

2. Does your DHB/NGO have a position designated as area-wide Director/Associate Director of Mental Health Nursing (or equivalent)? ☐ Yes ☐ No

2a. If yes, does the operational control apply to:
☐ All Mental Health and Addiction Nurses
☐ Some Mental Health and Addiction Nurses
If some, please give details, ______________________________________

3. Please indicate any specialist services currently provided in your DHB/NGO:
☐ Child & Adolescent Inpatient Services
☐ Forensic Mental Health
☐ Early Psychosis
☐ Psychiatry of Older Age
☐ Mood Disorders
☐ Perinatal Mental Health
☐ Psychiatric Intensive Care
☐ Promotion, Prevention & Early Intervention Programme
☐ Alcohol and Drug Services
☐ Other (please specify), ______________________________________

4. Which definition best describes the location of your DHB/NGO?

☐ Urban – inner city
☐ Urban - suburbs
☐ Rural – large town(s)
☐ Rural – small town(s)
☐ Industrial
☐ Remote
☐ Mixed Urban & Rural
☐ Other (please specify), ______________________________________

5. Please list any notable features about the population served by your DHB/NGO (e.g. age groups, ethnicity, remoteness…).

____
____
____
____
____
____
____
____
____
____
____
____

PART TWO: MENTAL HEALTH & ADDICTION NURSES

6. How many Registered Mental Health and Addiction Nurses work in your DHB/NGO?____________

7. Is Professional Supervision available to Registered Mental Health and Addiction Nurses in your DHB/NGO?
   ☐ Yes - all ☐ Yes - some ☐ No

8. Do you provide your Registered Mental Health and Addiction Nurses with access to information on Professional Supervision?
   ☐ Yes ☐ No

8a. If yes, what information do you provide and how do nurses access this?
____
____
____

9. How many nurses working in mental health and addictions in your DHB/NGO attend Professional Supervision?
____

10. Is there a record (database) of nurses who receive Professional Supervision?
   ☐ Yes ☐ No

10a. If yes, in what way is this record/database useful?
____
____
____

10b. Are there any disadvantages to keeping this record/database?
____
____
____

PART THREE: PROFESSIONAL SUPERVISORS

11. How many fully trained Professional Supervisors does your DHB/NGO currently use? (Internal or external supervisors)______________________________________

12. Have you sufficient supervisors to meet the needs of your Mental Health and Addiction Nurses? (Please comment)
____
____
____

13. Who are the Professional Supervisors in your DHB/NGO? (I.e. professional background. discipline, internal/external to the service, job title, qualifications)
____

14 Do you use supervisors internal or external to the organisation?

☐ Internal ☐ External ☐ Both

15. If you use external supervisors is this cost effective? (Please comment)

16. Is there a record (database) of those able to provide Professional Supervision?

☐ Yes ☐ No

16a. If yes, is this database easy to access? ☐ Yes ☐ No

Please give access details: __________

16b. In what way is a record/database of Professional Supervisors useful?

16c. Are there any disadvantages to keeping a record/database of Professional Supervisors?

17. If you have internal supervisors, do they receive Professional Supervision themselves?

☐ Yes - all ☐ Yes - some ☐ No

17a. If yes, who provides Professional Supervision to them? (I.e. professional background, discipline, internal/external to the service, job title, qualifications)

18. Are the Professional Supervisors required to be accredited by the DHB/ NGO?

☐ Yes ☐ No

18a. If yes, please provide brief details:

19 Are supervisors clear of their responsibilities and accountabilities to the organisation? (Please comment)

____

____

____

PART FOUR: CONSUMER INVOLVEMENT AND CULTURAL APPROACHES

Do consumers/consumer groups have involvement in any of the following?

20. Development of Professional Supervision programmes ☐ Yes ☐ No

20a. If yes, please give details:

____

____

____

21. Training of Professional Supervisors ☐ Yes ☐ No

21a. If yes, please give details:

____

____

____

22. Delivery of Professional Supervision ☐ Yes ☐ No

22a. If yes, please give details:

____

____

____

23. On-going support of Professional Supervision programmes ☐ Yes ☐ No

23a. If yes, please give details:

____

____

____

24. Monitoring/ evaluating Professional Supervisor programmes ☐ Yes ☐ No

24a. If yes, please give details:

____

____

____

25. Do you think it would be possible for consumers to become more involved in the development and monitoring of Professional Supervision Programmes?

☐ Yes ☐ No

25a. If yes, please give details:

____
____
____

26. Is there an expectation that the cultural needs of staff are met though Professional Supervision?

☐ Yes ☐ No

26a. If yes, please explain:

____
____
____

26b. If not, why not?

____
____
____

27. Do your Registered Mental Health and Addiction Nurses have access to specific cultural supervision?

☐ Yes ☐ No

27a. If yes, please explain how:

____
____
____

27b. If not, why not?

____
____
____

PART FIVE: PROFESSIONAL SUPERVISION CONTENT & APPLICATION

28 What makes supervision successful in your organisation? (Please comment)

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____
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____
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____

29. Is a theoretical model used to guide the training and/or delivery of Professional Supervision?

☐ Yes ☐ No ☐ Don't Know

29a. If yes, please give details:

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____

30. How frequently does Professional Supervision of Mental Health and Addiction Nurses occur?

☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Yearly ☐ Other_______________

31. What is the usual length of each professional supervision session? (In hrs) _______________

32. Is Professional Supervision undertaken in..? ☐ Groups ☐ One to one ☐ Both

33. Is supervision integrated with annual performance reviews? ☐ Yes ☐ No

33a. If yes, how does this occur?

____

____

____

34. Is supervision integrated with Professional Development & Recognition plans?

☐ Yes ☐ No

34a. If yes, how does this occur?

____

____

____

35. Does the Professional Supervision of Mental Health & Addiction nurses occur in work time?

☐ Yes ☐ Sometimes ☐ No

36. Does the training of Professional Supervisors occur in work time? ☐ Yes ☐ No

37. Is there a formal contract of Professional Supervision between nurses and their Supervisor?

☐ Yes ☐ No

38. Is there a documented DHB/NGO policy on Professional Supervision?

☐ Yes ☐ No

If yes (to Q38), please attach a copy of the policy to the survey and return

39. If yes, is Professional Supervision mandatory for all Mental Health and Addiction Nurses?

☐ Yes ☐ No

40. Is adequate funding allocated to support Professional Supervision in your DBH/NGO?

☐ Yes ☐ No

41. Please outline any issues related to funding:

____

____

42. Has the local system of Professional Supervision been evaluated? ☐ Yes ☐ No

42a. If yes, is a report available? ☐ Yes ☐ No

43. Do you think it would be beneficial to have a nationally agreed model of training and evaluation for supervisors and supervisees for Professional Supervision?

☐ Yes ☐ No

44 What would be the benefits to a national process of Professional Supervision?

____

____

45. What are the major barriers to a national process of Professional Supervision?

____

____

46. Is there anything you would like the researchers to know about your service that has not been included in the survey? Please feel free to write your comments in the space provided below and/or attach extra pages if required.

____

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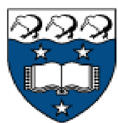
THANK YOU

Please take a few minutes to check that you have completed the entire questionnaire and then return it in the pre-paid envelope provided or by using the address below:

Centre for Mental Health Research,
School of Nursing,
Faculty of Medical and Health Sciences,
The University of Auckland,
Private Bag 92019
Auckland

APPENDIX SIX: PROFESSIONAL SUPERVISORS SURVEY



PROFESSIONAL SUPERVISION SURVEY - PROFESSIONAL SUPERVISORS OF MENTAL HEALTH & ADDICTION NURSES (or equivalent) IN DHBs & NGOs.

We are a research team from the University of Auckland conducting a national survey on the Professional Supervision of mental health and addiction nurses in NZ.

Professional Supervision for mental health & addiction nurses is important to ensure competency, fitness to practice and gain an Annual Practising Certificate under the Health Practitioners Competence Assurance Act 2003. This survey hopes to ascertain the number of nurses receiving/not receiving supervision; the models of supervision followed; the characteristics of those providing supervision; views of Professional Supervisors on the effectiveness of supervision and the accountability for any Professional Supervision programmes undertaken.

The information collected from this survey will contribute to the design of a nationwide best practice of Professional Supervision for mental health and addiction nurses; therefore we invite you to participate and air any comments/ideas you may have regarding supervision.

The questionnaires are regionally coded to aid with sampling and response rate calculation; however questionnaires are anonymous and the data within will remain strictly confidential. The research team will ensure questionnaires are stored securely and that individual nurses/managers/supervisors will not be identifiable during data collection, distribution or publication.

We advise you to read the accompanying Participant Information Sheet for further explanation of this project. Completion of this survey is taken to imply consent to participation in the project.

Please complete this survey if you are a Professional Supervisor of Mental Health & Addiction Nurses.

Simply tick the appropriate boxes and write within the dedicated spaces to answer questions. Please complete both sides of each page

Kind Regards,

…………………………………………
Associate Professor Brian McKenna, Valerie Williams & Katey Thom

PART ONE: PERSONAL DETAILS

1. What is your age?
   - ☐ 20-29yrs
   - ☐ 30-39yrs
   - ☐ 40-49yrs
   - ☐ 50-59yrs
   - ☐ 60yrs or over

2. What gender are you? ☐ Male ☐ Female

3. Please indicate which ethnic group you identify most with out of the following:
   - ☐ Maori
   - ☐ Pakeha/European
   - ☐ Pacific Island culture
   - ☐ Asian
   - ☐ Other, please specify:____________________

4. How many years of mental health or addictions clinical experience do you have?
   ☐ 1-5yrs ☐ 6-10yrs ☐ 10yrs or more

5. Please describe the speciality practice area you primarily practise in, in the space below:
   ____
   ____

6. Which DHB/NGO do you practice in?
   ____

PART TWO: YOUR CURRENT EMPLOYMENT

7. Is your current job contract…? ☐ Permanent ☐ Temporary ☐ Casual

8. Are you employed…? ☐ Full time ☐ Part time

9. Is your current position…?
   - ☐ A mental health or addiction nurse position
   - ☐ A generic mental health worker position
   - ☐ Other, please specify: ____

10. What is your current employment role?
   - ☐ Registered Nurse
   - ☐ Clinical Nurse Specialist
   - ☐ Clinical Nurse Educator
   - ☐ Nurse Educator
   - ☐ Clinical Nurse Consultant
   - ☐ Nurse Practitioner
   - ☐ Nursing Unit Manager
   - ☐ Nurse Manager
   - ☐ Senior Nurse Manager
   - ☐ Cultural Support Worker
   - ☐ Other, please specify: ____

11. Who is your front line manager?
- ☐ A Registered Mental Health and Addiction Nurse
- ☐ A manager
- ☐ A Registered Nurse without a mental health specialty
- ☐ An allied health worker
- ☐ A psychiatrist or other Doctor
- ☐ Other, please specify:________________________________

12. Where is your usual place of work?
- ☐ Hospital Mental Health Unit
- ☐ Community mental health service
- ☐ General Hospital (Non-Emergency Dpt)
- ☐ Clinic/Outpatient department
- ☐ General community health service
- ☐ Emergency Department
- ☐ Mental health residential care facility
- ☐ Corrective services
- ☐ Child & Adolescent mental health service
- ☐ Higher education institution or other tertiary education provider
- ☐ Other, please specify: ________________________________

13. How many years have you worked as a nurse since obtaining your initial nursing qualification?________________________________

14. Have you attained any post-initial qualifications in mental health or addictions? (E.g. after your initial/undergraduate nursing qualification) ☐ Yes ☐ No

14a. If yes, please identify your qualification(s) in mental health or addictions, the educational institution and the year of completion.

Qualification	Educational Institution	Completion date
1.		
2.		
3.		

PART THREE: YOUR MENTAL HEALTH NURSING PRACTICE / CLINICAL PRACTICE

15. Do you work mostly with service users of a particular age group? ☐ Yes ☐ No

15a. If yes, please indicate one of the following:
- ☐ Children & Adolescents (0-17yrs)
- ☐ Adults (18-64yrs)
- ☐ Older Adults (65yrs+)

17. Do you work mostly with a particular group of service users, such as those indicated below? ☐ Yes ☐ No

17a. If yes, please indicate one of the following:
- ☐ Early intervention (psychosis)
- ☐ Culturally diverse background
- ☐ Maori or Pacific Island peoples
- ☐ Homeless
- ☐ Substance abuse & mental health
- ☐ Forensic

☐ Developmental disability & mental health
☐ Children &/or young people
☐ Other, please specify__________

PART FOUR: PROFESSIONAL SUPERVISION
- AS A SUPERVISEE

18. Are you currently in receipt of Professional Supervision yourself? ☐ Yes ☐ No

19. If yes, for how long have you been receiving Professional Supervision?
☐ Less than a year ☐ 1 - less than 2yrs
☐ 2 - less than 3yrs ☐ 3 - less than 4yrs
☐ 4 - less than 5yrs ☐ 5yrs+

20. What is the profession of your Professional Supervisor? ____________________

21. Is your Professional Supervisor…?
☐ A peer
☐ Your manager
☐ External to your DHB/NGO
☐ Other, please specify: ____

- AS A SUPERVISOR

22. For how many years in total have you given Professional Supervision? __________

23. Do you currently provide Professional Supervision to others? ☐ Yes ☐ No

24. Do you have formal Professional Supervision contracts with the nurses you supervise?
☐ Yes ☐ No

25. Do you undertake supervision…?
☐ Inside your own service
☐ External to your own service
☐ External to your DHB/

26. How often do you see each supervisee?
☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Yearly ☐ Other__________

27. What is the usual length of each professional supervision session? (in hrs) __________

28. Does the Professional Supervision of Mental Health & Addiction nurses occur in work time?
☐ Yes ☐ No

29. Are your Professional Supervision sessions usually held…?
☐ In a group
☐ Individually (1 on 1)
☐ Other, please specify: ____

30. Is there a theoretical model of Professional Supervision endorsed by your DHB/NGO?
☐ Yes ☐ No ☐ Don't Know

30a. If yes, please provide brief details: ______________________________

____

____

____

31. Are your Professional Supervision sessions guided by a particular model?

☐ Yes ☐ No ☐ Don't Know

31a. If yes, please provide brief details:

____

____

____

32. Please indicate the three topics most frequently discussed in your professional supervision sessions:

☐ Organisational & Management issues
☐ Reflection on clinical work
☐ Professional development
☐ Team functioning
☐ Cultural issues
☐ Interpersonal issues
☐ Educational support
☐ Case file review
☐ Conflict resolution
☐ Other please specify: ______________________________

33. Are there any barriers to you providing Professional Supervision?

☐ Yes ☐ No

33a. If yes, please describe them below:

____

____

____

34. Are there circumstances in which Registered Mental Health and Addiction Nurses are directed to you to undertake Professional Supervision ☐ Yes ☐ No

34a. Was this useful? Please explain:

____

____

____

34b. Did this cause difficulties? Please explain:

____

____

____

35. Is supervision integrated with annual performance reviews? ☐ Yes ☐ No

35a. If yes, how does this occur?

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____
____

36 Are you clear of your responsibilities and accountabilities to the organisation? (Please comment)

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37. How do you monitor / evaluate the effectiveness on your Professional Supervision?

____
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____

38. What motivates you to give Professional Supervision?

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____

39. What makes supervision successful in your organisation? (Please comment)

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40. Is there anything you would like the researchers to know about your service that has not been included in the survey? Please feel free to write your comments in the space provided below and/or attach extra pages if required.

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THANK YOU!

Please take a few minutes to check that you have completed all of the questions and then return it in the pre-paid envelope provided or by using the address below:
Centre for Mental Health Research,
School of Nursing,
Faculty of Medical and Health Sciences,
The University of Auckland, Private Bag 92019, Auckland

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