Clinical Supervision

Clinical supervision is a structured professional arrangement between one or more supervisees and a supervisor purposely developed to provide critical reflection on work issues (Snowdon et al., 2020). Within the legal and ethical practice parameters, supervision is a confidential relationship (Watkins & Milne, 2014). Experts perceive clinical supervision as an essential part of modern, efficient healthcare services and educational programs for mental health professionals (Allan et al., 2017). Mental healthcare providers must understand supervision because it can be crucial in improving and preserving the expertise of mental health professionals (Allan et al., 2017). Clinical supervision can refine evidence-based practice, minimise medical errors, reduce patient waiting time and minimise healthcare costs. However, clinical supervision is a hierarchical relationship indicating that the supervisor holds an influence on the career of the supervisee, making the supervisee vulnerable (Ellis et al., 2014). This paper will focus on the pros and cons of clinical supervision in supporting safe and effective mental health nursing practice and evaluate current supervision arrangements in my workplace and how such arrangements can be improved.

Clinical supervision gained more prominence and popularity globally in the early 2000s. The recognition of clinical supervision has been formalised through the formulation of national rule development in the United Kingdom, Australia, New Zealand, Sweden and Scotland. Multiple cases of suicide involving community mental health nurses in remote rural areas were a starting point that placed the need for professional supervision at the forefront of treatment (Hines-Martin & Robinson, 2006). These appalling events sparked an inquiry calling for better supervision of community mental health nurses in rural areas. The report indicated that inadequate supervisors had been given to nurses, and it was revealed that programs should be established to facilitate day-

to-day supervisory meetings. The investigation also recommended that nursing facilities, in particular mental health nurses, should incorporate clinical monitoring as an integral part of the growth of the practice (Hines-Martin & Robinson, 2006). The stress on contemplation, self-awareness, healing self-use and professional knowledge enthused by the therapeutic procedure has led to the implementation of clinical monitoring in mental health to ensure clinical competence and quality care.

One way through which clinical supervision can support safe and effective mental health nursing practice is by minimising non-purpose activities and improve intentionality to maximise clinical competencies, preserve quality control and increase trust in the overall aim of refining client outcomes (Cruz, Carvalho & Sousa, 2012). Clinical supervision is a continuing supportive learning process for the development, progress, assessment of clinicians at all levels and, if necessary, remediation of professional functioning. Supervision is a unique expert speciality with an aspect of experience, knowledge and attitudes (Tomlinson, 2015). By the supervisee working under the guidance of the supervisor, there is effective focusing on the activities that are productive, and the supervisee improves their experience, skills, attitudes and knowledge in practice. While mental professionals have the education background, they need practical experience. Happell (2008) argued that while nursing education contributes to negative attitudes towards mental nursing, the clinical experience can alleviate the negative attitudes. However, this can only occur if the mental nurses experience a competent experience which clinical supervision can create.

Clinical supervision is also applied as a learning tool by mental health practitioners in psychotherapy, recovery or delivery of psychosocial mental health mediations at all points for cultivation, appraisal, improvement and, if necessary, remediation and professional functioning

(Snowdon, Leggat & Taylor, 2017). Self is an integral part of the therapeutic process for routinely targeted supervisors and mental health practitioners. Integrating self into mediation strategy creates self-care issues that need to be resolved by supervision (McTighe, 2011). Therapists can learn to utilise these emotional resources to improve the efficiency of expert self-use through self-exploration. The level to which mental health psychiatrists are committed to navigating the difficulties of their lives and engaging in individual development is commensurate with the ability to contribute to the client's attempts to solve their challenges. Supervisory progress is evaluated through reflective journaling by managers, video appraisal of therapy meetings, and examination of the group and personal management issues. Supervisory assessment is carried out through the self-reporting of supervisees and the review of clinical work by supervisors (Stark & Greggerson, 2016). In this way, clinical supervision is critical for enhancing the competence of mental health practitioners which in turn improves the satisfaction and success of patients or clients in the long term.

Clinical supervision also creates an atmosphere that promotes the development of leadership and cultural competence among clinicians in mental health environments. The creation of multicultural competencies is critical for the development of clinical competence. In mental health professions, multicultural competencies include attitudes, knowledge, beliefs, skills and activities that offer an outline for optimising patient contact, contribution and benefiting from psychotherapeutic interventions (Allan, McLuckie & Hoffecker, 2017). Multicultural skills growth fields include professional self-awareness of mental well-being, human world experience, therapeutic collaboration, and mental health and advocacy approaches. There are various obstacles to the supervision of cultural viewpoints, comprising the need to elucidate the challenge of recognising the cultural birthright and socio-political significance of human suffering. Through

practices such as interpersonal interactions and outside activities, the supervisor can instil cultural humility in the supervisee (Hook et al., 2016).

Studies indicate that clinical supervision has a substantial influence on the outcomes of patient care and the success of medical graduates. In their study, Snowdon, Leggat & Taylor (2017) found that the severity of clinical symptoms of patients treated by mental health professionals participating in reflective practice is lower than that of patients treated by unsupervised mental practitioners. The study found that outpatient medical practitioners and the reflective supervision of a multidisciplinary emergency response team were affected by direct supervision. Mental health practitioners' reflective practices dramatically increase their performance of assignments, patient engagement, tracking patient development, safeguarding patient rights and evaluation. The enhanced treatment method represents the efficacy of treatment through a substantial increase in patient outcomes (Snowdon, Leggat & Taylor, 2017). Mental health nurses have widely recognised the lack of organisational support, skills and resources as primary barriers to the adoption of evidence-based practices (Mahmoud & Abdelrasol, 2019). These issues can be overcome by clinical supervision, which offers guidelines, resources and guidelines to physicians to improve the application of EBP.

However, while clinical supervision supports safe and effective mental health nursing practice, it also has its negative effects on supervisee, supervisors and patient outcomes. The realisation of the benefits of clinical supervision depends on the supervisors' consistency, proceedings during supervision, and the factors that affect the choice of the supervisor, the characteristics and the disadvantages induced by the management process. Ellis et al. (2014) argued that the occurrence of harmful clinical supervision has received attention and defined harmful clinical supervision are any supervisory practices that result in physical, emotional and

psychological harm to the supervisee. McNamara et al. (2017) have argued that based on narratives from clinical supervisee, harmful supervision is described as traumatic and has physical and psychological effects such as digestive issues, fatigue, headaches and weight loss. In a study by Ellis (2017) evaluating the harmful supervision narratives, participants reported various negative outcomes from being victimised to feelings of helplessness and powerlessness. A major reoccurring effect was also the self-doubt that is developed by harmful supervision, in turn, resulting in negative attitudes towards clinical practice. When supervision instils negative attitudes as opposed to positive attitudes, then the supervisee is unable to acquire the goodwill to practice competently, and this affects patient outcomes.

Another major challenge of clinical supervision is the increase in workload for both the supervisor and the supervisee. The supervisor, as a practitioner in the same clinical settings, has other roles and supervision then becomes an added role. This can result in effects such as burnout, work-related stress, traumatic experiences and other psychological issues (Hoffman & Daniels, 2020). Which this occurs together with harmful clinical supervision, the effects are exacerbated, and the patient outcomes are affected (Bos, Silén & Kaila, 2015). In addition, the added workload on the supervisor can result in feelings of abandonment in that the supervisors can feel the management is imposing a high workload. This can, in turn, affect both the supervisory role as well as other clinical roles resulting in poor outcomes for the supervisee and patients. While clinical supervision is significant in improving outcomes, it is significant to consider that the supervisors are still practitioners who need to fulfil their roles and obligations as mental health professionals. Failure to balance the supervisory role with other roles can result in harmful supervision as elucidated earlier, affecting the supervisee in the long term (Clevinger, Albert & Raiche, 2019).

In Australia, bodies such as the Australian College of Midwives, Australian College of Mental Health Nurses and the Australian College of Nursing have made a joint statement that all nurses have to undergo clinical supervision. In the current workplace, clinical supervision is provided through face-to-face meetings in dyads. Supervision specific models have been developed over time by the organisation such as clinical facilitation, clinical teaching, buddying roles and preceptorship facilitated by professional development through peer review, coaching and mentoring (ANM, ACN, ACMHN, 2019). To facilitate the role, there are daily handovers to brainstorm, monthly clinical discussion forums, and annual appraisal by supervisors to identify areas that need improvement for further training in order to be effective in clinical supervision. Counselling networks are available in case of traumatic incidents. These models are; however, all embedded in the support and growth model as developed by Faugier (1992) (Franklin, 2013). The role of the supervisor is viewed as supporting the supervisee to experience growth professionally by instilling skills and capabilities to practice competently. Nurse are able to acquire cultural competency, satisfaction, trust and the goodwill to remain reflective in practice. Professional and personal development emanating from this supervision has been useful in helping new nurses integrate their theoretical education into practice to become autonomous practitioners.

However, there are several challenges being experienced in the workplace concerning clinical supervision. First, there is inadequate time to provide clinical supervision due to increased workload. There is a shortage of mental health practitioners in the organisation, and this has increased the workload. Again, confidentiality and dignity lack despite being a core requirement of all clinicians as staff become familiar with each other impacting on set boundaries and affect the supervisory relationship. Professional obsolescence and currency in training are sometimes

lacking and requires constant improvements through compulsory competency completion. The quality assurance team needs sensitisation on the lacking areas.

These changes are an indication that there is a need for continuous improvement in the supervisory programs developed in the workplace. The organisation has to ensure that nurses have a manageable workload to be able to engage in supervisory roles. Supervisors should not be overloaded with work to the extent that they miss their supervisory role or inadequately supervise. This can result in harmful supervision as elucidated earlier. Another change would be to ensure that the confidentiality of supervisory relationships is maintained as required. Confidentiality is a major requirement in healthcare practice, and when supervisors as more experienced practitioners fail to observe confidentiality, their role of guiding supervisees is compromised in that they set a bad role model. In addition, supervisors should be skilled and competent in current supervisory practices.

Summarily, clinical supervision is progressively earning prominence as a fundamental professional proficiency in the mental health field, besides being an indispensable constituent of contemporary, operative health care organisations. Pundits have associated clinical supervision with the effectiveness of treatment and improvements in the care process, which could encourage commitment to improved patient outcomes-related procedures. However, clinical supervision must be understood as an ongoing process that requires significant investment from both the supervisor and the supervisee. Organisational support is also vital to ensure the successful application of oversight, which is transparent, inclusive, respect the principles of preference and is culturally sensitive. Clinical surveillance is also an innovative and collaborative approach designed to enhance delivery and treatment processes in the current mental health system and improve client outcomes.

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