

Conceptualising the Foundation of an Effective
Clinical Supervision Cycle in Mental Health Nursing

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ABSTRACT

Clinical supervision is an activity that is interpreted widely in terms of its definition, purpose and its practical application to the practice of mental health nursing. Despite methodological limitations in research, in general terms the weight of evidence significantly supports the view that clinical supervision is effective. It is seen to enhance professional and personal development, provide support in the clinical workplace and consequently by direct and indirect means, facilitates improvement in the provision of care.

This small study seeks to develop a greater understanding of the determinants of 'effective' clinical supervision from the perspective of the mental health nurse. A cohort of ten Registered Nurses working in a range of nursing positions within a large District Health Board Specialist Mental Health Service was interviewed utilising a semi structured interview format. The descriptive data generated from these interviews was interpreted using thematic analysis and coded into 22 sub-themes. These were the identified factors that participants believed impacted on the effectiveness of their clinical supervision. The sub-themes were organised via sub-thematic clusters into related groupings in most cases. Through an ongoing interpretative process, three over-arching themes emerged.

The themes were subject to a further stage of analysis which allowed synthesised core conceptual meanings to be interpreted and an over-arching framework for effective clinical supervision to be developed. The framework outlines two core requirements, the positive interpersonal relationship and the functional structure. They cumulatively create the working interface of clinical supervision, the effective supervisory environment, thereby fulfilling the essential foundational requirements for effective supervisory function. The consequence for the supervisee is that they are likely to achieve outcomes which are meaningful to them. This it is suggested will reinforce confidence in the interpersonal relationship and effectiveness of the supervisory structure, thus closing the circle and creating the effective clinical supervision cycle.

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CHAPTER 1

INTRODUCTION

RESEARCHER CONTEXT RELATED TO THE FORMULATION OF THE RESEARCH QUESTION

As a mental health nurse, my introduction to clinical supervision was similar to many of my peers. In my formative nursing years, mental health nursing clinical supervision was at an embryonic stage. Consequently, I knew virtually nothing of it and accorded it no value beyond an uninformed suspicion that as it was new, it was probably not useful. My understanding of mental health nursing came from experience and the experienced; from peers whose ability I judged in my ignorance to be worthy of scrutiny. As I gained experience and presumably attained more knowledge and developed abilities, I perceived that I was becoming a more effective nurse. I also gradually began to understand that my abilities were fundamentally intuitive; that I did not really understand what being a mental health nurse meant in clear definable terms. I had a strong sense at this time that I was undirected; waiting for something to enlighten me and assist me to understand what it was I was actually doing and why I was doing it. At that stage of my development, I did not know that I should or could get guidance on the matter. The solution to my dilemma came with my engagement with clinical supervision in 1996. For the first time in my nursing career, I was able to understand not only 'What it was', but I could begin to conceptualise 'Why it was' and to understand 'What I knew'. More importantly I also came to understand and accept, not necessarily the same thing, 'What I did not know'.

My experiences of clinical supervision have been resoundingly positive since my first contact and consequently my advocacy is assured. On being assigned to a nursing leadership position, I assumed responsibility for running a large (approximately 340 supervisees, 314 being nurses) clinical supervision system. It quickly became clear to me that clinical supervision was not always effective for a proportion of nurses and I soon formulated a complex web of rationale as to why this was. My ideas were rather unsystematically targeted. They ranged from theories around the matching of

participants, the systems in use, participant attitudes and commitment to the supervision models we utilised. The reality was though that I really had very little idea and this became more apparent to me with the passage of time, a case again of realising I did not know what I needed to. As the study progressed, this was reinforced as a number of my dearly held truths regarding clinical supervision were consigned to the scrapheap of uninformed or ill-informed interpretation, in most cases, much to my surprise.

I appreciated that increasing my understanding of why clinical supervision worked effectively and why it did not would have advantages to everyone who participated. Increased knowledge would allow supervision practice development and would provide a pathway to more effective outcomes, an outcome desired by all. It was seen that a better understanding of the determinants of effectiveness could inform supervision orientation and training processes, guide system functions and the targeting of resources and research amongst other things. Consequently, it could serve to more securely embed the programme within identified core nursing professional development processes with the ultimate aim of enhancing the care we as nurses provide.

It was in this context that the research question: “What are the factors that affect the success of a clinical supervision relationship?” was formulated. To take this question forward, it was deemed useful to identify an operational definition of clinical supervision.

CLINICAL SUPERVISION

The meaning of clinical supervision is discussed in detail in the literature review chapter and a number of definitions could be applied to this study. Although the context of the study generally does not demand definitional conformity, Bond and Holland’s (1998) definition, seen to be contextually appropriate, will be used as a basis to conceptualise the core principles adopted:

Clinical supervision is regular, protected time for facilitated, in-depth reflection on clinical practice. It aims to enable the supervisee to

achieve, sustain and creatively develop a high quality of practice through the means of focused support and development. The supervisee reflects on the part she plays as an individual in the complexities of the events and the quality of her practice. This reflection is facilitated by one or more experienced colleagues who have expertise in facilitation and the frequent, on-going sessions are led by the supervisee's agenda. (p. 12).

Clinical supervision by this definition is clearly distinguished from preceptorship, mentorship, supervised practice, peer support and managerial supervision. It is not suggested that the purpose of these other processes will not be met through clinical supervision. In some cases they may be, as functions overlap to some extent. It is the primary functions of supervision that are targeted though. Any other benefits are peripheral to the core purpose(s).

THE USE OF TERMINOLOGY

The term 'clinical supervision' has been utilised in preference to that of 'professional supervision' throughout this study. There is no definitional difference for the purposes of the study, but to use it was a not a straight-forward decision. 'Professional supervision' has been the favoured option in New Zealand over recent years. This is primarily due to it being viewed as descriptively covering a wider spectrum of nursing roles than just the clinical ones suggested in the 'clinical supervision' title (McKenna, Thom, Howard, & Williams, 2008). The current international preference appears to sit with the 'clinical' term. Literature sourced predominantly used the 'clinical supervision' variation and it was thought that its use would generally serve to enhance overall textual continuity. Exceptions were made when literature being examined refers to 'professional supervision' and coherence is enhanced through its use. Additionally, the understanding that has historically been attached to 'clinical supervision' in mental health nursing has not been interpreted as limiting role applicability. As a final point, the study setting uses the 'clinical supervision' version and was almost exclusively used by the participants.

The shortened 'supervision' is regularly substituted for the full title throughout the study text. Again this is alternated with the other terms and is predominantly used to aid sentence structuring. The terms 'clinical supervisor' and 'clinical supervisee' are often substituted by 'supervisor' and 'supervisee'. In the case of the research participants, they are referred to as 'participants', 'nurses', or some overtly related variation. The title 'mental health nurse' is substituted regularly by 'nurse'. Where the term 'psychiatric nurses' is used in the literature, it is also utilised in the text, thus maintaining a link with the source terminology.

When reference is made to this study, it may be referred to as 'the study', 'the research' or an overt variation on either.

THE STUDY CONTEXT

This study was conducted within the Canterbury District Health Board (CDHB) Specialist Mental Health Service (SMHS). The CDHB is the second largest District Health Board in New Zealand, employing across all divisions approximately 9000 people and serving a catchment population of 521,832 people (Statistics New Zealand, 2006). The SMHS provides services to the Canterbury region across the mental health and addictions spectrum as a range of specialist services and to the South Island region in several specialist services. The Service employs approximately 700 nurses. The vast majority fall into the 'Registered Nurse' category. At the time of the study 314 nurses (45%) were actively engaged in a formal clinical supervision relationship. Clinical supervision is recommended to SMHS nurses in line with the *National Guidelines for the Professional Supervision of Mental Health and Addiction Nurses* (Te Pou, 2009), but is not mandatory. The participants were all Registered Nurses with a scope of practice allowing them to work in mental health settings. They worked in a wide range of community and inpatient services and were all employed in clinical roles or nursing leadership positions.

The CDHB SMHS was at the forefront in the development of clinical supervision for mental health nurses in New Zealand. Established and developed by the visionary Mike Consedine in the early 1990's, the 'Role Theory' model of clinical supervision remains the numerically and philosophically dominant model supported by the SMHS.

Heron's 1973 'Six Category Intervention Analysis' approach (Heron, 2001) is the other framework supported. A further contextual point is that the CDHB SMHS employment rate for registered nurses trained in the United Kingdom has increased greatly in recent years. They have risen from 2.4% employed in 2000 to 27.8% in 2009 (Canterbury District Health Board, 2010). This has posed some practical challenges in that an increasing proportion of the supervised nursing workforce has had exposure to supervision models other than those adopted and actively supported by the service.

THESIS STRUCTURE

Chapter 1 explains the background context to the study from the researcher's and organisational perspectives. It broadly states the adopted definition of clinical supervision and outlines the use and interchangeability of key terms.

Chapter 2 describes the literature review process, explains the search strategy and summarises clinical supervision in nursing. Alternative definitional conceptualisations and purposes of clinical supervision are described and the New Zealand context is reviewed. Three methodologically diverse clinical supervision frameworks representing a range of interpretations are described. Literature pertaining to effectiveness is reviewed through examination of evaluative studies and other literature. Finally, literature related to factors influencing effectiveness is scrutinised.

Chapter 3 offers an overview of the research methodology used in the study. It briefly explains qualitative research, its applicability to this study and links it to the mental health nursing context. Qualitative description is described and the analytical framework 'thematic analysis' is defined and its steps described. Ethical considerations are explained, including the approval process, consent, confidentiality and anonymity and a discussion on risk to the participants. The specific design considerations and working strategies of the study are explained in detail. This encompasses preparation for the research process, data collection and data analysis. Finally the system of documentation is described.

Chapter 4 is the first of three findings chapters. The sample group is described and the findings from theme 1, 'Working with Engagement' are recorded. The theme examines the factors that determine the supervisee's potential to engage in and maintain a functional supervisory relationship. This chapter and the following two findings chapters are supported where indicated by the use of direct participant quotes. They are organised into sub-themes, thematic clusters (where applicable) and themes through the use of thematic analysis methodology. Finally, the theme findings are summarised.

Chapter 5 reports the findings related to theme 2, 'Applying Effective Supervision Process'. It investigates the functional requirements of the clinical supervision process through the effective provision of supervisory structure and the application of effective supervisor abilities. The chapter concludes with a summary of theme findings.

Chapter 6 reports the findings in relation to theme 3, 'Achieving Positive Outcomes'. Elements identified as direct developmental benefits resulting from engagement in the clinical supervision process are identified.

Chapter 7 examines the findings in relation to relevant professional literature. It synthesises the themes into core determinants of effectiveness and describes the resultant 'Effective Clinical Supervision Cycle' that emerges from the analysis. Each of the determinants is discussed in relation to the cycle and the whole is tied together in a concluding section.

Finally, implications for clinical practice are formulated from the study and recommendations linking outcomes with clinical supervision practice are developed in relation to both the local and national context. Credibility and confirmability of the study are discussed and strengths and limitations of the research are noted. The chapter concludes with a discussion of the implications of the study for future research.

CHAPTER 2

LITERATURE REVIEW

INTRODUCTION

The literature review has been undertaken to summarise information related to clinical supervision relevant to the study. From the supervisee's perspective, the question being asked in this research is: "What are the factors that affect the success of a clinical supervision relationship?" The review has been structured to establish the context in which mental health nursing clinical supervision lies, both internationally and nationally. It will then explore the understanding of its perceived effectiveness, the determining factors within the supervision relationship and the structural features that result in an effective process. It is the cumulative knowledge of these three streams of enquiry that inform the relevance of the research.

In broad terms, the conceptual origins of clinical supervision in New Zealand originate in the United Kingdom, sharing as they share basic commonalities in core health systems and specifically in this case, in mental health nursing. Many studies focusing on empirical review and analysis originate in the United Kingdom and some in Australia and Scandinavia. Literature from the United States was briefly reviewed, but the understanding of clinical supervision in relation to definition, purpose and structure was quite clearly different. To give the United States literature equal significance, would in many cases render discussion so broad that clarity would be reduced rather than increased.

The literature search has been organised into sections. The first section explains the search strategies utilised and notes their effectiveness. The development of clinical supervision and the broad conceptual roots that have positioned it in contemporary mental health nursing practice is then briefly described. This is followed by an exploration of the literature pertaining to definition and purpose and an overview of the national clinical supervision context. A section outlining a range of broad clinical

supervision framework approaches is followed by a brief overview of three representative models. A review of literature pertaining to the overall effectiveness of supervision is then undertaken; in the first instance through examining evaluative studies and then through other literature. The next section focuses on identifying the factors within the clinical supervision relationship that define the functional potential of the process as a pathway to effectiveness. A concluding section explains the research question and positions the study focus in relation to it.

LITERATURE SEARCHES

Literature searches were undertaken using a number of sources. The University of Otago databases, libraries and services were utilised and interloan services to several other New Zealand university libraries were used where texts were unavailable locally. The Christchurch City Council Library services were used and privately owned texts were sourced.

The Cumulative Index to Nursing and Allied Health Literature (CINAHL) was found to be the most productive database searched, but Medline, Embase, PsychINFO, Proquest, Kiwi Research Information Service (KRIS), The New Zealand Index (Knowledge Basket) and Nursing were also used with some success. Literature overlapped in many databases, particularly CINAHL and Medline. Texts were used where they were regularly referenced, seen to inform discussion and interpretation of supervision knowledge and theory and / or are accepted as seminal works.

As most databases were not nursing specific, they were found to be useful in expanding the scope of searching beyond a core nursing focus. Access to information related to the wider disciplinary features of the clinical supervision process was more easily facilitated when search terms omitted the use of the term *nurse* or some variation of this. Examples of information emerging from this approach included inter-disciplinary supervision arrangements and commonalities between counselling processes and clinical supervision. In addition to nursing, information emanating from clinical psychology, social work, occupational therapy, medical and physiotherapy professions was utilised. Widening the scope also had the effect of eliciting a significant volume of information that was not relevant. Common examples were in the large body of

information pertaining to the complex analysis of advanced supervisor technique, the clinical practice and education supervision of student nurses and information that framed clinical supervision in a therapy context.

Searches were conducted in a set pattern in relation to a number of major databases. Initially the search strategies were broadly focussed. The terms *clinical supervision* and *mental health* and then *clinical supervision* and *nursing* were used. Although relevance was low in percentage terms, the substantial volume of initial information found resulted in a useful volume of relevant data emerging. Combining searches for *clinical supervision*, *mental health* and *psychiatric nursing* were productive. Exploratory searches utilising the term *professional supervision* instead of *clinical supervision* were less productive numerically but qualitatively similar as duplication of results was high. The main difference in results between the two terms was that using *professional supervision* increased access to data which focused on non-nursing specific aspects of clinical supervision. This was therefore found to be useful.

Although result volumes of some searches were high, the initial approach taken was to sort data relevance by viewing every document that appeared to have any potential utility. Whilst not a time-efficient approach, it did result in wide content coverage. An advantage was that the researcher was able to build understanding of the wider issues pertaining to clinical supervision, even in those cases where direct relevance to the focus of this study was somewhat tenuous. At a later point, where a more narrowly focussed information content was sought, additional words and phrases were searched in an attempt to filter result content. These were used in numerous combinations. Examples of filtering included bracketing broad search terms such as *clinical supervision* with words such as *definition*, *effectiveness*, *effects outcomes*, *support*, *studies* and *surveys*. Search phrases were also used. Examples are: *effects of clinical supervision*, *benefits of clinical supervision* and *studies of clinical supervision*. When few term filters were used, result volumes were high, but relevance was low. Adding additional search term filters reduced volumes greatly, but relevance remained at a similar level to broader search strategies. Overall, refining searches resulted in a relatively small volume of useful new data being found, but nonetheless added to the overall body of information.

The New Zealand context for clinical supervision was examined in large databases (CINAHL, Medline, Embase, PsychINFO), but results were sparse and of very limited relevance to the study. The New Zealand Index (Knowledge Basket) returned low result volumes despite a broad search strategy. Relevant data was found to be useful in examining non-nursing related aspects of clinical supervision in New Zealand. Refining searches reduced volumes but did not aid relevance. Using the term *professional supervision* in lieu of *clinical supervision* lowered volumes without conferring any benefits. Searching research streams specifically *mental health nursing research* and *mental health nurse relationship* elicited information that was qualitatively informing.

The Kiwi Research Information Service (KRIS) database was also searched. Utilising broad search terms yielded a low volume of data, though information on the effectiveness of clinical supervision was informative. Other sources emanating from the New Zealand mental health sector added to the information relevant to the New Zealand context. Publications or electronic databases of government departments or non-government health agencies were searched. These provided a small, but valuable body of information, though a moderate proportion was replicated in other search strategies. Examples of the departments or agencies utilised were the 'New Zealand Ministry of Health' (MOH) and 'Te Pou o Te Whakaaro Nui, the National Centre of Mental Health Research, Information and Workforce Development' (Te Pou) and the Nursing Council of New Zealand.

Library catalogues, predominantly the University of Otago were searched and were found to be productive in relation to texts relevant to clinical supervision and also in linking to journals not available on electronic databases. The Otago University library also allowed access to studies completed for academic qualifications, though this avenue was not particularly productive in relation to relevancy.

CLINICAL SUPERVISION IN NURSING

Clinical supervision has developed through multiple pathways across the health sector. Due to differences in understanding as to what it constitutes, its developmental pathways are complex. It is clear though that it developed in a number of health

professions over an extended period. It is seen to have originated in psychoanalysis (Jubb Shanley & Stevenson, 2006). Psychotherapists were formally required to receive clinical supervision as early as 1925, though the practice had been embedded for some time before this (Mattoon, 1995). Social work supervision in various forms has a history dating back to the 19th century (Kadushin & Harkness, 2002). In the nursing profession, contemporarily recognisable aspects of clinical supervision have been commonly practiced by the nursing profession since the days of Florence Nightingale (Winstanley & White, 2003). Yegdich (1999a) cites literature related to nursing clinical supervision commencing from the 1920's.

Clinical supervision was well embedded in psychotherapy, psychology and social work professions before beginning to enter the common consciousness of nursing in the late 1970's (Mullarkey, Keeley & Playle, 2001; Winstanley & White, 2003). The contemporary development in nursing was led predominantly from the United Kingdom (Kelly, Long & McKenna, 2001a). It also gained an early foothold in Finland where it expanded to cover all professions in the 1980's (Paunonen & Hyrkas, 2001). Nursing gradually embraced the concept through the 1980's, which led to a higher profile within nursing literature and greater adoption in the mid 1990's (Davey, Desousa, Robinson & Murrells, 2006; Sloan, 2006). In the United Kingdom, the exploration of clinical supervision was forcefully encouraged in a government report in 1993 (Department of Health, 1993). Its value was further endorsed in a position document from the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (now the Nursing and Midwifery Council) in 1996 (United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 1996). The formal position taken has been mirrored in development of national policy in the United Kingdom, Australia, New Zealand, Sweden and Scotland (Hines-Martin & Robinson, 2006). Since this time, it has gathered impetus so that it is now viewed by some as an absolute necessity in nursing practice (Bishop, 2007; Driscoll & O'Sullivan, 2007).

THE DEFINITION AND PURPOSE OF CLINICAL SUPERVISION

In attempting to define clinical supervision, it is difficult to separate definition from purpose; they are symbiotic as defining will inevitably describe purpose to some extent as well. Clinical supervision is widely interpreted and diversely practiced. It

may be conducted in a one to one relationship or in small groups, can be confined to same discipline or can be inter-disciplinary. It may be conducted internally with a peer or externally. It can, depending on the model and application, cover a range of purposes, from educative to therapeutic and personal support or even to support performance monitoring systems. Sometimes the process of supervision is so minimally defined that to attempt to do so would not be possible. In contrast, in other cases it may be tightly defined and structured. The modus of control within the supervisory relationship varies from predominant supervisor control to primary supervisee responsibility. In some models, control is inflexibly applied. In others it is subject to the judgment of the supervisee and / or supervisor and may change depending on circumstances arising.

It is no surprise then that clinical supervision is a process that does not attract a single categorical definition. It has been commented that it is defined differently by every commentator (Bond & Holland, 1998), "...lacks internal consistency" (Cutcliffe, 2005, p. 471), that no model is dominant (Yegdich & Cushing, 1998) and that numbers of definitions are infinite (Nichols, 2004). While this last observation is obviously overstated to stress a point, it serves to reflect the broad range of interpretations clinical supervision is subject to. Todd and Freshwater (1999) warn that such is the expected scope and efficacy of supervision that it is in danger of being unrealistically viewed as a cure-all for nursing practice. Adding to an already complex situation, Wilkin (2009) believes that the ongoing development of clinical supervision leads to some authors regularly changing their definitions of the process. Referring to clinical supervisions' philosophical underpinnings and methodological application, Jones (2001) says that there is no consensus on how supervision is carried out. He adds though, that he does not believe this is undesirable because the adoption of different approaches to supervision allows the use of a range of ideas in a range of ways and in this, it reflects diversities in nursing practice. The view that clinical supervision should embrace different approaches is also strongly advocated by others (Cleary & Freeman, 2006; Cutcliffe, 2005; Freshwater, Walsh & Esterhuizen, 2007; Mullarkey et al., 2001). The acceptance that clinical supervision theory and methods of application are diverse is strongly evidenced throughout the literature. At times this is through direct reference to the structures of the models utilised and at others by analysis of the

processes used within the act of supervision itself. This definitional diversity suggests that attempting to define precisely what clinical supervision is will obscure as much as illuminate.

The definitional variations suggest that supervision's intended purposes will also be broad. Driscoll and O'Sullivan (2007) attempted to synthesise common themes. They suggest the purposes are: to ensure standards of care are maintained, to evidence a commitment to learning, to recognise professional responsibilities and accountabilities and to contribute to care delivery through reflection on practice, to develop professional knowledge and skill, to contribute to professional development and to support the practitioner to make personal change and thus enhance practice. Bishop (2007) suggested purposes as; emotional support, a buffer mechanism, an opportunity to receive critique, a means of professional development, time to reflect and develop trust. A further variation is suggested by Morton-Cooper and Palmer (2003) who suggest that clinical supervision is about valuing oneself in the workplace, coping with increased demands and providing dedicated time to think about and analyse one's actions so a good standard of care can be provided.

The purpose of clinical supervision most widely accepted as its principle aim is to enable an improvement in clinical care (Bishop, 2007; Bond & Holland, 1998; Cleary & Freeman, 2006; Cutcliffe, Butterworth & Proctor, 2001; Driscoll & O'Sullivan, 2007; van Ooijen, 2003; Yegdich, 2001). When amalgamated as a group of functions, they are congruent with this purpose. Whilst it is important not to oversimplify clinical supervision purpose, the principle of improving the provision of clinical care is important if supervision is to be embraced and the other benefits it is perceived to provide are to be experienced (Kelly et al., 2001a).

Early and in some cases enduring, conceptualisations of clinical supervision were based around psycho-dynamic origins. Working intensively within a personalised relationship enabled the supervisee to manage intra and interpersonal phenomena emerging in them in the context of a therapeutic relationship (Winstanley & White, 2003). In clinical supervision, this was understood to be based on the supervisee developing an understanding of the hitherto unconscious processes that drive responses. The knowledge gained was translated to advance their personal

understanding and therefore their effectiveness in their therapeutic roles (Hines-Martin & Robinson, 2006; Jubb Shanley & Stevenson, 2006; Tsui, 2007). The main aim of the supervisor was to assist the supervisee to work through psychological phenomena they experienced that impacted on the quality of the therapeutic relationship (Winstanley & White, 2003).

Emerging from this approach is the linking of clinical supervision with supervisee personal and professional growth. This view has strong and influential proponents (Butterworth, Faugier & Burnard, 1998) and has led to the development of a number of important clinical supervision models such as those developed by Proctor and Fowler (Kelly et al, 2001a). The linking of personal and professional growth has its critics, primarily Yegdich (1999b), who believes that combining these aspects of clinical supervision leads to "...disenchantment with both" (p. 1273) because each has divergent and incompatible aims.

Notwithstanding this view, frameworks which aim to support both personal and professional growth, by having to encompass a wider functional focus have resulted in eclectic methodological approaches. These have allowed supervisory intent to be broadened and have therefore encouraged "...educational and evaluative elements of the Supervisory (sic) situation" (Winstanley & White, 2003, p. 9) to be incorporated. Reflecting on his personal experience of a flexibly structured process, Sloan (2006) noted that encompassing broad approaches ranging from the didactic to the cognitive had enabled him to effectively process emotions emerging from his clinical work.

The view that clinical supervision is a functional pathway to professional development is commonly held (Bond & Holland, 1998; Driscoll & O'Sullivan, 2007; Sloan, 2006; van Ooijen, 2003). It is seen by Wilkin (2009) as one of the two primary supervision tasks and its importance is widely espoused across health disciplines (Clouder & Sellars, 2004; Herkt, 2005; Stoltenberg, 2005). The role of reflection and analysis as a direct conduit to professional awareness and a link to professional development has been stressed in the development of supervision (Bond & Holland, 1998). Critical reflection in the clinical supervision context is credited by Gilbert (2001), as enabling the supervisee to develop "...an unsoiled understanding of the complexity and uniqueness of their nursing actions" (p. 200). In general, the development of skills and

knowledge through reflective processes is a common theme in clinical supervision (Davey et al., 2006; Bond & Holland, 1998).

A further development of this school of thought stresses the welfare of the clinician or supervisee by prioritising their wellbeing and supporting them within the supervisory relationship (Bishop, 2007; Cleary & Freeman, 2006; Davey et al., 2006; Grant & Townend, 2007; MacCulloch, 2009). Supervision is seen to be supportive and respectful of the supervisee because the employer is prepared to invest in them and thus it is assumed, they are valued (van Ooijen, 2003). In the context of mental health nursing, support to attend supervision is seen as a pathway to help nurses who are stressed and distressed due to the nature of their work (Nichols, 2007).

The previously noted developments in clinical supervision leave open the potential for a focus that includes the organisation's needs. They are distinguished though, from approaches that hold central the organisations monitoring, core quality assurance and organisational risk management targets. Health organisations are required to meet demands related to standards of care, policies and related guidelines and the clinical supervision process is often seen to aid various organisational goals (Bond & Holland, 1998). Examples of these are: the pursuit of organisational change, policy directives, accountability issues and the meeting of standards (Bond & Holland, 1998). The role that clinical supervision plays in meeting these demands is a point of contention for many though. Its use as a component of a quality assurance process through line management conducted supervision has been criticised (Bond & Holland, 1998; Consedine, 2000; Kelly et al., 2001a; Yegdich, 1999a). In these circumstances, clinical supervision is seen to have moved away from its previously assumed primary interest in enhancing practitioner ability in the delivery of care, to an approach that stresses managerial oversight, control and management of risk (Cottrell, 2002; Grant & Townend, 2007; Jubb Shanley & Stevenson, 2006; Winstanley & White, 2003). Line management supervision is perceived by some as a performance monitoring tool to assess coping skills and as a means to impart disciplinary processes (Bishop, 2007; Davey et al., 2006). Line management delivered supervision is thought by some as being unable to satisfactorily address developmental functions (Consedine, 2000) and to lead to restrictive practice, confusion and mistrust (Bond & Holland, 1998). Some interpret managerial supervision as a form of management surveillance (Driscoll &

O'Sullivan, 2007; Gilbert, 2001) and a strategy to manage risk and achieve corporate strategies (Driscoll & O'Sullivan, 2007). According to Kelly, Long and McKenna (2001b), the result can be: "...confusion and uncertainty regarding the value of supervision" (p. 43). Noting these conflicts, they suggest that managerial supervision and clinical supervision should be kept separate, but equally, should serve a complementary purpose (Kelly et al., 2001a).

CLINICAL SUPERVISION IN NEW ZEALAND

Clinical supervision is now considered an important part of mental health nursing practice in New Zealand (Ministry of Health, 2006). The volume of literature specific to the national context is not high, but a body of relevant work is available.

Over the last three years, the national workforce training organisation 'Te Pou o Te Whakaaro Nui, the National Centre of Mental Health Research' (Te Pou) has published two documents that are significant in the national context. The first, a review titled: *Professional Supervision for Mental Health and Addiction Nurses* (McKenna et al., 2008), is a comprehensive multi faceted review and analysis of clinical supervision in New Zealand. The general aim of the review was to assess support for a national approach to supervision training. The focus of the document is very wide. Consequently it is able to provide an extensive overview of the national situation in relation to nursing in the mental health and addiction sectors; information that was not accurately known previously. Information is compiled from international and national literature and from the analysis of data emerging from a nationwide survey of both provider arm and non-governmental organisations within the mental health and addiction sectors. Included are sections on supervision models, effectiveness (from multiple perspectives) and extensive information on utilisation, supervisee /supervisor professional profiles and demographics, issues in supervision and training. The complexity of the document reflects the broad interpretive frameworks and diverse application in New Zealand. It concludes that nationally, 75% of mental health and addiction nurses receive clinical supervision in some form and that a wide range of models and amalgams of models are used. The quoted percentage is qualified in the report by noting that databases and organisational processes are not particularly efficient. As a consequence, there may be cause to doubt its accuracy.

Also discussed is an emerging recognition of the requirements of the Māori mental health nursing workforce and the need to amalgamate cultural and clinical supervision into a coherent framework. All data is considered in the formulation of six recommendations. The broad aim is to develop nationally endorsed supervision governance and training structures.

The second document from Te Pou is the *'National Guidelines for the Professional Supervision of Mental Health and Addiction Nurses'* (Te Pou, 2009). It was developed in response to a recommendation in the *'Professional Supervision for Mental Health and Addiction Nurses'* review (McKenna et al., 2008) noted previously. The document fills a significant gap in the provision of a governance and implementation framework for nurses in the mental health and addiction sector. It discusses 'professional' supervision, provides a description and definition and discusses the influences of contextual factors. Implementation guidelines are outlined and roles and responsibilities of all involved from the organisation to the supervisee are explained. Finally, organisational implementation guidelines are outlined. Of particular note is the promotion of an overarching supervisory framework of administrative, educative and supportive functions as outlined by Kadushin (Kadushin & Harkness, 2002). These are congruent with the three functions defined in Proctor's Supervision Alliance Model, namely the normative, formative, and restorative as described elsewhere in this literature review (Proctor, 2001). The guidelines however do not recommend adoption of any particular model, merely that the functions noted are covered. Also of note is the significance assigned to cultural (in the wider sense) aspects of the supervisory process, but emphasising bi-cultural factors and the requirement for supervision to meet identified needs, both personal and legislative.

The *'National Guidelines for the Professional Supervision of Mental Health and Addiction Nurses'* document was augmented recently by three guideline documents from Te Pou. These are the *Professional supervision guide for nursing leaders and managers* (Te Pou, 2011a), *Professional supervision guide for nursing supervisees* (Te Pou, 2011b), *Professional supervision guide for nursing supervisors* (Te Pou, 2011c). As the titles suggest, these are resource documents that provide each of the targeted groups with a brief description and guide to involvement in the 'professional supervision' process.

New Zealand nursing professional and statutory bodies strongly support the provision of clinical supervision for nurses (Te Pou, 2009). The Ministry of Health released a discussion framework in 2006 that unequivocally supported its use (Ministry of Health, 2006). The New Zealand Nurse's Organisation, the dominant national nursing professional body released a position statement in 2005 with the same intent (New Zealand Nurse's Organisation, 2005). Their position was that "...professional and clinical supervision is essential for all nurses and midwives." (p. 2). The Nursing Council of New Zealand in its *Competencies for the Registered Nurse scope of practice* document (Nursing Council of New Zealand, 2007) supports supervision and the New Zealand College of Mental Health Nurses (NZCMHN) mirrors this position (Te Ao Maramatanga New Zealand College of Mental Health Nurses, 2004).

The *National Mental Health Sector Standards* (Standards New Zealand, 2009) specifies that clinical supervision should be available to clinical staff in the sector. This standard emphasises the integration of clinical supervision into mainstream thinking in relation to quality assurance processes generally and its contribution to the quality of direct nursing care delivery specifically. The *Health Practitioners Competence Assurance Act* (2003) also supports provision of supervision (Te Pou, 2009; Simmons Carlsson, Coups, Mueller, Neads & Thornley, 2007). Also significant is the link with supervision practices of the "*Let's get real*" mental health and addiction workforce development framework (Ministry of Health, 2008).

A further point of interest in New Zealand is supervisory purpose in relation to cultural aspects of supervision practice. Clinical supervision is seen as an effective way to develop cultural competence (Te Pou, 2009), but integrating clinical and cultural skills is difficult to achieve as the challenges "...are intertwined" (McKenna et al., 2008, p. 9). Te Rau Matatini, the Māori Mental Health workforce development agency, directly supports the provision of both clinical supervision and cultural supervision (Maxwell-Crawford, 2004). Eruera (2007) notes though that developments in western clinical supervision models are not well suited to the self determination and development needs of "...tangata whenua practice..." (p. 142), but observes that there is a paucity of relevant literature. She describes Kaupapa Māori supervision in the context of a "Māori worldview" (p. 144), conducted by Māori and focussing on practice standards, cultural development and support processes. According to Eruera, it is distinguished

from cultural supervision which does not position Māori as unique within the obligations of the *Treaty of Waitangi [Te Tiriti o Waitangi]* (1975), New Zealand's founding document.

Eruera's work was published in text edited by Wepa (2007) which explored clinical supervision in New Zealand from a broad professional base, wide practice setting and multi issue perspective. In attempting to cover this range, it explored the development and history of supervision, its process and implementation in diverse settings and disciplines and cultural interpretations and variations. The text is useful in bringing together a general overview of the wider clinical supervision context in New Zealand. While a text of this type will inevitably be limited in detail due to its wide scope, it has genuine value in attempting to understand the clinical supervision environment and support its development.

MODELS AND APPROACHES TO CLINICAL SUPERVISION

The literature pertaining to models of clinical supervision is broad, representing the wide range of frameworks and diverse applications. Attempting to summarise them fully is a task well beyond the scope of this project, therefore a decision has been made to briefly discuss three approaches that have been adopted internationally and nationally. They are seen to be representative of common approaches for conducting clinical supervision and two are utilised in the area where the study was conducted. Conceptualising the rationale for the development and utilisation of clinical supervision models, Sloan and Watson (2002) call a supervision model: "...a conceptual framework that can assist in the delivery of clinical supervision. Such a framework can highlight significant stages of the supervisory process, important functions of supervision, roles for clinical supervisor and supervisee and suggestions on where to focus attention" (p. 41). From this description, it can be concluded that a clinical supervision model is an organised process that governs or guides interactive approaches in order to meet general goals. Jubb Shanley and Stevenson (2006) describe three distinct core approaches to clinical supervision, humanistic, psychoanalytical and behavioural. Conceptually, the humanistic is seen to focus on the feelings, the psychoanalytical on interpreting and analysing the relationship and the behavioural has a focus on the content of relationships.

The three approaches to supervision selected, Proctor's 1986 Supervision Alliance Model, Heron's 1973 Six Category Intervention Analysis approach and Consedine's c1985 Role Theory model each represent a different approach to clinical supervision. According to McKenna et al. (2008), they respectively emphasise purpose, technique and a psychotherapeutic approach. A specific approach may be preferred for numerous reasons. For example, its perceived effectiveness in meeting organisational aims, its match to available resources such as financial, people and training resources, supervisor preference and customary practice to name a few. A clinical supervision model or approach is likely to be delivered with wide technical variations. Generally they are not designed to be prescriptive, but to provide a process to guide rather than dictate practice (Mullarkey et al., 2001).

Proctor's Supervision Alliance Model

Proctor's model, developed in 1986, is the most common model of clinical supervision used in the United Kingdom (Bishop, 2007; Bowles & Young, 1999). It is considered an effective method for a range of nursing applications, including mental health settings (Sloan & Watson, 2002). The model was developed from Kadushin's 1976 framework (Kadushin & Harkness, 2002) for social work supervision. Proctor defines three groupings of tasks and responsibilities; normative, formative and restorative (Proctor, 2001). These broad functional descriptors, categorising the purpose of the supervision focus (McKenna et al., 2008) are used to manage, interpret and guide the clinical supervision process.

Normative components deal with management issues and professional standards (Bond & Holland, 1998; Sloan & Watson, 2002). They are described by Winstanley and White (2003) as: "Promoting and complying with policies and procedures, developing standards and complying with clinical audit" (p. 13). Formative components address educational components, developing professional skills and focusing on increasing nursing knowledge standards (Bond & Holland, 1998; Sloan & Watson, 2002; Winstanley & White, 2003). Restorative components have the function of contributing to the management of supervisee stress (Bond & Holland, 1998; Sloan

& Watson, 2002) and increasing understanding of job related stress and the ability to manage it (Winstanley and White, 2003).

Heron's Six Category Intervention Analysis Approach

Heron, a psychologist working in the United States developed the Six Category Intervention Analysis approach as a conceptual framework for understanding human relationships and to aid the delivery of interventions (Driscoll & O'Sullivan, 2007). Due to its: "...comprehensive repertoire of interventions....it can be adapted and applied to a broad range of occupational groups" (Heron, 2001, p. ix). It has been utilised clinically as an interactional framework in the United Kingdom since 1975 (Driscoll & O'Sullivan, 2007) and as a theoretical framework for research (Sloan & Watson, 2002). When used as a framework for clinical supervision, the focus remains on developing supervisee understanding of the therapeutic relationship (Heron, 2001). The 'six category framework' reference relates to the approach the supervisor takes to therapeutically engage with the supervisee. The categories are: *prescriptive*, *informative*, *confronting*, *cathartic*, *catalytic* and *supportive*. These categories are grouped into two broad approaches, *authoritative* and *facilitative*. The two clusters have fundamental distinguishing characteristics. The authoritative mode (applied to the first three categories listed above) allows the supervisor to hold the modus of control over the interaction. The facilitative mode encourages the supervisee to direct proceedings. Which approach is taken by the supervisor is decided by the judgment they form of the nature of the issue(s) at hand and their perception of supervisor ability and need (McKenna et al., 2008; Sloan & Watson, 2002).

Consedine's Role Theory Model

Consedine developed the role theory model in New Zealand during the mid 1980's. It can be broadly categorised as a psychotherapeutic approach (McKenna et al., 2008). Consedine's model has its foundations in the work of Moreno (Consedine, 1994). Moreno (1953) was an important figure in psychotherapy for almost fifty years from the 1920's. He founded the psychodrama movement and was influential in the development of group therapy. He explored the components of roles and the

influences they had on an individual's relationship with their world. His enduring theories on interpersonal relationships are still respected (Hare & Hare, 1996).

The focus of the role theory model is developmental, specifically the development of effectiveness within the therapeutic relationship through developing awareness of learned roles, conscious and sub-conscious. Roles, defined as the way a person interacts with the world around them through their thinking, feeling and acting are seen to determine the behaviour and responses of the clinician within the therapeutic relationship (Consedine, 1994). The knowledge gained, personal and professional, is then able to be applied in effective interventions within the therapeutic relationship. It is facilitated by using the functional relationship as a pathway to progress and to enable more creative and effective approaches to practice (Consedine, 1998). The developmental function of the clinician is held in this model to be the core purpose of clinical supervision. It is clearly delineated from the accountability function, which is seen as a line management responsibility. Consedine believed that the maintenance of standards was a line management function and that professional development, particularly the development of the nurse as a therapeutic agent was a clinical supervision function (Consedine, 2000).

THE EFFECTIVENESS OF CLINICAL SUPERVISION

Introduction

A body of literature on the effectiveness of clinical supervision in mental health nursing has been built up since the early 1990's. As the contextual elements encapsulating clinical supervision are complex and widely defined, its effectiveness may be judged from a number of perspectives, sometimes with significantly different primary goals. Outcomes therefore are also likely to be widely interpreted and weighted. This is not surprising as nurses themselves do not agree on the purpose of clinical supervision (Jones, 2006) and some believe that little is known on how it should be conducted (Hyrkas, Koivula & Paunonen, 1999). An additional impediment to the accumulation of data is that most of the studies are conducted using qualitative methods and use small samples (Hines-Martin & Robinson, 2006; Winstanley & White, 2003). There is widespread agreement that more research is required (Brunero

& Stein-Parbury, 2008; Buus & Gonge, 2009; Hines-Martin & Robinson, 2006; Kelly et al., 2001a; Veeramah, 2002). A belief is also represented that research methodology is often flawed and inconsistent (Buus & Gonge, 2009; Hyrkas et al., 1999; Milne & James, 2002; Winstanley & White, 2003). This view has not been seriously challenged in relation to clinical supervision. However a literature review of empirical studies in psychiatric nursing supervision conducted by Buus and Gonge (2009) concluded that a significant consensus in relation to the general effectiveness of clinical supervision was evident. While they also identified major methodological variations as a significant impediment to meaningful comparisons between studies, the collective and cumulative message was nonetheless clear.

The issue of measuring effectiveness is a major challenge for clinical supervision research (Milne & James, 2002; Veeramah, 2002; White & Roche, 2006). The use of measurable research tools in studies assessing the effectiveness of clinical supervision has been rigorously promoted (Butterworth, Carson, White, Jeacock, Clements & Bishop, 1997; Carson, 2007; Winstanley & White, 2003). Experience gained through the '*It is good to talk*' study (Butterworth et al., 1997) [see: The Effects of Clinical Supervision – Evaluative Studies] and via a process of follow-up interviews (Carson, 2007; White, Butterworth, Bishop, Carson, Jeacock & Clements, 1998), led to the development of the Manchester Clinical Supervision Scale (MSCC) (Carson, 2007; Winstanley, 2000; Winstanley & White, 2003). The MSCC was the first internationally validated tool to measure effectiveness of clinical supervision from a supervisee's perspective. The three functions (normative, formative and restorative) defined in Proctor's Supervision Alliance Model are used as a functional base. Five instruments thought to be compatible with these functions are used (Bishop, 2007); the '*Minnesota Job Satisfaction Scale*' (Weiss, 1967), the '*Maslach Burnout Inventory*' (Maslach & Jackson, 1986), the '*General Health Questionnaire*' (Goldberg & Williams, 1988), the '*Nurse Stress Index*' (Harris, 1989) and the '*Cooper Coping Skills Questionnaire*' (Cooper, Sloan & Williams, 1988).

The scale outlines seven separate components that cumulatively define the overall effectiveness of an individual's supervision (from the supervisee's perspective). Each of these seven components is broken down into between three and seven descriptive measures (totalling 36). Each clusters is analysed, the emergent information compiled

and a score allocated, resulting in an understanding of the effectiveness of each component. The results from all seven components are combined for a total score, this being the overall measure of effectiveness (Winstanley, 2000; Winstanley & White, 2003). A strength of the MCSS is that it explores all three functions defined by Proctor's model, thus addressing perceived shortcomings of previous studies (Bishop, 2007).

Of the three following sections, the first two identify literature that has a primary focus on the effectiveness or benefits of clinical supervision. Some of this literature also discusses factors influencing effectiveness within the supervision process and these are also noted. An overlap was not uncommon, as the exploration of effectiveness often elicits enquiry into the factors which determine it. The third section: 'Factors Related to Effectiveness', views literature that has a more direct focus on determinants of effectiveness.

The Effects of Clinical Supervision – Evaluative Studies

The '*It is good to talk*' evaluative study (Butterworth et al., 1997) was conducted in England and Scotland through the University of Manchester in 1995-7. It evaluated the development of clinical supervision and mentorship, the content, impact on participants and development opportunities afforded (Butterworth et al., 1997; Carson, 2007). The study involved 23 sites and 586 participants. It found that supervision should have a strategic resourcing plan, and had a clear correlation with good quality practice. It protected and supported staff and had utility in organisational human resource terms through advantageous effects on recruitment, retention and professional development. It also found that specialised training for supervisors was indicated and resources needed to be allocated for the conducting of the supervision process itself (Butterworth et al., 1997). A lack of an effective scale for assessing the effectiveness of supervision was an identified gap (Carson, 2007). Some components of supervisory structure were seen to be informative, particularly relationship factors, the creation of a positive supervisory environment, boundary issues and confidentiality. The link made between supervisor skill and training was clearly explained and was thought to reinforce, albeit indirectly, the importance of supervision process delivery.

Kelly et al. (2001b) conducted a survey of community mental health nurses in Northern Ireland. This study had a primary goal of assessing demographic details pertaining to the provision of clinical supervision in this cohort. It was found that clinical supervision had broad acceptance for those surveyed. It was perceived to significantly improve standards of care, support personal and professional development and the acquisition of skills and knowledge, to provide personal support, reduce isolation and increase confidence. There was a strong resistance to clinical supervision being provided by managers. This translated clearly into the view that the Line Manager role was not “...concerned with supervising work” (p. 39). Support for supervision training and a desire for supervision sessions to be clearly structured was also strongly evident.

A survey of clinical supervision was conducted by Veeramah (2002) among community mental health nurses in the United Kingdom. Demographic data was recorded and the perceived benefits reported by nurses were also surveyed. It was found that clinical supervision had significant benefits in assisting and directing reflection around the delivery of care by guiding ethical considerations and providing a supportive milieu for the nurse.

Improvements in the delivery of care were also found by Bradshaw, Butterworth and Mairs (2007) when they investigated the effects that clinical supervision had on nurses during psycho-social intervention education programmes. They found that knowledge was enhanced, practice supported and therapeutic ability enhanced through concurrent clinical supervision. Factors within the supervisory process that contributed to the accrued benefits were not discussed in informative detail.

The influence of clinical supervision on burnout in a group of community mental health nurses was the focus of a study in Wales by Edwards et al. (2006). The study aimed to measure the effects of supervision on burnout and correlate them to both the provision of supervision and in those cases, where it was provided, to its effectiveness. The MCSS (Winstanley, 2000) was used to gauge effectiveness from the supervisee’s perspective. Emerging data was correlated with survey results relating to burnout. Outcomes found that burnout was significantly lower for the nurses who perceived that their clinical supervision was effective. Some factors contributing to effectiveness

in the supervision process were discussed. These were related to length and frequency of supervision sessions, the venue, choice of supervisor and professional relationships with the supervisor. The impact of trust and respect within the relationship was considered along with the impact on the quality of the personal relationship and the sense of participant safety attained. These points of discussion were all seen to be informative.

Hyrkas (2005) conducted a study with Finnish mental health nurses focussing on job satisfaction and burnout. She found that nurse's perceptions of supervision effectiveness improved when they had been engaged for some time, when it was more frequent (even if it was shorter in duration). Effectiveness was also increased when those supervised were themselves supervisors. Hyrkas also noted the need to invest resources and a positive correlation between clinical supervision and the reduction in burnout and increased job satisfaction. The study had a main focus on affirming benefits of the clinical supervision process, but it did not examine in any depth the means by which these were achieved.

Increasing access to supervision, defining what it was, understanding the effects on the quality of care and the ability to evaluate it were the aims of a study with mental health nurses conducted in Northern Ireland by Rice, Cullen, McKenna, Kelly, Keeney and Richey (2007). Recommendations for implementation thought to meet clinical governance agendas including improvements in clinical care delivery were developed. Benefits emerging from engagement in clinical supervision were found. These were related to self-esteem, confidence and competence, safety, job satisfaction, professional development and promotion of a reflective culture. The factors which determined these benefits were not discussed in informative detail.

A study which elicited perceptions of clinical supervision by a cohort of nurses of which one group was mental health nurses was undertaken by Davey et al. (2006). The mental health nurses reported a significantly positive perception of their clinical supervision. The study utilised Proctor's Supervision Alliance Model (Proctor, 2001) as a structural framework and reported significantly positive outcomes in all but one of the 12 categories examined within the three functions, normative, formative and restorative. Met and unmet needs were explored within the clinical supervision process

and enabled a broad understanding of their supervision context to be interpreted. This was informative, though exploration of factors contributing the meeting of needs was not a study focus.

Using Proctor's Supervision Alliance Model (Proctor, 2001) as an evaluative framework, a study of nurses by Bowles and Young (1999) focussed on accessing and comparing the benefits of clinical supervision across the three functions, normative, formative and restorative. It was found that the level of benefit across all three functions were substantially similar. A strong statistical correlation between clinical supervision and reported benefits was reported. The relatively narrow focus on the benefits accrued from clinical supervision was a limitation of the study.

Berggren and Severinsson (2000) conducted a study of registered nurses in Sweden that explored the link between clinical supervision and decision making. The four themes that emerged were that the nurses became more self-assured, increased their ability to form a relationship and support the patient and became more adept at assuming responsibility. Again benefits were noted but determinants of effectiveness within the supervision relationship were not scrutinised.

The effects of clinical supervision on the perception of support that nurses experienced was a focus of a Norwegian study undertaken by Begat, Ellefsen and Severinsson (2005). It found that supervision had a positive impact through a reduction in physical symptoms and anxiety and a reduced sense of not being in control. A link between enhanced clinical ability and clinical supervision was found, but supervision process effectiveness determinants were not discussed.

Cooper and Anglem (2003) undertook a broad descriptive study of clinical supervision for the Specialist Mental Health Service of the Canterbury District Health Board and several non-government organisations that fell under their funding umbrella. The study used Proctor's Supervision Alliance Model as an evaluation framework (Proctor, 2001). It covered all numerically significant health professions including mental health nurses who made up a distinct majority of those surveyed. The report collated a wide range of quantitative and demographic data and described the range of clinical supervision conducted within this group. It also collated feedback on supervisee

perceptions of the effectiveness of the supervision process and identified factors such as 'good' qualities of the supervisor. The report also noted that organisational risk management processes were perceived to be met through the provision of clinical supervision. Overall, this report has marginal utility as its assumptions about the nature and purpose of clinical supervision are conceptually strongly aligned with organisational governance processes. Whilst personal benefits to practitioners are reported, the study by its nature, does not add new evidence to the area.

Research was conducted in New Zealand by Mernick (2009) that focussed on the impact of clinical supervision on the therapeutic relationships mental health nurses had with consumers. Mernick's research was seen to have points of interest, principally in the broad conceptualisation of effective supervision structure and exploration of some supervisee and supervisor qualities and abilities within the supervisory relationship.

A widely scoped study of supervision of occupational therapists in New Zealand was undertaken by Herkt (2005). She explored the nature and purpose of the supervisory process, why it was needed, whether it was perceived to be valuable and if it actually was in practice. The supervision context described is specific to this professional group and some differing points of emphasis are apparent in comparison to nursing supervision. Despite this, some areas of scrutiny were relevant to the exploration of effectiveness in the wider supervisory context. Examples are the nature and effects of power and its effects on open communication, the preparation for supervision and the place of challenge and trust. Of significance is the discussion on the importance of the supervision relationship and structure.

Sutcliffe (2007) conducted a study that attempted to understand the meaning of supervision for mental health support workers. Whilst not working with the mental health nursing workforce, some relevance is identified in the exploration of supervisory meaning. Sutcliffe discusses the broad purposes of supervision (learning, accountability and safety) and defines very broad factors that influence effectiveness.

Murray (2006) explored the nature of supervisory issues in a descriptive quantitative study involving mental health nurses. The study rated supervisor issues emerging from critical experiences within supervision relationships against predicted prevalence from

three broadly related studies. A number of issues discussed were related to effectiveness, but methodological differences inhibit relevance. Of interest was the frequency of emerging 'issues' and the finding that distinct approaches to supervision provision resulted in distinct supervisory purpose being realised.

The Effects of Clinical Supervision – Small Studies, Commentaries and Opinion Pieces

The practice of clinical supervision is widely supported in literature outside evaluation studies. The limitations of this literature are obvious, but it is worthy of some scrutiny as it often collates, summarises and analyses information from a wide range of sources. It may also offer a perspective not covered in research and as such, has generalised utility. A clear consensus that clinical supervision is effective exists in this literature.

Notwithstanding methodological shortcomings and inconsistent approaches (Buus & Gonge, 2009; Winstanley & White, 2003), this view is consistently held. It is also reinforced by the absence of evidence concluding that supervision does not have a positive impact or that it has a negative effect. Studies or commentaries that have a negative view of supervision almost exclusively focus on the power, role, responsibility and trust confusion apparent in supervision provided via a line manager (Gilbert, 2001; Grant & Townend, 2007; Johns, 2001; Jones, 2006; Veeramah, 2002).

Clinical supervision is perceived by MacCulloch (2009) to have a direct correlation to improving quality of care and supporting the practitioner. He sees supervision as a conduit to personal growth, heightened self-awareness and integrating meaning and purpose. Kavanagh, Spence, Wilson and Crow (2002), while sceptical about the rigour of many studies, note that supervision "...does aid the acquisition of complex clinical skills" (p. 248). Their view is qualified when they note that it is crucial to the effectiveness of the supervision relationship that it is delivered via a functional supervisory structure. They also note increases in job satisfaction and morale as an outcome of effective supervision. Johns (2003) discusses the role that clinical supervision plays as a pathway to the development of clinical leadership. This could be seen as a parallel to skill attainment in other areas as discussed by Kavanagh et al. (2002).

Peternelj-Taylor and Yonge (2003) conducted a literature review and utilised experience gained from teaching psychiatric nurses in order to explore subjects related to building potential within the therapeutic relationship. Findings include a focus on the contribution clinical supervision makes to understanding the dynamics involved in boundary setting and enhancing this aspect of clinical practice.

Supervision in a multi-disciplinary context has been a point of interest in the clinical supervision literature. Mullarkey et al. (2001) advocate that supervision from outside the profession is desirable for mental health nurses. They believe it challenges barriers between professions and increases understanding of non-nursing skills and knowledge. The benefits are also noted by Cutcliffe and Lowe (2005) who conclude that the ability to supervise effectively is more important than being expert in a nursing specialty. Van Ooijen (2003) sees the benefits accrued by a multi-disciplinary approach to supervision training are similarly valuable. The positive views held by some on multi-disciplinary supervision contribute to an understanding of the range of potential effects it has on perceived effectiveness within the supervisory relationship.

Factors Related to Effectiveness

Literature that primarily examines and identifies factors related to effectiveness in the supervision relationship is relatively sparse. Effectiveness in this context is defined by the supervisee attributing various aspects of their development to the clinical supervision process. Development could be achieved directly through means such as skill acquisition. Indirectly, it could be achieved through for example, the provision of personal support which may positively impact on clinician confidence and thus enhance therapeutic capability (Bishop, 2007). A body of literature has been reviewed that relates to the perceived benefits of specific factors within the clinical supervision relationship. The prevalent focus though is to note a benefit without attempting to analyse and explain its contributing determinants. The literature reviewed in this section is seen to have a primary focus on understanding the factors within the clinical supervision relationship that the supervisee perceives as contributing to its success.

A study that identifies a clear link to determining effectiveness factors was conducted by Sloan (1999) with nurses in the United Kingdom. The study is limited by both the

small sample ($n = 8$) and the fact that it examined data from contemporary clinical supervision's more formative years. It is therefore not informed by subsequent development. It is nonetheless still important as it collated the information available on this subject to date and re-examined it in the (then) contemporary context and from a supervisee's perspective. It is evident that the review brought forth information that spotlighted diverse understandings around the definition and purpose of clinical supervision. This resulted in a very broad conceptual range of supervision being examined. Sloan initially identified 32 good characteristics of a supervisor in his study, subsequently reduced on discussion with the participants to 25 and finally to the ten considered most important. These ten characteristics encompassed factors related to effective relationship management and the application of sound clinical supervision processes. The broad characteristics identified were related to establishing a strong supportive and sensitive relationship, role modelling, commitment, attentiveness and that the supervision process was perceived to be supervisee driven. Sloan's study was of particular interest as findings were derived from the supervisee's perspective and clearly focussed on what they perceived to be important determinants of effectiveness.

Another relevant study was conducted by Edwards et al. (2005) with community mental health nurses in Wales. The study utilised the Manchester Clinical Supervision Scale (Winstanley, 2000) as an evaluative base. The study examined a number of supervision structure variables to determine the influence they had on effectiveness outcomes within the supervision relationship. The conclusion was that effectiveness increased when supervision sessions lasted more than one hour, were conducted outside the workplace, occurred at least monthly and the supervisee could self-select their supervisor. The three influential factors were summarised as time, space and choice. Although the findings were narrowly focussed, they were clearly identified as influencing supervision effectiveness.

The effect of specific factors within the supervisory relationship providing a basis for an effective supervision relationship is also discussed by Berggren and Severinsson (2006) in a study of nurses in Sweden. The supervisees identified important effectiveness factors as: the provision of a safe supervisory environment, facilitating theory to practice, focusing on core nursing issues rather than organisational ones, promoting reflection and perceived fairness, showing respect and sensitivity to

supervisee feelings and being able to challenge. The study findings were of interest in adding to the understanding of supervision effectiveness determinants.

Van Ooijen (2003) developed a table (p. 37) listing a range of desirable skills, qualities and attitudes for clinical supervision participants. They were divided into lists for supervisee and supervisor as well as those shared. The lists were extensive and thought to be very relevant in contributing to an understanding of potential effectiveness determinants.

Bond and Holland (1998) collate and describe good supervisory technique in relation to effectiveness from the supervisor's perspective. They note general agreement in relation to setting a supervision agenda, confidentiality, information giving, challenge and support. These factors are all informative in regard to supervisor skills and focus, but a limitation is that the supervisee's perspective is not primary.

CONCLUSION

The literature indicates that clinical supervision is variably framed and applied. Variations, depending on the perspective taken, may be perceived as a weakness or as a strength. Significant obstacles exist to drawing clear causal links in relation to the effectiveness of the supervisory process as it is highly complex and every pathway to effectiveness is affected by numerous others. A major obstacle identified is the subjective nature of the concept of effectiveness, which is compounded by the differing views and needs of the relevant stakeholders involved.

Two distinct subject streams were found in the literature relating to the research question: "What are the factors that affect the success of a clinical supervision relationship". The first point of focus was to gain an understanding of how effectiveness and benefits of the supervisory process were conceptualised. A substantial body of literature was found that explored the subject. The second focus of the literature review was on identifying factors occurring within the clinical supervision process which allow the identified benefits of clinical supervision to be realised in practice.

The view strongly held in the literature is that clinical supervision is effective and the benefits of engagement substantial. New Zealand literature on the subject is quite limited though, possibly in part due to the relatively small population. A substantial volume of literature has emerged from the United Kingdom predominantly and to a lesser extent Australia and Scandinavia. The systemic and practice similarities between these countries and New Zealand enable greater applicability of this body of work and thus reduces the impact of the paucity of New Zealand literature. The main point of difference noted between the international and national context is in relation to Kaupapa Māori supervision (Eruera, 2007) as this has some distinct and unique conceptual underpinnings that limit shared understanding. Also of note, the international literature pertaining to effectiveness of supervision had a greater focus on nursing and particularly mental health nursing, than the literature sourced nationally.

Literature related to the factors which determine effectiveness in the supervisory relationship is much less comprehensively documented than the literature pertaining to the effects it has. The literature examined presented a range of limitations. Exploration was not always conducted from the supervisee's perspective or in some cases, solely the supervisee's perspective. It was undertaken with varying professional groups and was thus subject to wider interpretations of purpose and approach. Additionally, the volume of literature exploring effectiveness determinants was insufficiently large to allow broad agreement about findings to be reached. Conclusions are therefore difficult to form from an international perspective and categorically not possible from a national one as so little evaluative information was available. This naturally substantially limits understanding of effectiveness determinants in the New Zealand mental health nursing context.

Relating the literature to the research question allows limitations in the literature to be linked to research intent. It is concluded that:

1. A need is identified to enhance understanding of the factors influencing the effectiveness of clinical supervision in mental health nursing.
2. A need is identified to enhance understanding of the factors influencing effectiveness of clinical supervision in mental health nursing in New Zealand.

3. The supervisee's perspective on factors influencing effectiveness in clinical supervision is not conclusively identified.

It is these three gaps that the study will explore.

CHAPTER 3

RESEARCH METHODOLOGY

QUALITATIVE RESEARCH

Qualitative research aims to describe the experiences of people. It does this by ascribing meaning to subjective experience. The questions of ‘what’, ‘why’ and ‘how’ are examined, but the ‘how often’ and ‘how many’ type of question are not (Buston, Parry-Jones, Livingstone, Bogan & Wood (1998). Meaning is gained from the analysis of what people say or by observing and interpreting their behaviour. Qualitative research accepts the premise that “...the humans that live and operate in this world are not governed by universal laws, but by the meanings that they share” (Cutcliffe & Goward, 2000, p. 591). Assumptions are made that ‘a reality’ does not exist in definitive terms. Rather it is defined as a construct that is individually determined and takes cognisance of a range of sociological and individual factors determined to be influential. Analysis is understood to be made in relation to each study’s designed parameters and consequently interpretative disparity is probable. Disparity is generally not seen as a research failure as interpretative validity is clearly defined. Rutter (2006) comments that qualitative research is a developmental process. She believes that openness to emerging ideas or concepts enables the determination and exploration of key factors during the process of research itself.

In examining what qualitative research is, it is useful to define quantitative research because by doing so, it helps to define what qualitative methodologies are not. Quantitative research attempts to explain and understand the world in terms of universal laws. It is objective, measurable, establishes a clear cause and effect relationship, produces numerical data and is randomised, representative and not least of all, is historically perceived to be scientifically robust (Cutcliffe & Goward, 2000). In contrast, qualitative research is seen to be subjective, descriptive, seeks meaning, is theoretical and purposeful and at least historically was perceived by some to be scientifically compromised (Cutcliffe & Goward, 2000). Qualitative methods have

been accused of being “...soft science, unscientific or exploratory or subjective and labelled as criticism and not theory” (Denzin & Lincoln, 2000, p. 7). This perspective is becoming less common though (Cutcliffe & Goward, 2000) and a methodological hierarchy has been dismissed as unhelpful by some (White, 2003; Long, 2001).

Qualitative methodology is designed to examine selected areas of inquiry. As it does not focus on the validity of a pre-determined hypothesis, it is usually able to deviate from research design to some extent should the focus expand and develop during the process of the study. Rutter (2006, p. 73) states that: “Research protocols summarising the plan for the study and the samples of the people who will be involved may therefore be amended as the qualitative study proceeds.” The allowance for a shift in primary focus and developmental progression is not routinely compatible with most quantitative research because these methods rely on a “clear and pre-determined experimental design” that “should not deviate from protocol” (Rutter, 2006, p. 74).

Trochim and Donnelly (2006) state that qualitative methods are chosen to gain experience with the phenomenon, because it is highly effective for investigating complex and sensitive issues and because it produces information that is very detailed. Denzin and Lincoln (2000, p. 5) note that it “...creates and brings psychological and emotional unity to an interpretive experience”. Gergen and Gergen (p. 1027) state that “...many argue that the empiricist emphasis on quantifiable behaviour left out the crucial ingredient of human understanding, namely the private experiences of the agent.”

As a final point, rather than categorising types of research as qualitative or quantitative or alternatively hard or soft, White (2003) suggests that they are better categorised as either good or bad research.

QUALITATIVE RESEARCH IN MENTAL HEALTH NURSING

Research in mental health nursing has utilised diverse methods, each of which has advantages and disadvantages. All research is subject to the pressures and influences of any science. Understanding the external and internal forces at play, the nurse researcher’s role in qualitative research is to hear and/or observe the individual and

apply a research method that enables the information gathered to be organised, analysed and presented in a coherent fashion.

In direct contrast to some other disciplines, most prominently the medical profession, nursing research has historically displayed a preference for qualitative methods (White, 2003). The rationale for this is undoubtedly complex and varied. One possibility is suggested by Denzin and Lincoln (2000, p. 7) when they note that research methods selected by specific professional groups each have a relationship with "... [their] own disciplinary history." One could speculate in the contemporary context that this may be related to the way the nursing profession is educated and by its philosophical underpinnings or the apparent desire to develop a discrete professional identity.

The practical similarities in relationship anchored approaches used in practice by the mental health nurse and the relevance and congruity of these to qualitative research methodology in general is high. Qualitative methods dovetail neatly with the emphasis nursing places on the experience of individuals, their interaction with and interpretation of the world around them. Denzin and Lincoln (2000, p. 8) state that qualitative researchers "...emphasize (sic) the value laden nature of inquiry. They seek answers to questions that stress *how* social experience is created and given meaning".

Another element common to the qualitative researcher and the mental health nurse is that whilst there is an absolute requirement to empathise, to meaningfully enter, understand and share the world of the patient or research participant, there is equally a need to function in what Cutcliffe and Goward (2000) term a 'second world', one that is the nurse's or the researcher's. Kalisch (1973, p. 1548) describes this as being "...always aware of *his* own separateness." The requirement for the researcher to retain independent and objective oversight whilst understanding the participant's world, to be empathic, is an important and indispensable feature of qualitative research methodology and is seen to be attractive to the nurse researcher (Cutcliffe & Goward, 2000).

It is not suggested that nursing research could or should be compartmentalised into one area of methodology. There are multiple pathways by which nurse led research can increase knowledge and by doing so better understand those who we work with.

The application of either quantitative or qualitative methods or a combination of both is entirely valid in this context. It is the researcher's task to choose a method which will provide the quality and form of information that they seek.

The research method and data analysis framework are described in the following sections. The rationale for the adoption of the research method is specifically explained.

QUALITATIVE DESCRIPTION

The research method adopted for this study is qualitative description as described by Sandelowski (2000, 2010). Qualitative description is a credible and functional approach to conducting qualitative research, but is rarely distinguished as a distinctive method. Sandelowski notes that in defining qualitative description "...there is no bounded entity constituting a pure method" (2010, p. 78) as it is diversely conducted, and does not conform to a tightly constrained set of rules and procedures. It is described as the least theoretical of qualitative approaches and "...the least encumbered by pre-existing theoretical and philosophical commitments" (2000, p. 337).

Qualitative description has its base in naturalistic enquiry, studying phenomena in their natural state (Sandelowski, 2000) and attempting to interpret them through the meanings they are given (Denzin & Lincoln, 2000). Central to the qualitative description method is the "...presentation of the facts of the case in everyday language" (Sandelowski, 2000, p. 336). The desired goal is to deliver "descriptive validity" (p. 336) and an accurate accounting of events or meaning. Information emerging from qualitative description is minimally theorised by the researcher, enabling an intimacy with the data to be maintained and straight descriptions of phenomena to be sought (Sandelowski, 2000, 2010).

These points do not imply however that interpretation of data is not required. Indeed, it is essential as the conceptualising of meaning through basic presentation of uninterpreted raw data will not achieve this purpose and therefore "...researchers [must] make something of their data" Sandelowski (2010, p. 79).

Qualitative description was utilised for this study for a number of reasons. Central was that it would provide both a framework that would answer the research question and also allow the experiences of individuals to be described. The research question does not seek answers which orientate understanding within what Thorne, Kirkham, and MacDonald-Emes (1997, p. 170) call the “...shared components of experience...” Rather it emphasises the broad view of all involved. In a small study, the emphasis is particularly on capturing the meaning that participants ascribe to experience (Holloway & Wheeler, 2010). This emphasis is strongly congruent with the qualitative description method. Sandelowski (2000, p. 337) states that “Qualitative description is especially amenable to obtaining straight and largely unadorned (i.e., minimally theorized [sic] or otherwise transformed or spun) answers to questions of special relevance to practitioners and policy makers.” As data is minimally interpreted in qualitative description, the voice of the individual, unencumbered by philosophical or abstract frameworks may always be heard and a focus on the complete range of experience is facilitated (Sandelowski, 2010). Additionally, because qualitative description interferes minimally with data and everyday language is used, research consensus is facilitated through a lessening of interpretive ambiguity (Sandelowski 2000).

Qualitative description promotes an empathic approach to the research relationships. This breaks down interpersonal barriers and facilitates closeness to emergent data. An approach which has empathic intent acknowledges and respects the participant’s views, yet encourages them to be objectively viewed by the researcher. The researcher is required to identify what their preconceived views are as a conduit to understanding the influences they have on collection and interpretation of data. The dynamic nature of research development possible within a qualitative description framework is acknowledged by there being no commitment to stay with the theory or framework originally conceived (Sandelowski, 2010).

Researcher’s Preconceptions

Sandelowski (2010) notes that the researcher will inevitably hold some preconceptions; they cannot be completely open-minded. She believes that preconceptions should be understood and communicated, but equally that they may be

challenged and can change over the course of the study in response to emerging information. Kvale (1996) acknowledges that to find one correct, objective and true meaning is not a requirement of many forms of research and that multiple interpretations are both possible and valid. By the researcher identifying their preconceptions on a subject, they become more aware of interpretive possibilities (Sandelowski, 2010; Ashworth, 1997) and therefore are better able to “...suspend judgement and prior knowledge about the experience and phenomena...” (Lauterbach, 2007, p. 219).

The researcher identified three preconceptions held prior to conducting the study. The first was that clinical supervision is an effective process to develop nursing practice. The second was that the supervisor’s ability in a clinical supervision context is vital to achieving effective outcomes. The third was that supervisee motivation is a defining factor in determining supervision effectiveness.

THEMATIC ANALYSIS

The data analysis framework adopted for the study is thematic analysis as described by Boyatzis (1998). The qualitative description method does not outline specific sampling, data collection and data analysis approaches, but thematic analysis is noted by Sandelowski (2010) to be an effective approach. The process captures qualitative information and facilitates its organisation, interpretation and understanding. The emphasis on structure is important if the findings are to maintain credibility on one hand and serve their ultimate purpose on the other; that is, to inform and influence.

When information is gathered by qualitative means, it is likely to be loosely configured in preliminary stages. Its content may be unpredictable and as a consequence, a broadening of research scope and in extreme cases, possibly even the fundamental thrust of the research may be required. An analytical framework that works to establish structure, but permits adaptation is therefore completely appropriate in this context.

Boyatzis (1998, p. 4) describes a theme as “...a pattern found in the information that at a minimum describes and organises the possible observations and at a maximum,

interprets aspects of the phenomenon.” He notes (p. 1) that a pattern will be identified within the three structural precepts of seeing. They are: a) the recognition of an important moment, b) seeing it as something, and c) interpretation of the encoded information using the interpretative paradigms selected by the researcher. The themes can be investigated and understood from direct observation of the information (the manifest level) or by interpreting the information underlying the phenomena (the latent level). Braun and Clarke (2006) refer to these levels as a semantic (explicit) level or a latent (interpretative) level.

Themes may be developed inductively or deductively. An inductive approach closely links the themes to the data and by doing so avoids the need to fit emergent themes into pre-existing frameworks or to a researcher’s interpretative inclination. It is described as a “...bottom up...” approach (Braun & Clark, 2006, p. 83). This implies that the research is conducted with awareness of researcher preconceptions, but that openness is sought and is driven by emergent data. A deductive analysis is conversely an approach that explicitly sets pre-determined areas of interest and focus and develops themes that are framed by them.

Boyatzis’s Thematic Analysis Framework – The Inductive Approach

Boyatzis (1998, p. 29) describes three core stages in the application of a thematic analysis study. They are:

- 1) Deciding on sampling and design issues.
- 2) Developing themes and a code.
- 3) Validating and using the code.

The three stages are common to each thematic analysis variation, but all differ in some ways in the breakdown of the stages into sub-steps. The approach selected for this research is a latent and inductive one.

Stage 1: Deciding on Sampling and Design Issues and Selecting Sub-samples

Decisions regarding sampling are vital to set a research agenda that is relevant, adequately focussed and achievable within the magnitude of the project. Working with

inductively formulated thematic analysis poses challenges and offers advantages with all of these requirements. The use of an inductive approach improves interrater reliability due to the researcher being close to the data. Boyatzis describes this first stage as having two steps; 1) deciding on sampling and design issues and 2) selecting sub-samples (if relevant).

Choosing samples is a pivotal step in commencing the research as they are the source from which the raw data is produced. Research design will dictate to some extent the sampling possibilities. The sample in this study is assumed to be sub-sampled due to the restricted number and range of participants involved. Sub-sampling was not attempted in this analysis for two reasons. Firstly, the sample numbers are too low to provide clear meaningful subsamples and secondly, due to the sample size, if it was divided, participant confidentiality would be risked.

Stage 2: Developing Themes and a Code

Boyatzis (1998) describes stage 2 as containing 5 steps. They are:

- 1) Reducing raw information
- 2) Identifying themes within subsamples
- 3) Comparing themes across subsamples
- 4) Creation of a code
- 5) Determining the reliability

The researcher's role in stage 2 is to review each piece of raw data from each sample, identify relevant information and summarise it in a reduced form so that it becomes accessible. Themes are then identified within the sample. The summaries of each sample made are compared and similarities or patterns of information are noted within a thematically organised framework.

Themes are then compared across the sample. Boyatzis notes that whilst the identification of patterns that are 'intellectually coherent' (p. 47) is important, attempts to apply a theoretical framework at this point are premature. The need to differentiate the theme development aspects of the methodology from the interpretative parts is therefore clearly delineated. The researcher in non sub-sample size studies is required

to use personally embedded knowledge or theories or other research to express themes (Boyatzis, 1998).

Step 4 of this second stage is the creation of codes. Boyatzis (1998) says that this step is used to differentiate samples. This is done by the construction of some statements which describe a preliminary theme and are termed 'codes'. Boyatzis (1998, p. x) describes a good code as having "...5 elements:

- 1) A label
- 2) A definition of what the theme concerns
- 3) A description of how to know when the theme occurs
- 4) A description of any qualifications or exclusions to the identification of the theme
- 5) Examples, both positive and negative, to eliminate possible confusion when looking for the theme."

The development of a code may require revisiting the initial statement as early / prior conceptualisation may not satisfactorily meet the requirements of the template noted above. Non sub-sample studies will not facilitate clear differentiation, therefore it is not attempted.

The fifth step in stage 2 is determining the reliability or consistency of judgement of the coders. In the standard approach to thematic analysis, the use of interrater reliability is tested by directly comparing coding judgements with another researcher. Small studies will assume that the researcher is basing their theory and subsequent code development on contemporary or seminal research. Additionally the limitations of the methodology with the sample size are clearly noted during the research itself. There is a risk that the researcher may hold views that are contrary to general empirical knowledge, but supported to some extent in literature. The researcher's academic supervisor will be relied on to validate coding judgements in the absence of collaborating research partners.

Stage 3: Validating and using the Code

This is the final stage in the thematic analysis process. Boyatzis (1998, p. 50) notes two steps: “...

- 1) Coding the rest of the raw information
- 2) Validating the code statistically or qualitatively”

In the qualitative method, step 1 requires the researcher to visually compare the differentiation in the samples in relation to the themes in the code (Boyatzis, 1998). In non subsample size studies, validity must be assumed as noted in the discussion on stage 2, step 5. The theme is considered valid if differentiation is displayed, this being the second step in stage 3. Boyatzis (1998) notes that using inductive methodology with its inherent advantage of close connection to the raw data grants a primary validation to the code development.

ETHICAL CONSIDERATIONS

The nursing profession places emphasis on the value of the individual (Barker & Buchanan-Barker, 2009). This approach is philosophically aligned to the research principles of beneficence, to do good and non-maleficence, to do no harm (Lakeman, 2009). The study has been configured to adhere to these principles. The research method selected is also judged to be able to fulfil what Munhall (2007) identifies as the most important ethical obligation of the qualitative nurse researcher; that is to”....describe the experiences of others in the most faithful way possible” (p. 504). This section, ‘Ethical Considerations’ covers the approval process, consent, confidentiality, anonymity and potential risks to the participants.

The Approval Process

The study was approved through a mandatory process. This required scrutiny and approval from the relevant regional ethics committee, the University of Otago Board of Studies and the Canterbury District Health Board, Specialist Mental Health Service Senior Management Team and Pakeke of Te Korowai Atawhai (Māori Mental Health Service). The Participant Information Sheet (see Appendix 1) and Interview Consent

Form (see Appendix 3) were both in their entirety approved by the Ethics Committee and the Board of Studies Committee.

Informed Consent, Confidentiality and Anonymity

All potential respondents from the initial recruitment stage were sent copies of the Participant Information Sheet and Interview Consent Form. The opportunity to discuss the study in more detail was offered to all. Every respondent who replied indicated that they were willing to participate and an email was sent to them explaining the selection process. Once the participants had been selected, an interview appointment was organised. At this appointment and prior to the interview commencing, the researcher discussed the study in detail again unless the participant declined the offer to do so, one choosing this course of action. A further copy of the Participant Information Sheet was given to them along with an Interview Consent Form. The content of the Interview Consent Form and the research process was explained, with emphasis on the voluntary nature of their involvement and stressing their ability to withdraw fully at any stage up to the point where integration of analysed information took place. The process concerning maintenance of anonymity and confidentiality outlined on the information sheet was reiterated. An explanation of the confidentiality provisions regarding the professional transcriber (who was provided through The University of Otago) and the researcher's academic supervisor was also repeated. The consent form was signed prior to the commencement of the interview, once both parties were clear that their respective positions were understood and accepted. All information obtained was confidential and secure. Computer files were kept in the researchers secure database and hard copies when not in use, were always locked in a secure file with access available only to the researcher. As a further safeguard the participant's records were anonymised by the use of coded titles. These took the form of 'Nurse A' through to 'Nurse J'; the letters being randomly assigned to each participant.

Potential Risk to Participants

The process protecting participants from risk was required to comply with a mandatory verification process governed by the University of Otago. The nature of the

study was expected to pose minimal risk to the participants. All were made aware of the pathway they should pursue if they identified any issues, ethical or otherwise that affected their ability to be involved and / or their perception of personal safety. The Participant Information Sheet (see Appendix1) explicitly explained the actions they could take to address any concerns that confronted them. The option to do this independently (and without the knowledge) of the researcher was clearly explained and the process was reiterated at the commencement of the interviews. The participants were also apprised of their ability to withdraw without explanation as described in the previous section. This was noted in the Participant Information Sheet and verbally prior to interviewing. The researcher explained in detail to all participants that they could with-hold information as they judged fit during the interview process. Additional to these processes were a range of professional support systems each had available to them. These included access to clinical supervision and access to a confidential employee assistance programme in every case.

The researcher as noted previously is employed in a nursing leadership position and at the time the study was undertaken, administered the clinical supervision programme. Questions could be raised therefore regarding the potential for undue influence or coercion influencing participant responses. The issue was discussed with the researcher's academic supervisor and it was judged that a number of factors satisfactorily managed the risks. None of the participants were in positions that reported or were accountable to the researcher, participation was completely voluntary and informed consent was obtained. As clinical supervisees, the participants all engaged in supervision on a voluntary and confidential basis. The researcher had no role in judging any aspects of their perceived performance in the supervision context, either directly or through intermediaries. Additionally, due to the confidential nature of the research arrangements, information would not be available to anyone else in regard to the supervision context. Finally, during the interview process, a neutral and respectful approach was pursued. This extended to the researcher taking care to convey a non-judgmental attitude through both verbal and non-verbal means.

A potential risk was identified to the participants in relation to possible sub-sample selection. On discussion with the researcher's academic supervisor, sub-sample delineation was not attempted as participant anonymity could not be guaranteed due to

the study's low participant numbers and limited range. The rationale for this decision is in accord with Boyatzis's (1998) view as explained in stage one of the thematic analysis process.

RESEARCH METHOD

Preparation for the research Process

Recruitment

Inclusion criteria were that participants were registered nurses working in the mental health sector and were actively engaged in clinical supervision (as supervisees) within the system administered by the CDHB. Practically, this required them to be registered by the Nursing Council of New Zealand (Te Kaunihera Tapuhi o Aotearoa) as a registered nurse with scope conditions that allowed them to work in a mental health setting. It also required that their names were entered on a clinical supervision database maintained by the CDHB. The database listed 336 individuals, 314 (93.4%) of whom were registered nurses and therefore eligible for the study. Of the 314, 302 (96.1%) were employed by the CDHB. The remainder were all employed within the wider mental health sector in the geographic area administered by the organisation and were all in the employ of non-government organisations.

All eligible nurses were sent an email requesting their participation and explaining the study via the Participant Information Sheet (see Appendix 1). It is not known how many respondents accessed the request, but 42 (13.4%) individuals replied, agreeing to become involved if required. Each respondent was contacted by the researcher and all agreed to participate if selected. An offer to discuss any issues arising from their initial scrutiny of the study was accepted by two respondents. It is probable that some potential respondents did not access the offer within the timeframe allowed.

Participants were selected for interview by attempting to provide a cross-section of supervision experience. Gender differentiation was also sought, but was constrained by the low response rate of males. Following selection of participants, contact was made with all other respondents thanking them for their offers of involvement and

advising them that their participation would not be required. An opportunity to discuss the research and process was offered and was accepted by four respondents.

The primary consideration when making sampling decisions was that the voice of the individuals was heard. Qualitative methods are generally seen as being most effective with small numbers studied in depth (Denzin & Lincoln, 2000; Holloway & Wheeler, 2010). This reflects the high volume of rich data obtained from these methods. The case-orientated nature of qualitative research is impeded by large sample sizes, whereas in contrast, the variable orientated focus of quantitative research is strengthened (Sandelowski, 1995). Large sample sizes in qualitative research can result in data that has less depth and richness (Holloway & Wheeler, 2010). A further point of consideration in choosing sample size is the data saturation point (Haber, 2010; Houser, 2008). This point is identified when new themes cease to emerge as data is accumulated and analysed. Polit and Tatano Beck (2004) state that there are no rules regarding sample size in qualitative research. They view data saturation as the defining indicator and state that it is highly variable and that judgements are made in response to the "...sufficiency and volume of the data..." (p. 308).

Data Collection

Data was gathered through the use of a semi-structured interview format. Each interview was audio taped and transcribed by a professional transcriber appointed by the University of Otago. The researcher reviewed the nature and quality of raw data after each interview and a cumulative estimate was maintained in relation to both the quality and volume of information. Through discussion with his academic supervisor, the researcher's preference for a greater mass of raw data resulted in ten interviews being conducted. These took place over a three month period.

Interviews were predominantly conducted during the normal work hours of the participants. Approval for release time was obtained by the participant from their line managers. Interviews were estimated to take about an hour each. Permission was sought to conduct a brief follow-up interview if information was either unclear or analysis suggested that areas of investigation required more inquiry. This scenario was not found to be necessary. The actual time for each interview ranged from 40 to 80

minutes; most lasted approximately an hour. Interviews were held in every case at a private venue chosen by the participant. The arrangements proved satisfactory.

A range of factors were considered in relation to effective interviewing technique. During the interviews, the researcher took care to assume a neutral stance, one that was curious and non-judgemental. Care was taken that questions were open-ended and did not convey opinion, thus minimising the risk of influencing participant responses. The use of open-ended questions allows more detailed information to be elicited (Houser, 2008). Cognisance of the need to keep questions unambiguous was maintained, both with structured and follow-up questions. The use of non-verbal and verbal cues facilitated a sense of openness, respect, interest and engagement. Paying attention to these details is thought to promote interviewee confidence and consequently increase the effectiveness of exploratory enquiry (Holloway & Wheeler, 2010; Kvale, 1996).

The interview guide was developed from the literature review. The conclusion of the literature review chapter summarised the gaps in the literature in relation to the research question. Once the literature review was completed and gaps had been identified, a draft question guide was formulated. It was reviewed with the researcher's academic supervisor and minor changes were made as a consequence. The guide was further reviewed through academic supervision at intervals during the interview period.

Some 'administrative' discussion took place before the interviewee formally commenced the formal interview. In addition to serving as a 'warm-up' (Holloway & Wheeler, 2010), the discussion also ensured the participants were familiar with the research and interview process. The pre-interview discussion followed the following format:

- a) A personal introduction
- b) A process to ensuring that consent procedures were fulfilled, which included the participants' understanding of their right to withdraw
- c) Discussion pertaining to information in the Information Sheet

- d) An opportunity was offered for extended discussion and explanation re any aspects of the interview or the study identified by the participant
- e) An overview of the semi-structured interview format and practical aspects of the interview process including the audio taping

Initial questions from the interview guide were then asked, but as explained below, the interviews all assumed an individual structure. The semi-structured 'Base Interview Question Guide' (see Appendix 2) was composed of eleven questions. Follow-up questions were asked on the basis of information emerging from the initial set. In semi-structured interviews, the base questions are formatted in an order that attempts to approximate predicted information flow, but the actual sequencing depends on the emerging information and responses (Holloway & Wheeler, 2010). It became apparent in reviewing the questions, that ordering interview questions less flexibly tended to stifle engagement and narrative flow and an adaptable process was seen to be more effective. Referencing back to the interview guide at intervals ensured that relevant streams of enquiry were not omitted and that the data focus was broadly similar for every participant. As points of interest emerged, brief notes were taken when required so that relevant information was not lost and could be re-visited if indicated.

Data Analysis

Prior to the analysis of the transcripts, a system of documentation was developed to track the process. This required the development of numerous versions of each document type, reflecting the complexity of the subject matter, subtleties in definition, development and organisational complexity characteristic of the large volume of raw data emerging from qualitative methods. The documents provided a record of developmental continuity that facilitated those reflective and analytical functions central to thematic analysis. In this way, both organisational integrity and confirmability were upheld. The analysis process is now discussed and each document category is explained in relation to their purpose in the process.

Once the transcribed interviews were completed, a copy of each was made. They were proof read and by reference to the audio tapes were corrected. Inaccuracies were noted

and a corrected copy was made. An identification code known only to the researcher was allocated and this code was followed at all subsequent stages of the study. The researcher then read the completed transcripts and identified and named possible sub-themes. They were noted in the margin of each transcript and tabulated in summarised form in a series of documents labelled 'Sub-Theme List' (4 versions).

At this early point, in-depth analysis was not conducted. The data was included not on the basis of its quality or volume, merely its presence. The initial list of potential sub-theme titles numbered 53, but a preliminary review reduced the actual discretely definable number to 48. Difficulty was initially experienced in defining some sub-themes as variations in some cases were subtle and the need to amalgamate them was indicated. This typically involved grouping two or three, but up to four sub-themes together. The consequence of sub-theme amalgamation was that the definition of some sub-themes were changed, reflecting development of interpreted meaning.

All potential sub-themes were allocated a number which was maintained through every change, including when they were amalgamated with another sub-theme, deleted or had their titles changed to more accurately describe them. By doing this, all changes were traceable to the earliest documented version and the continuity of process development could be tracked to its initial formulation.

The next task undertaken was to develop themes by analysing and grouping related sub-themes. When first attempted, four themes emerged, reducing to three at an early stage as theme definition was refined. The defining and naming of the themes was developed throughout the analysis process, including the discussion stages of the thesis. The three early stage themes identified proved analytically robust and their original core meaning and titles were maintained to the conclusion of the study with only subtle changes. A record of the development of groups of sub-themes into themes was tracked through the 'Theme/Sub-Theme Development List' document category (26 versions). These documents also served to track changes in sub-theme definitions, integration of sub-themes and sub-theme deletions.

A further point of refinement during the analysis process was through the allocation of sub-themes to only one theme. Prior to definitional development, sub-theme

definitions were generally broadly interpreted. Consequently some sub-themes spanned two and occasionally all three themes. As analysis advanced, the transcripts were reviewed in detail over a number of cycles. This enabled continual development in the interpretation of participant meaning and resulted in ongoing refinement of sub-theme definition. Theme definition was therefore also refined and as the thematic focus became more specific, discrete allocation of sub-themes was achieved and those judged to be insufficiently supported were deleted. The continuous process of refinement and development reduced the sub-theme count from the initial 53 (with some spanning more than one) to a final 22.

The development and refinement process was complex and required regular validation as described in the thematic analysis section. Progression was tracked through the use of the 'Theme/Sub-Theme Development List'. This document group ensured that the progression of development was able to be logically tracked through all 26 versions.

In parallel with the 'Theme/Sub-Theme Development List' category documents, a series of index documents, the 'Sub-theme Index' (28 versions) was maintained. These documents enabled a rapid and generalised assessment of the quality of evidence available to be made, as only information seen to be qualitatively robust was indexed. Additionally, they also allowed the volume of evidence available for each sub-theme to be crudely estimated as listed index entries in a basic visually quantifiable form.

The final point of refinement was to group sub-themes (where possible) into sub-thematic clusters. Of the three themes, two were able to be divided, one into three sub-thematic clusters and the other into two. The outcome of this process was recorded into a final organisational summary format labelled 'Thesis Findings Structure' (19 versions). In chronological terms this commenced soon after the initial sub-theme identification and thematic development had occurred, so as such functioned concurrently with them rather than sequentially.

SUMMARY

The research methodology chapter has discussed qualitative methodology and its application to mental health nursing. Qualitative description was described and the

thematic analysis framework outlined. Ethical issues were discussed and the research method explained. Preparation for the research process was described through reference to the recruitment process, sampling method and a description of the participant group. Data collection was outlined by explaining the interview process, discussing sampling considerations, the development of the interview guide and its practical application. Finally, the practical aspects of data analysis were explained. The system to track and document the thematic analysis process was outlined and an explanation of the process of development and interpretation of data was given.

The following three chapters discuss the findings emerging from the semi-structured interviews. The socio-demographic and professional characteristics of the participant group are described. Themes have been identified and findings related to each are presented. Quotes from the transcripts have been inserted to illustrate key findings. As sub-themes may not always be discreetly bordered, a degree of mutual inclusivity is apparent in some cases. Twenty two sub-themes emerged from which three themes were formulated. The themes identified are:

- 1) Working with Engagement
- 2) Applying Effective Supervision Process
- 3) Achieving Positive Outcomes

Each theme has variable numbers of contributing sub-themes; 13, 7 and 2 respectively and theme three is not divided into sub-thematic clusters. The consequence of this is that data volume of each theme is also highly variable. As the findings are data led, variation in the volume of findings could not be avoided without compromising research coherence. A basic summary of the reported importance of sub-thematic findings is collated in the document 'Summary of the Significance of Sub-thematic Factors' (see Appendix 4).

CHAPTER 4

FINDINGS: THEME 1 - WORKING WITH ENGAGEMENT

THE SAMPLE

The range of socio-demographic and professional characteristics of respondents was relatively narrow. Of the ten selected to participate, eight (80%) were woman. Their ages ranged from late twenties to early sixties and they had been employed in mental health settings as registered nurses between nine and twenty six years. Four (40%) were employed at the time of their interview in inpatient settings, five (50%) in an outpatient setting and one (10%) in a clinical support role. All participants identified as New Zealand European.

Participants were strongly characterised by a high level of nursing experience and exposure to the clinical supervision process. All had been receiving supervision between three and nineteen years, predominantly on a regular basis over two to six week intervals. They had also all received supervisor training and provided supervision for others. Collectively the ten participants had experience as supervisees with three distinct clinical supervision frameworks. All had experience at some time with the 'role theory' model. One participant had additionally also been supervised within two other frameworks, while two had experience with the role theory model and one other. At the time of interviews, seven of the ten worked with role theory. As supervisors, seven were trained to supervise with the role theory model and three with alternative frameworks.

The matter of sub-theme delineation has been generally discussed during earlier sections. Specifically in relation to the sample group, sub-theme delineation was not attempted. As noted, the potential risk to participant confidentiality was not acceptable. The second factor influencing the decision not to sub-sample was that participant numbers were judged were too low to allow meaningful sub-sample interpretation.

INTRODUCTION

Clinical supervision is highly dependent on the quality of the supervisory relationship (Sloan, 1999; Wilkin, 2009). It is important therefore to gain an understanding of the influences; personal, interpersonal and professional that determines the supervisee’s potential to engage and maintain a functional relationship. These factors are identified and their effects explored. They are grouped under the theme labelled ‘Working with Engagement’. The theme has been sub-divided into three general sub-thematic clusters which are displayed below in Table 3:

TABLE 3: THEME 1 - WORKING WITH ENGAGEMENT

Supervisor Factors	Supervisee Factors	Matching Factors
Supervisor personal qualities	Supervisee preparedness	Gender
Supervisor professional experience	Supervisee responsibility	Age
Supervisor professional skills	Supervisee perception of supervision	Interpersonal compatibility
Supervisor professional background		Shared values
Supervisee – Supervisor professional relationship		Supervision model

These first two sub-thematic clusters, ‘Supervisor Factors’ and ‘Supervisee Factors’ are broadly defined as the personal and professional factors related to each individual or alternatively, their personal and professional profiles. This definition specifically excludes matters related to the supervisor’s ability in relation to the application of the supervision process as they are covered by the following theme. It is accepted though that the area of mutual inclusivity between personal and professional skills on one hand and supervision process ability on the other is likely to be significant. The third sub-thematic cluster ‘Matching Factors’ is focused on the perceived importance of matching the supervisor and supervisee in relation to the five sub-themes identified. The supervisee - supervisor matching system within which the participants work is completely subject to the agreement of both supervisor and supervisee. The assumption

made is that a personally acceptable level of interpersonal comfort will have an influence on engagement. If augmented by working within identified probable success parameters, positive impact in the matching of supervisory participants will be evident.

It should not be assumed that this group of sub-themes is representative of a comprehensive overview. Limitations in study scope and sample size resulted in some potentially fruitful areas of focus being omitted due to an insufficient volume or quality of evidence.

Supervisor Factors

Supervisor Personal Qualities

‘Supervisor Personal Qualities’ is defined according to the supervisee’s understanding of a range of subjectively desirable or compatible qualities they perceive the supervisor to have. These qualities will be highly variable between individuals. Given the potential for diversity, it was found that a numerically small range of supervisor core personal qualities were identified as important.

A large proportion of participants identified a range of supervisor personal qualities as affecting engagement in both initial and maintenance phases of the relationship. The need for the supervisor to convey a sense of personal integrity and honesty was noted by a small majority of participants. The perception was that the supervisor should always behave ethically and in any circumstances would behave in accordance with their (the supervisee’s) personal beliefs and standards. One participant commented that her personal experience was how she judged a supervisor or potential supervisor’s integrity:

...I judge people myself rather than what other people say and I guess what I want is someone who’s honest and trustworthy above all, whether it’s in work or out of work. (G.15).

Standing alongside these qualities, the supervisees all held a significant belief that a supervisor should convey a sense of wisdom. This resulted in the perception that they understood issues and responses that were important, often complex and subject to individual interpretation. Within these broad parameters, the supervisees also expected

the supervisor to display behaviours that they perceived to be caring and supportive of them as individuals. The participants understanding of what constituted caring and supportive behaviour was subject to widely differentiated interpretation and appeared to reflect participant individual relationship needs in combination with preferred communication styles. Nurse E noted that her supervisor was:

The kind of person I relate to as a friend. She's not my friend, I'm quite clear about that, but she has qualities of a lot of my friends (E.13).

Another personal quality that two supervisees identified as desirable in their supervisor was a sense of humour. Most referenced it indirectly, but a few did so directly:

...a sense of humour is actually paramount to survival ultimately, so yeah, I like a sense of fun as well (E.19).

This participant noted that with clinical supervision being an important support for clinical work, the sense of humour spilled over into her clinical supervision relationship. That she saw it as fun was important to her because it assisted her to anticipate clinical supervision sessions in a positive manner. For her, an underlying sense of humour balanced the more psychologically demanding aspects of supervision, conceptualised as 'hard work' and practically assisted her ongoing engagement within the clinical supervision relationship. The general view was that a sense of humour was compatible with other ostensibly more 'professional' supervisor qualities.

The summarised view held by the participants was that the personal qualities of their supervisor were important to them in relation to them engaging and maintaining the relationship. They identified that they should be trustworthy, honest and caring, that they should have a compatible sense of humour and convey a sense of wisdom within the relationship.

Supervisor Professional Experience

The sub-theme of 'Supervisor Professional Experience' was considered in relation to the impact it was perceived to have on supervisee–supervisor engagement within the clinical supervision relationship. Professional experience is defined as the experience

the supervisor has in relation to their professional role. It takes cognisance of the length of time involved in the mental health sector, in nursing or in other professional vocations which are seen to have relevance to their professional profile. It also takes account of the nature of their clinical experience; whether it is clinical or non-clinical, inpatient or outpatient or any combination of these. It notes impact of the clinical areas where experience has been gained, the roles performed and the levels of clinical and leadership responsibilities held.

Supervisor professional experience does not directly reference age, though it was generally perceived that experience and age are often significantly correlated. This linear correlation was not considered to be vital though as professional experience was usually perceived within qualitative parameters. That is, the quality of experience was generally perceived to be more significant than the quantity.

The importance of supervisor professional experience varied significantly across the group. It was a factor considered by several to be of great significance, by most to be somewhat significant and by one to be conditionally unimportant. Several supervisees conceptualised a linear relationship between length of professional experience of their supervisor and their level of clinical expertise. In these cases, a direct influence on the perceived ability to engage was found. Beneficial influences were characterised by a positive attitude and confidence in the supervisor's ability. Nurse B discussed the direct link:

...I think experience in some ways informs ability. You can have a theoretical understanding but if you can incorporate that into clinical experience, then I think you've got a powerful combination (B.6).

He clarified further:

I guess I'm after some experience, enough experience to bring the model that they've trained in to life and to have a nice clinical experience to understand I guess topics that I'll be bringing to the relationship (B.6).

Nurse C agreed with this idea. She had a very clear preference for someone who was more experienced than she was:

To me it was important that someone who's worked, done the yards for the years preceding me, that I can kind of feel yeah, that they, for some reason, that's the thing with me. I just need to feel someone's more experienced, a lot more experienced than me (C.10).

One nurse in response to an inquiry about the importance of professional experience in her supervisor said that without a high level of professional experience, understanding and an ability to relate may be difficult. Discussing why she considered professional experience vital, she said:

I think because if they don't understand the world that you work in, it could for some people raise a hesitation in talking about things when people don't know about it (J.12).

Another concurred:

...I would need to know that the person had a really reasonable nursing experience and had the ability to understand my clinical responsibilities... (E.14).

Opinions varied widely in relation to the importance of similar clinical experience though. Some felt it to be essential. The absence of broadly comparable clinical experience limited or even excluded understanding of the practical realities that the supervisees were confronted with and the issues they subsequently brought to supervision. It was not implied that the supervisor had to work in the same clinical area, but it was found that they needed to perceive it as similar enough so that they had confidence that their experiences would be interpreted accurately. Nurse I explained:

It was helpful to have regular contact with someone who I had a growing professional relationship with who wasn't involved in my immediate work area so there was no conflict of interests, but if I had like I had, there was just one difficulty after another with policies, procedures, the way things were run, patient management, all sorts of things and I could take them along and put them around the table and we'd have discussions. It was very useful (I.3).

This was a view that Nurse F agreed with:

...it's about knowing and understanding difficulties that can come up, you know like in the nursing team or within the system so I guess I see that as you need to be in it to know it and the ability to be able to reflect back and talk through issues and I guess you know, having a level of experience in doing that (F.13).

Some others felt that the ability of the supervisor in the supervisor role and within the relationship was the more important factor for them and the supervisor's ability to engage and facilitate their development was central. Nurse D was very open to options. She said:

Providing they were able to offer me what I needed, it would be fine (D.17).

The issue of role position related experience was generally perceived to be of some importance. Participants held variable views, but there was agreement that comparative job positioning did affect engagement within the relationship. Participants who discussed the longitudinal development of their clinical supervision noted significantly changing requirements as their professional roles and positions changed. All participants employed in formal leadership roles or who perceived themselves to be in an informal leadership role, placed value on having supervisors senior to them. Some participants noted that when they moved to more senior positions, a less functional dynamic developed. One participant explained the significant effect this situation had on her ability to engage within the relationship. She noted that the dynamic became stressful for her supervisor and ultimately led to the supervision relationship terminating, even though nothing else was perceived to have changed:

...she felt inadequate were her words and she suggested that I look for someone else because she felt she was out of her depth (A.30).

Nurse B, working in a leadership position found his experience of a perceived mismatch manageable, but not ideal. He said that closer professional matching:

....would be helpful, but not essential (B.8).

The participants' views varied on the importance of formal versus informal leadership roles. There was a shared belief that they could, but would not always co-exist. Some participants were clear that their supervisor having a formal 'more senior' position was important to give them the confidence to engage openly. Others linked it to their belief that a supervisor who worked in a 'leadership role' would have abilities that would functionally translate to effectiveness in the clinical supervision role. This was seen by Nurse C as an advantage in terms of her career development:

...I wanted someone that I thought was more senior to me, who could assist me with supervision in more of a you know, lower management role (B.4).

In summary, participant views on the effects that supervisor professional experience had on the supervisory process were highly variable. No clear congruence was found in any of the areas discussed and opinions on particular points of focus generally covered a broad range.

Supervisor Professional Skills

'Supervisor Professional Skills' is defined as the subjectively interpreted level of nursing professional skill attributed to the supervisor by the supervisee. It may be assumed therefore that a common view regarding an individual supervisor's professional skills is not important, as it is only the supervisee's perception that is relevant. In the context of initial engagement with a clinical supervision relationship, it is possible that supervisee judgment of supervisor professional skill may be formed through opinions of trusted third parties as participants may not have previously known each other.

The sub-theme of professional skills is clearly delineated from that of professional experience. A supervisor could be experienced and may have worked in a variety of relevant clinical settings, but could still be perceived by the supervisee as not possessing an appropriate level of professional skill. Professional skills are defined as being contextually separated from a supervisor's level of profession related knowledge. This removes any assumption that a sound theoretical knowledge automatically translates to clinical effectiveness.

A majority of the participants directly referenced supervisor professional skills as important to them in regard to their engagement in supervision. However it was a sub-theme that whilst noted relatively frequently, was often peripheral to other discussion streams. The participants considered a high level of supervisor professional skill as an ideal because they perceived its presence as increasing their level of confidence and respect toward their supervisor. This had the secondary effect of facilitating engagement. Nurse A stated the point very simply:

I need to be confident that the person knows what they're doing (A.18).

She explained that there were other factors in the equation though.

...it's probably about their personality style; there's something about their skills as a clinician and the way that they think when I've talked to them (A.18).

Nurse E thought similarly. She directly equated supervisor skills and professional nursing skills. In relation to her supervisor and discussing her (the supervisor's) nursing skills, she said:

Their qualities are more around the person having the skills and the skill base to be a supervisor. It's really, really important (E.15).

Nurse H agreed. She was respectful of the wide range of professional skills her supervisor had. This engendered a high degree of confidence in the supervision relationship and process and was further reinforced after initial engagement by a supervision relationship that she found was effective. She said that:

...[name] had credibility, he also had experience as a nurse and as a psychotherapist, as a psychodramatist and also he'd been in...had an educator role within the organisation as well, so those things, I think were all quite useful things... (H.21).

For one Nurse, the key factor was that she perceived that her supervisor was more skilled than her. Other participants did not identify this need, but she had experienced a supervision relationship where she felt her supervisor was functioning at a similar level. She perceived this to be a fundamental barrier to effective engagement:

I just felt that I could supervise her you know and that I was in the supervisee role, so it didn't fit for me... (C.11).

In summary, the belief that supervisors should be competent professionally was strongly held. Several participants did however separate levels of clinical and supervisory skills, focusing on the ability to deliver effective supervision as primary in importance.

Supervisor Professional Background

‘Supervisor Professional Background’ is defined as the professional background that a supervisor has in relation to:

- The professional discipline or disciplines they are trained in (e.g. nursing/social work/ clinical psychology)
- The discipline(s) they have historically worked in
- The discipline they currently work in

This sub-category examines the perceived influence of broad background factors related to supervisor discipline and training, rather than focusing on the supervisee’s perception of supervisor skills and professional experience. It is the supervisee’s attitude, experiential or otherwise, towards the supervisor’s professional discipline and the effect on engagement in the supervision relationship that is examined. The sub-theme could be analytically subsumed by the sub-themes of supervisor professional experience and supervisor professional skills as the definitions of each are relatively closely linked and may have areas of mutual inclusivity. Consequently, it was examined only when the influence on supervisee engagement was clearly attributed to this sub-theme and could be clearly differentiated from others.

The participant group had limited experience with supervisors who were trained in a non-nursing profession. All were currently supervised by health professionals trained as registered nurses, but four participants had been supervised by a non-nursing health professional in the past. Other participants offered opinions based on their beliefs. These obviously did not have the insight borne of personal experience. Some had formed beliefs from contact with peers who had experienced and discussed a cross disciplinary

supervision arrangement, while other beliefs had been formed for less tangible reasons. How these are interpreted is beyond the scope of this study.

No clear congruence emerged regarding cross disciplinary supervision. The four participants who had actual experience in this type of supervisory arrangement expressed varying degrees of satisfaction with the concept in principle and practice. It appeared to correspond to other factors in general; often to the overall sum of supervisee perceived supervisor skill. Nonetheless some impressions were formed. Nurse D was adamant that the professional discipline of her supervisor was unimportant:

...I don't see it as important. I think it's about them as a person, about them being well grounded with the supervision process (D.21).

Some were focused on closely matching their current role to comparable supervisor experience. For them a cross disciplinary relationship was seen to dilute understanding and profession specific development. Nurse A did not perceive this at the time, but on reflection it was apparent:

...I think at the time I didn't think there was a disadvantage. When I look back I think there was (A.9).

She explained how this affected her:

I think there was like almost a gap in my development in terms of my nursing. I think for a while I slipped back in terms of nursing development if that makes sense (A.15).

Despite this, she maintained a belief that with correct matching, a supervisor with a different role could be acceptable, even advantageous, particularly in focusing on leadership skills development. She felt that not being open to the potential of cross disciplinary supervision arrangements was a significant loss in some areas:

...so we lose that ability to where there is actually really good skills, but because the way our systems are set up we don't trust it, so we don't use.....we don't even consider it as an option (A.27).

Nurse C was adamant that cross-disciplinary supervision was not possible, even in principle:

I can only speculate that this wouldn't work for me at all (C.11).

While some preferred in principle or demanded in practice to be supervised by a nurse, others were open to broader possibilities. Nurse E was one who was flexible:

Anything's possible. I believe it's really useful having a nurse personally because they understand the role, but I don't know that that's paramount. I guess it's just a comfort thing for me that I am being supervised by a nurse, that there's some common kind of knowledge there... (E.28).

Nurse B was completely open:

I'd rather be supervised by someone who had previous qualities that I mentioned and I don't give a hoot which discipline they come from..." (B.21).

In summary, the professional background of the supervisor was found to be of variable importance to the group. Several participants were adamant that supervision being provided by someone other than a nurse was not acceptable to them, whilst others were more open to the possibility, sometimes informed by previous positive experiences of cross-disciplinary supervision.

Supervisee – Supervisor Professional Relationship

This sub-theme examines the impact that professional relationships between the supervisee and supervisor outside the clinical supervision setting have on engagement in the supervision relationship. The relationship may be a direct and current working relationship or an indirect one, through for example, having links to the supervisee's workplace or area.

Several participants had personal experience of a dual relationship with a colleague who was also their supervisor. Those who hadn't had this experience nonetheless formed opinions on the subject. None of the participants felt that being clinically supervised by an immediate working colleague was an acceptable arrangement. They were realistic though that their supervisor would not necessarily be someone with whom they had not had previous knowledge or contact. This was obviously the case where they self-

matched, an option available in the system they work within. The participants who had experienced a close professional relationship with their supervisor were quite clear that it was not ideal for them. Nurse B had experienced this and he summarised the view:

...we knew too many people in common and I still have that view on it today. I have a preference not to receive supervision from a person so immediate (B.14).

He expanded on this point by explaining the discomfort he felt at this closeness and discussed the resulting sense of vulnerability regarding personal disclosure:

...I still did not want to bring some personal information about other people I was working with to that, into that supervisory context. It was just a bit too close in terms of proximity and units and all that... (B.11).

Most participants noted the distinction between team support and clinical supervision. Nurse F commented specifically how she valued the closeness and support of her team, but found it invaluable to get an independent perspective through clinical supervision by a person relatively unconnected to her workplace:

...so to be able to get outside of that and work through that in a safe environment, that I know that none of that's going to get back to them, I can deal and talk about my own issues was really important for my survival in the team and as a nurse (F.22).

In some cases, the supervisee and supervisor knew each other and had professional contact, but this was occasional, not seen as close and as such was viewed positively. It was seen as a head start in its contribution to a functional supervision relationship. Nurse F said:

...she's known me from before the supervision relationship, so I guess there's a sense of history there and I think that's useful with some of the issues that I've taken (F.6).

Another nurse, although she worked in close proximity and in the same team as her supervisor had virtually no professional contact due to the very individual nature of the work and the respective roles each held. She felt this was acceptable for her:

Well, she has quite a different role in the team so it didn't feel like we were working in the same team at all (G.13).

Nurse H expressed caution about the supervisory role and the risk of blurring boundaries, professionally and within the supervision relationship. This was something she was aware of in both supervisee and supervisory roles:

Yeah, but in terms of holding information about someone as a supervisor and then working with them in the clinical area, that was something I was always mindful of ...that tension really (H.27).

This nurse identified her need to be quite removed from her supervisee. She believed that a supervision relationship required separation from other roles and in fact, to some extent, non professional relationships:

I guess one of the things I'm always aware of is that boundary between this professional relationship and the social relationship... (H.27).

Summarised, all participants identified some degree of clinical separation to be desirable in their relationship with their supervisor. The distance required varied between individuals and was dependent on a number of independent factors, but issues of safety and openness were generally considered to be important considerations.

Supervisee Factors

Supervisee Preparedness

The sub-theme of 'Supervisee Preparedness' is defined as factors identified by the supervisee relating to initial preparation for engagement in the clinical supervision process. It does not relate to preparation for individual supervision sessions. The sub-theme has distinct areas of mutual inclusivity with some others such as those related to supervision method and supervisor ability. In these cases the distinction between them may be subtle. The examples noted will overlap because sound application of supervisory structure and advanced supervisor ability will act to make supervisee preparation a less glaring omission.

This sub-theme was one that drew comment from all participants, in most cases in significant volume and detail. The findings in relation to it were emphatically clear. All participants commented on the new or prospective supervisee's need for information and preparation relevant to the clinical supervision process. It was found that clinical supervision is in practice a professional development tool that is often not well understood by those who have not previously experienced the supervision process. Limited understanding is also a factor for those being introduced to a framework that is practically and philosophically different from those they have previously experienced. One example of the latter is in relation to the blurred boundaries in some models between line management focused supervision and predominantly professional development focused models.

A large majority of the participants had found their initial experience of commencing supervision confusing. Some experiences were not recent, but were noted frequently enough in relation to the last three to four year period to reinforce the view as relevant in a contemporary setting. In most cases, the supervisees came in to the supervision process poorly informed and had to navigate their way as part of an experiential process. Nurse B explained that this wasn't always successful:

...I didn't really have a clear idea of what supervision was all about and was finding it going around in circles and I couldn't really I guess I didn't know how to use the supervision process well... (B.9).

Another articulated the concept in simple terms. She was clear that she would have benefited from better preparation:

I think I would have got more out of my own supervision if I'd understood (H.2).

Nurse E found the same thing. She persisted with supervision, but enlightenment was a long time coming:

I would say probably a couple of years before I'd really begin to understand what supervision's about (E.10).

Nurse F's experience was similar. Due to her having little idea what supervision was designed to do, she felt uncertain and confused. She felt unclear if she was 'performing adequately' in the supervisory context. Explaining how being trained as a supervisor had given her much more knowledge of the purpose of supervision, she was able to understand how little she knew at the time:

...when I first started supervision, I struggled to figure out how I was supposed to use supervision and I guess, I didn't disclose to my supervisor or I didn't at times where I felt like I never got the answer of, am I doing.... am I using this wisely? Am I doing it right? (F.3).

This was a view shared in general terms by Nurse I:

They don't know what to expect when they come in and they're kind of anxious that they're going to be analysed or put on the spot or made to be responsible for something... (I.6).

All of the participants felt that a very structured approach to preparing a nurse new to the clinical supervision process would be ideal. Nurse B commented that:

...if all those things are present back when I had my first taste of supervision I would have found that incredibly helpful (B.11).

The view generally held was that being trained as a clinical supervisor was advantageous to the supervisee experience. For Nurse B, the experience of having been formally taught about the process of preparation for supervision in his supervision training enabled him to reflect that having knowledge of the process would have assisted his early experiences.

I would have found that more helpful, just so that I knew I was more informed of the process and the rationale for the process of supervision... (B.10).

In summary, the belief that supervisee preparation was a vital factor in enhancing the supervision relationship was uniformly held. All participants noted that a sound grounding in principles and practices of the supervisory process would have enhanced their supervision relationship and the experiences they had.

Supervisee Responsibility

Clinical supervision is identified by the participants as a relationship based process. As such, it can only function effectively as a partnership and this implies that the responsibility for its success is shared. It is implicit therefore that both participants in the relationship must be committed for it to succeed. This sub-theme encompassing the supervisee's level of commitment has been labelled 'Supervisee Responsibility' and it is recognised most obviously by activities and behaviours that indicate active supervisee commitment to the clinical supervision process. The impact of this in relation to the effect it has on engagement within the clinical supervision process is discussed. Many factors, professional, personal and attitudinal will affect and define the level of supervisee commitment to the supervision relationship.

A majority of participants commented on this area of study. Their responses were in some cases based around their experience as clinical supervisors in addition to a supervisee's perspective. All those who commented reported that supervisee commitment was indispensable to an effective clinical supervision relationship.

Participants generally noted a strong correlation between their level of commitment to the process and its effectiveness. Nurse A had a first supervision relationship that she judged to be ineffective. She ascribed a number of reasons for this, including her lack of commitment to its success. She noted how she took a very passive role and this led to a dysfunctional cycle in the relationship and eventually its demise:

...I'd be struggling to think of anything and would end up sort of meandering through and I thought supervision's hopeless and I'd keep cancelling, (A.31).

Nurse D in contrast discussed a relationship she had where there was incentive for her to work positively. The nature of this supervision relationship was such that she was motivated to keep thinking about the area of focus between sessions as well as during them. Whether this was primarily due to competent supervision technique or due to her level of motivation was not discussed, but her strong perception was that her positive approach encouraged an effective relationship:

...I never envisaged myself living up to her, but it was a wee bit about being able to come back and saying that in my previous supervision, I've managed to achieve something. (D.12).

From both a supervisor's and supervisee's perspective, clear expectations about a positive approach to supervision were stressed in relation to its contribution to meaningful engagement. Nurse I spoke from his experience as both a supervisee and supervisor. He expected any supervisee to be committed to the process, an approach he practiced as a supervisee:

.. I didn't come along to have a chat about things in general or to have to tease the conversation out of a person and you know, they've got to come along with a bit of will... (I.19).

Nurse A discussed a functional supervision relationship that she had. In contrast to her first attempt at supervision, she approached her second one very positively. Her precursors for success were present and this engendered in her, a very positive attitude:

...I actually made a conscious decision that I needed, or maybe an unconscious decision I'm not sure, to start doing some work, some proper work.... (A.36).

A number of participants who were supervisors themselves believed that the supervision process needed to have a philosophical congruence for them or the process lost meaning for both parties. Nurse J summed this up neatly, explaining that some supervisees sought supervision for reasons that she felt were not honest or respectful:

...people that join in being supervised because it's going to allow them to continue with their PDRP [Professional Development Recognition Programme] and things like that and there's not a real commitment to the process. It's more an academic kind of tick the box (J.17).

In summary, supervisee commitment to their supervision was viewed as important by all the participants. A number of them noted historical supervision relationships where they were not committed and the poor outcomes arising from these reinforced their views.

Supervisee Perception of Supervision

The broad understanding of what clinical supervision is, what it is for and the effect it has on the nurse engaging in the process is discussed under this sub-theme of 'Supervisee Perception of Supervision'. Because it is primarily involved with the pre-engagement and initial engagement period, the questions elicited discussion focusing on participants' early experiences with the clinical supervision process and how the impression of supervision they held prior to this affected their engagement. Chronologically, the participants' experiences over their early engagement covered numerous years and consequently reflect to some extent, the changing face of clinical supervision technique and process in the setting studied.

This subject area was discussed by a small majority of the participants and congruence was strong. Those participants who had commenced their clinical supervision programme during its more formative years noted that the general perception of clinical supervision was then quite negative. Nurse H was one who discussed the historical context:

I think one of the things at that time was the way supervision was framed up. It was framed up in such a way that you got supervision if you were in the shit basically or if you were, it was seen as something you were directed to if you had problems (H.8).

Nurse J agreed:

I think they thought that this was a little bit of that ghastly what have I done wrong, I have to have supervision (J.16).

That this view has not fundamentally changed for some was noted by Nurse B, explaining an insight in a more recent period. Employed into a new role, he was encouraged to commence supervision, but was not altogether convinced that this was something he wanted to do:

...I had this expectation that somehow, I was having to go there because this was some form of monitoring my performance. It wasn't my process, it was their process, so I guess knowing that the onus is on the person being supervised, it's their process, would have been useful (B.9).

Some participants had held the view that rather than viewing clinical supervision as primarily a professional development process, it was regularly identified as a quasi line management tool, used to monitor and manage performance. Nurse H thought that changing the consciousness of nurses in relation to supervision was important:

...so I think if one thing could have been done differently, then it would be just for it to be framed up more in a way that wasn't punitive, because I think that puts a lot of people off supervision. It was as if the people who accessed it often were the people that had performance issues (H.8).

Nurse F explained that prior to commencing supervision, she was more positive about the process because her training emphasised reflection on practice and she saw clinical supervision as completely congruent with these principles:

Because I think for me I do hold dearly; that critical reflection on practice is really important and I've always had a sense of this... (F.22).

Nurse H had little knowledge of the supervision process prior to commencing. She explained how she felt anxious about exploring areas that she was psychologically not yet ready to enter. She perceived supervision as potentially threatening:

I guess looking back now, part of my anxiety about that was, was I going to be asked to do things that I felt were really uncomfortable about or talk about things that I felt really uncomfortable about...(H.11).

In summary, in some cases it was not until participants gained more knowledge of the process or were subject to positive experiential influences that they were able to believe in its functionality in practical rather than just theoretical terms. Participants who engaged in clinical supervision in more recent times also spoke of a wide range of views held by their peers, but as the process has become more embedded, this had proved less of an obstacle to engagement.

Matching Factors

Gender

This sub-theme is simply defined as the impact that gender has within the supervision relationship in relation to effective engagement. The interview did not examine gender related factors that could have been identified outside the supervision relationship for individual participants.

All but one participant commented on the effects supervisee – supervisor gender matching factors had on their ability to engage in the clinical supervision relationship. Questioned on preferences they held, a range of views were elicited, but the volume of opinion strongly favoured the view that gender matching was not a significant issue for them. While this view predominated, several of the group felt it could be significant for them under some circumstances and this suggested that categorical assumptions should not be made.

Nurse G was quite clear that supervisor gender was of no importance to her at all. Her focus was on human and professional qualities:

No it doesn't matter; it all comes down to a respect thing (G.19).

Nurse H agreed with this view. Her focus was also on personal qualities, but she did think that for some supervisees, gender matching was an issue:

...it's more about the connectiveness and the relationship, but for some people, I know it's really important, the gender's really important for them (H.22).

Whilst gender wasn't a great issue for her, she did profess some overall preference for a male supervisor because she believed that a male might be more likely to elicit positive responses from her:

....no, I didn't feel uncomfortable with the fact that he was male at all, I don't know.....in actual fact, I think I probably would have got away with a lot more if he'd been a woman actually (H.21).

One participant, Nurse I had changed his viewpoint over time. He had been clear during his early involvement with the clinical supervision process that same gender matching was very important to him. More recently he had not expressed a preference and the subsequent positive experiences had changed his previous view. Asked if it gender matching was important to him, he said:

The last three have been males at my request because I think there were a few gender issues tied up with the way we work and things and I wanted to be absolutely frank, but now I see it as less of an issue (I.12).

The views expressed by Nurse I were shared in general terms by several others. It illustrated the dynamic nature of individual perceptions, opinions and needs in regard to gender issues.

Although all but one participant shared the view that gender matching was not important for them, a number of them had found that it could be important for some. The one participant whose personal preference for same gender matching was strong was able to conceptualise this in reference to childhood trauma she had experienced. This quote is not attributed for confidentiality reasons:

...which in today's terminology would actually mean CYFS [Child Youth & Family Service] etc, and I've never really thought but to some extent I think maybe there's a transference for me with [name] and this [non-professional role], it just kind of clicked for me now so I guess for me it's around trust with females. I have plenty of men that I do trust but I think I feel more comfortable with women.

The overall view was that participants did not profess to any particular preference about the gender of their supervisor except in the case of the person noted above. In general, gender matching was not seen to influence the effectiveness of the supervision relationship, though the need for sensitivity should be assumed as illustrated by the last example.

Age Factors

The matching of supervisee and supervisor age was considered in relation to the effects it was perceived to have on engagement in the clinical supervision relationship. The participants generally discussed age relative to their own, rather than forming judgments in non-relative terms. There was some sense of mutual inclusivity with the sub-theme of 'Supervisor Professional Skills' for one participant who perceived age and professional competence to be linearly correlated.

A large majority of the participants commented on this sub-theme. That age was relatively unimportant to them was a view held by all but one. A common link was that respecting their supervisor was more important to them than their age. Nurse E encapsulated this idea:

...I relate across all ages reasonably well, so that isn't an aspect for me. Obviously it has to be for me, it has to be someone that I can respect for whatever reason (E.13).

Nurse I agreed with her:

...if they came highly recommended and they really knew their stuff and they'd been through all the right training and that sort of thing, then yeah, I'd give it a go (I.14).

He expanded on this comment, explaining that his supervisor was very process oriented and this reinforced his view:

...it's the process that they're going through and that's not reliant on the amount of experience they've had... (I.15)

Nurse D was also quite clear. She was also very focused on supervision structure and technique and this made supervisor age unimportant:

Providing they were able to offer me what I needed, it would be fine (D.6).

Nurse A agreed about the pre-eminence of supervisor ability over age:

...but you know if I think about it, if I had a supervisor who was significantly younger; would it matter I actually don't think it would if they've got the skills (A.22).

One participant qualified his viewpoint. Whilst he didn't feel that an age difference was an impediment to a successful relationship, he did have a slight discomfort about having a supervisor who was too much younger than him:

...if it was by more than sort of 7-10 years and yeah, I may have to explore that. For me it's more around ability than age (B.6).

One participant held a different view to others. She had a preference to someone her own age or older. Her view appeared to have been formed through the assumption that a linear link between experience and age exists.

In summary, the matching of supervisee and supervisor age was not equally important to all the participants. The perception that age and professional ability were closely related was clearly identified by one participant and she would not consider having a supervisor significantly younger than them. Others were more flexible. It was generally speculated that having a supervisor who was a lot younger would be less ideal and could sometimes be psychologically uncomfortable. In general most participants were reasonably open to possibilities that were not perceived to be grossly mismatched.

Interpersonal Compatibility

In considering the potential for two individuals to engage in a supervision relationship, the impact and importance of interpersonal compatibility was considered in this sub-theme. This facet of the matching process was found not to predictably reflect personal preferences reportedly held by the supervisees outside the clinical supervision relationship. All the participants commented on this sub-theme and no clear congruence was found. However, a majority felt that working with a supervisor who was significantly similar in terms of personal characteristics was not important, though two participants held a slightly different view.

Nurse C generally held strong opinions in areas related to matching. She saw some advantages in having someone who she perceived to have a different personality style. She felt that differing characteristics would be more likely to take her on reflective pathways less familiar to her with the consequential effect of broadening her outlook:

I think from a personal/professional development perspective, it would probably be good for me to not always have someone that I can think is like minded... (C.15).

Nurse I, whilst generally quite open to a range of supervisor characteristics, identified some supervisor traits that he was clear would make engagement more difficult. Generally though, he didn't appear inflexible in regard to limiting the range of supervisor personality characteristics that he felt would work for him and would support engagement:

...I couldn't really have supervision with someone who's too flippant for example, so yeah personality does have a part to play, but on the other hand I do look at things as being a challenge... (I.15).

Nurse D wanted the relationship to be a comfortable fit for her in personality terms. She saw this as encouraging meaningful engagement. She did not stress similarity and referred to compatibility instead. For her, this was not particularly limiting:

...definitely personality, I mean I think supervision has to have a good fit. It's a bit like going to a counsellor and having a good counsellor that you feel comfortable with and that's important to me. (D.20).

The participants were quite clear about some characteristics that they had found were important to them. Nurse A wanted someone with whom she believed she was intellectually well matched:

...I think that there are people who I think are naturally attracted to intellectually that you would feel more readily able to discuss issues with... (A.36).

A combination of rationality and good humour were Nurse B's preferences in his supervisor:

...I'd go for the more rational personality style yes, but they'd have to have some life about them, you know they couldn't be all dry and factual, but if someone who can yeah does have a good rational component to them' (B.19).

Two participants felt that having someone who was in significant ways similar was important to them engaging. They discussed this to be related to finding it easier to establish good rapport, confidence and trust.

In summary, the participants had ideas that were slightly variable in regard to interpersonal compatibility with their supervisor. Most viewed a similar personality as not being necessary, but did identify certain qualities which set parameters of compatibility. These included intellectual ability, attitude and cognitive style. Several participants preferred supervisors who had personality characteristics that were broadly similar to their perception of their own.

Shared Values

The importance of the supervisee and supervisor sharing values and the effect on engagement was examined under this sub-theme of 'Shared Values'. It was often seen to encompass aspects related to life experience, as this was commonly seen as a major influence on how an individual's judgment or views on the world are formed.

The participants all discussed shared values and had two distinct points of view. A slight majority felt that supervisor values did not need to be either known to them or confirmed to be similar to their own, distinct from them being known to be dissimilar. A minority felt that it was important to them that their supervisor's core values, both personal and professional, were philosophically aligned with their own. They were clear that philosophical alignment was a key component in establishing trust and rapport and therefore facilitating initial engagement:

...they have to have the same ethical and moral standards that I see that I have and I don't think that I consciously think about it, but I am aware that I am mindful of it... (A.11).

Congruence was also sought in relation to the perceived commitment supervisors had to their professional role. Several participants held a view that lay between the two disparate groupings. They didn't expect their supervisor to necessarily share the same values, but a degree of similarity was preferred:

...I don't go to anyone and expect they're going to work in parallel with my beliefs. There will be differences within them and I'm quite comfortable with that..... (E.20).

A small majority of participants had ideas that were broadly related, but they did not require positive affirmation that values were shared. An assumption in the absence of discussion or disclosure supported by an attitude that was not obviously opposed to the supervisee's expressed or implied values was adequate for them to feel comfortable:

...if my supervisor was quite homophobic and that came across then yes that would absolutely be an issue, but I don't think [name] is but at the same time if she is, she certainly doesn't show it, so it's fine (F.26).

Some participants felt that their perception of gain from engagement in the supervision relationship was the primary and over-riding consideration. It was evident that significant importance was not attached to the exploration and comparison of values. Nurse I explained this quite clearly:

...I guess it's a matter of how out there the person wants to be with their belief system. I can't be bothered with people who kind of feed me stuff all the time, they're welcome to have their own belief system it's not my affair (I.17).

That supervision was very process oriented in his case was evident from a strong sense of supervisor non-disclosure that he described:

It wouldn't really make any difference, if they had a professional relationship with me, then that's all that matters (I.17).

Nurse F supported this view. She clearly identified an effective professional development focus as a core expectation from her supervision. The supervisor was not expected to 'get in the way' of this process. She felt that the focus was clearly on her

and that the supervisor's role was to ensure that this was maintained and supervision structure was focused to this end:

I think that if the supervisor could I guess, keep to a professional role and listen to whatever the differences were and still reflect back to where I was at, then that would be ok, but if their beliefs kept stopping that supervision and that learning process, then I would have a problem with it (F.26).

In summary, this was a factor identified quite diversely within the group. The results were split between those who had a very clear 'supervision only' focus and those who viewed their supervisor in a broader context in which supervision was only one component. The former cluster felt that shared values were not vital to the realisation of effective outcomes. The latter group, a majority, believed that their ability to engage was affected by the overall beliefs of their supervisor.

Supervision Model

The supervision relationship determinants identified as being directly attributable to the presence and application of a particular supervision methodology are explored in this sub-theme of 'Supervision Model.' It was found that personal characteristics of the supervisee and the supervisor, coupled with the degree of relationship symbiosis they form, will have a significant effect on the functional value of the supervision relationship. In theory at least, the supervision process will be structured by the supervisor according to the 'rules of engagement' outlined in the design of the supervision framework being utilised. Clinical supervision models in mental health nursing are numerous and diverse and this raises the question as to how important it is to match the supervision model and related factors to the individual supervisee. This sub-theme was one that all participants commented on, often in length and detail.

Nurse A had experienced a supervision relationship where she had no idea about the model at all. This relationship proved to be unsuccessful and with the benefit of hindsight coupled with extensive experience, she found this to be unacceptable:

...we actually never talked about a model I know that sounds terrible...
(A.7).

A majority of participants were clear that they had a preferred model. Knowing and trusting the model used was significantly important to them. Nurse G was not practically or philosophically tied to a specific framework, but did identify a degree of personal comfort working with one that she both knew well and favoured. Referring to the model, she said:

...it's just that I understand it and where it's going more and I, you know, I know what it's designed to do, whereas the others I don't (G.11).

Nurse E only had experience with one model. She thought along similar lines to Nurse G, liking what she had, but being open to other options, though unsure of the effectiveness for her. Asked if she would be open to different models, she said:

...I certainly wouldn't say no to someone who had been trained in some other method, but I don't know if it would fit with my thinking (E.21).

One participant had been supervised in two distinct frameworks as well as receiving supervision by a 'method' that he could not identify and that his supervisor did not attribute to one. These experiences enabled him to form a clear preference for a specific model. Having identified one that was effective for him, he had formed the view that he:

...would choose people who have been trained in [name]'s style of supervision because I'm familiar with it as well (B.7).

In several cases, a perceived lack of success had led to a clear desire to try another model. In these cases, the participants rationalised the reasons for doing so as being related to a sense of how much of a personal 'fit' their preferred model had with them as individuals. Those that commented believed this factor to be quite important. Nurse B commented:

....she was using the [model] approach that I felt didn't there were some useful aspects to it, but there was something there that just wasn't fully clicking with me, we clicked more on the aspects of both being nurses and both having done [alternative health model] studies, but I

guess the style of supervision didn't fully match my expectations or I guess, my way of operating (B.11).

He liked the fact that the model had a structured approach, but the techniques used made him uncomfortable at times. He expressed this as not extending him. Whether this was due to interpersonal compatibility or method incompatibility was not clear:

...there was structure there, but it was I guess the methods of exploring the topics brought up in the clinical supervision that were ok, but I think didn't fully extend me to the degree that I was hoping (B.3).

Whilst the participants viewed the specific model used to be of variable importance, one idea raised by half the participants was model adaptability. Whilst easily conceptualised as a determinant of supervisor ability, it was also attributed to model flexibility or adaptability. The sense of the clinical supervision model being flexible and responsive to supervisee need was perceived to be important. Nurse C said that two supervisors she had:

...actively encouraged questions about how you're feeling work's going and there's usually some issue that come up within work and it's sort of addressed, but not in using role theory. Occasionally roles have been referred to, but its semi structured, but not too rigid (C.23).

Nurse D had always been supervised in only one model, but she liked an adaptable structure. Outcomes were paramount for her:

I think if the purpose of supervision is actually served and I come out of it feeling as if I've had a good supervision session, because role theory isn't used in every session (D.8).

The identified requirement for supervisor adaptability and flexibility was shared by Nurse I. It could be construed as both an aspect of supervision methods and as a consequence of supervisor ability. It had in any case been experienced as an important factor in engaging with the supervisee:

...you have to be able to introduce the subject in a palatable way; otherwise you're going to lose the person because they're not interested and they find it too threatening or whatever it is... (I.13).

Summarising this sub-theme, most of the participants thought that the supervision model they were supervised within was of some importance to them, but were divided about their willingness to try an unfamiliar model. They were all unified in their view that working with a model that was compatible with their interpersonal style and characteristics was necessary and that a clear supervisory structure, flexibly delivered was important.

SUMMARY

This theme can be conceptualised as factors other than process related ones that are perceived by the supervisee to have an effect on their potential to engage in the supervisory relationship. Information emerging is useful as it aids understanding as to what degree the identified determinants are likely to influence engagement. By understanding and pragmatically responding to these factors in matching the supervisee and supervisor, the chances of a functional relationship developing will be enhanced.

Breaking down personal experience into meaningful generalised themes and sub-themes is not a simple process. Individuals do not interpret and experience the world around them in a uniform pattern. Additionally, a person's unique perception of the world around them under the influence of internal and external factors is likely to be dynamic in nature. When a group of nurses are subject to the same or similar experiences, their interpretations and responses are likely to be significantly variable. This was apparent with the participants in this study. Some expressed categorical opinion about points that others found to be unimportant. Areas of examination elicited a range of responses, sometimes diametrically opposed, at other times very similar or somewhat related. This variability was initially found to be unhelpful in defining themes related to effective engagement as it opposed categorical interpretations. However on further examination, it was seen to be an advantage as it found that individual responses to some subject areas were significantly and unpredictably variable. Consequently, it was concluded that generalised assumptions dictating a narrow approach to dealing with the engagement

question should not be made. In factors where significant variability was present, approaches which were mindful of the need for flexibility and adaptability were indicated.

The findings emerging from this theme absolutely stress the critical role the establishment of a positive relationship has on the effectiveness of clinical supervision. The factors individually contributing to the positive relationship were not uniformly perceived. This was particularly apparent in regard to supervisor profile and in issues of matching. Having an awareness of a probable range of individual preference and refraining from narrowly focussed judgments and approaches is suggested.

Broad conclusions drawn from this theme are that the supervisor should be perceived by the supervisee to be honest and ethical, caring and good humoured. According to the participants in the study, it did not matter if some supervisee / supervisor personal qualities were considerably different. However it was important that those perceived qualities of the supervisor were respected by the supervisee. Professional competence was highly valued in supervisors, but the nature of their professional experience was perceived to be of variable importance, ranging from unimportant to essential. Working in separate settings was considered necessary. Being supervised by a clinician from a discipline other than nursing attracted variable views, some resulting from practical experience and some hypothetically. The only assumption that could be made was that it would be acceptable for some under some circumstances; certainly not a mandate, but equally not a clear contra-indication.

The participants all considered that they as supervisees had a significant effect on the perceived success of the relationship. They held a categorical belief that they (the supervisees) needed to be committed to the process for it to be effective for them. Overlaid on this view was that a positive perception of clinical supervision before engaging in the process was a significantly important requirement. They agreed that time and effort spent in preparatory work, organisational or professional, enhanced this belief in clinical supervision. This led to a greater ability to understand the process and consequently more effective engagement. Some supervisees had experienced clinical supervision relationships where for various reasons, they had not fully committed to the process or had even sabotaged it. The reasons why this occurred were varied. Generally

they were attributable to a dysfunctional supervision relationship, a lack of belief in the supervision process (and consequently little commitment to it), insubstantial supervision structure or a perceived absence of effective outcomes.

Issues related to matching were less important than most other factors. Gender mix did not matter to this group and age was relatively unimportant, though gross mismatches, particularly with a younger supervisor were not considered ideal. Supervisees drew a distinction between interpersonal compatibility and similarity. They generally did not mind their supervisor having significantly different personality characteristics from them, but they required them to be within their perceived comfort range. How the comfort point was defined was highly variable. Similarly, so were beliefs on the need for shared values. Views ranged from those who thought it essential to those who judged it irrelevant. The latter perspective partnered the belief that effective delivery of the clinical supervision session privileged other factors. Finally, there was disparity regarding the importance placed on the framework of clinical supervision, including its match with the supervisee's past experiences. For some participants, framework compatibility was vital, while others found this issue less of a concern.

CHAPTER 5

FINDINGS: THEME 2 - APPLYING EFFECTIVE SUPERVISION PROCESS

INTRODUCTION

Concurrent with the pre-requisites for successful engagement, this study found that application of the process of supervision was another critical factor affecting its perceived effectiveness. Accordingly, this section examines the theme ‘Applying Effective Supervision Process’. It discusses the dynamics of the supervision process in relation to its actual delivery. This is done by examining the application of a comprehensible and rational structure and by relating it to key abilities that the supervisor is perceived to require. The assumption made in relation to the latter is that clear and effective process is only possible in the presence of adequate supervisor ability. The theme is divided into two sub-thematic clusters, ‘Supervisor Ability Factors’ and ‘System Factor’ as shown below in Table 4.

TABLE 4: THEME 2 - APPLYING EFFECTIVE SUPERVISION PROCESS

Supervisor Ability Factors	System Factor
Process Integration	Access to supervision
Supervisee driven	
Supervisor commitment	
Supervisor perceptiveness	
Supervisor assertiveness	
Safety	

The first sub-thematic cluster ‘Supervisor Ability Factors’ comprises a set of identified abilities, skills and process needs that the participants believed their supervisor should have and provide. The second cluster (or factor as there is only one) ‘System Factor’, relates to the supervisee’s ability to practically access the clinical supervision process. This is to some degree determined by the level of support provided by the organisational system within which the supervisee works. The level of support they receive practically impacts on their ability to engage in the clinical supervision process.

Supervisor Ability Factors

Process Integration

The clinical supervision process is widely interpreted across numerous variables. The examination of the sub-theme ‘Process Integration’ considered the importance of recognisable structure and the means by which it is applied.

This sub-theme attracted a high volume of comment. The views expressed by every participant were very similar and amongst the most categorically clear of any factor examined. Broadly summarised, participants thought that structure within the clinical supervision session was significantly important. They perceived that a clear and recognisable structure provided a sound base from which they could tackle important issues which were emerging for them within the supervision session. A structured supervision format enabled issues to be deconstructed and worked through to a logical conclusion:

...it doesn't matter whether the problem is here or it's a problem with a staff member or a problem with patient care or a problem with anything else, I need a process to work through things (A.20).

The need for guidance in interpreting and conceptualising issues that emerge in supervision was an idea that most participants discussed. Supervisor attention to a structured approach was usually interpreted as skilled and insightful. Nurse E termed her supervisor ‘strategic’, but this could also be interpreted as process focussed:

...she's also strategic, she's very strategic and will gently guide me to wherever or prompt me whatever around whatever the issues are...
(E.18).

Participants found that when they trained as supervisors, their increased understanding of clear supervision process enhanced the effectiveness of their supervisee role as well as clarifying their supervisory goals. Nurse F commented:

...and so being able to go and have the frameworks as a supervisor, I got to see as a supervisee how to use that better, more efficiently and confirm actually I was pretty much doing it ok, however it gave a structure and an aim, a vision in some ways... (F.3).

In spite of a strong desire for their supervision to be process driven, most participants also expressed a preference for flexibility and adaptability from the supervisor. The ability to take this approach was perceived as an advanced supervisor skill and was often seen to be applied with great subtlety. Sometimes, to the extent that it was not obvious except in hindsight. Nurse H described her supervisor being sensitive and 'in touch' with how she was managing. She felt he adapted the overt application of a structured approach to enable her to work effectively 'in the moment':

...he'd use structure sometimes and he wouldn't be so structured other times, but he was really there was always looking back, there was always a purpose ... (H.17).

Nurse F found the application of a structured approach to her supervision reassuring. She came away with clear ideas about what had been achieved and what required ongoing attention:

...I guess there's also a direction, so it feels like we're you know, she's able to be listening or hearing where I'm going and there's not necessarily a conclusion at the supervision session, but there's always a feedback... (F.6).

Nurse I, found that a focus on effective outcomes from the supervision relationship were more important to him than having a supervisor who was sensitive and nurturing.

He categorised the approach, in reference to his current supervision relationship as different rather than preferable to other approaches, but he enjoyed the predictability and rationality that it encompassed. He conceptualised it as somewhat impersonal, but the clear focus on outcomes made it quite acceptable to him:

... I probably need somebody who's more clinical in their approach and can unearth you know, more minor issues with those, with a better clarity... (I.11).

All participants who had experienced a supervision relationship that was unstructured reported that outcomes were ineffective. Invariably they had become frustrated and in some cases, quite disillusioned with the clinical supervision process. Nurse A discussed a supervision relationship she had experienced that had little discernable structure. She perceived this to be the primary reason that the process had been ineffective. She said the sessions would:

...end up sort of meandering through and I thought supervision's hopeless and I'd keep cancelling, and I'd keep cancelling... (A.31).

Nurse D was another who discussed the same issue. Over a long period, she eventually recognised the lack of structure was impeding her progress:

...the structure wasn't there and I just felt that my own personal growth from the supervision as much as it was happening, it wasn't at the same rate (D.14).

A majority of the participants identified the importance of structure in assisting to clearly define supervisee outcomes. The absence of 'results' from their supervision led to frustration and disenchantment with the relationship, sometimes the process itself. Nurse D found the lack of tangible outcomes very frustrating:

...I would bring something to supervision and I would come out of it not feeling as if I've actually come to this resolution or solution or outcome with his assistance. It sort of felt like as you say, it was more like a mentoring you know because the things I was bringing up were similar for a mighty long time and nothing was changing for me (D.14).

Summarising views, the participants strongly believed in the need for a process driven and structured approach. It was categorically accepted that the provision of a clear supervisory structure greatly enhances the clinical supervision process.

Supervisee Driven

Clinical supervision is applied in multiple settings and with a range of models and philosophies to govern and guide it. The issue of by whom it is driven, meaning in this context, who determines matters such as subject focus and defines acceptable parameters of inquiry, is a fundamental issue in the provision of supervision. Differences in approach result from variations in system governance structures, professional and organisational demands and in individuals approaching the task differently. This sub-theme, titled 'Supervisee Driven', examines the views on this issue that participants hold from their experience of clinical supervision and the impact they conclude it has on effective supervision delivery.

Every participant commented on supervisee driven factors, some directly and others peripherally. They all perceived the concept to be a core ingredient of a successful supervision relationship. However, it did not manifest in the supervisee experiencing the need to have dominance in the relationship; rather that they had governance over matters which they believed were important to them. They did not want the supervisor to be passive and benignly non opinionated. On the contrary, they clearly wanted the supervisor to bring a defined structure and process to the relationship. They unanimously agreed though that the choice of subject focus should be theirs to determine and that their own ideas and developmental skills should drive outcomes. This enabled them to feel they had an investment in the outcomes. They were pleased to have guidance and to be exposed to ideas as options, but had no desire to be told exactly what to do. The distinction from a mentoring approach was thus clearly differentiated and absolutely preferred.

This preference was explained by Nurse D. The advantages of using her own skills, knowledge and experience to find a course of action were important for her. She acknowledged that her solution might not be optimal in an objective sense, but it was congruent with her personal development and sense of accomplishment:

Because I think in the end, it allows me to even explore it in a different way, but providing they've got the right tools for me to do that with and steer me in not necessarily the right direction, but a good direction (D.22).

The supervisor's ability to guide or suggest, but not direct was a supervisor ability that was highly regarded by the participants. In some cases it was displayed by the supervisor showing great patience in working with the issues as the supervisee interpreted them. Nurse F explained how her supervisor displayed this quality. She was gently guided to develop her own ideas and solutions in a manner that allowed her to proceed at her own pace and understand and manage her personal safety:

It didn't feel like she was coming down saying, you've said this is what are you're going to do about it, but she didn't also not say it when I've got to that point of feeling, maybe I'm meant to do something about this. She was able to reflect back and said yes and so it felt that it was a nice.....she was able to let me get to that point myself with those issues (F.15).

Taking this approach was perceived by the supervisee to increase confidence in her own ability on one hand and to take an approach that was reflective and analytical on the other.

Several participants had been in long-standing supervision relationships and commented that as those relationship matured, they tended to become more self-directed. Even in these circumstances though, the supervisor's ability to guide and question was found to be useful.

As a contrast to the positive experiences of supervisee driven solutions and focus, some participants also discussed supervision relationships when it did not occur. The loss of 'control' and 'ownership' of the process usually resulted in supervisee alienation. Nurse D commented on a supervision relationship that eventually terminated because she perceived it to be supervisor driven. She explained that she would often emerge from a supervision session with formulated solutions, but because

the ideas did not originate with her, the link to her own developmental process was absent. She found this reduced her investment in the plan:

...when I really, really thought about it, what I was gaining was that he was giving me clear advice rather than me trying to work it out for myself (D.13).

The supervisees all desired a sense of control and choice over the supervision process. This enabled them to work within self-imposed limits and within their 'comfort zone' and therefore manage any personal psychological risks that presented. The ability to make key process safety decisions, but with the reassurance of supervisor ability and supervision structure to guide and support them when required, was an important factor.

Supervisor Commitment

'Supervisor Commitment' was a sub-theme that the participants all talked about directly or peripherally. It is subjectively defined by the supervisee when they interpret supervisor behaviours and responses to be indicative of an ongoing interest in the relationship; a sense that they have a genuine investment. It is the sense of shared interest that is the focus in this sub-theme.

The participants did not conceptualise supervisor commitment in a particularly uniform fashion, but it was identified as important by them all. Those who had not conceptualised and analysed it at the time were clearly able to name and describe it in retrospect. A large majority of participants commented on what could be termed as 'evidence' of commitment from their clinical supervisor. Supervisor commitment was subjectively viewed as more than being merely available for supervision and attending to the practical arrangements that gives the process an organisational base to work from. Having noted that, supervisor availability was logically viewed as a core component of commitment, in the simple sense that not being available can never be seen as displaying commitment. In this case, supervisor commitment has been more widely defined to encapsulate the supervisee's perception of supervisor investment in the relationship.

Nurse I had a supervisor who was obviously very committed to the relationship. In this case, commitment was reinforced by ‘extra things’ that the supervisor did with him. This, in Nurse I’s view was clear evidence of commitment and interest in him:

...he would look at it for you; go through it in his own time. I’d never had that with previous supervisors and I found it incredibly supportive... (I.10).

Nurse F found the attentiveness of her supervisor indicative of genuine interest. She bracketed the concept of interest with caring and wanting to know her as an individual as well as professionally:

...when I’ve you know, come with questions or concerns or issues, I’ve really felt she’s someone who was interested, who was really caring, who’s understanding, who knows me as well (F.6).

The sense of interest was one that most participants discussed. It was often perceived as being bracketed with a sense of respect. Nurse J explained how attentiveness conveyed respect and openness, which supported her perception of general supervisor commitment:

...it indicates to me that I’m being heard, that I’m being heard in probably an unjudgemental manner, that the person is with me you know, they’re fully present and that my values are understood (J.10).

Active listening was perceived as another link to respectfulness and commitment. Nurse C discussed how her supervisor was circumspect in how she would intervene. This was perceived to offer her scope to say what she needed to and the feeling that she was being heard and understood:

...I just felt very sort of reassured that she assessed very well what I was talking about, that I always left the session feeling that we had talked it through in a way that it was at a really good place for me (C.10).

Overall, each participant held similar views. Some required more obvious evidence of supervisor commitment than others, but supervisee confidence in the clinical supervision process was undoubtedly increased when its presence was identified.

Supervisor Perceptiveness

In examining the effective application of supervision process, one of the more common sub-themes to emerge was that of ‘Supervisor Perceptiveness.’ As a supervisor skill, it was considered important by a large majority of participants. It was perceived to contribute significantly to the success of the clinical supervision relationship. Supervisor perceptiveness is recognised when the supervisee perceives that the supervisor is able to identify patterns of responses in the communication between them and is able to adapt their approach to maintain supervisory effectiveness.

The importance of supervisor perceptiveness was highlighted by the fact that no participants disagreed with the concept, although two identified it peripherally rather than directly. All the participants placed high value on their supervisor being able to identify issues and to then direct the session in a manner that enhanced supervisee awareness, reflection and development. It was an ability that inspired confidence in the relationship and consequently in the clinical supervision process. The factor was discussed by Nurse E. She felt that her supervisor was able to see issues more objectively because she was not personally involved. Coupled with her openness, this was found to be very helpful:

...having the skills to actually direct, guide and get information around what the issue actually is that I'm bringing (E.16).

Many participants discussed, often peripherally, the view that supervisor perceptiveness was indicative that they (the supervisee) were understood as individuals. Nurse A explained it as a ‘connection’ and an ability to understand her reality. She believed the ability to connect was enhanced by similarities in cognitive processing styles. The similarity was perceived as enabling her supervisor to be responsive to her needs in a fashion reflecting the dynamic nature of the supervision session. She explained that her supervisor was:

...a really good listener, I think she thought in a way, she thought very similarly to me, so I think that was really helpful because I could talk about something and she seemed to have an innate understanding of what I was talking about... (A.10).

Some supervisees encouraged interpretation from their supervisor as a means to drive the supervision session forward when they were struggling to progress with their own ideas. It may have been that independent objectivity was sought at these times. Nurse F, discussing a period where she was under significant pressures noted that:

...to hear from her what I was discussing and what she thought about that, so her opinion also really counted in that situation (F.18).

This ability for the supervisor to be more objective was also noted by Nurse J. who noted the beneficial effect this had on seeing the 'true picture':

...I still think of her as being slightly more objective than me, that she will also bring in the odd other thing that I haven't quite got (J.12).

Contributing to supervisee confidence was the supervisor's ability to understand the supervisee's personal situation or well-being in the midst of the clinical supervision session. Being aware that they were for example, stressed or uncomfortable with the process, subject or other matters at a particular moment was perceived to be important. Participants who discussed experiences where clinical supervision raised feelings of personal vulnerability reported a very high degree of awareness of the perceived level of sensitivity their supervisors displayed. Nurse H was one who discussed this. She perceived her supervisor to be very sensitive and adaptable to her personal needs and limits at any time:

...he could read when it was getting really uncomfortable or when it wasn't going to be useful to go down that particular track... (H.11).

She had conceptualised in hindsight that he was very subtle in adapting his approach. She only became aware of what he'd done when reflecting on the situation at a later point:

I think it was rather than going, you know straight to the issue, he'd take the securest route around that and I thought he was quite clever. It took me quite a few years to realise why he's actually doing that (H.17).

These examples show that a high degree of supervisee vulnerability was able to be managed by a sensitive and perceptive response from the supervisor. It contributed significantly to the establishment and early steps towards a positive supervision relationship and in the longer term, in its maintenance and ongoing development.

Supervisor Assertiveness

A sub-theme identified by a large majority of participants as contributing to the effectiveness of the clinical supervision relationship was 'Supervisor Assertiveness'. The sub-theme is recognised by the supervisee perceiving that the supervisor was appropriately assertive or challenging in directing the supervision session. Being assertive and / or challenging does not imply that the supervisor is controlling and dominating. It does indicate though a shared trust in the relationship and an ability to extend the boundaries of exploration into areas that are productive, but not always comfortable. How this ability is brought to the process is highly variable; expected when dealing with individual differences in personality types, experience and boundaries imposed by the unique dynamics of any relationship.

A large majority of participants commented on this issue. All agreed that it was important to them to have a sense of control over the subject they wished to scrutinise. They identified a clear preference though for a supervisor who had an assertive approach to their role. They were open to be challenged to explore areas that they would or could not otherwise.

As long as they are quietly assertive and tell me what I need to know. I don't know whether it's personal or what, I wouldn't work well with someone who is what I suppose I would call pussy-footing about with me, someone who's too soft (G.10).

Nurse F clearly thought that an unassertive supervisor could not be effective and that it did not conform to her concept of a partnership within the relationship:

....it would frustrate the hell out of me if I had a supervisor that wouldn't step up at times and say you know, this or continue just to let me talk and not necessarily come up with alternative views or give their opinion (F.17).

Another participant discussed how supervisor assertiveness placed some limits over how she developed her ideas in the context of the supervision session. They could be conceptualised as being able to stay more grounded and rational

...I can go off on a flight of fancy and need someone to say, hang on a minute, there might be another side to this and I find that helpful... (C.19).

Five participants discussed that an effective use of assertiveness was in challenging their assumptions, conclusions or even their beliefs. They conceptualised this ability as an advanced supervisor skill, able to be utilised if the relationship was perceived to be strong. Supervisor challenging was perceived by Nurse D as a link to ideas and possibilities that she had not understood previously:

Appropriately challenging, to help me see, to recognise my own behaviours, to understand what's actually happening and also to recognise that it might be some pattern to this behaviour of mine.... (D.16).

Several participants found a challenging style of supervision personally difficult, but effective in terms of progressing supervision issues. Nurse I discussed times that his supervisor had almost transgressed his personal tolerance. With great difficulty he was able to deal with the rawness of the challenging supervision style. Reflecting in hindsight though, he thought he had developed both personally and professionally as a consequence:

I very nearly walked out of some of [name]'s sessions; not walked out, but very nearly discontinued my good relationship with him on a couple of occasions, but looking back on it, that's really got more to do it seems to be the subjects that we were discussing and my inability to look at them at that time rather than any other indicators. (I.5).

In summary, supervisor assertiveness was perceived to be a useful ability and technique. It increased the effectiveness of the clinical supervision process, but required a sensitive and individual approach to maintain supervisee engagement.

Safety

Nurses in the mental health sector often work with people and situations which are inherently demanding and have the potential to be personally exposing. Subjects explored in a clinical supervision relationship range widely. Some are relatively benign and consequently have little impact personally while others are highly challenging and have potential for significant, even profound personal impact. Consequently, the supervision relationship must be mindful of issues of supervisee safety. Safety in this context is characterised by supervisee confidence in the confidentiality of the relationship and trust that the supervisor will always act in the supervisee's interests. Trust is also manifest in the creation of a supervisory environment that is non-judgmental and which has an openness that limits the imposition of rigid process constraints.

All the participants commented on the sub-theme 'Safety'. It was noted with great regularity, but often in a relatively indirect manner through reference to another aspect of their supervision experience. However it was clear that this group positioned safety as one of the core building blocks of a successful relationship. Nurse J reflected on its significance:

I think the sensitivity is important, but I guess in my thinking it has to be coupled in with safety and to me you could be less sensitive but very safe and to me the safety was the thing... (J.7).

This comment also reflects the way that safety and processes related to it are embedded within many other factors within the supervision process. Comments relating to safety were often intertwined with other factors being discussed.

Reinforcing the point made about the central role of safety, several participants noted experiences of clinical supervision relationships that they viewed as unsafe. Nurse A recalled one from many years ago which she perceived to be unsafe. It had

consequently proved to be traumatic for her. Only subsequent long exposure to positive supervision experiences had enabled her to feel confident that supervision would or could be safe for her:

I found it really stressful and distressing and I was really never..... I said I'd never go back again and in actual fact I got forced to the following time, two times and so I actively worked to sabotage my role in it to get me out because I was so scared about it really (A.4).

Many participants commented directly about the general concept of trust and the safety they identified in the relationship as a consequence. This was always perceived as having a beneficial effect on supervision effectiveness. Nurse F saw the positioning of her supervision relationship outside the team as reassuring as it enabled her to explore issues confidentially. Consequently, she could take a personally comfortable and openly naive perspective that she perceived to decrease her sense of personal risk:

...so to be able to get outside of that and work through that in a safe environment, that I know that none of that's going to get back to them, I can deal and talk about my own issues was really important for my survival in the team... (F.22).

A further aspect raised by several participants was around the supervision relationship providing an environment where they were able to reflect openly and flexibly and not be subject to the judgment of their peers. Nurse D spoke of how the quality of safety in the relationship removed constraints and barriers in her approach to issues being raised:

...I don't have to hold back because of fear of how the other person, my supervisor might react, that it's done totally non-judgmentally, that it's confidential and I actually.....and I feel comfortable enough to be emotive because I find if I can't do that in that place, where the hell else does it go (D.10).

Nurse A held the same view. Her needs broadly encapsulated this group's feelings on this issue:

...I think you need to be able to give what you give of yourself, feeling that you're not going to get stripped raw... (A.33).

In summary, safety was a core ingredient of the effective supervisory environment. It was identified as an absolute necessity in establishing an effective relationship.

System Factor

Access to Supervision

The sub-theme 'Access to Supervision' has a focus quite distinct from the first cluster in this theme, Supervisor Ability Factors'. 'Access to Supervision' examines the environment created by everyday workplace process, practices and attitudes that in some way influence the supervision relationship and influence its potential to be effective. Broken down to its core principles, it is defined as the degree of support that the clinical supervision process receives. It does not examine the effects of personal and professional profiles of the supervisee and supervisor, attitudinal factors or the issues involving compatibility or matching of people and method.

All of the participants commented on the effect that ease of access to supervision had on their engagement with the process. None commented on the perception they had of organisational support. A possible reason for this could be that an individual's interface with the supervision organisational system will predominantly involve interface at the immediate clinical workplace level rather than at the broader and less visible organisational level.

Support from the nurses' managers was considered important, both in the perception gained and the practical structuring of time to enable appointments to occur. Nurse B summed up the general perception:

Yes, it's an essential part. You have to have support, line management support (B.19).

The support of professional colleagues was variable, but most participants felt that peer support was appreciated rather than essential, possibly explained by the positive

attitude the participants held about supervision. Several commented that their colleagues were sometimes sceptical of the worth of supervision, but accepted it as part of the direction mental health nursing has taken. Nurse J was determined that clinical supervision was a priority for her. She explained a passive acceptance among some of her colleagues:

....active support, I don't know if I'd go that far, but what I get is a resigned acceptance that I go off and do it (J.18).

The issue of inpatient versus outpatient settings was a reoccurring factor in relation to accessing supervision. With the inpatient environment being generally less flexible, finding a convenient time to attend supervision appointments was sometimes a problematic issue. Supervision was often viewed by team members in inpatient settings as less important than other matters. Nurse F explained the expectation that clinical supervision was not prioritised over other 'normal' nursing activities. She said that if the ward got busy, supervision was:

...the first thing to go for a lot of people. If the ward is busy, you're expected to pull out of supervision because it's not as important as other things on the ward (F.21).

On a positive note though, generally attitudes to supervision were perceived to be more positive and it was becoming more accepted as a core nursing activity.

Arranging supervision was less difficult in outpatient areas due to the (generally) more independent and autonomous roles and subsequent greater flexibility with scheduling. Nurse F had changed from an inpatient to outpatient work setting and the change made access to supervision much easier:

...being a community nurse is totally different to being an inpatient nurse though. The supervisees that I have find it really difficult to get away sometimes and when I look back here I can cross it in my diary and it's done... (F.20).

Nurse I felt very well supported to attend supervision. He spoke very positively of how attendance at supervision was supported in a philosophical and professional sense.

In addition he received practicable support which enabled him to stay very well engaged in the process:

I mean in terms of time and in terms of payment as well. I get paid for my time. I do it in overtime more often than not and I get time off the ward whenever it's required. There's never a question (I.18).

Another issue was system flexibility in supporting supervisor responsiveness to supervisee need, particularly in relation to matters considered urgent by the supervisee. When support was available, the benefit was obvious. Nurse F explained how her supervisor's ability to make time available for her during what she perceived to be a crisis was very supportive and reinforced the confidence she had in the effectiveness of the process:

...so [I] was able to ring her and say I need to see you and I need to see you now. I've got these things so and she said yeah sure come (F.18).

In summary, the supervisees were united in their view that support from their line managers was important in enabling them to schedule and attend supervision. They did not comment on organisational support beyond this personal interface. The support they received from their peers was sometimes a factor, but was also generally not critical because their belief in the importance of clinical supervision overcame obstacles and negative attitudes. Support had become more prevalent in recent times as supervision became more commonly integrated into practice.

SUMMARY

The findings in this theme were clearly agreed in relation to every sub-theme examined. Some participants spoke from the perspective of positive experience only, but their view was supported by those who had encountered negative experiences of supervision at some time. The negative experiences enabled a broader perspective to be gained and served to reinforce the conclusions drawn.

All participants believed that the consistent application of a structured approach to the clinical supervision session was vital. It was not stated or implied that supervisory

structure should be rigidly applied, just that an overarching and comprehensible framework was used. There was strong agreement that the actual application of supervision should be flexible and mindful of supervisee contextual factors. An essential factor required in the supervision session was for the supervisee to feel that the process was safe for them.

Participants believed that it was important for the supervisee to identify supervision direction and focus. A clear distinction was made between the process of clinical supervision and professional mentoring. Supervisees did not want to be mentored in this setting. They perceived that knowledge should be gained from their own deliberations, emerging from the structured supervision process, as it would then have more meaning and personal significance for them.

The supervisory ability of the supervisor was judged to be fundamental and was reflected in the importance supervisees placed on their supervisor's perceptiveness and specific skills such as assertiveness. Skills such as these could be viewed as techniques or components within a supervision model. However, the ability to integrate them into the supervision session flexibly and with sensitivity was thought to be vital and illustrates the perception that the supervisor's skill set competence is highly significant.

Supervisor commitment was judged to be important. At its simplest level, this applied to the supervisor being reliable in relation to simply being available and communicating matters of supervision organisation and administration diligently. It extended significantly beyond this though. Relationships were thought to be greatly enhanced when the supervisee perceived that the supervisor had a shared investment in the relationship itself and in its outcomes. Supervisor commitment was strongly reinforced to the supervisees when the supervisor acted overtly by some means to enhance supervisee welfare.

The organisational system that clinical supervision was provided in was seen as a significant factor in the facilitation of the clinical supervision process. The supervisees who were actively encouraged to attend by their managers, leaders and peers felt supported. For them, the issue of attendance was virtually unobtrusive because it became routine and had no negative impact. Some found it highly affirming to be

encouraged to attend and their belief in the process was strengthened. Those who experienced lesser levels of support held varying views. None of the participants in the study were actively discouraged from attending, but the relatively low priority that clinical supervision was perceived to hold became obvious for some when workplace matters readily subsumed supervision need. There was still some resistance from peers in some cases, but this was reported to be more passive once supervision had gained a strong foothold in clinical workplaces. In every case where peer support was low, supervisee commitment overcame obstacles to attendance.

CHAPTER 6

FINDINGS: THEME 3 - ACHIEVING POSITIVE OUTCOMES

INTRODUCTION

This short chapter explores the third and final theme ‘Achieving Positive Outcomes’. It examines elements that the mental health nurse identifies as direct developmental benefits acquired through engagement in a clinical supervision relationship. Understanding what factors related to the clinical supervision process are perceived by the supervisee to be rewarding and acting to enhance them will increase the probability of effective engagement in the relationship. Two factors have been identified and are listed in Table 5 below. Whilst they are examined separately to aid clarity, the distinction between professional and personal factors is an artificial construct as the areas of mutual inclusivity are inevitably high.

TABLE 5: THEME 3 - ACHIEVING POSITIVE OUTCOMES

Supervisee Development Factors
Role Development
Personal Development

Role Development

The sub-theme ‘Role Development’ is defined by the participant’s perception that clinical supervision is an integral part of their professional development process. All participants commented on this sub-theme in some detail and identified a direct link between developing their professional roles and the clinical supervision process. It was viewed as the most common rationale for engaging in the first instance, although other factors such as curiosity and peer pressure also played a part. A number of participants

commented that clinical supervision had become the most important component of their professional development.

I think that allowed me to I guess take on the roles that I did because I would never have envisaged doing that (D.11).

Oh it's had a big impact; yeah it's had a huge impact on my ability to do the job well and my ability to relate to other people generally because of the number of insights I've had during supervision sessions over the years (I.18).

Half the participants commented that supervision opened a pathway to a more rounded, less emotive and more objective understanding of their clinical and professional interfaces. This view was widely held and clearly articulated. Supervision was seen to be highly relevant to developing roles and nursing skills. Nurse F felt that her supervision allowed her to step outside the immediate stresses and emotional engagement of the therapeutic relationship and critically reflect in a more objective manner:

...being able to look back and look at ok, what are potentially the difficulties going on between the therapeutic phase of the [client group] or I'm getting really pissed off by this particular colleague or this thing keeps happening, I need to think about this a bit more rather than just allowing it to continue (F.23).

Supervision opened up new possibilities for her in terms of being able to see what she hadn't previously been able to:

...it gave me a sense of being able to see, it was like turning a light on in a room and actually seeing the whole room... (F.25).

Nurse C was another who discussed the importance clinical supervision had in developing her ability to be less emotive and more reflective and objective. She described how her increased ability to reflect in an objective manner had made her a more effective clinician:

...rather than just reacting to my thoughts and reacting to what's around me, it does help me stop and reflect more, there's more than what I just immediately initially think... (C.9).

Several nurses felt that successfully progressing to new and demanding professional roles was positively influenced by engagement with clinical supervision. One explained how supervision enabled her to develop effective behaviours (or roles) congruent with her new position. It provided a setting where she could explore how she should present herself in a professional capacity, whilst also feeling supported to deal with the attendant emotions and pressures. Managing these issues allowed her to convey a sense of being in control:

...to me that's really important because in my work place I like to have a how would I put it, a stabilising influence rather than being all over the place (D.9).

The idea that clinical supervision resulted in a professional development focus that had a wider, more inclusive perspective was noted by two participants. They accepted limitations in their ability to see what they described as 'the complete picture' and felt that their supervision enabled them to practice in a more rounded way. Supervision was seen as a means by which disparate ideas and views could be filtered and reflected upon. Away from the immediate workplace pressures, supervision provided an environment that was conducive to reasoned discussion and reflection.

Some participants reported that previous supervisory experiences had left them feeling dissatisfied in terms of their overall progress and sense of role development. In fact, all of these past supervision arrangements had since terminated. The apparent failure of these relationships served to reinforce the importance of perceived role development for the nurses in this study. When professional benefit was perceived to be absent from supervisory relationships, the participants' response was to conclude that the relationship was not worth pursuing.

Personal Development

In the sub-theme ‘Personal Development’, content is identified by the participants noting personal effects and consequences of their involvement with the clinical supervision process. It was not possible to separate professional and personal development at times, therefore some duplication is evident. This is not surprising with nurses working in the mental health area as the professional role is intrinsically linked with interpersonal abilities.

The participants commented on this sub-theme in a majority of cases. Generally the link to personal development was expressed in broad descriptive terms rather than with a discrete and specific focus. The perceived link between clinical supervision and generalised personal growth and consequential positive impact on the participant’s non-work related life was nonetheless quite significant. All the participants who recognised personal development secondary to their involvement with clinical supervision held the same view.

Nurse I was quite clear that professional and personal development were absolutely linked. For him, the correlation was impossible to miss. He was quite clear that advances in his professional capacity were paralleled by those in his personal life, reinforcing further that clinical supervision was a worthwhile process:

I made some quite substantial moves forward in my life generally as a result of the supervision at that time (I.5).

Nurse D held substantially similar views. She described the processes conducted within the supervision relationship as providing a path to personal discovery and understanding:

...my supervision with her for the whole 10 years was very, very intense and that sort of I guess was part of my own self discovery (D.11).

Personal gains from engagement in supervision were more often conceptualised in general developmental terms, implied rather than stated specifically. One participant felt she had become more confident as a consequence:

I think one of the biggest things that I gained from that initial supervision was confidence” (D.11).

Nurse I was less specific, but discussed gains specifically around a cluster of relationship related professional skills, but linked them clearly with his personal development:

...it's had a huge impact on my ability to do the job well and my ability to relate to other people generally... (I.18).

Only one participant found the professional and personal development link less tangible. Her uncertainty may have been influenced by factors beyond the scope of this sub-theme (such as the non-nursing profession of her then supervisor). The link, whilst not discounted, was not certain for her:

I think I developed personally. Whether I developed as a nurse I'm not sure (A.13).

The personal development resulting from engagement with clinical supervision was perceived by a majority of this group as personally important, in several cases profoundly so. The link between role development and personal development was clearly identified, often to the extent that they were inseparable.

SUMMARY

The importance of the clinical supervision relationship as a conduit to development was clearly made. It encompassed both role and personal development. The participants found that a direct connection between clinical supervision and positive developmental gains, professional and personal, strengthened their commitment and belief in the process. Those who had experienced clinical supervision relationships where they did not experience or perceive developmental advantages were unable to maintain their enthusiasm. This remained so even when the process was otherwise comfortable for them. In each of these instances, the relationship was either formally terminated or passively avoided; in any case the end result was the same.

Clinical supervision was seen to be an integral part of professional development. When supervision was experienced as effective by the supervisee, it was seen to provide an environment that enabled open and forthright reflection and examination of professional ability, attitudes, knowledge and practice. This was seen to be highly advantageous to the development of professional ability. It also gave the nurses confidence to challenge limitations in their clinical practice and to tackle new and challenging roles.

The participants also perceived, passionately in some cases, that clinical supervision had a significant positive influence on their personal development. They identified personal gains and increased confidence in relation to their approach to life in general. Supervision was seen to be supportive and an important tool in managing workplace stress, but also in providing a positive pathway to personal growth and achievement.

The discussion chapter follows. It considers information previously presented and interprets its significance in the context of the study setting. Information from the literature review and research findings is discussed in relation to the research question. Three core principles are interpreted and synthesised into a conceptual development of an effective clinical supervision cycle. Implications and recommendations for clinical practice and for future research are formulated along with an assessment of the limitations and strengths of the study.

CHAPTER 7

DISCUSSION

The findings from each theme have been summarised in the previous three chapters to develop an understanding of their significance. The information emerging from the summaries is synthesised and analysed. The relationship and significance they have in relation to the research question is discussed. It is not proposed that the component parts of each theme will be examined as this is covered in the findings chapters. The numerically small and narrow participant sample in the study does not allow categorical conclusions beyond the scope of the study to be made. The conclusions made have been developed with this factor clearly acknowledged.

THEME SYNTHESIS

The three themes emerging from the study have until this point been examined as separate entities. The effects they have on the supervisee's perception of the effectiveness of their own clinical supervision are a consequence of their symbiotic relationship. It is their cumulative underpinnings that form the basis of the answer to the research question, 'What are the factors that affect the success of a clinical supervision relationship?'

In addressing the research question, a further step of analysis is required. The themes are interpreted so that the collective data can be reduced to core conceptual meanings, linking the emergent findings as rich data which has been thematically classified. A conceptual framework is developed that integrates knowledge into an understanding of the determinants of effectiveness within the clinical supervision process.

The analysis of reduced data identified three core determinants of effectiveness. They are:

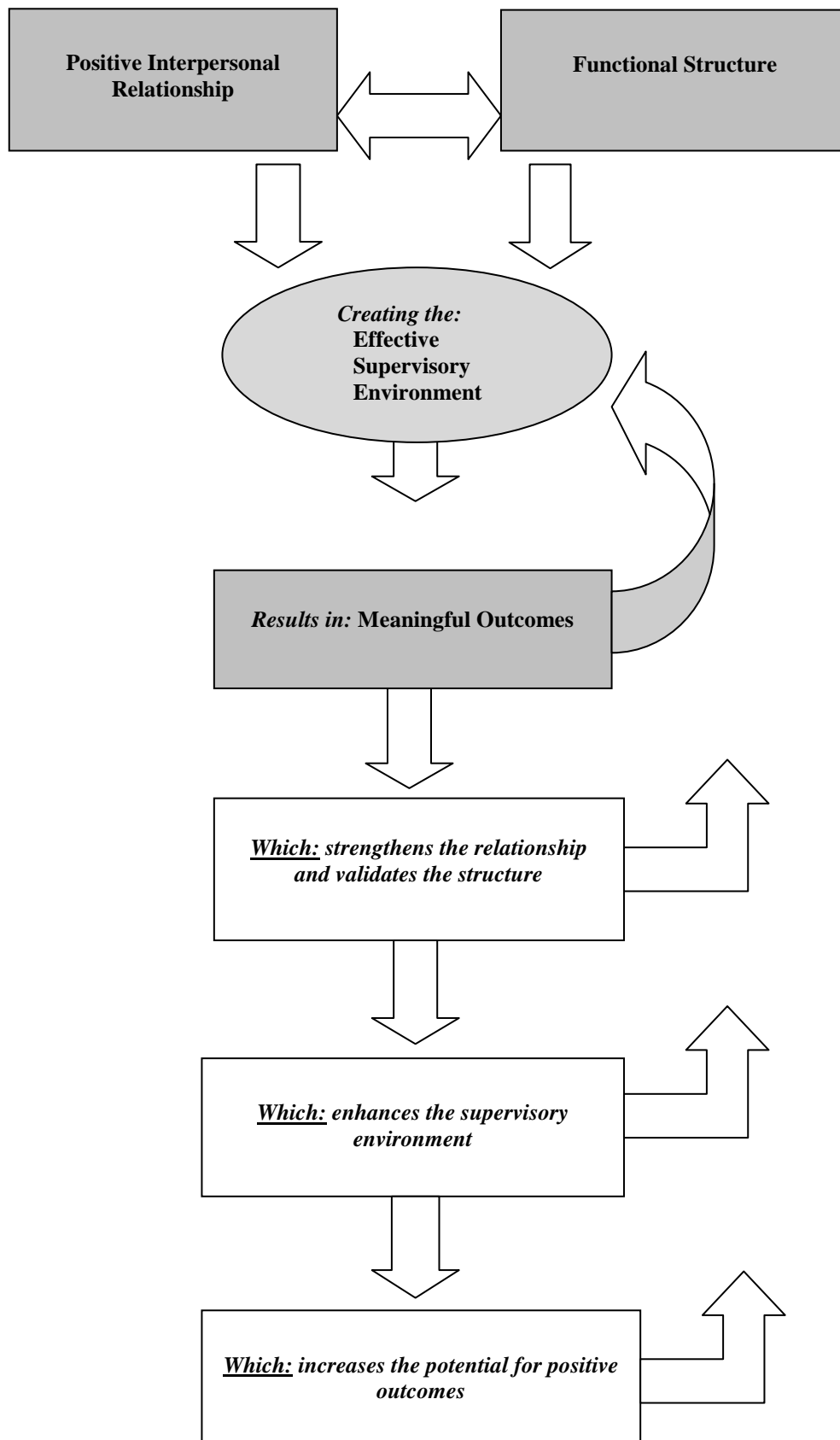
- 1) A positive interpersonal relationship
- 2) A functional structure
- 3) Meaningful outcomes

Each determinant addresses a different aspect of the clinical supervision process, but the overall function of the supervision relationship is dependent on the collective effectiveness of each part. Cumulatively and in broad conceptual terms, these three determinants provide a perspective on the research question.

Where these determinants sit in relation to each other is an interesting point. One could consider them as a continuum, but to do so would disregard the symbiotic relationship that exists. Collectively they form a process or system and this interdependence inevitably means that all factors are important. The differentiation between them is that the first two determinants are judged to result in the third; the outcomes that are meaningful to the supervisee. The functional link between the positive relationship and the functional structure is that together they create the effective supervisory environment. If the combination of the positive relationship and the functional structure is congruent with supervisee need, it enables or at least increases the potential for effective outcomes.

The process does not conclude at this point though, as a significant cyclical aspect is also present. If the supervisee continues to experience positive outcomes from their supervision, trust is strengthened, both in the relationship and in the structural components of the process. As these elements are validated over time, investment in the process is reinforced and engagement is consequently more effective. Conversely, supervisee perception that supervision is not delivering positive outcomes will result in a lessening of trust in both the relationship and the structure being applied. The potential for effective engagement is thus reduced. The cycle is displayed below in Diagram A.

Diagram A: The Effective Clinical Supervision Cycle



Creating the Effective Supervisory Environment

Component 1: The Positive Interpersonal Relationship

The first component of the effective supervisory environment is the 'positive interpersonal relationship'. A feature of some findings related to this thematic stream was that the participants held a wide range of views as to what the constituent parts of a positive supervisory relationship actually are. For some, this meant for example a close match in relation to aspects such as personal values, professional experience and expertise. Others felt that these factors did not matter as long as some other groupings of criteria important to them were satisfied. Notwithstanding this variance in identified compatibility criteria, a belief in relationship primacy is clearly evidenced.

The findings show that the interpersonal relationship in clinical supervision is important for the participant group. This is not surprising as nursing has been long acknowledged as a relationship orientated profession (Murphy, 2009; Raingruber, 2003). The key aspect to a functional relationship is the ability for each participant to engage with the other so that communication is facilitated and the goals of the relationship, stated or assumed, may be met. The clinical supervision relationship operates within the same paradigm (Kavanagh et al., 2002; Knutton & Pover, 2004a; Wilkin, 2009). It is critical that the supervisee and the supervisor effectively engage on both an interpersonal level and an ongoing basis to provide the foundation for progress (Sloan, 1999). This view is extensively supported in clinical supervision literature.

Hadfield (2000) describes a model which identifies the interdependency of three processes; the relationship, working through and outcomes. The conclusions reached have similarities to those reached in this study. Hadfield's findings reflect the seminal and highly influential work of Rogers (1951), who discussed the centrality of the relationship to the supervision process. He believed that supervisors should display empathy, genuineness and unconditional positive regard in order to create a safe environment that offers a pathway for development. Sloan (1999) states that the ability to form good relationships is a characteristic of a good supervisor, while Kilminster and Jolly (2000) maintain that the supervision relationship is the single most important factor governing the effectiveness of clinical supervision.

Relationship primacy is illuminated more clearly when examining the contrary situation, whereby the supervisory relationship is not experienced positively. There is a strong body of evidence that reports ineffectual outcomes from the clinical supervision process if the relationship is not perceived to be positive. This appears to be more commonly evident in line management forms of supervision (Johns, 2001; Kavanagh et al., 2002; Sloan 1999; Yegdich, 1999a).

All determinants of engagement are eventually brought into focus in the spotlight of the clinical supervision session. It is there that the supervisee and supervisor each make a decision, conscious or sub-conscious, as to whether they are able to engage on an interpersonal level. Wilkin (2009) ascribes equal relationship responsibility to both participants and says that “There must be mutual trust, respect and honesty: enough ‘togetherness’ to guarantee that the supervisory journey is a shared undertaking with boundaries agreed beforehand” (p. 657).

Engagement, initial and ongoing within a clinical supervision relationship is not an event; rather it is a process. Individuals will experience the relationship in different ways, but in every case, how it is viewed will be dynamic rather than static. Some participants, supervisee or supervisor, will for example engage more quickly than others, some more superficially. Some may be more open, less judging or critical, while others may be less flexible about essential characteristics of their partner.

An explanation of why a good relationship is important to the supervisee and to a lesser extent the supervisor has been given. Its presence is also facilitative in relation to defining the boundaries into which the supervision structure must fit. This is because the potential for effective application of supervision process is always defined by the strength of the relationship. How the process of supervision is applied is the other essential element in the creation of the effective supervisory environment.

Component 2: A Functional Structure

As discussed above, the effective application of supervision structure is the second determinant in the creation of the supervisory environment. The two determinants are diagrammatically grouped on the same tier because a cyclic link between the

supervisory relationship and the supervision structure exists. In conceptual terms, the structure works to apply a system of supervision, but its potential effectiveness is governed by the relationship parameters and its unique characteristics, both positive and negative. The process is however not a one way stream. Effective application of supervision structure, working within the limits of the current relationship dynamics also nurtures and reinforces the relationship. By doing so, the potential facilitative scope of the supervisory structure is enhanced.

The ability the supervisor possesses in regard to the relationship has been considered previously. In real terms though, the distinction between relational ability and the ability to provide a functional structure around the relationship is an artificial one. It is important to give credence to the supervisor's ability to provide a functional structure as it plays such a vital part in the creation of the effective supervisory environment (Edwards et al., 2005; Hadfield, 2000). The importance is shown in the findings chapter of this study. It was identified that some of the participants felt the ability of their supervisor to structure and deliver a supervision session was more important than their (the supervisor's) personal qualities and interpersonal compatibility. For these nurses, the supervisor's compatibility was defined by the supervisee primarily through their perceived ability as a supervisor.

It may now be useful to provide a definition, formulated from the findings of what is meant by a functional structure within this context:

- a) A distinct supervision model or framework is used
- b) The supervisor has the abilities required to apply the model in an effective manner
- c) The organisational factors required to positively facilitate attendance are present

It is seen that there are two broad points of focus. The first, referring to points a and b, is related to the delivery or facilitation of the supervision session. Its parameters are defined by supervisor ability in the broadest sense. The second focus, point c above, is the degree of practical and logistical support provided by the organisation that the supervisee perceives to be necessary in order to enable them to functionally access the process.

Looking at the first requirement, the facilitation of the supervision session, the central premise is that the supervisor must have the capability to effectively structure the session. Taking cognisance of the points defining effective structure noted previously, it is seen that the supervisor will be required to have specific knowledge and abilities in order to be meet this requirement. This implies that they must be trained to deliver supervision within a specific model (or models). Additionally, their training must be sufficiently effective and regular that the principles espoused are able to be effectively applied within the clinical supervision session.

The findings indicated a clear link between a perceived absence of structure in the supervisory relationship and ineffective outcomes. The use and effective application of a supervision model is seen by the supervisee to increase the probability that effective outcomes will be achieved. There are numerous reasons why this occurs and whilst it is beyond the scope of this project to examine them in detail, a brief exploration may be useful. It should be noted that the impact of the application of a model is dependent both on how it is applied and the compatibility it has with the individual supervisee. Sloan and Watson (2002) say that supervision structure highlights stages in the process, clarifies important functions, roles for the participants and provides focus. A structured approach to clinical supervision enables or even demands that the goals of supervision are clearly kept in view (Sloan & Watson, 2002). In doing this, it places boundaries on what is relevant within the supervision session and supervisee focus is able to be channelled into effective exploratory pathways. Stoltenberg (2005) describes the relationship between supervisory goals and structure succinctly when he says: “Having a destination in mind is a nice start, but having a road map that provides guidance on how to get there is equally valuable” (p. 862).

Keeping goal focused is not a confining dynamic in the supervision process. The application of structure is flexibly determined by the supervisor working within their practical ability as a supervisor and the capability they judge the supervisee to have. Increased supervisor ability enables approaches to the supervision model to be more flexible, imaginative and spontaneous (Consedine, 2003). This potentially enhances access to understanding through more flexible application of a model’s core principles. It may validate some supervisory techniques such as the use of ‘authority’ and

‘challenge’ (Hadfield, 2000; Knutton & Pover, 2004b) that might otherwise sit beyond the interpersonal comfort zone of either participant.

Working within a distinct structure has the potential to positively influence the relationship in a number of ways. It is not desirable to be rigidly tied to a mechanistic approach (Hadfield, 2000). However, clear structure will allow the supervisee’s perception of success to be less constrained by the limitations of the interpersonal dynamics in the supervision relationship. This has an emancipatory effect on the supervision process. It allows the supervisor to use approaches that expand on the boundaries otherwise defined and limited by the scope and quality of the core relationship. The supervisee’s acceptance of the model or process, characterised by a belief in its efficacy and its safety, allows the supervisor to explore more eclectic supervisory methodology (Kavanagh et al., 2002; Stoltenberg, 2005). This increases the potential for effective outcomes to be achieved. Whilst it is recognised that the supervisory relationship is absolutely fundamental to the effectiveness of clinical supervision, it is clearly bolstered by the application of sound supervision structure.

In addition to reinforcing supervision as a safe process for the supervisee, structure also gives the supervisor an understanding of the supervisee role and responsibilities (Landmark, Storm Hansen, Bjones & Bohler, 2003; Sloan & Watson, 2002). Ideally the supervisee would gain understanding as part of a preparatory process before commencing a supervision relationship. Even if that did not occur though, a supervisor will have responsibilities to discuss with their supervisee what happens, when it happens and who does what. By these means, the supervisee will know what to expect from their supervision and what part they might play.

The application of structure will also serve to explain the supervisor’s role to the supervisee. The approach will vary depending on the supervision model being practiced. In any case though, it will enable the supervisor to position their role within that supervision framework. This will allow both them and the supervisee to know what they are trying to do and in non-specific terms, the ways they might go about it (Kavanagh et al., 2002). For the supervisor, it provides a flexible process to follow. The process provides a general guide when used in a flexible and adaptive way. It can also outline a specific set of approaches to take when their ability or focus is

challenged by the context emerging from the supervisory session or process. The clear application of structure will also become familiar and trusted by the supervisee and will enable more effective integration into the supervision process. The supervisory partnership will be enhanced and positive supervisee outcomes will become more accessible.

The second requirement of effective structure is that infrastructural elements of the system in which clinical supervision is governed are perceived by the supervisee to be facilitative rather than obstructive (Landmark et al., 2003). This requirement translates to an organisational position that responds through actions which confirm that clinical supervision is important. An organisation may hold this view for a range of reasons; for example, belief in the correlation to improved care, to employee support or to their capacity to satisfy systems compliance demands. In the final analysis though, the reasons for its support are less important than the fact that it is supported. An organisational mandate requires a functional governance process to stand behind it (Kavanagh et al., 2002), which in turn involves implementation of practices that support engagement with supervision. It is unlikely that clinical supervision will be unanimously supported by every key person in an organisational chain. This suggests that the organisation's support must be categorically stated and accompanied by clear process demands. The ability for the supervisee to effectively engage in the clinical supervision relationship is absolutely dependent on the organisational systems related requirements being met.

Meaningful Outcomes

Whether the subject 'meaningful outcomes' should be included in this discussion was initially a matter of some conjecture, because outcomes could be interpreted to only be a consequence of the process components of the clinical supervision cycle. On reflection though, it was thought to play such an integral part in the creation of a functional supervision cycle that its inclusion was deemed to be fundamental. Meaningful outcomes stand outside the effective supervision environment category because rather than existing as a component part of it, it is conceptualised as being a product of it.

The consequence for the supervisee of a positive supervisory relationship and a functional supervision structure is that positive outcomes are far more likely to be achieved. It could be assumed therefore that the realisation of meaningful outcomes have a passive role in the cycle. This perspective though ignores an important point. The realisation of outcomes also has the effect of imparting confidence and trust in the interpersonal aspects of the supervisory relationship and in the effectiveness of the supervision structure. The cycle created, labelled 'The Effective Clinical Supervision Cycle' is therefore completed and both the effectiveness and potential of the positive supervisory environment is enhanced.

The cycle is likely to influence supervisor perception of the clinical supervision process. If positive outcomes are conceptualised as such by the supervisee, it is probable that because the supervision relationship is a partnership, the supervisor will also react positively to success. Whether this will result in them becoming a more effective supervisor is speculative and beyond the limits of this project. It would be hard to argue though that it would not at the least reinforce their commitment and enthusiasm, qualities which are perceived to be important by supervisees in promoting relationship engagement. If additionally, it also has the effect of developing supervisor ability as suggested by Wilkins (2009), a case of development begetting development would be evident. The highly probable, possibly inevitable outcome of this is further development, clearer supervisory focus and enhancement of the supervisory environment.

CONCLUSION

This study aimed to establish from the clinical supervisee's perspective, an interpretation of their responses to the research question "What are the factors that affect the success of a clinical supervision relationship?" The response has emerged in two forms. The first one directly addresses the question through a specific factor by factor analysis generalised into three broad themes. The second part identifies in broadly defined conceptual terms, the core principles that determine success within the clinical supervision process.

At its first point, it was thought that the fundamentally simple research question would attract findings that would be similarly straight-forward. Through the analysis of the sub-thematic factors, a direct understanding of the importance and potential consistency of the individual sub-thematic factors influencing success *for this cohort, at this time and in the existing context* was made. From this information, explained in detail in the Findings chapter, it was seen that the effects of some sub-thematic factors were consistently perceived, while others were not. This is significant because where effects were consistently found, generalised assumptions may be more reliably made regarding the impact they are likely to have on the supervision process. Of equal utility, the inconsistency of other factors suggests that assumptions should not be made in these cases. Instead, consideration of a supervisee's individual circumstances and characteristics should be weighted more heavily when considering the practical application to the actual practice of supervision.

The second component of the analysis defined core principles of the determinants of success within the clinical supervision relationship. It moved beyond the literal focus on individual factors and their correlation to success and defined instead the overarching conceptual needs of the effective supervisory partnership. Two initial broad requirements for success were identified from the three themes, namely the existence of a positive interpersonal relationship and a functional supervision structure. The two descriptors, each an amalgam of inter-related factors, combine to form the basic foundation of the supervision process, the effective supervisory environment. It is the functional and pragmatic real-life translation of this abstract formulation that defines the probability or even the possibility of the supervisee perceiving that the clinical supervision process is effective for them. This is reflected in the third core principle; whether the supervisee perceives that supervision has enabled them to achieve meaningful outcomes or in simple terms, whether the process has succeeded or failed for them.

Implications and Recommendations for Clinical Practice

Clinical supervision in mental health nursing exists for the participant group within both a national and local context and is required to take cognisance of both. Wider

applicability beyond the mental health nursing context is not excluded, but the limited scope of the study does not allow broader implications to be drawn.

All implications and recommendations arise from the key requirements identified within the local context of the study. On one hand, they are formulated to either directly or indirectly address specific individual factors identified by the participants that influence the success of each clinical supervision session. Alongside the individual factors, recommendations targeting the identified core principles within the effective clinical supervision cycle are addressed. Unsurprisingly, a degree of mutual inclusivity is evident.

In developing all implications and recommendations, reference was particularly made to the '*National Guidelines for the Professional Supervision of Mental Health and Addiction Nurses*' report (Te Pou, 2009). Doing so allowed the broad national overview or direction to be factored, thus ensuring congruence within the limitations in study scope. The development of implications and recommendations for clinical practice is explained below.

The analysis of findings concluded that an effective supervisory environment, formed from the combined effects of a positive relationship and a functional structure, is the foundation of an effective supervision process. Consequently, a focus on enhancing these requirements is likely to positively influence effectiveness. In hand with development of the supervisory relationship and structure is a mechanism that enables the effects to be understood. A process to evaluate outcomes is required. Data emerging from outcome evaluation is directly relevant to the ongoing development of clinical supervision. The supervision participants, trainers and the organisation will benefit from findings and it may also contribute towards national and international perspectives and knowledge.

The three implications emerging from the study are noted below. They are briefly explained and the links with the study are made. Broad recommendations that will address them are formulated.

Implication 1: Supervision effectiveness is enhanced through increased supervisee knowledge of the supervision process at all stages, particularly during preparation phases.

A consistent message from the participants was that an understanding of respective roles, the purpose of clinical supervision and how it is conducted is important. The study clearly found a strong relationship between increased supervisee knowledge and their perception of its effectiveness. Participants reported that increased levels of supervision knowledge decreased supervisee stress and anxiety, reduced barriers to open communication, increased trust and generally enhanced the quality of the supervisory relationship. Preparation for engagement was considered particularly important. All participants in the study also believed their own supervision was enhanced when they undertook supervisor training themselves. Recommendations are therefore made to target supervisee knowledge and understanding of the clinical supervision process.

Recommendations

- Comprehensive supervision orientation programmes are provided to the supervisee prior to their commencing supervision.
- The SMHS web based supervision information and education resource will be expanded. Specifically, information will be collated and categorised to cover:
 - SMHS supervision orientation information.
 - Access to national supervision information and orientation resources.
 - Supervision frameworks information (in SMHS supported frameworks) to support ongoing development and maintenance of supervision participants.
 - Supervision research.
 - An article database.
- The SMHS will collaborate with nursing education providers so that nursing students are orientated to SMHS supervision practice prior to and during their SMHS clinical placements.

- Orientation requirements will be embedded into SMHS supervision policy.
- Supervisees will be supported to undertake supervision training and deliver supervision to others.

Implication 2: The ability for the supervisor to create an effective supervisory environment is central to the effectiveness of clinical supervision.

The findings showed that supervisor ability is a foundation of effective clinical supervision delivery. The supervisor is required to amalgamate a complex and dynamic set of interpersonal and environmental variables and organise them into a coherent supervision session. The practical ability to positively influence the supervision relationship and create a functional supervisory structure was clearly identified. It was found that the supervisor must possess a range of effective interpersonal skills and satisfactory knowledge of the supervision framework they use. Alongside these characteristics was the ability to functionally apply them in the supervisory environment. A set of recommendations are therefore aligned to emphasise supervisor training.

In addition, the study found a second determinant in the creation of the effective supervisory environment; whereby the supervision system supports the supervision delivery process. Embedding support and continuity into operational policy is important so that support is mandated, not optional. Further recommendations are developed to integrate organisational and system support with effective supervisor ability. Ensuring that supervisor performance is assessed, maintained and developed is a key goal. The provision of a formal supervisor competence assessment process will enable competence to be tracked and consequential training requirements to be planned.

Recommendations

- Localised supervisor training will be provided, using a credible, consistent model that is mandated by the organisation and consistent with national sector development.

- Training will emphasise factors related to the provision of a positive supervision relationship and a functional supervision structure.
- Research findings (from the study) will be made available to inform local clinical supervision training programmes and to add to the organisations supervision information resource.
- The matching system used within the SMHS will be reviewed to further emphasise supervisee choice. Participant matching processes will adopt practices which reflect national workforce development recommendations. Factors influencing engagement identified in this study will be incorporated into system guidelines.
- Supervisor training will include a regular schedule of ongoing development training.
- An accreditation process will be developed to recognise, support, develop and report supervisor competence.
- Organisational clinical supervision policy is developed which mandates requirements for organisational support.

Implication 3: Clinical supervision outcomes should be assessed.

The findings of the study showed the cyclic link made when the supervisor perceived that supervision enabled them to realise outcomes that were important to them. Understanding the effects and effectiveness of clinical supervision was seen to be fundamental to its provision. There are numerous stakeholders in a clinical supervision system and all will have interest in its outcomes. Most obviously they are the supervisee, the supervisor, the resourcing organisation and the training providers. Additionally nursing education providers have an investment so supervision education alignment can be maintained. The final focus of supervision assessment and outcomes is as a contribution to the national perspective. Development of clinical supervision is highly relevant to national workforce development organisations, the Nursing Council of New Zealand, academic bodies and nursing professional organisations.

The recommendations listed below aim primarily to enhance understanding of what supervision achieves for the supervisor. Effects will be understood and development, particularly training and systems needs will be informed. This will encourage shared investment in supervision provision and in it achieving positive outcomes. Audit and research are two avenues which would facilitate effective data collection. The utilisation of nationally aligned processes where they are available is indicated.

Recommendations

- Key performance indicators (KPIs) will be developed and embedded in clinical supervision policy.
- Mandatory evaluation of clinical supervision outcomes will be undertaken at scheduled intervals through agreed processes such as audit.
- Outcome evaluation processes will converge with national processes where these are available.
- Research, audit and supervision training evaluation processes will be incorporated into training programmes development.
- Research into supervision outcomes will be supported where practicable.

Implications for Future Research

The weight of evidence in the study supports the view that clinical supervision is a positive experience for the participants. It is ultimately the supervisee's individual experience of the functional utility of the clinical supervision process, the delivery of meaningful outcomes in whatever form they exist which is spotlighted. Two main foci of scrutiny for future research have been identified and they reflect the conclusions reached from the analysis undertaken in the discussion chapter.

More research is required into the individual factors which influence the effectiveness of the clinical supervision process. As noted in the section on data analysis, many more potential sub-thematic factors were identified during the initial analysis of the transcripts. The final number scrutinised though (22) was only 34% of the originally

identified cumulative sub-thematic sample (64). This numerical reduction resulted from an analysis of the quality and quantity of the data originally identified. Those factors subsequently omitted were seen to be deficient in the quantity and/or quality of data available and could consequently not maintain contextual credibility. Notwithstanding this filtering, a proportion of these omitted factors were thought to be potentially relevant and informing. Research that extends the parameters of the interview focus and works with a more diverse sample could potentially yield a wider and more discretely definable data set. This would increase understanding of the influence these factors have on supervision effectiveness. A more complex analysis of sub-thematic factors, specifically targeting the effects that they have on the creation of the effective supervisory environment would be a positive focus for future research.

The first determinant on the effective supervisory environment is a focus on the positive supervisory relationship. Whilst a great deal has been written of the importance of the relationship, the focus on it in relation to clinical supervision specifically is less comprehensive. Identifying and increasing understanding of supervisory relationship dynamics and the relative influence that identified thematic and sub-thematic factors have on them is of immense relevance in supporting the formation of a positive relationship. Embedding this knowledge will allow a clear focus for training and will allow supervision resources, human and fiscal, to be more coherently allocated.

The second determinant of the formation of an effective supervisory environment is the provision of a functional supervisory structure. The study has identified the shared primacy of this factor by highlighting the imperative of clinical supervisor ability, specifically focussed on the application of supervision methodology. Acknowledging its importance, research into what is required to embed supervisor competence is indicated. Questions concerning the form and extent of training along with a longitudinal view on ongoing supervisor ability development and maintenance would be worthy subjects for future research. It would dovetail neatly with inquiry into the supervisee's perception of methodological effectiveness.

Following on naturally from the two determinants of the effective supervisory environment, the focus moves to the effect of its existence, the outcomes perceived by

the supervisee. Whilst this area has been studied in some detail in relation to mental health nursing, the results are often quite specific to the cohort studied and to a system or framework of supervision more generally. Studies which utilised the Manchester Clinical Supervision Scale (Winstanley, 2000) as a measurement tool cannot be replicated by studies which do not use Proctor's Supervision Alliance Model (Kelly et al., 2001a; Proctor, 2001). The difficulty therefore faced is to conduct research that is credible in methodological terms, useful to the supervisee and the supervisor, and informs training and organisational needs. The view assumed is that understanding outcomes is always useful and that whilst research consistency is desirable, it may not always be possible. In the localised context in which this research was conducted, an understanding of what clinical supervision achieves would be beneficial. Applicability in the wider mental health nursing context would not be so certain, but as a component of a wider evidential base, some utility is highly probable.

Limitations and Strengths of the Study

The project was a small qualitative study, limited to ten participants and was confined to one organisation. The subject was reasonably narrowly focused and as such excluded information that may have been useful in the wider context of mental health nursing supervision. Due to these limitations, it may be assumed that caution in its wider applicability should be exercised. The participants worked with one predominant and two less utilised models of supervision. Whether the results that emerged are transferable to other renditions of supervision frameworks are not and cannot be, definitively known. Where other evidence is available that supports findings, it has been noted though. In these cases, credibility is enhanced through the overall weight of evidence in related literature.

In addition to their numerically small number, the participants also represented a reasonably narrow range of potential supervisees. They were all mental health nurses, but it was a limitation that all were experienced, as it was that all were current supervisors as well as supervisees. It is noted that whilst participants were selected by a convenience sampling method, virtually all respondents were current supervisors. This suggests that as a group they were likely to be well disposed towards the concept of clinical supervision and this may have narrowed the perspective gained. Balancing

this was the fact that amongst the participants, there were a number who reported significant negative experiences of clinical supervision in the past, even though currently they all experienced it positively. It may have been informative to interview nurses who had less professional and clinical supervision experience, but the one potential participant available who met these criteria withdrew from the study for unrelated reasons prior to interview.

A further limitation was that males were greatly under-represented in the initial group of respondents. This reflects gender imbalance in the local nursing workforce, but it was even more marked in the respondent group. A similar limitation occurred in relation to ethnic diversity of the participant group. Ethnic identification was not sought during the recruitment process. The fact that all participants identified as European New Zealanders posed obvious barriers to wider cultural interpretation.

As previously noted in the 'Implications for future research' section, the limited study scope resulted in some promising points of focus not being pursued. Some data interpreted to be of meaningful quality was found, but the volume was inadequate to support research credibility. In other cases, a point of focus was widely discussed, but was found to be qualitatively insubstantial and was therefore also not pursued. A larger study may have elicited more discussion and may have taken at least some of these factors over the required threshold for inclusion.

On the positive side, the methodology used proved effective. It enabled the identification and collation of a large volume of raw data, its conversion from individually identified factors into clusters of related significance and finally into core conceptual meanings. Credibility was enhanced as data eligibility demanded that volume and quality thresholds be attained. The process ensured that findings could literally only support what was adequately found. When participant discussion was interpreted, direct quotes were used to illustrate typical ideas or key points and this further embedded the requirement for accuracy and relevance. Credibility was further reinforced through the systematic application of methodology which was tracked through the maintenance of a comprehensive documentation process.

Through the tenure of the study, a continuous reflective process was adhered to. Academic supervision was regularly attended and clinical supervision was also utilised. Reference to respected contemporary and seminal literature dictated that the emerging data was continually scrutinised and ideas were developed and tested. Attending to methodical systems demanded that high standards of academic rigour be attained throughout the process, from the early identification of potential data through to the final stage of interpreting core principles.

Confirmability was also enhanced through the extensive document tracking system employed. Whilst the volume of documents was substantial, each version of a document relates to other versions in an identifiable progression. Each is also linked logically with all versions of other document categories as well. This system has the advantage that data that is not processed through to the study conclusion for a wide variety of reasons, but is considered to be potentially of interest for future research is readily available in an identifiable and accessible form.

This small study has unsurprisingly not discovered any new and profound 'basket of knowledge' about clinical supervision. It has though, allowed a view into the supervision world of a group of mental health nurses. Through their openness and intelligence, an understanding has been formed about what they understand clinical supervision is, what it does and what it should do. Clinical supervision in mental health nursing can no longer be viewed as vulnerable in the sense that it is now a widely accepted process. To develop in this context, to effectively meet its conceptual aims demands a focus on purpose and outcomes that are aligned with improving the human experience. It is hoped that the study will contribute.

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APPENDICES

APPENDIX 1: PARTICIPANT INFORMATION SHEET



Specialist Mental Health Services

Mental Health Nursing Clinical Supervision Information Sheet

You are invited to take part in a study that will identify, define and understand factors that affect the utility and efficacy of the Canterbury District Health Board, Mental Health Service (CDHB) nursing clinical supervision programme.

THE STUDY

Information will be sought that will inform Clinical Supervisors, nursing leaders, supervision providers and line management budget holders at all levels, how the probability that individual clinical supervision relationships will be effective, can be increased. The understanding of 'successful' in this context will be defined by reference to the afore-mentioned group and by the supervisees themselves.

It is proposed that a group of eight respondents be sourced. The research will focus on your role as a supervisee. Whilst you may also be a supervisor, only information pertaining to your supervisee role will be targeted. Information will be sought in relation to your ability to participate in the project over an adequate period in the absence of unpredictable events or issues arising.

The participants will be selected by advertising through the organisational nursing networks. The list of nurses compiled will be sorted by convenience sampling to represent as well as possible, a cross section of nurses engaged in the clinical supervision programme. This will be facilitated by reference to the Nursing Directorate.

WHAT WOULD YOU HAVE TO DO?

If you are interested in being involved in the study, you will be given a copy of this information sheet. You will have the opportunity to ask questions about any aspects of the study that you are unclear about.

Once you have agreed to participate, an interview will be arranged. This will take approximately 1 hour, though this time will be dependent on the volume and nature of the information that emerges. The interview will be recorded on an audiotape and the investigator may take notes and /or request clarification of points that are unclear at or before the transcription phase. Information will be securely stored (see Confidentiality) for a period of 5 years after the end of the project, after which it will be destroyed.

A range of structured questions will elicit information and data and about you and your clinical supervision experience. Data on your work area and work experience,

your age and role, the length of time that you've been in a clinical supervision relationship and your patterns of attendance will be discussed. Your perception of the profile of your Clinical Supervisor will likewise be investigated. Your subjective experiences of clinical supervision and the efficacy of the relationship(s) will be explored and the impact on you professionally and personally will be discussed. Your understanding and interpretation of the purpose and method of the clinical supervision process will be investigated and related to factors that you judge to affect the effectiveness of the process. During the interview, generalised themes should emerge in response to initial questions. The investigator will ask follow up questions to increase understanding of factors identified. It is not possible to accurately predict what these may be, but possible examples could include the effects on the supervisory relationship of:

- The relative ages of the supervisee and supervisor
- Ethnic or cultural beliefs
- Your frequency of attendance
- The degree of structure provided during supervision sessions
- Support from your Line Managers
- The experience your supervisor has in your clinical area
- The type of training that your Clinical Supervisor has had
- Your experience as a clinical Supervisee
- Your experience as a clinical Supervisor

The use of structured questions will maintain a general continuity between interviews, but the individual nature of responses will identify a range of themes and dictate the direction of follow-up questions.

Indications of structured questions are noted below.

- Can you tell me about your nursing background?
- What clinical area do you work in?
- Where did you receive your nursing training?
- What age (range) are you in?
- How long have you received clinical supervision?
- Do you provide clinical supervision for other nurses? If so, what training did you receive?
- Do you know the clinical supervision model that your supervisor uses?
- What position is your supervisor employed in?
- What age (range) is your supervisor in?
- How often do you attend clinical supervision?
- Are you supported to attend clinical supervision by your:
 - Professional Leader
 - Line Manager
- How effective has clinical supervision experience been for you?
 - Personally
 - Professionally
- Can you discuss why?
- How do you think supervision could be changed to support your nursing practice?

WHO CAN TAKE PART?

You will be required at the time of your interview:

- To be a Registered Nurse with a current Annual Practising Certificate
- To be employed by the CDHB, Mental Health Service
- To have been engaged as a Clinical Supervisee for a minimum of two years
- To make a commitment to be involved in the parts of the research required for each participant

COMPENSATION

No payments will be made.

GENERAL

Your participation will be entirely voluntary (your choice).

The investigator will obtain approval from your line manager to interview you during working hours. If this is not given, the investigator will negotiate a time to interview you that is convenient for you.

You will be able to consult the study supervisor should you have any queries or concerns about it. You will be given contact information, so that if you desire an independent route of contact to the study supervisor, you can contact them directly.

CONFIDENTIALITY

No material which could personally identify you will be used in any reports on this study. A pseudonym will be used in any documentation pertaining to the study. All records will be stored so that only the investigator is able to access them. A locked filing cabinet with investigator only access will be used for hard copy material and audio tapes. Electronic records will be kept on the investigator's personal work computer. Access to this is limited to the investigator by CDHB password protection processes. Clerical staff specifically trained to correctly manage confidential information will be given access to information as required to carry out administrative processes such as typing transcription records.

RESULTS

You will be given the opportunity to read the final document. This will be available at the conclusion of the academic process. The final document could take some time before it is produced / published.

SENIOR MANAGEMENT APPROVAL

The project has been approved by the Mental Health Service through the Divisional Executive Management Group.

ETHICS COMMITTEE APPROVAL

This study has received ethical approval from the Upper South B Regional Ethics Committee.

If you require more information about the study please contact Craig Cowie: Phone number provided.

APPENDIX 2: BASE INTERVIEW QUESTION GUIDE

1. Can you tell me about your nursing background?
2. What clinical area do you work in?
3. What age (range) are you?
4. How long have you received clinical supervision?
5. Do you provide clinical supervision for other nurses?
If so, what training did you receive?
6. Do you know the clinical supervision model your supervisor uses?
7. What position is your supervisor employed in?
8. What age (range) is your supervisor in?
9. How often do you attend clinical supervision?
10. Are you supported to attend clinical supervision by your:
-Professional Leader
-Line Manager
11. How effective has clinical supervision experience been for you? Personally /
Professionally

APPENDIX 3: INTERVIEW CONSENT FORM

MENTAL HEALTH NURSING CLINICAL SUPERVISION

CONSENT FORM

Principal Investigator:

Craig Cowie.
Nurse Consultant
Adult Community Service
Mental Health Service
Canterbury District Health Board

I have been invited to participate in this study that aims to identify, define and understand factors that affect the utility and efficacy of the nursing clinical supervision programme in the Mental Health Service, Canterbury District Health Board. This project has been approved by the Upper South B Ethics Regional Committee.

Information will be sought that will inform Clinical Supervisors, nursing leaders, supervision providers and line management budget holders at all levels, how the probability that individual clinical supervision relationships will be effective, can be increased. I have read the Information Sheet and understood the explanation of the study. I have been given the opportunity to discuss the study with one of the investigators if I have any questions.

I understand that:

- It is my choice that I participate in the study (voluntary).
- I am free to withdraw from the study at any time without having to give reason.
- Participation in this study is confidential, and information that could identify me will not be used in any reports pertaining to the study
- I have read and understand the Information Sheet.
- I understand that this study has received ethical approval from the Upper South Regional (B) Ethics Committee.
- I wish to receive a copy of the results of this study: Yes / No
- I consent to take part in this study.

Participant's signature: **Date:**

Participant's name:

APPENDIX 4: SUMMARY OF THE SIGNIFICANCE OF SUB-THEMATIC FACTORS

Theme	Sub-thematic Cluster	Sub-theme	Importance
1. Working with Engagement	Supervisor Factors	Supervisor personal qualities	Important
		Supervisor - professional experience	Highly variable
		Supervisor - professional skills	Important
		Supervisor - professional background	Variable
		Supervisee – Supervisor professional relationship	Important
	Supervisee Factors	Supervisee preparedness	Important
		Supervisee responsibility	Important
		Supervisee perception of supervision	Important
	Matching Factors	Gender	Not important
		Age factors	Not significantly Important
		Interpersonal compatibility	Variable importance
		Shared values	Variable importance

		Supervision method	Variable importance
2. Applying Effective Supervision Process	Supervisor Ability Factors	Process integration	Important
		Supervisee driven	Important
		Supervisor commitment	Important
		Supervisor perceptiveness	Important
		Supervisor assertiveness	Important
		Safety	Important
	System Factors	Access to supervision	Important
3. Achieving Positive Outcomes	N/A	Role development	Important
		Personal development	Important