



# A Report: Clinical Supervision for Allied Health Professionals in Rural NSW



*“...there needs to be recognition that every Allied Health Professional is entitled to and should have access to Clinical Supervision.”*

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## CONTEXT

Allied Health Professionals are tertiary qualified health professionals who apply their skills and knowledge to restore and maintain optimal physical, sensory, psychological, cognitive and social function. Allied Health Professions in the NSW public sector may include, but are not limited to: Audiology, Nutrition & Dietetics, Exercise Physiology, Medical Radiation Science (Medical Imaging and Radiation Therapy, Nuclear Medicine), Occupational Therapy, Orthoptics, Orthotics, Pharmacy, Physiotherapy, Podiatry, Psychology, Social Work, and Speech Pathology.

The 4 nominally Rural Area Health Services in NSW (Greater Southern, Greater Western, Hunter New England and North Coast Area Health Services), employ over 1800 Full Time Equivalents (FTE) across the Allied Health Professions, in a range of settings and services including Mental Health, Acute Health/Hospital Services and Community Health.



These Area Health Services vary significantly in size, population, demographic, workforce, services and management structures. Since 2006, each Area Health Service has employed an Allied Health Advisor or Director working in a predominantly strategic position to lead and support the Allied Health Professionals within their Area Health Service.

The NSW Institute of Rural Clinical Services and Teaching has as one of its key strategic directions to work with the rural Area Health Services to support rural Health Professionals including Allied Health Professionals. In particular the current work plan of the Rural Allied Health Project Officer identifies the development of a Professional Development Framework for the Rural and Remote Allied Health Workforce and as a strategy to achieve that objective:

- Conduct a literature search on models of clinical supervision.
- With the Area Allied Health Directors and Discipline Advisors conduct an audit of clinical supervision models and protocols in use, quality and effectiveness
- Develop Recommended Models of Clinical Supervision.

## **LITERATURE REVIEW**

### **Title:**

The development of a model of formal Clinical Supervision in the context of supporting Allied Health Professionals in rural and remote practice in New South Wales.

### **Methods:**

A literature search was conducted on-line using CIAP/CINAHL electronic database search, full text documents. Search terms included Clinical Supervision, Allied Health, and Rural. The NSW Health Library conducted a search with the same terms.

The Northern Territory PPSS Project Officer supplied a reference list. Existing Policies from WA, QLD Health, and NSW Area Health Services were cited and their references explored. Rural Allied Health Academics were approached for any papers. An online search through SARRAH Conference proceedings and National Allied Health Conference Proceedings for relevant documents and presentations was carried out. A structured interview of Allied Health Advisors in rural NSW was conducted by telephone.

### **What is known about Clinical Supervision for Rural Allied Health Professionals?**

Clinical Supervision has only recently been defined empirically, despite having clear clinical and organisational benefits. Despite a rising tide of Clinical Supervision policy and organisational expectation, Allied Health disciplines are not uniform in their access to, training in, understanding of, or uptake of Clinical Supervision, with the Mental Health professions having the strongest culture around Clinical Supervision. Rural and Remote Allied Health Professionals face barriers in their work including professional isolation, impacting negatively on retention and clinical service delivery. Clinical Supervision is emerging as a mechanism across the Allied Health professions and agencies in Rural Australia to seek to address these issues, yet delivery of Clinical Supervision is in itself impeded by the same barriers, increasing risk to quality of care, the workforce, and the organisations.

### **What will this paper add?**

This paper explores the critical elements of Clinical Supervision, notes how the Clinical Supervision landscape is changing across rural Australia, and canvasses the Rural Allied Health leadership in New South Wales to determine how policy and practice fits against the defined elements identified in the literature. While local policy does have a strong correlation with those elements, it is clear from the audit that resourcing, training, application, and measurement of Clinical Supervision is inadequate. Furthermore, while 'flexible' is consistently used to describe how organisations determine whether, how and to what degree Clinical Supervision will be delivered to a particular Allied Health Professional, none have defined what 'flexible' or 'case-by-case' means. This paper proposes a pan-discipline model for the sustainable and effective provision of Clinical Supervision for rural Allied Health Professionals. It also develops a profiling tool or matrix of considerations to identify risk and need for Clinical Supervision for rural Allied Health Professionals based upon variables from the literature.: professional setting, geographic remoteness, level of experience (general and specialty), Clinical Supervision culture of discipline level of organisational support, and exposure to areas of work with inherent clinical, professional or personal risk.

## Clinical Supervision – what is it exactly?

Clinical Supervision is increasingly recognised as a vital part of modern, effective health care systems (Milne, 2007), yet clear definition of the concepts and practices of Clinical Supervision approaches by medical, nursing and allied health professions have been elusive. There are however some similar features described, from the now hundreds of scholarly papers and presentations around Clinical Supervision, which are generally now agreed as core to the Clinical Supervision content and process. (Nguyen, 2003).

Even though there have been many papers published about supervision, there has also been criticism about the quality of the research. Nguyen (2003) in reviewing these criticisms suggests that supervision research appears to be independent and does not build on previous research. There has also been insufficient empirical data describing how to apply the supervision models and frameworks into practice and how supervisee practices are changed by Clinical Supervision (Holloway and Hosford, 1983). There is also a lack of efficacy studies comparing different supervision models (Goodyear and Bernard, 1998). However there appears to be several common consistencies in the literature about Clinical Supervision, its nature and functions.

Milne (2007) in his critical review of many current definitions of Clinical Supervision in use over the last decade, states that there has been wide acceptance of the Bernard and Goodyear (2004) definition: *‘...an intervention provided by a more senior member of a profession to a more junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s), monitoring the quality of professional services offered to the clients, she, he, or they see.. and serving as a gatekeeper for those who are to enter the particular profession’*.

Kirk et al (2003) cite the UK Dept of Health which in its 2003 report *A Vision for the Future* states that *‘Clinical Supervision is a term used to describe a formal process of professional support and learning, which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protections and the safety or care in complex clinical situations. It is central to the process of learning and to the scope of practice and should be seen as a means of encouraging self-assessment and analytical and reflective skills’*. In the same paper, Kirk et al also argue that *‘inherent in this definition should be the need for supervision to be undertaken in a safe environment, providing the opportunity to explore and reflect in a supportive and confidential setting’*. Elsewhere in the same year, Clinical Supervision has been defined as *“ a structured, formalised approach (for which time is set aside) for discussing professional practice with a colleague or peer that encourages reflection on, and evaluation of, clinical decision-making and outcomes.”* (UK DOH Allied Health Report 2003).

These definitions have been criticised for their lack of precision, specificity, measurability in operational settings, and corroboration by evidence (Milne, 2007). The working definition of Clinical Supervision developed by Milne (below, and laid out in Table 1 over page) seeks to provide a precise, specific, operational, and corroborated approach:

*‘Clinical Supervision is the formal provision, by approved supervisors, of a relationship-based education and training that is work-focused and which manages, supports, develops and evaluates the work of colleague/s .The main methods that supervisors use are corrective feedback on the supervisee’s performance, teaching, and collaborative goal-setting.*

*It therefore differs from related activities, such as mentoring and coaching, by incorporating an evaluative component. Clinical Supervision’s objectives are “normative” (e.g. quality control), “restorative” (e.g. encourage emotional processing) and “formative” (e.g. maintaining and facilitating supervisees’ competence, capability and general effectiveness).*

*These objectives could be measured by current instruments. This definition is supported by recent reviews of the empirical literature.* (Milne, 2007). For the purposes of this paper, this definition will be adopted.

**Table 1.** The working definition of clinical supervision (with clarifying comments)

‘FORM’ OF SUPERVISION:
<p><b>‘The formal provision</b> (i.e. sanctioned by relevant organization/s);  <b>by senior/qualified health practitioners</b> (or similarly experienced staff)  <b>of an intensive</b> (i.e. typically 1:1 and regular/ongoing, at least, three meetings with protected time, of at least 3 hours total duration),  <b>relationship-based</b> (inc. confidential and highly collaborative, being founded on a learning alliance and featuring (e.g.) participative decision making and shared agenda setting; and therapeutic inter-personal qualities, such as empathy and warmth),  <b>education and training</b> (general problem-solving capacity or ‘capability’ aspect, not just competence enhancement)  <b>that is case-focused</b> (supervisee guides topics and tables material and supervisor typically overlays professional and organizational considerations/standards)  <b>and which supports, directs and guides</b> (inc. also ‘restorative and normative’ topics, addressed by means of professional methods, inc. objective monitoring, feedback and evaluation; and by reference to the empirical and theoretical knowledge-base)  <b>the work of colleagues (supervisees)</b> (inc. CPD/post-qualification colleagues)</p>
‘FUNCTIONS’ OF SUPERVISION:
<p><b>(1) quality control</b> (inc. ‘gatekeeping’ and safe, ethical practice);  <b>(2) maintaining and facilitating the supervisees’ competence and capability; and</b>  <b>(3) helping supervisees’ to work effectively</b> (inc. promoting quality control and preserving client safety; accepting responsibility and mostly working independently; developing own professional identity; enhancing self-awareness and resilience/effective personal coping with the job; critical reflection and lifelong learning skills).</p>

The definition in Table 1 was based on the integration of existing definitions (esp. Bernard & Goodyear, 2004; Department of Health, 1993; Proctor, 1998; Watkins, 1997). It includes any supervision format (e.g. group supervision), profession or therapeutic orientation, and it covers pre- and post-qualification supervisions. It excludes staff training, consultancy and performance management. (Milne, 2007)

Just as the definition of Clinical Supervision reaches its maturity, it seems that the number, diversity and inter-relationships of the health professions involved in a modern health care system is applying pressure to the definition, with the different terms Practice Supervision (Qld Health, 2008), Clinical Practice Supervision (Sp Path Aust 2007), and Professional Practice Supervision (NT DHCS, 2008) variously appearing in formal policy and guidelines very recently for Allied Health and Mental Health professionals. For the purposes of this paper, it seems clear that these terms are used interchangeably with Clinical Supervision, being consistent with the form of Clinical Supervision described by Milne.

#### Informal Clinical Supervision

It is important to acknowledge that elements of Clinical Supervision undoubtedly occur informally in the professional life of health professionals. It makes intuitive sense that a professional working especially as part of a professional department or team receives input from senior colleagues that educates, trains, supports, directs and/or guides their practice. It may be for some professionals that this is the only or predominant form of supervision they receive, or have received for much of their career, perhaps especially for some of the Allied Health professions with an immature or absent

culture of formal Clinical Supervision. Much informal Clinical Supervision may be valuable, and meet many of the requirements of the supervisee, and quality and safety of care issues. However, without formal agreements in place, structured time, and record-keeping the outcomes cannot be measured. The prevalence or impact of such informal professional supervision is not the primary focus of this paper.

Fone (2006) describes a mentor as a colleague who is selected to assist, guide, advise and counsel, but who is not a formal supervisor or assessor of the mentee in the workplace but rather is one to provide guidance and support in a non-judgmental way. (Fone, 2006). This supports Milne's assertion above about mentoring not having an evaluative component.

Administrative or Line Management Supervision has many valuable functions for an Allied Health Professional, and at its simplest may focus on issues such as attendance, work allocation and workplace (Qld Health, 2008). The line manager also has clear responsibility in much of the literature to assist staff to arrange for appropriate professional supervision, ensure that a formal agreement is in place, and to ensure that staff have access to adequate resources or infrastructure for Clinical Supervision (NCAHS, 2008) In some cases it is noted that the line manager may be the department discipline senior and provide supervision. In such instances, it is often recommended practice that the supervisee be enabled to seek an additional source of clinical supervision in consultation with the line manager.

### **The Development of Theoretical Approaches to Clinical Supervision and its 'Functions'**

The model or form of Clinical Supervision defined by Milne is the result of an evolution of theoretical approaches. The North East London Mental Health Trust (NEHMLT) (2005), in its 'Guidelines for Clinical Supervision' (page 6) briefly acknowledges this body of literature, and highlights the work of Brigid Proctor (1987) as the source of many subsequent derivations. This model is incorporated into Milne's thinking (Milne, 2007), and Table 2 describes also the 'functions' of Clinical Supervision, which fall into the categories of Formative (learning function), Restorative (support function), and Normative (accountability function). These functions can be focused on all at once or individually within Clinical Supervision sessions.

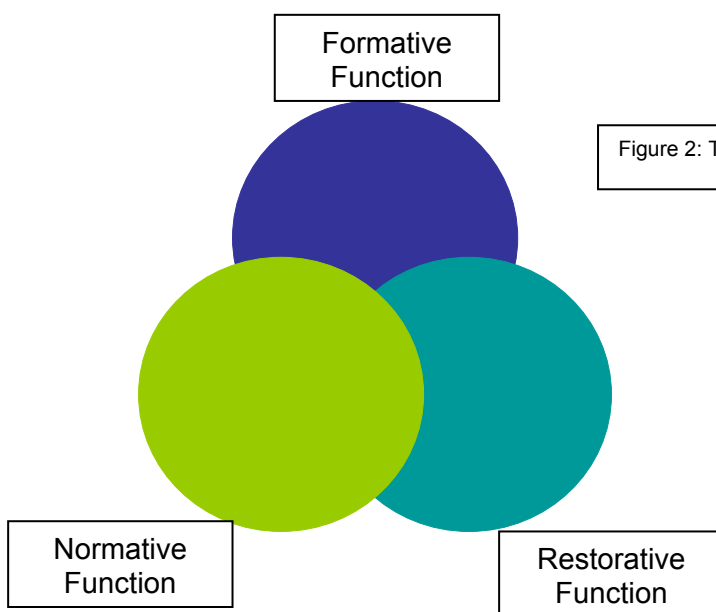


Figure 2: The overlapping functions of Clinical Supervision .

### Functions of Clinical Supervision :

- (1) **quality control** (inc. 'gate keeping' and safe, ethical practice);
- (2) **maintaining and facilitating the supervisees' competence and capability**; and
- (3) **helping supervisees' to work effectively** (inc. promoting quality control and preserving client safety; accepting responsibility and mostly working independently; developing own professional identity; enhancing self-awareness and resilience/effective personal coping with the job; critical reflection and lifelong learning skills).

Table 2

It is useful to reflect on this literature which focuses on the development of theoretical approaches or 'models' of Clinical Supervision, exploring the psychotherapeutic aspects internal to the Clinical Supervision process (Eckstein and Wallerstein, 1959 cited in Leddick and Bernard, 1980), and more recent work adapts these concepts as a *developmental* process for the practitioner undergoing Clinical Supervision.. Stoltenberg and Delworth (1987) described a developmental model focussing on three levels of supervisees: beginning, intermediate, and advanced. Within each level they noted a trend to begin in a rigid, shallow, imitative way and a transition towards competence, self-assurance, and self-reliance. Their work was also supported by Worthington (1987) who reviewed developmental supervision models and described recurring themes and patterns. Typical development in beginning supervisees would find them relatively dependent on the supervisor to diagnose clients and establish plans for therapy. Intermediate supervisees would depend on supervisors for an understanding of difficult clients, but would chafe at suggestions about routine situations. Advanced supervisees are described as functioning independently, seeking consultation when appropriate, and behaving professionally responsible for their correct and incorrect decisions.

Stoltenberg and Delworth (1987) described each level of supervisee competence as being comprised of three processes (awareness, motivation, autonomy), then developed content for each level. The eight areas they described are: intervention, skills competence, assessment techniques, interpersonal assessment, client conceptualization, individual differences, theoretical orientation, treatment goals and plans, and professional ethics. The concept is that the Clinical Supervisor assists their supervisees to identify their own strengths and growth areas, enabling them to be responsible for their life-long development as both therapists and perhaps to become, in turn, effective Clinical Supervisors.

An *integrated* model was devised by Bernard and Goodyear (1992) and focuses attention on the supervisory roles of teaching, counselling and consulting. The Discrimination Model they developed describes each of the roles as being specific to different tasks in Clinical Supervision. When the supervisor instructs, informs and advises, they are assuming a *teaching* role. If the task is to explore the supervisee's weakness or dual reliance on the therapeutic relationship, then a counselling role might be more appropriate, whilst collegiate interactions around case complexity are more akin to a *consulting* role. Leddick (1994) describes the Discrimination Model as primarily a *training* model focusing on building skills in processes, conceptualisation and personalisation. NEHLMT (2005) also cites the Double Matrix Model by Hawkins and Shohet (2000) as demonstrating a comprehensive and developmental approach to Clinical Supervision, which acknowledged the wider context of professional, organisational and external factors as important in the Clinical Supervision process. This approach is reinforced in the *National Practice Standards of the Australian Association of Social Workers: Supervision*. (July, 2000) which stipulates the interrelated administrative, educative, and support functions, as important *within* the organisational context.

To further expand on the organisational ‘co-ownership’ of Clinical Supervision, Shulman and Safyer (2006) devised a framework which illustrates Professional Supervision is both a concept and process. Table 3 is adapted from their work. This framework clearly articulates the range of factors to be considered around the provision of Clinical Supervision.

Table 3 Clinical Supervision Concepts and Processes

Infrastructure	Supervision Process	Variables Impacting on Supervision Relationship and Environment
<ul style="list-style-type: none"> <li>• Organising Supervision</li> <li>• Room/Space</li> <li>• Technology</li> <li>• Ethical and Legal Considerations</li> <li>• Line Management Issues</li> <li>• Records</li> <li>• Frequency</li> <li>• Outside Session Contact</li> <li>• Evaluation</li> </ul> <p>(Formal Supervision Agreement)</p>	<ul style="list-style-type: none"> <li>• Techniques for Individual Supervision</li> <li>• Group Supervision</li> <li>• Line Management and Support</li> <li>• Email or not</li> <li>• Phone, Video/Chat Room</li> </ul>	<ul style="list-style-type: none"> <li>• Individual Differences</li> <li>• Cognitive Style</li> <li>• Theoretical Lens</li> <li>• Cultural Characteristics</li> <li>• Relationship Processes</li> <li>• Interpersonal Triangles</li> <li>• Working Alliance</li> <li>• Role of Attachment</li> <li>• Role of Anxiety</li> <li>• Transference and counter Transference</li> <li>• Professional ethos</li> </ul>

### Clinical Supervision- Why do it?

The discussion of functions of Clinical Supervision above assumes that these functions have value, to the consumer, the supervisee and the organisation. There is an increasing acceptance that Clinical Supervision brings a range of benefits to practice outcomes and workforce issues for Allied Health Professionals. Costs of the provision of Clinical Supervision are described as being in the order of 1% of salaries/wages costs of the professionals concerned, offset by reduced staff turnover, recruitment and retention, productivity and reduced professional drift or improved alignment to organisational goals. (Ref?)

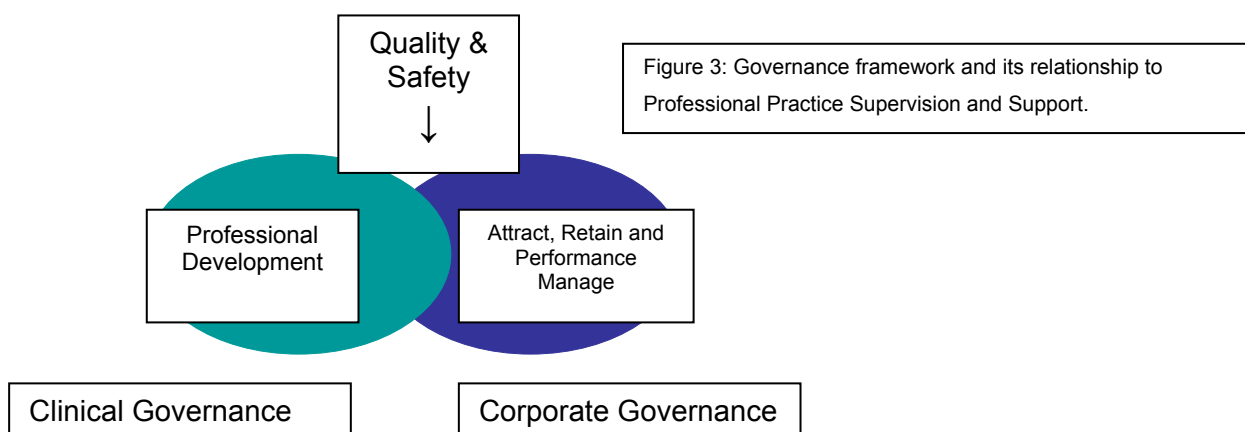
Kirk et al (2003) cite Byrne as he or she grapples with the reasons why Clinical Supervision is considered important; *‘In the caring professions where personal interactional skills are at the forefront, only by supervision can some attempt be made to measure both the quality of the standards of care and the demands on the client and worker’* (Byrne, 1994). In their commentary, they also explored the importance of supervision of preventing psychological distress in workers, particularly for those working in mental health areas. Kirk et al discuss how professions new to Clinical Supervision (such as dietitians) would need to enter the *‘debate which has been raging in the nursing and other professions in recent years’*, if they are going to reduce the stress and burnout of their workers.

Bishop (2007) described the importance of practice supervision to assist in inoculating child and family welfare workers against workplace stress and burn-out and how the industry was setting Clinical Supervision standards across Australia to improve service to vulnerable clients. This work is supported by the work of Kelly (2002) which explored the impact of support on decreasing rates of posttraumatic stress disorders in amongst remote health practitioners.

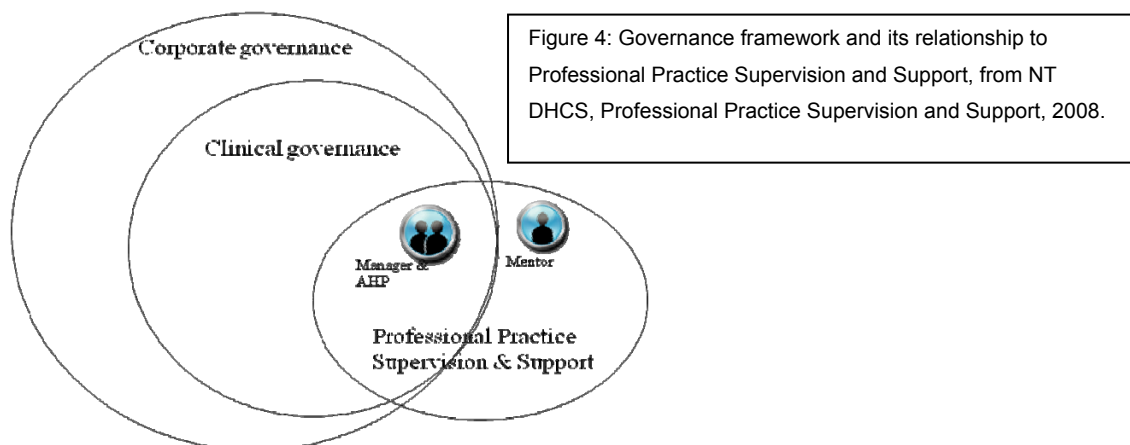
Fraser and Greenhalgh (2001), describe that traditional education of the health workforce has focused largely on enhancing competence (knowledge, skills and attitudes) but that in situations of complexity there is a greater need for capability, that is, the ability to change, generate new knowledge and continuously improve performance. The work describes capability as being enhanced through feedback on performance and the challenge of unfamiliar and non-linear

teaching methods, instead focusing on creating learning objectives, receiving feedback, reflecting and consolidating of the practice.

In his systematic review of Clinical Supervision (2007), Milne found that *‘the effectiveness ratings indicated a mean value of 2.4 for supervisees (therapists’ learning) and 2.3 for patients (clinical outcomes), which indicates that positive results were obtained overall, equivalent to 80% and 77% supervisory effectiveness, respectively. These results indicate that supervision, as defined and measured according to the present working definition, is associated with positive outcomes.’* (Milne, 2007). So it is clear that Clinical Supervision is intended to, and does, when applied formally, have benefits in quality and safety of care, together with individual practitioner and organisational benefits as corroborated by the evidence from 24 studies in Milne’s review.



These benefits are together considered so strong that in some professional groups, particularly those working in the mental health field (Social Work, Nursing, Psychology and Occupational therapy) consider Clinical Supervision *‘the cornerstone of clinical practice’*, (Kirk, Eaton & Auty, 2003) and in some professions Clinical Supervision is a statutory requirement (AASW, 2000 and NSW Psych. Reg. Brd. 2008). Agencies are recognising the risks of not supporting and promoting Clinical Supervision in their health professional workforce, as Kirk and her colleagues also describe the introduction of the concept of Clinical Governance, whereby *‘organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care can flourish’* (Kirk, Eaton & Auty, 2003). In NSW, all Area Health Services now have Clinical Governance directorates, and Clinical Supervision policies developed or under development for their health professional workforce. Queensland Health implemented a whole-of-State approach setting out standards of Clinical Supervision for developing and experienced Allied Health Professionals working in the mental health field (Queensland Health, 2008).



Speech Pathology Australia (2007) states that *'changes in both clinical practice and scope of practice have resulted in increased specialisation and heightened responsibility'* and that the growing need for education and training will *'necessarily be via the provision of direct professional support and clinical practice supervision within the workplace'*. They go on to state clearly that Clinical Supervision is a clinical governance, clinical leadership and duty of care issue for employers, and professionals and that all are obligated to play their part in support, and participation in Clinical Supervision, and that Clinical Supervision should be adequately resourced and accessible to all throughout their careers. (SPA, 2007).

The SARRAH position paper (2000) on provision of Allied Health Services to Regional and Remote Aboriginal communities, recommends *'risk assessment of any hazards that staff may be exposed to as part of their roles. In addition to this, on-going organisational risk assessments should be an essential component of service development to monitor clinical governance and potential risk to clients'*. The organisation considers it particularly salient to provide Clinical Supervision for remote AHPs, many of whom tend to be young and female, who are required to provide community based care in distant and disadvantaged communities. *'A requirement that AHPs accept on-going professional supervision, adhere to the standards of care set by their profession, and abide by the need to develop and deliver evidence-based care, can assist in managing these risks. Overconfidence in AHPs with less than 12 months experience in A&TSI communities should be monitored, and closer supervision provided to manage any professional and organisational risks associated with this.* (SARRAH, 2000).

Broader organisational benefits currently being ascribed to Clinical Supervision include staff recruitment and retention. Battye and McTaggart (2003) describe the main issues impacting on the recruitment and retention of Allied Health Professionals working in remote areas as professional isolation, and a lack of clinical support. Fitzgerald, Hornsby, and Hudson, (2000) clearly found a consensus that the retention of Allied Health Professionals in rural and remote communities was directly impacted upon by the levels of professional support or, conversely, the professional isolation experienced by Allied Health Professionals. Elsewhere, the Western Australian Allied Health Taskforce on Workforce Issues is cited as reporting that *'the lack of management support or lack of supervision structures was the second most cited reason given by Allied Health Professionals ...for leaving their positions over the last three years'* (Paskevicius 2002 in SPA, 2007). Also in the SPA paper comes the admonition that *'short-term cost savings that limit practitioners' involvement in such activities will inevitably result in long-term limitations to the quality of practice and health care services'*. (SPA, 2007 quoting Higgs, pg 3)

The provision of Clinical Supervision to the rural and remote Allied Health Professional workforce is a special case to be developed further by this paper.

## Clinical Supervision for all Allied Health Professionals?

Burton (2000) contends that while the development and utilisation of models of clinical supervision has been a feature of contemporary post-registration nursing and psychiatric practice for years, this is not *generally* the case for Allied Health disciplines. Historically though it could be said that Clinical Supervision has been a term specifically and sometimes precisely used by Allied Health Professionals in the counselling or mental health professions, particularly Psychology and Social Work, and more recently Occupational Therapy. These professions had adapted the concept (along with medicine and nursing) from the original work of researchers exploring psychodynamic approaches to psychotherapy in the mid 1920's (Burns, 1958 cited in Leddick and Bernard, 1980).

These 'Mental Health' Profession origins for Clinical Supervision have now grown, with the political and organisational construct of 'Allied Health' over the last two decades, to mean that other Allied Health Professions previously not exposed to concepts and practices of Clinical Supervision are being drawn variously into Clinical Supervision as a core professional and organisational expectation and function (Kirk, Eaton & Auty. 2003).

In line with the arising Clinical Governance ethos, recognition of the need for organisationally supported Clinical Supervision across the Allied Health professions is growing. In New South Wales, a 2004 report states that; *"Initially, there needs to be recognition that every Allied Health Professional is entitled to and should have access to Clinical Supervision"* (NSW CHN 2004).

Importantly, in the UK, the NEHMLT (2005) stated that *'while different professions for different reasons favour different models of Clinical Supervision .... the ultimate aim...is to work towards an integrated and inter-professional framework for Clinical Supervision'* and that training be implemented for practitioners in several models.

The literature supports the intuitive logic that Clinical Supervision is approached *differently* by the different Allied Health Professions. Whereas Allied Health Professionals working in mental health such as Psychologists, Social Workers and Occupational Therapists may expect and understand the importance of Clinical Supervision, other professions such as Physiotherapists don't ascribe the same level of importance. Sellars (2004) found that in physiotherapy there is a dearth of literature around Clinical Supervision that Clinical Supervision is not widespread in practice, and recommended that any model adopted must be flexible enough to meet the needs of both the individual and the organisation. Yet Proctor's normative, formative and restorative functions of Clinical Supervision were found to fit physiotherapist aspirations, and Clinical Supervision was enthusiastically supported in theory by physiotherapists in Sellars' study.

Generally all Allied Health Professions that are involved in education and counselling (including counselling to make lifestyle changes) ascribe benefit to receiving regular Clinical Supervision. The paper by Kirk, Eaton and Auty (2000) which described the ambivalence of the Dietetic Profession towards Clinical Supervision, also pre-empted concerns that making Clinical Supervision a formal requirement of the profession may seem onerous. They went on to state that there is an increasingly forceful argument that it should be a requirement in some parts of the profession. The authors note that a raft of government and professional initiatives which have Clinical Supervision as a fundamental element had been recently introduced in the UK, and described workloads as being a real barrier to general implementation across the dietetic profession.

## **Clinical Supervision for Allied Health Professionals in Rural & Remote – Barriers and Solutions**

The seminal study undertaken through the auspice of SARRAH (Fitzgerald, Hornsby, and Hudson, 2000) clearly found a consensus that the retention of Allied Health Professionals in rural and remote communities was directly impacted upon by the levels of professional support or conversely the professional isolation experienced by Allied Health Professionals. Lee and Mackenzie (2003) found that there was limited access to either Clinical Supervision or mentorship from more experienced Occupational Therapy practitioners in rural NSW.

Battye and McTaggart (2003) in their work around the North and West Queensland Primary Health Care organisation, describe the main issues impacting on the recruitment and retention of Allied Health Professionals working in remote Queensland were professional isolation, and a lack of clinical support. These predominantly sole practitioners were represented by mostly new graduates who felt they needed more input from experienced professionals. Battye and McTaggart go on to specify 'clinical and professional mentoring' as a strategy to improve recruitment and retention, and specify videoconference and teleconference) for 3 hours per month) supported by email communication. The authors also suggested the development of functional teams that related to client groups.

Apart from Indigenous Health Workers who are usually drawn from the local population, Allied Health Professionals in remote communities tend to live and/or work in cultures other than their own. Allied Health Professionals who grow up in rural or urban settings are likely to be unfamiliar with the culture of any remote community, be it mining, Indigenous, tourism or railway. Cultural isolation and 'culture shock' bring additional dimensions of stress to each day and to each situation until some form of adaptation occurs. In addition to geographical and cultural isolation, many remote Allied Health Professionals work hard to overcome professional and social isolation. The lack of anonymity and natural circuit breakers between work and home, and personal and professional lives which exist in small communities tend to intensify the impact of all forms of job related stress in remote areas (Kelly, 2002). This work explored the impact of support on decreasing rates of post-traumatic stress disorders in amongst remote health practitioners.

A survey of Allied Health Professionals in NSW by the Child Health Networks (NSW CHN 2004), identified that while some initiatives and policies existed for Clinical Supervision, adherence to policies was variable, and there was inconsistency of supervision for both new and senior professionals.

Although seemingly obvious, it is important that when designing a model of practice supervision for Allied Health Professionals in rural and remote NSW it is appropriate to attempt to ameliorate for barriers identified in the literature (Bracciano, 1986, Hodgson and Berry, 1993; Parkin et al., 2001; Struber, 2004). Barriers include long distances to travel, financial constraints, complex workloads and associated waiting lists, poor management support, child care and family commitments. In New South Wales, integrating Clinical Supervision into everyday clinical practice is acknowledged as complex, and Allied Health Professionals identified heavy workloads, a decline in the Allied Health Professional workforce and the geographic isolation of many practitioners as barriers to initiating or maintaining Clinical Supervision mechanisms (NSW CHN 2004). In the same report, Allied Health Professionals in managerial positions cited the added responsibilities of managing a department as compounding the difficulty in engaging in Clinical Supervision.

The 'tyranny of distance' is particularly a barrier to access to Clinical Supervision for Allied Health Professionals in Remote areas and those within sub-specialties such as paediatrics due to the small workforce available as Clinical Supervisors (NSW CHN 2004).

One of the strategies most effective in reducing travel time and costs as well as creating an immediate and routine response is through using technology assisted communication such as teleconferencing, videoconferencing, the internet and emerging telecommunications technology (Miller et al 2003, NSW CHN 2004).

'Telehealth' and similar concepts have grown to include a full range of technology based communication supporting clinical and professional practices as well as direct patient care. There has been some sound research exploring the use of such communication technology and infrastructure to support Clinical Supervision (Herrington, A and Herrington, J, 2006). Stamm explored clinical supervision via videolink for rural Allied Health Professional student placements in the USA (Stamm, 1998). The model Stamm explored a centralised resource providing links through group teleconferences (audio and video) with weekly individual telephone supervision as well as email. In this model supervisors also had a web page where supervisees could access information, bulletin boards and chat rooms as an adjunct to the formal practice supervision process. The study also explored the use of group supervision and found that factors such as access to the experience and expertise of the supervisors far outweighed any concerns which might have been raised by using the technology.

Primarily, the confidential nature of the Clinical Supervision session is described as critical to the learning process. Confidentiality issues are exacerbated with the use of video- and tele-communications and other communication technology with both supervisee and client or patient information being discussed via web, or phone et cetera. The additional complexity may present problems for the supervisee and not match their learning style. Some Allied Health Professionals may not be confident in the use of computers or other technology as a primary learning mode, whilst others have expressed difficulty accessing a work computer (McLeod and Barbara, 2005). Clinical Supervisor time may also be limited so the authors recommend that supervisor who uses information technology to support the Clinical Supervision relationship to be organised and ensure that the supervisees are getting a positive experience of the supervision process (Loganbill, Hardy and Delworth, 1982)

### **Development of a model of Clinical Supervision for Rural Allied Health Professionals in NSW**

There are examples of very recent development of Clinical Supervision models which are especially relevant in that their target workforce is Rural, and Remote Allied Health Professionals.

The draft Western Australia Country Health Service policy and guidelines (WACHS 2008) emphasise the flexibility required in determining what is appropriate clinical supervision for Allied Health staff, and supports provision of Clinical Supervision that is:

- Supervisee driven;
- Flexible, balancing the needs of the organisation and the individual in terms of process and delivery mode;
- with minimum standards;
- Developed as a strategy within the Performance Development process; and
- Allocated time within the clinician's Job Description Form.
- Is backed by training and system coordination.

Similarly, the Northern Territory *Professional Performance Supervision and Support (PPSS)* program, commenced in 2008, describes a mandated process for all Allied Health Professionals with flexibly-determined and individualised Work Partnership Plans (WPP). '*Embedding PPSS within WPP ensures that activities will be balanced in design so as to meet the needs of the allied health professional, as well as workplace needs in delivering best practice care to the NT community.*' (NT

DHCS, 2008). The model uses face to face, telephone, videoconferencing, teleconferencing, and internet technology supports of ,as well as joint interventions, observation and feedback, role plays, case study, discussion, reflective practice journaling, and placements in specialist services.

Queensland Health only this year released its human resources policy '*Practice Supervision in Allied Mental Health*', (Qld Health, 2008). This comprehensive document provides a very close fit to the definitions, concepts, processes and requirements discussed throughout this paper, to meet the provision of Clinical Supervision sustainably and effectively. The policy and appended sample forms and flow chart appears to set a gold standard for a model of clinical supervision , though shares most of its elements with the NT and WA work, and indeed as we will see as the result of an audit, the Allied Health Clinical Supervision policies in place in rural NSW.(Appendix 1).

So in the space of a year, at least three Australian jurisdictions have confirmed the provision of Clinical Supervision to Allied Health Professionals in policy. These geographically large states with many rural and remote Allied Health Professionals have almost simultaneously sought to bring a range of Allied Health professionals under very similar clinical governance frameworks. But what of New South Wales?

Closer to home a substantial report was developed from a survey of 468 Allied Health Professionals and focus groups with a further 154 Allied Health Professionals working with children across NSW. The NSW Child Health Networks considered that '*There is no "one-size fits all" model of clinical supervision. Clinical supervision programs must be adapted to meet local needs of the individual allied health professional or the allied health discipline. The survey has highlighted the variety of settings in which paediatric allied health professionals practice in NSW. Clinical supervision programs need to be tailored to cater for the needs of the sole practitioner in a remote area as well as the practitioner in a large team in a specialist children's hospital. In addition, the programs must be responsive to the changing career cycles of the individual allied health professional, including the novice as well as the competent and advanced practitioner.*' (NSW CHN 2004) While these recommendations and the report referred to Allied Health Professionals working with Children, the issues and themes are representative.

The report also cites Miller et al (2003) and recommends that '*an innovative approach is taken to clinical supervision for paediatric allied health professionals, particularly for individual disciplines and practitioners in remote areas. This means that challenging the traditional model of individual "one-on-one and face-to-face" clinical supervision to exploring the model of "group", "peer" or "multidisciplinary" clinical supervision and, most importantly, the expanded use of technology in terms of videoconferencing, the internet and emerging telecommunications*' (Miller et al 2003, NSW CHN 2004). Also '*The success of any clinical supervision program is largely dependent on the availability of a cohort of clinical leaders to assume the role of supervisor/mentor. In addition, there is a requirement for these leaders to be provided with appropriate training and preparation for their roles. There is a need to invest in and sustain an infrastructure of clinical supervision for allied health professions ... to ensure a critical mass of expertise in the longer term. There is also a need to establish a cohort of skilled supervisors and provide the opportunity for life-long (career) based learning.*'

The NSW Child Health network goes on to claim that:

A robust and sustainable system of clinical supervision for allied health professionals (working with children) in NSW is *essential* to:

- Support the multidisciplinary allied health team approach.....
- Respond to the need for team-building and the development of effective allied health clinician networks
- Provide support for the sole practitioner
- Facilitate the delivery of allied health care as close to home as possible.

## AUDIT

To develop a model for Clinical Supervision for rural Allied Health Professionals in NSW, it was decided to first conduct an audit of the Clinical supervision models and protocols in use in rural NSW and make some determination as to their consistency, levels of use, and their quality and effectiveness. To develop the audit tool (structured questionnaire) an analysis was made of the critical elements of Milne's definition (2007) together with the Infrastructure elements raised by Shulman and Safyer (2006). Considerations raised in recently developed and organisationally ratified policies and guidelines in the Northern Territory (NT DHCS, 2008), Western Australia and in Queensland (Qld Health, 2008) were used for comparison.

### *Audit of NSW Rural Allied Health Clinical Supervision – Structured Interview Questions*

1. Is there Area Health Service Policy on clinical supervision for allied health professions?
2. If No, is informal clinical supervision provided?
3. If Yes, which professions are covered?
4. Does the Clinical Supervision policy include:
  - Guidelines
  - Manual
  - Formal Agreement
  - Training for Supervisors
  - Funding Support for: Provision
  - Funding Support for: Training
  - Active Promotion of Clinical Supervision
  - Measurement/Evidence of use: Compliance
  - Measurement/Evidence of use: Uptake
  - Measurement/Evidence of use: Perceptions
  - Measurement/Evidence of efficacy
  - Workforce Impact or outcomes: Retention or Job Satisfaction
  - Clinical Impact or outcomes:
5. Does the Policy describe forms of Clinical Supervision?
6. Is the Policy flexible enough to recognise and meet different clinical supervision requirements?
  - Cater for differences in professions
  - Cater for differences in years of experience
  - Cater for differences in expertise
7. Does it specify guidance or requirement about who the supervisor should be?
  - Same discipline only
  - Interdisciplinary
  - Manager excluded or flexible
  - Peer and in which circumstances
  - Level of experience
  - Relative seniority
  - Training
8. Does the Policy address infrastructure/set-up?
  - Identify whose responsibility it is to organise supervision
  - Location
  - Conditions
9. Does the Policy address method?
  - Face to Face
  - Group
10. Does the Policy address use of Technology?
  - Phone
  - Email
  - Videoconference
11. Does the Policy address Frequency, specify?
12. Does the Policy address record-keeping?
  - Specifies what details are recorded, content and occurrence
13. Does the Policy address Confidentiality?
  - Who has access to detail of clinical supervision information
14. Does the Policy address Use of external supervisors?
  - Is it acceptable?
  - Is there a criterion of circumstances when external supervisors can be used?
  - Is it resourced?
15. General Comments

Table 4

The rural Allied Health Directors and Advisors from 3 of 4 rural Area Health Services in NSW agreed to a structured telephone interview, with the above questions. The audit was carried out in June 2008.

## Results

The results of the audit are appended (Appendix 2). This canvassing of the Rural Allied Health leadership in New South Wales served to determine how local policy and practice fits against the critical elements identified in the literature.

1. Each Area Health Service (AHS) had a Clinical Supervision **policy** for Allied Health Professionals, and had made special provisions within the policy or in a related policy for the statutory requirements of Psychology. Medical Radiation Science and Pharmacy were not consistently included in Clinical Supervision practices, having their own mechanisms. The Allied Health Professions were not defined in the policies.
2. Each AHS policy included **guidelines**, and may include sample documentation. No AHS had a more comprehensive **manual**.
3. Each AHS policy called for a **formal Clinical Supervision agreement** for every Allied Health Professional.
4. No AHS policy detailed Clinical Supervision **training** requirements for supervisors, and none had identifiable training programs in place. All agreed that this was a gap and that the development of a comprehensive training package, especially for those Allied Health Professionals and Managers with no substantial prior knowledge/experience in Clinical Supervision. None had identified funding support for training.
5. The provision of Clinical Supervision was supported by **funding** in all AHS, at least with the release of staff, and guarantee of access to resources, to be managed at a local level. None had specific budget allocated.
6. No AHS had any central reporting mechanism or collection of data or **evidence** around Clinical Supervision compliance/uptake, perceptions, retention or job satisfaction or clinical impacts.
7. Each policy described a range of **'forms'** of Clinical Supervision
8. Every AHS policy **catered for differences** in experience, expertise. One AHS articulated the differences in Clinical Supervision requirements between professions.
9. No AHS specified only **same-profession** Clinical Supervision, with one stating it was preferred.
10. One AHS policy mentioned **interdisciplinary** Clinical Supervision and one other was able to detail in practice examples of how interdisciplinary Clinical Supervision was in place (e.g. Dietitians in Mental Health with Clinical Supervision from a Psychologist)
11. **Managers** were able to be Clinical Supervisors, by agreement or not as the sole Clinical Supervisor.
12. Two AHS policies describe details of **peer** Clinical Supervision.
13. Level of **experience and relative seniority** of the Clinical Supervisor were specified in two AHS policies, and reported as the accepted norm in practice in the other.
14. All policies documented responsibility in provision or **resources and infrastructure** for Clinical Supervision.
15. All AHS policies specified **face-to-face and group** Clinical Supervision, with sanction for **phone and videoconferencing** as adjunct technology.
16. All address **frequency** of Clinical Supervision, at least as a minimum standard, varying with experience, but not profession.
17. Two AHS specify responsibility and details of **record-keeping**.
18. All address the issue of **confidentiality**, and access to Clinical Supervision records.
19. **External Clinical Supervision** is agreed to by all, with explicit criteria, and resourcing. Local and internal Clinical Supervision is preferred. One AHS with very remote areas reports 100% of sexual assault workers with external Clinical Supervision and in one profession 50% cross-border

## Discussion

It is a finding of this audit that models of formal Clinical Supervision for Allied Health Professionals consistent with the critical elements described in the literature (summarised in Table 5) can be found in each of the Area Health Services in rural NSW substantially at a policy level.

Critical Elements of Clinical Supervision for Rural Allied Health Professionals	Audit
• Formal Policy	✓
• Identified target groups (can be flexible)	✓
• Detailed Guidelines	✓
• Formal Clinical Supervision agreement with responsibility/accountability	✓
• Access to training, and support for same	X
• Funding and Infrastructure support for Clinical Supervision	✓
• Flexible or Supervisee-centric to cater for differences in risk and need*	✓/X
• Access to same-profession Clinical Supervision	✓
• Clear guidelines for interdisciplinary Clinical Supervision	X
• Clear guidelines for the role of Managers where supervisors	✓
• Access to peer supervision	✓
• Criteria for Supervisors including experience, relative seniority	✓/X
• Face to face and group as primary methods, with access to and support for phone, videoconferencing or other technological	✓/X
• Frequency of supervision set as minimum standards, with a process for identifying Allied Health Professionals with higher needs	✓/X
• Clear confidentiality guidelines, include access to records	✓
• Access to, and support for external Clinical Supervision in specified cases	✓
• Evidence gathering to improve evidence base for outcomes in workforce and clinical service provision	X
• *ideally 'flexibility' is defined: professional setting, geographic remoteness, level of experience (general and specialty), Clinical Supervision culture of discipline, level of organisational support, and exposure to areas of work with inherent clinical, professional or personal risk.	X
• Ideally a 'manual' for ease and consistency of implementation	X

Table 5

While local Area Health Service Clinical Supervision policies across rural NSW do have a strongly positive correlation with the critical elements, it is clear from the audit that resourcing, training, application, and measurement of Clinical Supervision in rural Area Health Services in NSW is inadequate. There isn't evidence that the policies are in use, or have had impact on workforce and clinical risk.

Risk management is a central focus for any adequate system of management. Inclusion of the need for Clinical Supervision in clinical risk analysis can be put forward to increase senior management commitment to resourcing the training and scheduling requirements for the provision of effective Clinical Supervision. It is clear from the audit there is a need to provide:

- training in the processes and purposes of Clinical Supervision
- greater flexibility in designing individual plans for Clinical Supervision
- clarification and overseeing the implementation of policies around Clinical Supervision
- greater access to telephone and e-mail, as well as other communication technologies
- systems of data collection to assess the efficacy of Clinical Supervision
- an enhanced regard for the practice of Clinical Supervision in workplace culture.

One Area Health Service which recently conducted a point-prevalence audit found that the highest levels of Clinical Supervision uptake were in the larger centres, and that the more remote Allied Health Professionals had poorer access, despite that this is logically the converse of what is

required, as sole practitioners in remote areas are often less experienced and at higher risk without good levels of Clinical Supervision. This was the only reported collection of data around Clinical Supervision in the audit.

The absence of training is identified by all as a priority to redress. Training of Clinical Supervisors was considered a critical element of success, yet little is known at an Area Health Services level or higher about the supports for, availability of, or access to such training. The limiting factor of *'availability of a cohort of clinical leaders... with appropriate training and preparation for their roles... to assume the role of supervisor/mentor'* (NSW CHN, 2004) is not being measured, nor have Area Health Services assumed responsibility for this beyond policy.

Barriers to the provision of Clinical Supervision include long distances to travel, financial constraints, complex workloads and associated waiting lists, poor management support, child care and family commitments. One of the strategies most effective in reducing travel time and costs as well as creating an immediate and routine response is through using technological and communication strategies to support Clinical Supervision. In New South Wales, there is currently a wide variance in Allied Health Professional access to Clinical Supervision across, and perhaps within the Area Health Services. While phone and videoconferencing is acknowledged in local policy, just how to best use a blend of methods including emerging internet and other technologies to meet the needs of any particular Allied Health Professional in any given setting has not been defined. If someone is remote, what percentage of their Clinical Supervision should be face-to-face?

If it is accepted that every Allied Health Professional in Rural NSW should have guaranteed access to Clinical Supervision, and that Clinical Supervision would be everybody's responsibility to promote and participate in, it is acknowledged that NSW Rural Area Health Services already have existing policy frameworks for the provision of Clinical Supervision to rural Allied Health Professionals which provide an opportunity for excellent Clinical Supervision tailored to each Allied Health Professional whatever their experience, wherever they practice, whatever their discipline. These policies have (mostly) been recently developed, at a time of great change, and Area Health Services should be commended.

However the implementation of formal Clinical Supervision across large areas, many disciplines, in many settings will require concerted attention to:

- Risk profiling: Identifying the needs of the Clinical Supervision needs of each Allied Health Professional
- Training of Clinical Supervisors, and
- Better evidence gathering to support the contentions that universal access to Clinical Supervision for Allied Health Professionals has positive impacts on clinical, professional and workforce outcomes.
- Overall resources and application of the Clinical Supervision policy

In short, the models of Clinical Supervision in use in rural NSW do not necessarily need changing; they require strengthening with more robust processes. There is strong evidence on the efficacy and positive impact of formalised Clinical Supervision on the capability of Allied Health Professionals. Applying a robust and sustainable model of Clinical Supervision in rural and remote New South Wales will require better application of existing policy as well as the creation of new strategies. The following pages suggest strategies for this.

## Defining Flexibility: Rural Allied Health Clinical Supervision Risk Profiling

Area Health Service policy and the jurisdictional policies explored in this paper do consistently suggest that there be a *flexible* approach to the supply and organising of Clinical supervision, which may be dependant on the employee's level of competence and experience and other unspecified factors. While 'flexible' is consistently used to describe how organisations determine whether, how and to what degree Clinical Supervision will be delivered to a particular Allied Health Professional, none have defined what 'flexible' or 'case-by-case' means. If an Allied Health Professional or their Manager are seeking to determine or prioritise strategies to meet their Clinical Supervision needs, where do they start?

Below is proposed a tool or matrix of considerations to identify risk and need for Clinical Supervision for rural Allied Health Professionals. The Rural Allied Health Clinical Supervision Risk Profiling (RAHCSRP) tool (Fig 5) considers the following 7 dimensions:

- professional setting
- geographic remoteness
- level of experience/competence generally
- level of experience/competence within a specialty
- Clinical Supervision culture of Allied Health discipline (education, training, perceptions, expectations)
- level of organisational support, and
- exposure to areas of work with inherent clinical, professional or personal risk.

Each dimension is assigned a risk scale of 1 to 3 more fully described in Table 6. Risk scores are added to develop the risk profile. The relative risks assigned in each dimension are based on the literature and observation, and are not weighted or validated. It will be useful to test this tool with cases:

### Case 1

Experienced Allied Health Professionals with a knowledge of rural and remote practice may intuitively know that a, say, new graduate physiotherapist may be best to start their career where there is access to formal and informal professional supports, and may suggest if asked that a larger centre with a department could 'fit' their needs. The same new graduate (3) physio (3) (who has received no training in Clinical Supervision) may actually find their first job is as a sole practitioner (3), in a very remote location (3), working for an organisation with no processes for Clinical Supervision (3), and find themselves involved in paediatric cases (3+3).

Using the RAHCSRP tool this Allied Health Professionals would score the maximum risk of 21. While this shows a very high need for Clinical Supervision, and suggest that other strategies for ameliorating professional, clinical and personal risk be taken. Not seeing paediatric or other specialist clients, being included as a close part of a multidisciplinary team, and/or a 'virtual' department, working in a hub-and-spoke model with outreach to remote sites, and formalising Clinical Supervision with excellent access to a senior professional supervisor through use of internet technology may all be steps which reduce risk, and keep the professional in place as they gain experience.

### Case 2

By contrast an experienced (1) Psychologist (1) with undergraduate and post-graduate qualifications, specialist training (1), and much experience in Clinical Supervision processes (1), who works in a regional centre (1) in Drug and Alcohol (3), within a department or team (1) with defined processes and formal support for Clinical Supervision reinforced with registration obligations, and clear funding, is a low to low/moderate risk (7-8). Clinical Supervision processes adopted will most likely address their needs.

**Case 3**

A Dietitian (2) with say 4 years of experience (2) is employed in a general position (1+1) with a division of General Practice in a rural location (2), as the only Dietitian as part of a small multidisciplinary team(2). The Division had recognised the need for its staff to have Clinical Supervision and have created formal agreements (1), and have sourced external supervision with a senior professional in a nearby regional centre. Total risk is moderate at 11.

Circumstances change and the Dietitian has general training and some experience in diabetes, but has been asked to be involved with insulin pump therapy (3). Specialist supervision is brokered, after consultation with the Clinical Supervisor, to lessen the clinical risk.

**Fig 5 Rural Allied Health Clinical Supervision Risk Profiling Tool**

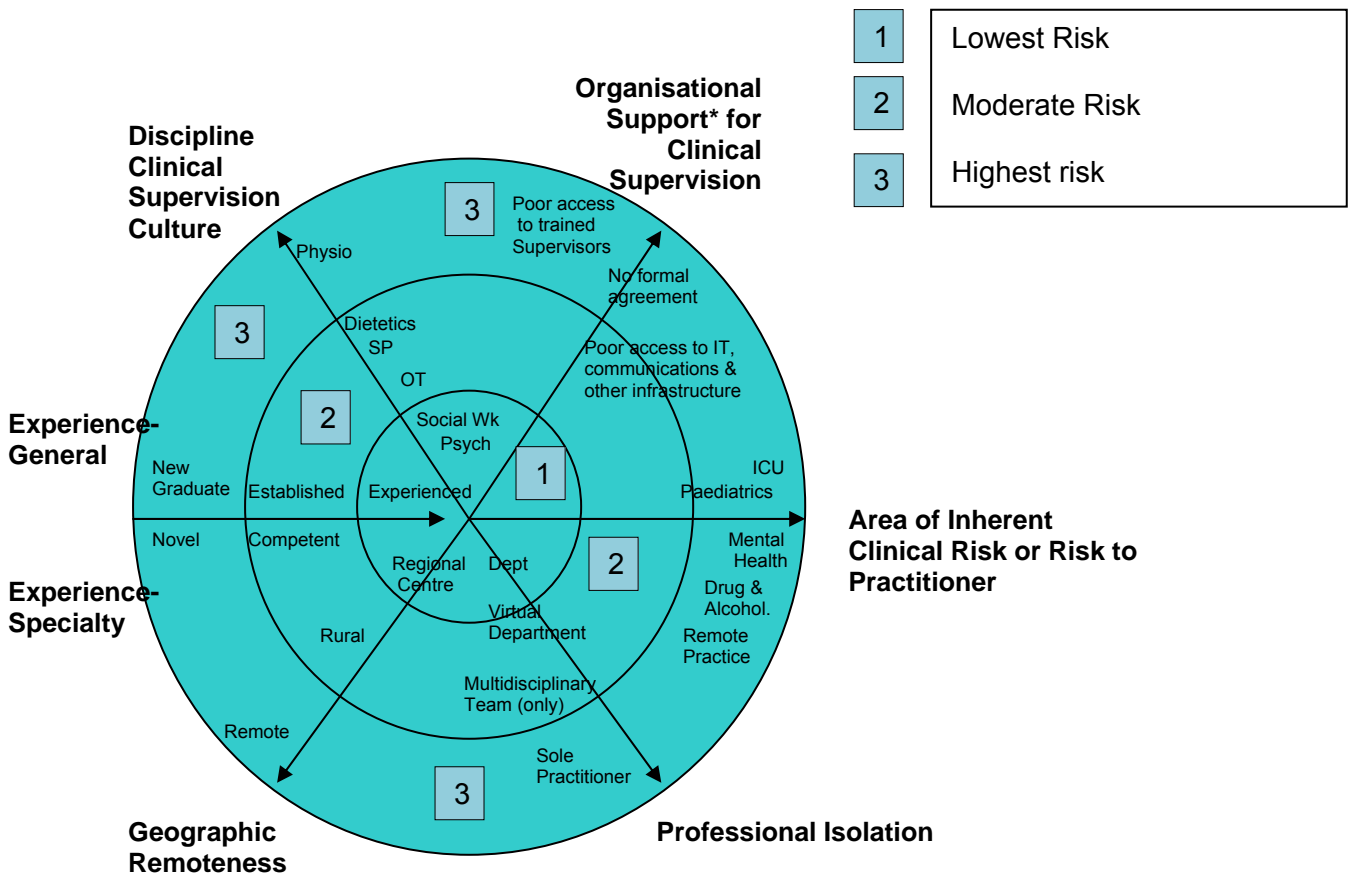


Table 6

<b>Rural Allied Health Clinical Supervision Risk Profiling Tool</b>				
<b>Dimension</b>	<b>Low Risk = 1</b>	<b>Mod Risk = 2</b>	<b>High Risk= 3</b>	<b>Score</b>
<b>Level of experience or competence generally</b>	Senior Practitioner – Highly experienced practitioner with ongoing continuing education	Established or Competent practitioner in general clinical areas	New Graduate at entry level competency in general clinical areas	
<b>Geographic remoteness</b>	Regional Centre (Greater access to a pool of peer and senior professionals, infrastructure etc)	Rural Location (More limited access to a pool of peer and senior professionals, infrastructure etc)	Very Remote or Remote Location (poor access to a pool of peer and senior professionals, infrastructure etc)	
<b>Professional Isolation</b>	High opportunity for formal and informal discipline-specific supervision. Eg larger department	Moderate opportunity for formal and informal discipline-specific supervision. Eg Multidisciplinary team (only) or Virtual dept	Low opportunity for formal and informal discipline-specific supervision. Eg Sole Practitioner	
<b>Discipline Clinical Supervision culture</b>	Higher levels of CS education, training, perceptions and expectations. eg Social work and Psychology	Moderate levels of CS education, training, perceptions and expectations. eg Sp. Path, OT, ? Dietetics	Lower levels of CS education, training, perceptions and expectations. Eg Physio, ? Dietetics	
<b>Level of organisational support</b>	Formal agreement, Training and funding support for CS. Strong processes, clear roles, flexible modes of delivery	Adhoc, Training and funding support for CS. Less defined processes, unclear roles, less flexible modes of delivery	No formal agreement Poor access to trained supervisors Poor access to IT, communications and other infrastructure	
<b>Exposure to areas of work with inherent clinical, professional or personal risk.</b>	Little to no involvement in areas of practice which present high clinical or personal risk (physical or psychological)	Work in areas of moderate risk (eg Human Services, Home visits) or moderate level of involvement in areas of practice which present high clinical or personal risk (physical or psychological)	High level of involvement in areas of practice which present high clinical or personal risk (physical or psychological) Eg Mental Health, D&A, Paediatrics or ICU	
<b>Level of experience /competence within a specialty</b>	Senior Professional with both training and experience within specialty	Competent practitioner, with specialist training and/or experience	Novel Practitioner within specialty, may be experienced generalist with recent shift into more complex role	
<b>Overall Risk: 7-11 = Low Risk 12-16 = Moderate Risk 17-21 = High risk</b>				<b>Total</b>

## **Potential Strategies to Address Risks and Needs raised by the Risk Profiling process.**

The RAHCSRP tool could also be developed further to assist managers and Allied Health Professionals in identifying specific strategies to reduce the risks identified in the process. It may be that a companion table could make suggestions for strategies specifically 'targeted' at the higher risk dimensions for any individual Allied Health Professional.

For example, the provision of CS to inexperienced practitioners assumes the availability of senior Clinical Supervisors who are from the same Allied Health Profession and who have experience in the same area of clinical practice as the supervisee. The availability of such supervisory staff is not a given, particularly in rural and remote locations. Strategies that have been suggested to recruit suitable supervisors are:

- use of a senior clinician providing supervision at a distance
- use of a local senior clinician of a different but related allied health discipline
- use of a local senior clinicians external to the public health system
- travel of supervisee to the senior clinician's location for formal supervision
- interdisciplinary Clinical Supervision particularly as an adjunct to like-profession supervision should also be considered for remote practitioners, perhaps as part of group supervision strategies

Also, travelling for supervision is not always realistic, as the degree of remoteness influences the feasibility of travel. Alternative modes of transportation are sometimes used to address this tyranny of distance. For example, in the NWQPHC model (Battye and Mctaggart, 2003) the policy is to fly Allied Health Professionals into remote locations if travel would otherwise be off-road.

Area Health Services should seek to employ current and emerging technologies to complement the required face-to-face intra-disciplinary Clinical Supervision to provide for human interactions within a virtual environment. For example, the model may include one face-to-face for every 2 or 3 teleconference and videoconference delivered individual or group Practice Supervision opportunities, dependent on the experience level of the Allied Health Professional. Examples of commonly used technologies are: telephone, email, web base telecommunications (e.g. Skype), and videoconferencing. Videoconferencing is not universally available as it requires access to appropriate facilities at both sites. However, there are promising developments for web based videoconferencing that may be useful. It must be mentioned, however, that confidentiality issues must be addressed in any supervisory arrangement using these technologies.

While distance is a contributing factor, professional isolation can also be experienced by sole practitioners, particularly if they are working outside a team setting. These clinicians will benefit from a hub and spoke model where there are regular face-to-face meetings of Allied Health professionals working in similar clinical areas. The frequency of these meetings can be adjusted according to the supervisee's need for guidance and the clinical management issues inherent in interprofessional practice settings.

## **RECOMMENDATIONS**

This paper provides a background for the consideration of policy and practice development around clinical supervision. Based on this review, several recommendations can be made with confidence. These include the need to:

- 1) Improve access to Clinical Supervision through training of Clinical Supervisors
- 2) Build a better evidence base for Clinical Supervision for rural Allied Health Professionals
- 3) Increase organisational support for Clinical Supervision

If formal Clinical Supervision is to be fully adopted, it should be supported by consistent resourcing, access to supervisors, tools and templates, and incorporation of Clinical Supervision into professional development plans for Allied Health Professionals. In particular the literature suggests that a formal agreement linking supervisors and supervisees assists in clarifying confidentiality issues. Such an agreement can also assist line managers to allocate resources to support practice supervision. The provision of Clinical Supervision should be embedded into position descriptions, orientation, performance management systems, and budget allocations for all Allied Health Professionals in rural NSW.

### **Improving access to Clinical Supervision through training of Clinical Supervisors**

It will be necessary to ensure that there is a pool of appropriately trained senior Allied Health Professionals willing to engage in Clinical Supervision for other Allied Health Professionals within their Area Health Services. The diverse nature of Allied Health Professionals, and the cultural and practice change that Clinical Supervision represents for many rural Allied Health Professionals gives further evidence that a training program is needed for potential Clinical Supervisors.

Clinical Supervisor Training Programs on an ongoing basis will need support across rural NSW. It would seem appropriate to link this training with one or more of the regional universities, and to consider the role of the University Departments of Rural Health, and/or other potential contributors such as SARRAH. Clinical Supervision for Allied Health Professionals in rural and remote settings is currently the focus of numerous projects and activities across Australia, so timely collaboration with these projects will be valuable, particularly in the Northern Territory and Western Australia.

It should also be ensured that Clinical Supervisors have the tools and resources to effectively carry out their role. Each Allied Health Professional, Manager and Clinical Supervisor would have access to a comprehensive Manual or Guidelines for the Provision of Clinical Supervision for Allied Health Professionals in Rural NSW. This could include flow charts, role descriptions for Allied Health Professionals, Managers and Clinical Supervisors, together with tools, agreement templates etc. The Rural Allied Health Clinical Supervision Risk Profiling Tool could be included.

System-wide strategies such as the availability, training for, and use of appropriate communication technology to support the provision of Clinical Supervision will be required and issues such as access to the technology and infrastructure must be addressed.

### **Building a better evidence base for Clinical Supervision for rural Allied Health Professionals**

Some form of standardized measurement must be built into any proposal. The Manchester Clinical Supervision Scale (Man.Sch.Nsing 2008) is one tool currently accepted for use in outcome measurement from a supervisee perspective. Rural AHS in NSW should consider mechanisms for measuring the clinical outcomes and workforce benefits of Clinical Supervision described in the literature. However, that discussion is beyond the scope of this paper.

Exploration of the organisational benefits of establishing Clinical Supervision Standards, including costing, economic modelling is recommended. While the literature estimates direct costs of about 1% of salaries for provision of Practice Supervision, no estimate is available of the costs of staff turnover, recruitment costs etc. The sustainable application of Clinical Supervision for Allied Health Professionals in Rural NSW requires adequate resourcing, perhaps with quarantined budget for each Allied Health Professionals appropriate for their needs and stage of practice as determined by their Clinical Supervision agreement.

### **Increasing Organisational Support for Clinical Supervision**

Some further suggestions to more fully engage organisational support for Clinical Supervision provision are:

- Agreement could be achieved between Area Health Services, to link of local policy with an overarching policy framework. Clinical Supervision could progress to the Policy Directive level within NSW Health.
- The establishment of a Steering Committee or Reference Group, to oversee the project development, garner organisational support, lend skills and leadership, and to lead the scoping of a full project to establish and roll-out the Program for Allied Health Professionals in Rural NSW. This group would include the Rural Allied Health Advisors/Directors, and key stakeholders.
- The role of the NSW Institute of Rural Clinical Services and Teaching may be key in:
  - Supporting establishment of the Steering Committee
  - Supporting Training initiatives
  - Supporting further research into Clinical Supervision, including by engaging partners such as University Departments of Rural Health
  - Assist Development of a Clinical Supervision Program for Allied Health Professionals in Rural NSW Manual and provide seed funding

## References

- Australian Association of Social Workers (AASW), *National Practice Standards of the Australian Association of Social Workers: Supervision*. July, 2000
- Battye, KM. and McTaggart, K. Development of a model for sustainable delivery of outreach allied health services to remote north-west Queensland, Australia. *The International Electronic Journal of Rural and Remote Health Research, Education and Policy*. *Rural and Remote Health (online)* 3, 2003: no. 194
- Bean, N. Evaluation of the introduction of professional practice supervision to all allied health staff in the Rockhampton Health district, paper presented at the National SARRAH Conference, 2006, Albury.
- Bernard, JM. & Goodyear, R. K. (1992 & 2004). *Fundamentals of clinical supervision*. London: Pearson.
- Bishop, M. Relational Learning: A strategy for providing supervision for child and family support workers. *Crossing Borders; Proceedings Conference of the Australian College for Child and Family Protection Practitioners*, Melbourne, 2007
- Bracciano, A. Occupational Therapy's role in rural health: an opportunity for growth. *Physical Disabilities Special Interest Group Newsletter*, 1986; 9, pps.1-8
- Burns, M.E. The historical development of the process of casework supervision as seen in the professional literature of social work. Doctoral dissertation. University of Chicago, 2958 cited in Leddick, G.R. and Bernard, J.M. The history of Supervision: a critical review, *Counsellor Education and Supervision*, 27, 186-196, 1980.
- Byrne, C. (1994) Devising a model health visitor supervision process. *Health Visitor* 67, 195-198
- Christensen, R. North Coast Area Health Services, NSW Health, *Allied Health Professional Clinical Supervision Policy*,
- Department of Health. (UK) (1993) *A Vision for the Future: The Nursing, Midwifery and Health Visiting Contribution to Health and Health Care*. London: The Stationery Office
- Eckstein, R. and Wallerstein, R. *The Teaching and Learning of Psychotherapy*, Basic Books, New York, 1959 cited in Leddick, G. R. & Bernard, J. M. The history of supervision: A critical review. *Counsellor Education and Supervision*, 27, 186-196, 1980.
- Edwards, D., Burnard, P., Hannigan, B., Cooper, L., Adams, J., Juggessur, T., Fothergil, A. and Coyle, D., Clinical supervision and burnout: the influence of clinical supervision for community mental health nurses, *Journal of Clinical Nursing*, 2006, 15, pps. 1007-1015
- Elliot-Schmidt, R and Strong, J. Rural occupational therapy practice: a survey of rural practice and clinical supervision in rural Queensland and Northern New South Wales, *Australian Journal of Rural Health*. 1995, 3, 122-131.
- Fone, S. Effective supervision for Occupational Therapists: The development and implementation of an information package, *Australian Journal of Occupational Therapy*, December 2006, 53(4) pps 277-283.

Goodyear, R. K. and Bernard, J. M. Clinical supervision: Lessons from the literature. *Counselor Education and Supervision*, 38 (1), 6-22, 1998.

Greater Western Area Health Service, *Area Practice Standard Allied Health Supervision*, March 2007, NSW Health

Herrington, A and Herrington, J., Using the internet for professional development: the experience of rural and remote professionals, *Proceedings of the 23<sup>rd</sup> Annual Ascillite conference: Whose learning? Whose technology?* University of Sydney, 2006

Hodgson, L and Berry, A. *Rural Practice and Allied Health Professionals: The Establishment of an Identity*, Toowoomba, Cunningham Centre, Queensland Health 1993.

Holloway, E. and Hosford, R. E. Supervision in counseling: Towards developing a prescriptive technology of counselor supervision. *Counseling Psychologist*, 11, 73-77, 1983.

Kelly, K. *Preventing Job Related PTSD Among Remote Health Practitioners: An Overview of the Evidence*, CRANA, Bush Crisis Line Occasional Paper Number 2, available at <http://www.bcl.org.au/publications.html>

Kirk, S.F.L., Eaton, J and Auty, L. Dietitians and supervision: should we be doing more? *Journal of Human Nutrition and Dietetics*, 2000, 13, pps.317-322.

Leddick, G. R. Models of Clinical Supervision. *EIRC Digest*, ERIC Clearinghouse on Counselling and Student Services, Greensboro, NC. April, 1994 downloaded from <http://www.ericdigests.org/1995-1/models.htm> on 13.03.2008

Leddick, G. R. & Bernard, J. M. The history of supervision: A critical review. *Counsellor Education and Supervision*, 27, 186-196, 1980.

Lee, S. and Mackenzie, L. starting out in rural New South Wales: The experiences of new graduate Occupational Therapists, *The Australian Journal of Rural Health*, 2003, 11(1) p 36-43.

Loganbill, C., Hardy, E and Delworth, U., Supervision: A Conceptual Model Counselling Psychologist, 1982, 10, pps 3-42 cited in Miller, T.W, Miller J. M., Burton, D., Sprang, R and Adams, J. Telehealth: a Model for Clinical Supervision in Allied Health, *The Internet Journal of Allied Health Sciences and Practice*. July 2003. 1 (3)

Manchester School of Nursing, *The Manchester Clinical Supervision Scale*, sourced from <http://www.clinicalsupervisionscale.com> .

McLeod, S. and Barbara, A. Online technology in rural health: supporting students to overcome the tyranny of distance, *Australian Journal of Rural Health*, 2005, 13(5) pps, 276-281.

Miller, T.W, Miller J. M., Burton, D., Sprang, R and Adams, J. Telehealth: a Model for Clinical Supervision in Allied Health, *the Internet Journal of Allied Health Sciences and Practice*. July 2003. 1 (3)

Mills, J.E., Francis, A and Bonner, Mentoring, clinical supervision and preceptoring: clarifying the conceptual definitions for Australian rural nurses: A review of the literature. *Rural and Remote Health* 5: 410 (Online), 2005. Available from <http://rrh.deakin.edu.au>

Milne D, An empirical definition of clinical supervision, *British Journal of Clinical Psychology* (2007), 46, 437-447, 2007.

NSW Psychologists Registration Board, *Supervision Guidelines, June 2008*. Available from [www.psychreg.health.nsw.gov.au](http://www.psychreg.health.nsw.gov.au)

Nguyen, Thuy Vy. *A Comparison of Individual Supervision and Triadic Supervision*, Dissertation Prepared for the Degree of Doctor of Philosophy, University of North Texas, August 2003, downloaded from <http://www.digital.library.unt.edu/permalink/meta-dc-4300:1> on 14.03.2008

North Coast Area Health Service. *Allied Health Professional/ Clinical Supervision Policy*, NCAHS NSW, 2008.

Parkin, A.E., McMahon, S. Upfield, N. Copley, J. and Holland, K. Work experience program at metropolitan paediatric hospital: assisting rural and metropolitan Allied Health Professionals exchange clinical skills, *Australian Journal of Rural Health*, 9, 2001, pps. 297-303

Paskevicius, A. Editor (2002). *Western Australian Allied Health Taskforce on Workforce Issues. Initial Report*. Health Department of Western Australia.

Proctor, B. (1998). Supervision: A co-operative exercise in accountability. In: M. Marken and M. Payne (eds). *Enabling and Ensuring*. Leicester: Leicester National Youth Bureau and Council for Education and Training in Youth and Community Work.

Queensland Health, *Practice Supervision in Allied Mental Health*, Human Resources Policy, G5 April, 2008.

Services for Australian Rural and Remote Allied Health (SARRAH) *SARRAH Position Paper on Provision of Allied Health Services to Regional and Remote Aboriginal and Torres Strait Islander Communities*, SARRAH website: [www.sarrah.org.au](http://www.sarrah.org.au).

Speech Pathology Australia, *The Role and Value of Professional Support*. 2007

Stamm, B. Telehealth in a clinical trial: Remote clinical and administrative supervision. In R. Gleuckauf (Chair), *Telehealth for persons with chronic medical conditions – program evaluation developments*. Presented at the 106<sup>th</sup> Annual Convention of the American Psychological Association, San Francisco, August, 1998. Available at <http://www.dartmouth.edu/~csp420/professional?> Cited in Miller, T.W, Miller J. M., Burton, D., Sprang, R and Adams, J. Telehealth: a Model for Clinical Supervision in Allied Health, *The Internet Journal of Allied Health Sciences and Practice*. July 2003. 1 (3)

Steenbergen, K. and Mackenzie, L. Professional support in rural New South Wales: Perceptions of new graduate Occupational Therapists. *Australian Journal of Rural Health*, 2004, 12 (4) pps. 160-165.

Stoltenberg, C. Approaching Supervision from a developmental perspective: the counsellor-complexity model, *Journal of Counselling Psychologists*, 28, 59-65, 1981.

Stoltenberg, C. D., & Delworth, U. *Supervising counsellors and therapists*. San Francisco, CA: Jossey-Bass, 1987.

Struber, J. Recruiting and retaining Allied Health Professionals in rural Australia: Why is it so difficult? *The Internet Journal of Allied Health Sciences and Practice*, April 2004 2(2)

Watkins, C. E. (Ed.). (1997). *The handbook of psychotherapy supervision* (Chapter 1). Chichester: Wiley.