Queensland Health

Supervision Guidelines

for Mental Health Alcohol and Other Drugs Services 2023

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Supervision Guidelines

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Foreword

Queensland Health is committed to ensuring that the mental health alcohol and other drugs workforce is adequately skilled and resourced to provide quality and safe clinical services to consumers and their carers and families. This is demonstrated through recent system reform initiatives and emphasised in *Better Care Together: plan for Queensland's state-funded mental health, alcohol and other drug services to 2027*[1], and the *Gayaa Dhuwi Declaration 2015*[2].

The Supervision Guidelines for Mental Health Alcohol and Other Drugs Services provide a standardised, non-discipline specific and flexible state-wide approach to supervision for all professionals involved in MHAOD service delivery. This document aims to ensure that general professional supervision needs, as well as specific requirements associated with clinical disciplines, are met as outlined by the principles of the *Human Resources Policy G5: Practice Supervision in Allied Health Mental Health*[3].

The Guidelines recognise that supervision is central to promoting the personal and professional development and wellbeing of the mental health alcohol and other drugs workforce across Queensland Health. In keeping with the principles of *Managing the Risk of Psychosocial Hazards at Work Code of Practice*[4] these guidelines provide a framework that encourages review and reflection in practice to maintain clinical standards, improve consumer outcomes, and support practitioner wellbeing.

The Mental Health Alcohol and Other Drugs Branch wishes to acknowledge the many consumers, carers, peer workers, Aboriginal and Torres Strait Islander health workers, clinicians, professional leaders, educators, service managers and policy officers that contributed to the development of this guideline.

Associate Professor John Allan

Executive Director

Mental Health Alcohol and Other Drugs Branch

Part One

1.1 Purpose

These guidelines provide a standardised, non-discipline specific and flexible approach to clinical and professional supervision for Queensland Health's mental health alcohol and other drugs workforce. The principles outlined will assist staff, supervisors, managers and services to:

- understand the purpose of clinical and professional supervision
- clarify their respective roles and responsibilities
- embed and participate in supervision as a core element in the provision of safe and high quality treatment and care.

1.2 Terminology

This guideline uses the terms *clinical supervisio*n, *professional supervision* and *supervision* synonymously to reflect and include a broad range of supervision models used by mental health alcohol and other drugs workforce, including Lived Experience (peer) workers. Refer to Section 1.6 What is supervision? for further definition.

1.3 Target audience

The following groups of professionals in mental health alcohol and other drugs services are expected to participate in clinical supervision and are included in this guideline:

- nurses
- allied health professionals
- allied health assistants and rehabilitation therapy aides
- Aboriginal and/or Torres Strait Islander mental health alcohol and other drugs workers
- Lived Experience (peer) workers
- medical practitioners
- other clinical / frontline administrative staff.

Queensland Health has a responsibility to ensure that all staff have access to appropriate professional development and support in the exercise of their duties.[3] Active participation in supervision by both the supervisor and supervisee demonstrates commitment to best practice in the delivery of safe, high-quality care. Supervision delivery should consider the organisational context of the supervisee and clinical governance requirements in addition to the support and development needs of the supervisee.[5]

1.4 Scope

These guidelines:

- outline the primary purpose and principles of supervision
- define the content, structure and process of supervision
- highlight the roles of all parties involved in supervision
- describe choice in supervision and criteria for selecting supervisors
- emphasise the importance of adequate resourcing for clinical supervision
- outline minimum standards for supervision[3]
- define the responsibilities relating to supervision at the level of the organisation, Hospital and Health Service, service, supervisor and supervisee
- outline requirements and resources to support the monitoring and evaluation of supervision at an individual and service level
- highlight the role of supervision in relation to support, wellbeing, performance and development of staff and clinical governance.[4]

1.5 Application

The Supervision Guidelines for Mental Health Alcohol and Other Drugs services:

- expect that all staff involved in the direct delivery of mental health alcohol and other drugs services receive regular supervision, including Aboriginal and Torres Strait Islander health workers and the Lived Experience (peer) workforce.[6]
- do not recommend a single model of supervision. Mental health alcohol and other drugs services retain the flexibility to implement programs and processes appropriate for their local context, and within their available resources.
- are intended to complement the more specific supervision requirements associated with some professions.
- complement processes for healthcare students on clinical placement and cadetship holders within Queensland Health facilities.
- acknowledge the requirements for all professional groups to work in a manner that is culturally inclusive, including the application of specific frameworks of relevance to working with and alongside people who identify as Aboriginal and Torres Strait Islander (Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033).[7,8]

1.6 What is supervision?

Multiple definitions of supervision exist for a range of practitioners across diverse settings, and the conceptualisations and requirements of this vary based on professional discipline and practice setting.[3,9,10]

In this document supervision is defined as a formal process of professional support and learning that enables staff to:

- feel respected, safe and supported to actively participate in the supervisory relationship
- be empowered to assume greater responsibility for their practice
- develop, enhance and maintain knowledge, skills, confidence and competence
- give and receive feedback, and reflect on their work
- explore safety and ethical issues arising in their work
- identify and manage workplace stressors and support psychosocial wellbeing[4]
- develop respectful and culturally safe practice[2,7,8]
- clarify boundaries in workplace relationships, including with consumers
- plan and utilise their personal and professional resources more effectively
- enhance safe high-quality consumer care and outcomes[1,5]
- develop and demonstrate accountability for the quality of their work.[9]

1.7 Underlying principles of supervision

These guidelines are underpinned by the following common principles for supervision:

1. Supervision is a formal process of support and reflection and is separate to a formal system of individual performance appraisal. It is about empowerment, not control.[11,12]
2. Supervision is a core function of Queensland Health that must be resourced, planned, managed, and evaluated at all levels of the organisation.[3]
3. Supervision is integral to mental health alcohol and other drugs practitioner role requirements and role descriptions.[3]
4. Supervision is one aspect of a wider framework of clinical governance activities designed to support staff and ensure the delivery of safe, ethical high-quality services and effective outcomes.[3,12,13]
5. A variety of supervision models and frameworks may be used, depending on the research evidence, best practice, context, and discipline group.[12,14]

6. Effective safe and ethical supervision means that supervisors are trained, can demonstrate recency of training and experience, and participate in supervision of their supervision.[8,15,16]
7. Access to evidence-based supervision training and regular supervision is to be supported at the service level by a range of interventions and modalities that support sustainable provision.[3]
8. Access to supervision of supervision for the purpose of enhancing supervisor development and supervision efficacy is supported and resourced.[3,17]
9. Supervision is the responsibility of the Hospital and Health Services to manage and ensure the efficiency, effectiveness, and availability of supervision.[3]
10. Supervision will be audited, evaluated, and documented at an individual practitioner and service level.[3]
11. Supervision involves appropriate information management, documentation, and confidentiality processes.[3,9]
12. Ongoing supervision for all staff involved in the direct delivery of services is critical to ensure quality assurance in practice, regardless of experience and level of appointment.[3,18]

1.8 Clinical supervision

Clinical supervision is a broad term encompassing a range of principles, activities, and areas of practice. To be inclusive of all mental health alcohol and other drugs professionals' supervision models, the terms *clinical supervision* and *supervision* are used synonymously throughout this guideline.

"Clinical supervision is a formal professional relationship between two or more people in designated roles, which facilitates reflective practice, explores ethical issues, and develops skills."

(Australian Clinical Supervision Association, 2015[14])

Clinical supervision is widely recognised as a central factor in supporting professional development, identity, and wellbeing and is essential for ensuring safe, high-quality, and effective services.[9,13,15] As a distinct professional activity supervision is a formal planned relational process that fosters high clinical and professional standards and culturally safe practices.[16,17] Supervision is foundational to the development of capability, knowledge, and skills through the facilitation of critical thinking, self-assessment, observation, feedback, evaluation, modelling, and problem solving within a safe and collaborative relationship.[10,17,19]

Supervision is one component of an overall model of clinical governance and professional development for mental health alcohol and other drugs professionals (see Figure 1). Other components include administrative, operational/line management, professional supervision, performance appraisal and development processes, mentoring, coaching, clinical education and training and participation in structures such as clinical review, team meetings, clinical handovers, and grand rounds.[9,10,12]

Clinical supervision is a consumer-focused activity. The content of supervision sessions should focus on issues relating to or impacting on the supervisee's practice and the delivery of consumer care.[18] Queensland Health recognises that supervision includes regular reflection on professional wellbeing and/ or personal issues which impact on care delivery.[4] Clinical supervision should **not** be regarded as personal therapy. When necessary, personal therapy and support may be provided by the Hospital and Health Service employee support programs or sought privately.[3,4]

Clinical supervision is a supervisee-led activity. This means the staff member chooses their supervisor, in conjunction with the Team Leader/Unit Manager/Operational Manager and Discipline Leader*, and in collaboration with their supervisor; determines the frequency of clinical supervision (within the specified standards), the purpose of supervision, the focus for each session and their own learning goals.[3,14,20]

* Discipline Leaders may include: Directors of Allied Health, Directors of Nursing, and other Discipline Directors and senior staff (for example, within the Medical, Aboriginal and Torres Strait Islander Workforce, and Peer workforce) who have responsibilities for mental health alcohol and other drugs staff.

Clinical supervision is not a performance appraisal process. These are separate but inter-related processes. Staff may choose to use supervision to help them prepare for a performance appraisal by identifying issues they may wish to raise and to use supervision to assist them in achieving the objectives that have been set during the review.[3,20]

Clinical supervision is not mentoring, coaching, preceptorship or an operational management activity and should not be confused with performance or administrative/operational supervision with line managers. Whilst there may be similarity in functions of these other forms of professional development with the functions of supervision, clinical supervision is distinctly separate.[11,12]

Clinical supervision can be intra and inter professional (conducted by members of same or another profession).

Supervision can be delivered in a variety of modes dependant on the workplace environment (e.g., rural and remote settings) and availability of supervisors. Methods include face–to-face, telephone, and videoconferencing, and in either individual or peer/group format. It is important to note when undertaking supervision in a peer or

group format it is done so with appropriate resources and specific training and agreements in place.[18,20,21]

It is critical that in addition to supervision, staff maintain their participation in the full range of professional development activities including education and training, and attendance at clinical review and team meetings, handovers, and grand rounds.

Figure 1: Conceptual map of supervisory activities, adapted from Bernard & Goodyear, 2014[18]

Purposes of Clinical Supervision

Clinical supervision has three main functions.[16,19]

- **Normative (safety and ethical practice):**

  Ensuring the professional maintains established standards of safe and ethical care by dealing with the quality control aspects of practice.[21,22] In the supervision setting, this is most powerfully achieved through reflection on practice and competence in a supportive relationship that is safe enough to challenge thinking.[16,22,23] It is the shared responsibility of both the supervisor and supervisee.[24,25]

- **Restorative (supportive):**

  Enabling the professional to sustain effective work by supporting psychosocial wellbeing and self-care in those who work with stress and distress.[3,4,5] This support is achieved by the supervisor having an unconditional positive regard for the supervisee (holding a continual respect for the individual despite the circumstances)24[,26] In this supportive setting, positive challenges to professional practice can be made for the purpose of supporting scope of practice and increasing professional resilience and enhancing professional identity for the supervisee.[19,23,25]

- **Formative (educative):**

  Enabling the professional's development of expertise and skills through education and experiential learning.[23] This learning is achieved through culturally aware and safe guided self-reflection on and during practice in a safe, time protected settings.[27,28,29]

1.9 Additional definitions of supervision

Additional forms of supervision may be practised instead of, or complementary to, clinical supervision, depending on the profession, role and cultural needs. These additional definitions of supervision are underpinned by principles, models and frameworks that reflect the unique nature of the practice and the workforce that participates in them. These additional forms of supervision support wellbeing, best practice, cultural capability and enhance service outcomes.

Aboriginal and Torres Strait Islander Reflective Yarning

Reflective Yarning is facilitated by the Aboriginal and Torres Strait Islander workforce for the Aboriginal and Torres Strait Islander workforce. The Aboriginal and Torres Strait Islander workforce includes all staff who identify as Aboriginal and/or Torres Strait Islander, and those in identified positions. It is a safe, secure, and healing space that recognises and supports the navigation of two worlds.

Reflective yarning is grounded by shared living experience to empower cultural growth, identity and belonging to enhance personal and professional development. It supports

application of culturally safe decolonising practices, using models and frameworks to improve Aboriginal and Torres Strait Islander people's health outcomes.[30]

Yarning is a term for talking, storytelling and deep listening that is grounded in reciprocal relationships and learning underpinned by collective experiences and mutual respect. [31] Yarning provides a sharing space where equity can be achieved, it is a relational, flexible process that acknowledges and upholds Indigenous ways of knowing, being, and doing. [31,32]

Reflective Yarning principles:

- Debriefs on the impacts of racism, social exclusion, colonisation, trauma, culturally unsafe work practices, and other negative historical and social determinants on Aboriginal and Torres Strait Islander social and emotional wellbeing.[2,7,31,32]
- Facilitates strengths-based feedback to navigate cultural complexities and challenges.[32]
- Provides cultural guidance to address stigma, discrimination, individual, systemic and institutional racism.[32]
- Provides support to navigate boundaries and tensions between community and organisational requirements, acknowledging that the worker returns to community when they leave the office each day.[32]
- Shares an understanding of relationships and the challenge of balancing workplace process and policies and community obligations.
- Recognises the importance of and supporting social and emotional wellbeing, self-care and our ways of healing.[31]
- Recognises the impact of vicarious trauma and cultural load and the important need for additional supports to enhance wellbeing and reduce fatigue.
- Supports the cultural safety and wellbeing of the worker, recognising cultural protocols and obligations which include connection to County, sorry business, kinship, family, spirituality and community obligations.
- Supports professional development, vulnerabilities, role progression, accountability for cultural practice and recognition of work performed.
- Provides cultural support and guidance for the worker to aid in best practice outcomes for the consumer.
- Supervision occurs in environment that recognises the importance of connection to County, place, space and time.
- Reflective Yarning is an integral component of broader supervision and professional support processes and requires the same level of formal recognition.

Multicultural Supervision

Multicultural supervision is essential to meeting the needs of individually and culturally diverse people and addressing the inequities and disparities in mental health and alcohol and drug outcomes.[3,8] Culture capability in supervision encompasses self-reflection and awareness surrounding one's own values, assumptions, and conscious and unconscious biases as these serve as the foundation from which one views the world including that of culturally diverse consumers.[33, 34] Culturally responsive supervision is often referred to as supporting the development of cultural capability in the practitioner to possess appropriate awareness, knowledge, skills, and attitudes in working with individuals and groups from diverse cultural backgrounds and increasing their confidence and ability to develop appropriate interventions based on this.[8,34,35]

Multicultural Supervision is underpinned by the following set of principles:

- Provides a safe space to enable reflection on how the practitioner's cultural background influences their own worldview, systems of values, beliefs, and expectations around treatments and how these can further playout in the professional relationship and broader decision-making process in the clinical encounter.
- Provides a culturally safe space for the practitioner to feel comfortable sharing their own perspectives on clinical aspects that might be initially seen as challenging the 'status quo' of the system.
- Provides a culturally safe space to explore the impacts of institutional racism and prejudice.
- Encourages and supports the supervisee to explore consumers' explanatory models and further integrate and advocate for consumers' cultural views on treatment to be integrated in their recovery plan whenever it is deemed safe, clinically sound and culturally appropriate to do so.
- Encourages and supports the supervisee to explore the impact trauma has on their consumers, how culture interferes with its manifestation, including on self-advocacy and the ability to access mental health care and navigate the systems.
- Provides and encourages self-care acknowledging the impact the work with culturally and linguistically diverse consumers could have on the supervisee and the high risk of burnout and shared helplessness.

Peer practice supervision

Peer practice supervision is an essential and distinct formal activity, in which Lived Experience (peer) workforce collaborate to strengthen, develop, support, guide and explore the principles of peer practice. The shared understanding of authentic peer experience creates a safe, trauma informed space for peers to unpack workplace experiences and align practices with peer values, principles, ethics, skills and

approaches that shape and define peer practice.

Principles

- Strengthen the value of authentic peer competencies and using lived/living experience in an intentional way.
- Develop an understanding of effective interdisciplinary collaboration which enhances shared decision making and optimises consumer, family and carer outcomes.
- Support and strengthen individual resilience, wellness and personal recovery.
- Guide self-reflection for professional and personal growth.
- Understand and unpack the complexities surrounding workplace organisational culture.
- Appropriate use of lived experience to create shared meaning, develop insights and deepen learning to enhance recovery strategies.
- Challenge systemic discrimination, stigma and inequality, acknowledge the significance of human rights and social justice in delivering care, and explore the impacts on individual peer workers.
- Recognises the importance of and supporting social and emotional wellbeing, self-care and diversity of recovery journeys.

For further information about Peer Practice Supervision Guide, see the supervision training and resources available through the Queensland Centre for Mental Health Learning (the Learning Centre) https://www.health.qld.gov.au/qcmhl.

Operational or line management supervision

Operational supervision primarily focuses on specific organisational governance and performance standards, administrative or operational line management issues such as attendance, work allocation, workforce wellbeing, and workplace issues.[9]

Professional (intra-professional) supervision

Distinct from managerial supervision, the terms professional and clinical supervision are often applied interchangeably. For some professions, professional supervision refers to the relationship between a clinician and a senior practitioner of that profession. The focus can have a stronger focus on profession-specific practice skills, professional gatekeeping, professional developmental stages, performance, and professional mentorship tasks.[18] Professional supervisors may utilise the same principles and models of clinical supervision. Due to the professional accreditation body standards for some professions, there can be specific differences in power dynamics, evaluative processes, safety and ethics, accountability, and confidentiality in professional supervision agreements that need to be transparent.

Supervision of supervision

Supervision of the supervisor's practice is considered an essential and valuable requirement for enhancing the quality and efficacy of the supervisor/supervisee relationship and supporting supervisor competency.[36,37] The practice of supervision of supervision creates an understanding of parallel processes and unconscious biases in supervision, supervision functions, reflective practices, responsibilities, and boundaries and culturally safe practice.[37, 38] Supervision of supervision primarily creates a safe holding space where the supervisor's reflective capacity is enhanced for the purpose of competent ethical practice, safeguarding consumer outcomes, and protecting against supervisor burnout.[17,37]

Part Two

2.1 Supervision Implementation

Supervision is a formal organisational arrangement that sits within an overall framework of clinical governance. Supervision is tailored to the needs of specific contexts and disciplines with the flexibility to change models according to research evidence, stakeholder evaluations and data generated by formal reporting mechanisms. The content of supervision sessions is confidential (except in certain circumstances to be discussed below) and is tailored to meet the needs of individual staff. Supervision is not a private arrangement; rather, it is conducted as part of core business of workplace activities in line with the goals, organisational approaches, and therapeutic modalities of Queensland Health.

Good beginnings - establishing and maintaining the supervisory relationship

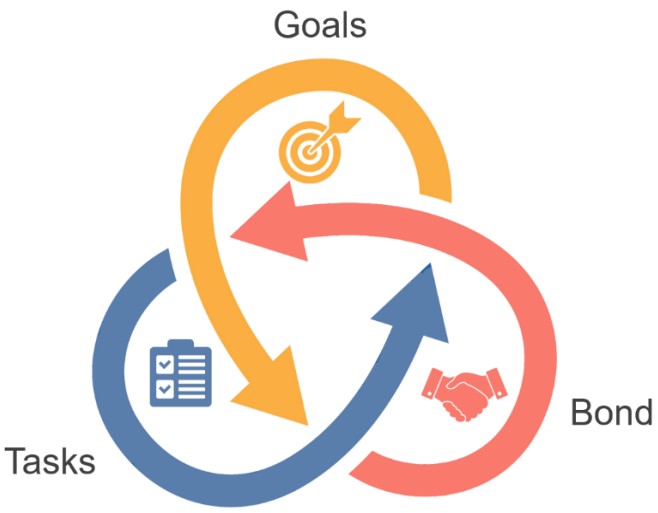

Figure 2: Supervisory Working Alliance (SWA) Model, Bordin, 1983[26] Image: Learning Centre, Queensland Health

Establishing and maintaining an effective supervision working alliance is considered critical to the delivery of safe and effective supervision.[18,20,27] An understanding of the supervisory working alliance model assists supervisors and supervisees in the establishment, maintenance and evaluation of the relationship and protection against harmful or ineffective supervision.[27,39]

The SWA model has three key interconnecting components illustrated in Figure 2:

1. agreement on supervision goals[26]
2. agreement on supervision tasks[25,40]
3. bond between the supervisor and supervisee.[19,24]

Fostering a safe, respectful and trusting environment that supports reflective practice and professional development is essential to the maintenance of the SWA.[14,20,27] Effective feedback processes are integral to the SWA and facilitate:

- clear achievable supervision goals[23,41]
- clarification of assumptions and expectations[18,41]
- tasks that are achievable, transparent, structured, and safe.[19,41]

Effective feedback in supervision enhances:

- supervision relationship[19,23,41]
- professional development and wellbeing[11,13,16]
- self-efficacy[34,39,40]
- professional practices[13,40]
- consumer outcomes[42,43,44]
- organisational outcomes.[42,45]

An example of the role of the supervisor-supervisee relationship in supporting effective feedback and action in supervision is depicted in Figure 3. It is important to note that this would look different across professions.

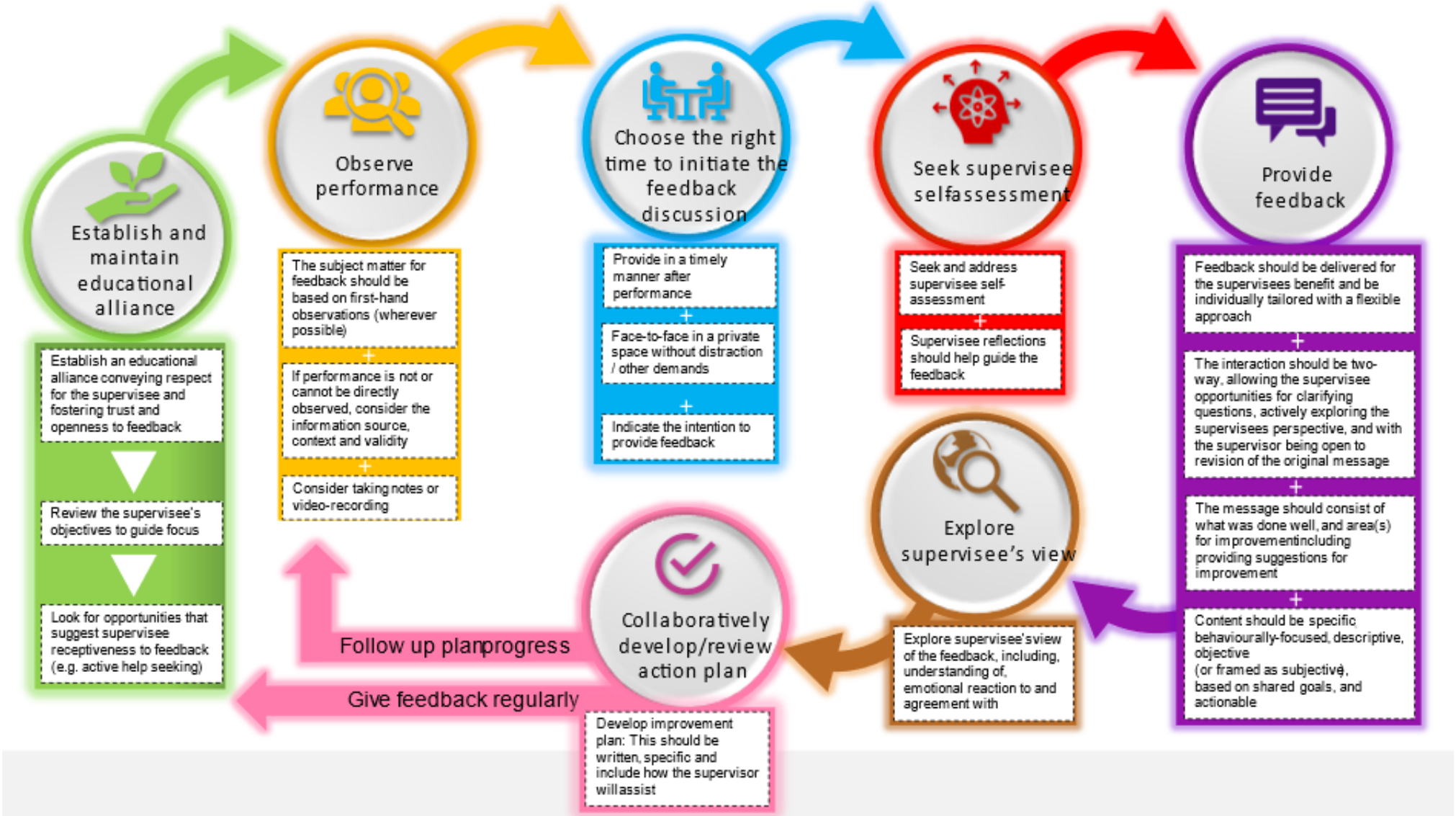

Figure 3: Guidance for providing effective feedback in clinical supervision in postgraduate medical education[41]

2.2 Establishing the Supervision Agreement

Investing time into the supervision agreement ensures the multiple functions of supervision are clarified at the beginning. Supervision relationships with well contracted agreements in place are associated with increased safety, reduced anxiety, clear goals, and open reflection. [40,44]

Effective clinical supervision agreements ensure that potential issues in supervision are recognised and managed proactively. [46] In establishing a clinical supervision arrangement, there should be discussion and agreement about how the supervisor and supervisee will work together.[18, 41] The supervisee's goals for clinical supervision and the boundaries of confidentiality are clarified and documented in the agreement (see Appendix 1 guidance for supervision agreement discussions and Appendix 2 sample supervision agreement). [3,11,40]

It is a condition of participation in supervision within Queensland Health mental health alcohol and other drugs services for an appropriate written agreement (Supervision Agreement) to be collaboratively developed between the supervisee and supervisor and reviewed regularly.

A written agreement protects both the supervisor and supervisee and provides a forum for exploring each person's expectations at the onset of supervision (Appendix 2 sample supervision agreement).[46] It also sets the boundaries and parameters for future sessions. Both the supervisor and supervisee should mutually negotiate the agreement within the first two to three sessions. [18,19,21]

The clinical supervision agreement will generally include:

- names of the supervisor and supervisee
- names of the health services facilities in which both work
- the date and location of the supervision
- the objectives for clinical supervision (goals and tasks), for example, supporting psychosocial wellbeing, education, working through personal objectives, or developing specific skills
- frequency and length of sessions, including agreement and responsibilities related to cancelling sessions
- privacy and confidentiality, including a statement about the limits of confidentiality, and any specific professional reporting requirements and processes for addressing any breakdown in the supervisory relationship
- record keeping and responsibilities for documentation
- any agreed methods for the evaluation of supervision

- outline of any particular responsibilities of each party
- review and renegotiation – date/s to review the success of the agreement and whether changes need to be made
- signatures of both the supervisee and supervisor (although not required, the supervisor and supervisee may choose to also have the supervisee's line manager sign the agreement).

Supervision agreements are subject to regular review and renegotiation and to unforeseen circumstances such as changes in workload, duties or workplace location. The guidelines suggest review and renegotiation on a yearly basis, whereas the written agreement can be negotiated by the parties at any time.

2.3 Structure of supervision

Supervision sessions are formalised, have an agreed purpose, work toward outcomes and entail an element of rigour. [46,47] As a formal activity, supervision sessions should occur in an appropriate private workplace location and not informal public spaces.[23,48] It is expected that all three primary elements of clinical supervision will be addressed: namely, issues relevant to clinical safety, skill and knowledge development (formative), support and debriefing (restorative) and quality control (normative).[23] Supervision and evidence-based supervision training for supervisors and supervisees are to be supported by a range of interventions and modalities within the context of sustainable provision.18,28,[49]

Supervision needs to be flexible in order to meet the needs of professionals in different disciplines and at different stages of their development.[9,25 50] The supervision requirements of a novice professional are likely to be very different from that of a highly experienced professional, and those of a psychologist, for example, will differ from those of a mental health nurse and also a general nurse working in a mental health alcohol and other drugs service.[20,47,48]

This section outlines, as a guide, the *common* structures and processes involved in clinical supervision.

Supervision is organised in an individual or group format, is commonly of one hour's duration and is held regularly. For recommendations on the frequency of clinical supervision refer to Table 2. Supervision sessions involve a professional (or group of professionals) and a supervisor working together in private and without interruption. The exact structure and format will depend on the supervisees needs and discipline and the supervision model being used.[47,48]

Supervision involves a range of processes to achieve agreed goals within the sessions.[41,]49 As outlined earlier, the focus of clinical supervision sessions is always on the professional practice and professional wellbeing of the staff member. It is the responsibility of the supervisor to ensure that sessions are appropriately structured to meet the needs of the agreed supervision agenda and engage the supervisee in discussion, reflection, and appropriate disclosure. 28,29,[40] A useful way of generating discussion and identifying the pertinent issues is through the review of activities related

to the supervisee's role such as assessments, formulation, recovery plan, care plan and care review for a consumer. Or regularly reviewing a project the supervisee is currently working on using transparent format for reflection and feedback.[41,44]

Depending on the profession additional supervision methods may, where appropriate, include facilitating critical reflection, direct supervisor observation of practice, co-facilitation of groups, video or audio recording of an intervention, and review of clinical notes and documentation.[40,41] Regardless of what method is used, the purpose of supervision sessions is to generate discussion and reflection on a broad range of issues directly related to service delivery.

This may include but is not limited to the following issues:

- the methods and modalities of clinical service delivery
- concerns the supervisee has in relation to any aspect of a consumer's care
- ethical, safety, or legal considerations the supervisee may have in relation to a consumer, carer or family they are working with
- lack of progress or challenges working with a consumer, carer or family
- awareness of the potential impact of the supervisee's personal values and beliefs on their practice
- identification of any negative impact on the supervisee's psychosocial wellbeing from a care scenario that they are working with
- issues related to establishing and maintaining appropriate boundaries in the workplace and with a consumer
- acknowledging and exploring the emotions and reactions to the work the supervisee undertakes
- ethical and professional practice and compliance with codes of conduct
- professional identity, role development, career goals
- skill, knowledge, and professional development
- issues related to organisational culture, context, workload management and team functioning as appropriate.

2.4 Best Practice Standards

Competency based supervision

Queensland Health is committed to competency-based supervision where competence is broadly defined as knowledge, skills and values.[15] Clinical supervision is a distinct intervention and specialisation that involves a specific set of generic competencies irrespective of professional discipline, practice setting, consumer focus and service delivery model.[15,51] Effective clinical supervisors are flexible and able to utilise a broad range of knowledge and skills to deliver quality supervision and fulfil their clinical, administrative and, where applicable, evaluative responsibilities.46,51

Such competency based clinical supervision is central to the successful implementation of evidence-based practice and for promoting quality assurance and outcomes in mental health alcohol and other drugs practice.[1,52]

The primary focus of competency based clinical supervision is on the practice of the supervisee.[27,28,53] Effective supervision relies on the development of a strong alliance between the supervisee and the supervisor.[26,43,44] Discussion of consumers and clinical practice is an integral part of the supervision process and provides tools for reviewing the practice of the supervisee.[44,54] However, the focus remains on developing professional capability and support for the supervisee, rather than on providing indirect treatment to the consumer.[44,45]

2.5 Supervisor competence, training accreditation and registration

Supervisor competence

Supervision will be provided by supervisors with demonstrated competence in both the clinical and supervisory practice settings.

Supervision will be obtained from a supervisor who has:

- at least two years of full-time employment in mental health alcohol and others drug practice with a preference of five or more years of experience
- demonstrated advanced skills in core competencies in mental health alcohol and other drug service delivery
- demonstrated understanding of clinical supervision practice.[55]

Developmentally, the supervisor will have at least the same or higher level of practice skills than the supervisee in the majority of specific competencies that are the primary focus for supervision.[51,52] Whenever possible, at least fifty percent of the minimum contact levels will be obtained from a supervisor with at least five years of experience in mental health alcohol and other drug practice and advanced relevant professional skills.[47]

Supervisors need to ensure that their clinical supervision practices remain within ethical and professional parameters.[47,48,56,57,58,59,60] Supervisors also need to take appropriate steps to safeguard themselves, the supervisee, and the organisation by ensuring that:

- they are appropriately trained to provide clinical supervision[52,54,56]
- they participate in regular supervision of supervision[3,17,36]
- their clinical supervision practice remains within their level of competence and capabilities
- they operate with clear contractual arrangements in relation to their role and responsibilities within the organisation, and in relation to their work with supervisees[3,61,62]
- they operate within the agreed parameters of confidentiality and privacy[61,62,63]

- they do not develop inappropriate boundaries or relationships with their supervisees.[39,63]

Discipline-specific requirements

For allied health staff, the practice supervisor's competencies are to be relevant to the clinician's current practice supervision needs.[3]

Aboriginal and Torres Strait Islander Health Worker Workforce require access to cultural supervision and culturally informed clinical supervision in order to meet their current practice supervision needs.

Only accredited Royal Australian and New Zealand College of Psychiatrists (RANZCP) supervisors may provide registrar supervision.[57,60]

It is mandated that psychologists who provide supervision to students on placement; provisional psychologists in an internship program or to those completing a registrar program are required to complete STAP (Supervision Training Accreditation Program) through a Board approved training program. Psychologists can then register to become a Psychology Board approved supervisor. Board approved supervisors are to maintain their Board approval by completing a master class every five years. Any other supervision provided by psychologists (i.e., psychology peer supervision outside of the above categories or provision of supervision to other discipline groups) does not technically require completion of STAP training or require a psychologist to be a Board approved supervisor.[47]

Supervisor caseloads

In order to sustain best practice standards, it is recommended that supervisors monitor their supervisory caseloads to ensure balance and safe practice. Consultant psychiatrists are limited to the requirements of the RANZCP in relation to numbers of trainees supervised.[59,60] In addition, it is recommended that practitioners engaged in the provision of clinical supervision continue to engage in clinical practice and maintain a clinical caseload.

Training

As supervision is a distinct professional activity it is crucial that supervision training is available for all supervisees and supervisors.[24,28,52] Supervisors should undertake regular comprehensive experiential training in building knowledge, skills, and capability in the facilitation of the goals and tasks of clinical supervision, specific supervision skills and methods and how to exercise supervisory responsibilities in a safe, respectful, collaborative, fair, and objective manner.[54,64,65]

Training in supervision is a requirement for all supervisors providing supervision within Queensland Health mental health alcohol and other drugs services.

In addition to any profession specific supervision training mental health alcohol and other drugs staff can access supervision training and resources through the Learning Centre https://www.health.qld.gov.au/qcmhl.

Refer to Figure 4 for available supervision courses.

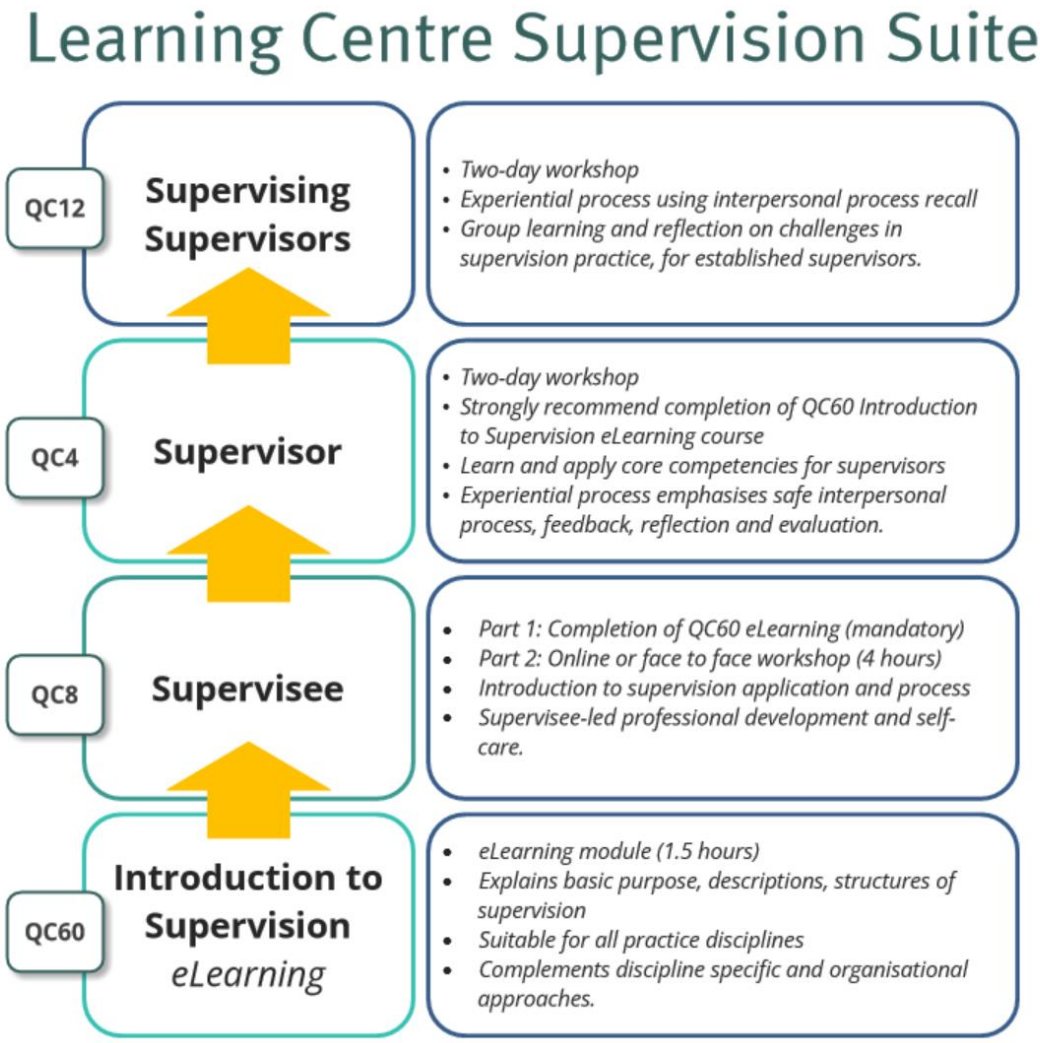

Figure 4: Supervision courses available through the Learning Centre

Core competencies for supervisor training

The recommended core competencies for clinical supervisors include knowledge, skill development and capability in:

- articulation and application of models and interventions used in supervision[56,64]
- use of all resources and roles that make for effective supervision (e.g., supporting, modelling, monitoring, exploring, and evaluation of goals)[28,56,64]
- working with supervisee professional development levels[41,65]
- establishing and reviewing supervisory agreement and maintenance of supervision records[18,40,47]

- establishment, development and monitoring of the supervisory relationship/working alliance[24,48,64]
- giving and receiving of accurate and timely feedback[41,50,66]
- facilitating critical reflection and linking to evidence-based practice[41,64,66]
- attending to and encouraging reflection on cultural diversity (i.e., race, ethnicity, culture, gender, sexuality, age, religion, language, ability, education, privilege, and power) between supervisee and supervisor, supervisee and the consumers they work with and the broader systems within which the work occurs[7,35,67,68, 69,70]
- acknowledging and exploring the supervisee's emotional reactions[56,64,71]
- assessing, developing, and evaluating the agreed goals and tasks[28,56,72]
- supporting professional wellbeing[4,19,39,47]
- safety, ethical, legal, professional, and organisational regulatory issues[3,4,62]
- application of supervision evaluation tools and processes.[64,73,74]

Research on the effectiveness of supervisor training supports the notion that supervision specific training coupled with supervision of supervision, increases supervisor competency, and generates improved supervisory outcomes.[49,52,53]

2.6 Flexibility and Choice

Supervision frameworks

Supervision is applicable for all staff involved in the delivery of mental health alcohol and other drugs services regardless of their level of experience or professional background. Queensland Health recognises the need for flexibility in providing supervision requirements for different workforce professional groups with different levels of experience. In addressing these different needs, a range of competency based supervisory frameworks that meet the applicable formative (learning), normative (accountability, ethics, safety) and restorative (support) needs of professionals may be employed.[6,47,48,57,58,59,60,75]

New staff

Within six weeks of commencing employment, new staff are to be provided with access to education regarding supervision as part of induction and orientation. Line/Operational managers and professional leads are to assist new staff to identify and access an appropriate and available supervisor.

Choosing and accessing a supervisor

Effective supervision relies predominantly on the development of a strong working alliance between supervisors and supervisees. Staff are more likely to participate actively in, and benefit from, supervision if they choose their supervisor.[20,48,71] Choosing and accessing a supervisor is ideally done in conjunction with the Team Leader/Unit/Operational Manager and Discipline Director/Senior. Where a staff member is working in a rural and remote setting with limited access to a discipline lead extra resourcing is required to support the staff member to access supervision. Choosing a supervisor is a planned process that is individualised to match the staff members needs to supervisor resources. Staff in lead positions for supervision may assist with knowledge of available supervisor resources across the state. Some services and professions (e.g., nursing & midwifery) have formal processes and Clinical Supervision Coordinators who support supervision allocation.[20,48]

The primary criterion for selecting supervisors is based on the supervisor's knowledge and specialisation in conjunction with professional discipline. It is recommended for all staff that at least fifty percent of supervision be undertaken with an appropriate supervisor from the same profession. This provision does not override the mandatory supervision and training requirements of individual professional registration boards and professional bodies such as RANZCP and the Psychology Board of Australia.[47,59] In relation to medical staff and in the case of junior doctors it is expected that the supervisor will be their line manager.[47,59,60]

Professional and practice boundaries in supervision

Staff should avoid undertaking supervision with a colleague who is also a friend or family member or someone with whom they have an operational reporting and evaluative relationship.

It is recommended that wherever possible line managers do not provide supervision to staff who report directly to them, with the exception of medical staff for example as outlined above. Although managers have responsibilities in the clinical supervision program (see Table 1), the purpose of clinical supervision is different from that of line management/operational supervision and the two processes should remain separate.[20,48]

In some circumstances, clinical supervision from the line manager may be appropriate. Those circumstances include examples where:

- a line manager has expertise in an area of practice that would be of benefit to the staff member. These potential benefits should be documented in the clinical supervision agreement with clear specific goals and task outlined and reviewed

regularly. The staff member should be aware when the meetings are for provision of clinical supervision and not operational supervision.

- staff are working in small teams in rural or remote areas. However, alternative clinical supervision arrangements for these staff should be implemented as soon as possible, which may include supervision by phone, video conference or by email. For staff in remote and rural areas, travel time and access to a vehicle may also be required to support clinical supervision.

Intra-HHS supervision (internal supervision)

Where practical, staff should seek out a supervisor from within the mental health alcohol and other drugs service or Hospital and Health Service (but not necessarily the team) in which they work and refer to any specific localised supervision procedures. Where a supervisor cannot be sourced then inter-HHS supervision may be appropriate.

Supervision by a Queensland Health supervisor outside the professional's local work area (inter-HHS supervision)

In some circumstances it may be necessary for staff to have supervision outside of the locality in which they work. This requires the approval of the line/operational manager in conjunction with the professional leads for both districts. As this may attract additional costs to both services, the staff member will have to demonstrate the need for seeking inter-district supervision. The staff member may outline their reason/s and negotiate any need for travel time with their service/unit manager.

Reasons for accessing supervision outside the professional's local work area may include:

- needing supervision in a specialist area of practice that is not available in the staff members work locality
- lack of availability and choice of supervisors in the workplace
- preference for supervisor of same profession,

For an example process, refer to the allied health Mental Health Clinical Supervisor Allocation Guideline: https://qheps.health.qld.gov.au/alliedhealth/html/mental-health.

External supervision requirements

Wherever possible professionals should obtain supervision from an appropriately trained Queensland Health supervisor. Where this is not possible and external clinical supervision becomes necessary, approval is required from the supervisee's operational manager, with adherence to local HHS procedures, policies and governance structures. The HHS must arrange for a credentialing process prior to the engagement of an external supervisor.

Appropriate credentials should include:

- evidence of relevant professional registration or equivalent
- evidence of recent practice relevant to the proposed supervision

- evidence of supervision training
- evidence of current professional indemnity insurance.

Names of appropriate referees must be obtained. It is the engaging service's responsibility to verify the accuracy of information obtained. In addition to providing the above information, a proposed external supervisor is required to:

- provide evidence of supervision competence that is recognised by Queensland Health through participation in a supervision training program within an agreed period, for example, six months
- sign a confidentiality agreement in line with Queensland Health policy.

Credentialing information or evidence that is obtained from an external supervisor should be retained by the professional's HHS in accordance with corporate and local record keeping policy requirements.[75] External supervisors are to maintain communications with the local HHS authority and other relevant interested parties, as identified in the supervision agreement.

Inter-professional supervision

Supervision by members of other professions is recommended when:

- professionals need to develop generic mental health alcohol and other drugs professional competencies (e.g., suicide risk assessment), or
- the supervisor has expertise in a specific skill area that is needed in the specific work setting, consumer group or care procedure.

The primary criterion for selecting supervisors or consultants from outside the staff member's profession is the level of relevant supervisor knowledge and specialisation, rather than their professional discipline. It is recommended that when accessing inter-professional supervision, the staff member still maintain some supervision from a supervisor of the same profession. For example, at least fifty percent of supervision contact should be obtained from a supervisor of same profession.

The amount and proportion of supervision that is obtained depends on:

- service requirements
- the professional's role
- negotiations between the clinician, team leader or line/operational manager, discipline lead, and the supervisor
- routine discussions of clinical supervision as part of the performance appraisal planning process.

When there is legislative or professional accreditation requirements related to regulating supervision within a particular profession, those requirements should be given priority and aligned to employment related practice duties where possible.

Multiple supervisors

A professional may have more than one clinical supervisor at any given time to maximise access to specific practice, clinical expertise or competencies across the full spectrum of mental health alcohol and other drugs service provision. Staff should consider having a primary supervisor and negotiate the use of additional supervisors on an 'as needed' basis.

The goals of the supervision sessions provided by any additional supervisors could be added to the existing supervision agreement between the supervisee and primary supervisor. The one agreement minimises inefficiencies with administrative workloads associated with the use of multiple written agreements. Additionally, having one agreement facilitates an integrated and coordinated approach to a supervisee's professional needs.

Changing supervisors

Staff may change supervisors following discussion with their current supervisor and informing their line/operational manager and Clinical Supervision Coordinator. The requirement to discuss changing supervisors should be documented in the current supervision agreement (see Appendix 1). As the agreement will identify the goals for supervision, it may be helpful for the supervisee to change supervisors once these have been achieved. Coordination in conjunction with the team leader or line manager, and discipline leader is central to this process.

Alternative supervision modalities

Although face-to-face supervision is the preferred method of delivery, other methods of supervision delivery including email, videoconferencing, or teleconferencing may be employed. The use of these alternative technological methods of supervision are particularly necessary and encouraged for rural and remote professionals, professionals focussing on developing specialist competencies or within services yet to attain a critical mass of supervisors. These alternative methods of clinical supervision should be augmented by face-to face clinical supervision where possible, with the recommendation that at least a quarter of devoted clinical supervision time is completed face-to-face.

Points to consider for technology facilitated supervision:

- Is there easy access to safe, confidential, protected space for supervision via technology?
- How will contact be made outside of planned technology assisted meetings?
- How will practice material be reviewed and feedback provided?
- How will the supervisor assess any files or documents necessary to facilitate reflective practice in supervision?
- What consideration needs to be made as to the supervisors understanding of the organisational practice setting of the supervisee?
- Are there any specific localised legal considerations to adhere to when using technology to facilitate supervision?

- What self-care considerations do the supervisee and supervisor need to be mindful of when maintaining a supervision working alliance via technology?

2.7 Professional Development and Role

Participation in supervision is expected for all professional positions in mental health alcohol and other drug services. For some professions role requirements and role descriptions identify the need for regular engagement in clinical supervision. Line managers and professional leads are responsible for supporting staff to engage in regular supervision. Participation should also be documented as part of the local HHS performance development processes.

Participation in supervision is mandatory for all Authorised Mental Health Practitioners appointed under the *Mental Health Act 2016*61

Regular participation in supervision is integral to mental health alcohol and other drug professional role requirements.

2.8 Information Management

Appropriate and discreet information management is essential for effective supervision. Supervisors and supervisees should be aware of and discuss and clarify the organisational and professional body policy and procedures in relation to confidentiality, record keeping and evaluation. 47,48,57,58,59

2.9 Confidentiality

Confidentiality in the supervisory relationship

The establishment of trust in the supervisory relationship is a critical factor for successful supervision.3,14,48 Supervisees have the right to expect that material presented to their supervisor be maintained by the supervisor in strict confidence with appropriate ethical requirements for all parties.3,4,62

The content of supervision is confidential except in circumstances of serious concern related to the ethical or professional conduct of the supervisee or the safety of a consumer.3,5,62 The intent is to allow for frank and open discussion about clinical practice in a safe environment, while developing essential trust in the supervisory relationship. Supervisees, generally, have the right to expect that material presented in supervision is kept in strict confidence. Any material used in supervision of supervision sessions (i.e., with the supervisor's own supervisor) should be de-identified and not include information that identifies the supervisee, their consumers, or colleagues.

Nonetheless, there are limits to confidentiality that need to be clearly understood by supervisors and supervisees when establishing the supervision agreement**.** On the one hand, there is an imperative to ensure the confidentiality of individual or group sessions in order to provide a safe and constructive learning environment and to encourage a sufficient level of disclosure.[21] Conversely, there is a need to ensure that any

sufficiently serious issues related to clinical practice are dealt with transparently, given the role of clinical supervision as a mechanism for clinical quality and safety.[3,5] The parameters of confidentiality need to be clearly documented and communicated to all participants in order to balance these two legitimate concerns.

To ensure an appropriate measure of accountability for supervision, confidentiality is limited in circumstances where there is:

- a breach of the Code of Conduct for the Queensland Public Service, HHS Health Code of Conduct.[62]
- a breach of professional ethics.[3,47,62,76]
- a breach of duty of care[3]
- serious concern about the safety of the supervisee or a consumer[3,5]
- an issue identified that is subject to mandatory reporting requirements.[47]

A statement about confidentiality and its limits in relation to supervision and the process for managing inappropriate practice or behaviour of concern should be included in all supervision agreements.[3,47] A clear agreement is especially important where supervision is delivered by the person who is also a line/operational manager undertaking performance appraisal. Adherence to these parameters requires that supervisors understand the professional role of the supervisee and are cognisant of professional codes of ethics and conduct, duty of care standards and mandatory reporting requirements. In instances where multidisciplinary or inter-disciplinary supervision is undertaken, and the supervisor's background is in a different profession to the supervisee, it is advisable that supervisors familiarise themselves with that supervisee's ethics and standards or seek the relevant information or resources and ensure this is reflected in the written and mutually agreed supervision agreement.

Managing performance issues and confidentiality

In any of the circumstances outlined above, it is the clinical supervisor's responsibility to first share their concerns with the supervisee and then to encourage them to take the issue to their support team or line/operational manager within a stipulated period (e.g., 48 hours). If the supervisee is unwilling or unable to take this step, the supervisor must take responsibility to involve the supervisee's line/operational manager as soon as is practical. In that instance, the clinical supervisor must inform the supervisee of their actions, prior to consulting with managerial staff.[76]

Problems arising within supervision should be addressed immediately through the following process:

- problems should first be addressed within the supervision
- unresolved issues and problems should be raised with the support team, line, operational manager, team leader or discipline lead
- both supervisee and supervisor should be kept informed of the resolution process.

If necessary, either supervisor or supervisee can engage a third party to assist in resolution of any issues arising in the supervision relationship3.

Confidentiality and privacy aspects of supervision and resolution of performance issues arising from supervision are integral to effective work practice and service delivery.[21,62,]63 Confidentiality in these circumstances needs to be understood essentially as discretion within the support team (i.e., the supervisee, supervisor, team leader or line manager, and consultant), and should be treated in the same way as confidentiality and privacy in relation to consumer care. Members of the support team may also consult with the professional's supervisor. (See *recording in exceptional circumstances* in the following section on documentation guidelines).

Considerable trust on the part of both parties is required if the supervision is to facilitate real staff development.[14,48] This presents a considerable challenge to organisations, supervisees and supervisors. This cannot be taken for granted and requires a conscious commitment and clear communication from both supervisor and supervisee.[21,46,76]

2.10 Documentation

Minimum standards

The minimum standards for documentation of supervision sessions include:

- a completed supervision agreement signed by the supervisor, supervisee and line/operational manager.
- a continuing record maintained by the supervisor of attendance at clinical supervision by the supervisee and signed by both parties at each occasion of supervision.

This information will be used in auditing and the information and is owned and confidentially stored by Queensland Health.

Best practice standards

It is recommended that supervisors and supervisees maintain further records of supervision that include:

- time and date of the session
- name of supervisee / supervisor
- outline of agenda for discussion
- outcomes and action plan
- date and time of next session.

It is recommended that the supervisee maintains their own notes of supervision including:

- professional and other issues raised in supervision

- a reflective diary of their supervision and professional growth, which may form part of their professional development portfolio.

If the outcome of a supervisory session involves any proposed change to a consumer's care plan, a clinical team care review is required. Clinical care review discussions are documented in the consumer's clinical notes without identifying the supervisor.

Records storage

Storage and ownership of process notes is to be negotiated between supervisee and supervisor within the policy guidelines and to be noted in the supervision agreement. Process notes written by the supervisor may be handed over to the supervisee at the termination of clinical supervision. Under ordinary circumstances, the written record should stay with the supervisee in confidential storage.

Notwithstanding potential impaired performance or code of conduct issues, access to clinical supervision documentation remains only with the supervisor and supervisee and is the property of Queensland Health. Where a supervisor keeps a record of any aspect of a session, they must ensure the record is kept in locked storage or password-protected file.

Recording of exceptional circumstances

On occasion, including but not limited to a breach of the local HHS Code of Conduct, or detection of impaired competence or performance, the supervisor may decide to give direct advice or instruction to the supervisee on what actions or interventions to take.

Where clinical advice is offered, the following actions are recommended:

- the supervisor will make a written record of the advice
- the record will be made available to the supervisee and signed by both parties
- supervisees will be provided with a photocopy of the supervisor's record
- the original record will be stored securely by the supervisor.

Documentation concerning impaired performance or detailing a breach of ethical or professional guidelines, duty of care or other problematic behaviour remains the property of Queensland Health.

Discipline standards

Record keeping by supervisors and supervisees will also be guided by the professional requirements or policies of their discipline. In some cases, an ongoing record is required for maintaining professional registration.[47,57,58,60] There are also specific professional and ethical codes that apply to the individual professions, and supervisors and supervisees need to be aware of appropriate codes.56 Specific codes apply to the following professions: Psychiatry; Mental Health Nurses; Social Workers; Psychologists and Occupational Therapists.[47,48,57,58,59,60] Additional ethical codes are applicable for all professionals working in Queensland Health.[3,62]

2.11 Evaluation

Evaluation within supervision is an important yet complex and dynamic process that can be fraught with concerns and difficulties for both supervisors and supervisees if not made transparent in the establishment of the working agreement.[41,64,73]

The evaluation task within supervision consists of two components.

1. **Formative (informal evaluation)** – involves the ongoing feedback mechanisms built into the supervision relationship, including feedback from the supervisor to the supervisee, self-feedback by both the supervisor and supervisee, and feedback from the supervisee to the supervisor on the alliance and agreed goals and task of the supervision.28[,41,74]
2. **Summative (formal evaluation)** – involves the formal assessment of, alliance, agreement, and competence from a professional and organisational perspective.64

Informal evaluations should occur as part of the ongoing process of feedback and learning, whereas formal evaluations will be carried out less regularly and will have functions related to managerial and organisational assessment functions.[46,74,76]

When undertaking evaluation, the following points are important:

- Evaluation purposes should be outlined in the supervision agreement with clear detail on the aim of the supervision relationship and the goals and tasks of the supervision that will be evaluated in order to increase supervisee self-assessment and self-regulated learning[41,64,73]
- exactly what is to be evaluated, and how the evaluation takes place should be negotiated with the supervisee from the beginning of the relationship23[,63]
- evaluation should have a clear and constructive focus on the supervisory relationship and supervisor or supervisee's practice and never become an evaluation of the person[41,66]
- evaluation is not punitive[22,39]
- evaluation should centre on the review, achievement or setting of goals as specified in the supervision agreement[41,28]
- feedback should be clearly related to how the issues evaluated affect service delivery and consumer outcomes
- evaluation of the quality and process of the supervisory relationship should also occur as part of the formal process22[,73,74]

There are multiple domains for evaluation in supervision – the supervisee, the supervisor, the supervisory relationship, and outcomes of agreed goals and tasks.64 Supervisors and supervisees can draw on a broad range of professional practice competencies and standards in order to inform what needs to be evaluated.[41,66] What constitutes 'competent performance' must be clearly communicated between the parties and may be drawn from relevant documents such as existing clinical standards,

mental health alcohol and other drug service standards, professional competencies and standards, and the organisational context and policies (Australian Psychological Society, 2014).[47] For examples of validated tools that may assist regular evaluation of supervision please refer to the evaluation tools section in the Learning Centre supervision training and resources: https://www.health.qld.gov.au/qcmhl.

Formal service level evaluation and quality assurance of supervision processes will be conducted independently by the individual Hospital and Health Services on a regular basis. Managers, supervisors, and supervisees are expected to engage in these processes. Records will be required for audit and review of the effectiveness of supervision and can also be used to provide evidence for the practitioner that they are participating in the service governance process.

Part Three

3.1 Governance of Clinical Supervision Delivery

The general governance responsibilities of each level of service delivery are outlined in Table 1.

Level of Governance	Broad Areas of Responsibility
1. **Hospital and Health Services**	• enable mental health alcohol and other drugs staff participation at all levels • enable choice and access to clinical supervision • enable culturally safe practice • enable quality improvement and evaluation • meeting the needs of the diverse workforce through facilitating access to all required forms of supervision noting that more than one form may be required (e.g., clinical and Reflective Yarning) • enable supervision resourcing including access to external supervision where appropriate and necessary
2. **Discipline Professional Leaders**	• support supervision of supervision processes • meeting the needs of the diverse workforce through facilitating access to all required forms of supervision noting that more than one form may be required (e.g., clinical and Reflective Yarning) • implement evidence-based research and clinical supervision practice • provide auditing and benchmarking of clinical supervision • provide resources and training for staff. Including profession specific implementation strategies for implementation of the supervision guidelines

3. **Hospital and Health Service (HHS)– Discipline Leaders in collaboration with Service Managers/ Team Leaders/ Unit Managers**	• enable coordination at a local level • meeting the needs of the diverse workforce through facilitating access to all required forms of supervision noting that more than one form may be required (e.g., clinical and Reflective Yarning for staff who identify as Aboriginal and /or Torres Strait Islander) • enable quality assessment and evaluation • manage staff clinical supervision allocations • provide resources and training for staff • ensure all staff are given the opportunity to participate in clinical supervision • induct new staff into the clinical supervision policy and practice • develop health service specific policies and procedures • identify potential clinical supervisors for participation in training and support of supervision.
4. **Service Managers/ Team Leaders/ Unit Managers**	• collaborate between local cross-sector partnerships/programs; service management, discipline seniors and staff • ensure effective and efficient use of staff specialised skills including discipline-specific skills • manage staff clinical supervision workload • provide access to resources and training for staff • meeting the needs of the diverse workforce through facilitating access to all required forms of supervision noting that more than one form may be required (e.g., clinical and Reflective Yarning) • ensure staff are given protected time to provide/receive clinical supervision • ensure individual employees include clinical supervision in their personal development plans and that it is integral to the work program • identify potential clinical supervisors for participation in training.

Table 1: Governance and the broad areas of responsibility

3.2 Specific Responsibilities for Service (Line) Managers, Discipline Leaders, Supervisors, and Staff

Service Managers/Team Leaders/Unit Managers/Discipline Leaders

Responsibilities of line managers include:

- ensuring staff are aware of the supervision guidelines, and the expectations of their participation.
- assisting staff (supervisees and supervisors) to manage their time effectively in conjunction with existing workloads and resources in order to participate in supervision.

- collaborating between local cross-sector partnerships and programs, and collaborating with service management, discipline seniors and staff.
- ensuring any issues brought to their attention as a result of supervision are dealt with promptly and appropriately. This includes any issues requiring investigation or disciplinary action.
- ensuring clinical supervisors access supervision of supervision processes on a regular basis.
- managing information obtained from clinical supervision processes according to organisational and professional clinical supervision reporting requirements, for example, reporting attendance numbers and frequency and associated costs and resources.
- maintaining quality clinical service delivery by taking reasonable steps to resolve any concerns raised by staff in relation to their clinical supervision.
- managing staff supervision allocations. This involves ensuring that staff are made aware of the processes for engaging a supervisor where an internal supervision model is in operation and undertaking any necessary approval processes for external supervisors as guided by local policies and procedures.
- ensuring effective and efficient use of staff specialised skills including utilisation of discipline specific scope of practice.
- ensuring staff are given the protected time required to attend clinical supervision. This includes making any changes in the workplace required to enable staff to attend; for example, rostering arrangements, making transport available, establishing group supervision arrangements and making meeting rooms available.
- ensuring that clinical supervision is integral to the work program and that individual employees have clinical supervision included in their role descriptions and personal development plans.
- identifying future potential clinical supervisors who will engage in the training and registration program.
- matching and linking staff to supervisors.

Supervisors

Responsibilities of supervisors include:

- Maintaining knowledge about organisational goals, supported treatment modalities of the mental health alcohol and other drugs service, and any relevant ethical codes, guidelines or standards, and the application of this to clinical supervision.3
- Ensuring supervisees are clear at the outset about the purpose of clinical supervision. Establishing and maintaining a supervision agreement that outlines what is expected of both parties, the functions, goals and tasks, the role of the supervisor, the parameters of confidentiality and privacy, agreed methods for

evaluating the tasks and goals of supervision and the appropriate mechanisms for addressing any difficulties or concerns about the clinical supervision process.3

- Ability to articulate the model of supervision used from the existing models of supervision and learning styles.3,28,56
- Establishing and maintaining the supervisory working alliance.27
- Acknowledging power differentials in the supervisory relationship.27,39,47
- Being available to the supervisee as agreed, preparing for supervision sessions, maintaining focus of sessions, monitoring the goals and tasks of supervision and keeping meetings to time.66
- Working collaboratively with supervisees to facilitate the goals and tasks for supervision sessions.41,47
- Facilitating processes for regular reviews of progress.46
- Facilitating a safe, respectful and trusting environment for clinical supervision sessions.20,47
- Exploring and acknowledging the supervisee's emotions and reactions to their work.39,64,71
- Working with cultural diversity and socio-cultural difference and being aware and sensitive to contextual variables including culture, race, ethnicity, power, gender, age, privilege, sexual orientation, ability, and lived experience between the supervisee and consumers, and between the supervisee and the supervisor, as well as understanding how this can impact on a range of working relationships and consumer outcomes.7,67,68,70,77
- Ensuring that clinical supervision sessions have structure and are working toward achieving all three of the purpose areas of clinical supervision (restorative, formative and normative).56
- Validating strengths and areas for improvement through both giving and receiving constructive feedback formally and informally.41,66
- Facilitating reflective practices to address legal and ethical dilemmas and improve safe practice and encouraging the supervisee to consider different perspectives.11, 22,41
- Challenging practice that is of concern, or which does not fit with the agreed treatment modalities of the mental health alcohol and other drug service and facilitating the development of skills for safe and ethical practice.3, 77
- Working within the agreed boundaries of confidentiality and following reporting governance requirements for reporting any serious issues to line managers and informing the supervisee when such a circumstance arises.3,47,77
- Participating in and making transparent to the supervisee any agreed evaluation, monitoring, or reporting mechanisms related to the provision of clinical supervision,

including the ability to facilitate a high standard of record keeping for supervision (e.g., agreement, record of sessions, reviews).[22,47,58]

- Understanding the importance of collaborative care, trauma informed care, recovery principles and consumer and carer perspectives.[1,4,5]
- Supporting workplace practices that increase cultural humility and multicultural competency.[7,29,30,32]
- Assisting supervisees to identify circumstances when accessing personal support may be appropriate.
- Participating in supervision of supervision and ongoing professional development training for supervisors. [17,37]

Supervisee/staff member

Responsibilities of staff (supervisees) participating in clinical supervision include:

- Working collaboratively with the supervisor to maintain the supervisory working alliance.[27]
- Negotiating arrangements for clinical supervision with the supervisor including developing a supervision agreement in line with organisational policies and procedures and with line management approval.[3,9,66]
- Reflecting on cultural diversity, being aware and sensitive to contextual variables for instance, culture, race, ethnicity, gender, religion, age, privilege, sexuality, ability, power, and privilege between the supervisee and consumers, and between the supervisee and the supervisor. And understanding how this can impact on a range of working relationships and consumer outcomes.[7,34,67,70]
- Understanding the importance of collaborative care, recovery principles, trauma informed care, and consumer and carer and family perspectives.[1,4,5]
- Ensuring regular supervision participation as agreed with the supervisor, by the organisation and in line with local policies and procedures.[3]
- Working with the supervisor to agree on focus, goals, and tasks of clinical supervision, and agree on ways of working together to achieve the desired outcomes.[20]
- Preparing for supervision sessions and agenda setting.[11,25,28]
- Regularly reflecting on the application of evidence-based practice to clinical decision making/outcomes.[40,44,56]
- Participating in regular reflection on ethics, safety and legal issues and implications to practice.[56,63,21]
- Taking action in relation to any developmental learning needs identified through clinical supervision.[41,44]
- Being open to critical reflection on practice and receiving feedback.[41,47,55]

- On-going participation in professional development and self-care.3
- Participating in any agreed evaluation, monitoring or reporting mechanisms related to the provision of clinical supervision.[9,] 28
- Maintaining records related to clinical supervision sessions as set out in local policies and procedures (e.g., agreement and record of sessions).[47]

3.3 Frequency of supervision

The following best practice guidelines are recommendations for implementation frequency. It is expected that additional factors, such as the availability of supervisors, may impact upon the service's ability to implement the guidelines according to these frequencies.

Team Leaders/Unit Managers, Discipline Leaders, operational managers, clinical supervisors and staff, in collaboration with Statewide Professional Leaders and professional leads as required, are best placed to ascertain the supervisory requirements of mental health alcohol and other drugs staff within the context of their service delivery model and available resources. Transitioning between the levels of clinical supervision frequency would be discussed and included in the supervisory agreement developed between supervisor and supervisee and would involve an assessment of competence on the part of the supervisor (see Table 2).

Level of Supervision	Weighting Factors	Minimum Expected Frequency
Level 1		
High frequency supervision	Novice professionals with less than two (2) years of experience (i.e., new graduates). Professionals with limited practice experience in mental health alcohol and other drugs. Professionals experiencing significant changes in their role (e.g., transitioning from youth to adult services or from acute to community-based work.	Four (4) hours of individual or group supervision monthly. At least 50% of supervision should be on an individual basis (*note* for new graduates it is recommended that 100% of clinical supervision be provided by a supervisor of the same professional). At least 50% of supervision to be of same profession unless otherwise specified by a registration or governing body.
Level 2		

Medium frequency supervision	Sole professionals and rural and remote professionals. Staff working in isolated specialist roles (e.g., Identified Aboriginal and Torres Strait Islander staff). Professionals with a higher or more complex caseload and focus of care.	Two (2) hours of individual or group supervision monthly. At least 50% of supervision should be on an individual basis. At least 50% of supervision to be of same profession unless otherwise specified by a registration or governing body.
Level 3		
Low frequency supervision	Experienced professionals with more than five (5) years of practice as a mental health practitioner.	One (1) hour of individual or group supervision monthly. At least 50% of supervision should be on an individual basis. At least 50% of supervision to be of same profession unless otherwise specified by a registration or governing body.

Table 2: Weighting factors for frequency of supervision

Additional factors for assessing frequency of supervision include:

- ***supervisory experience and developmental level*** (supervisor and supervisee) – duration, type and frequency of previous clinical supervision will determine the frequency of current supervision
- ***caseload/casemix/focus of care/degree of specialisation*** – higher caseloads and more complex casemix, focus of care and specialisation will require increased frequency of supervision
- ***practice area*** – specialist roles and rural and remote areas of work will equate to an increased high-medium frequency of supervision
- ***work/team setting*** – higher frequency of other means of support and professional development, i.e., frequency of team meetings, debriefing, grand rounds and reflective practice forums will equate to decreased frequency of supervision.

Special considerations in determining supervision frequency.

Specific supervision requirements are associated with some professions, for example, the requirements for probationary psychologists and medical staff. Peer review groups may replace individual supervision for psychiatrists. Specific requirements also apply for healthcare students on clinical placement, new graduates, and cadetship holders. To ensure the safety of consumers and that professionals are engaging in evidence based and ethical practice, the special supervision needs for these individuals must be considered when determining supervision level, frequency, and content.

Specific guidelines are to be followed when considering requirements for identified roles such as the Aboriginal and Torres Strait Islander workforce and Lived Experience (peer) workforce (refer to Section 1.9 Additional definitions of supervision for descriptions of Aboriginal and Torres Strait Islander reflective yarning and Lived Experience practice supervision). For instance, where a Lived Experience (peer) worker is identified as an Aboriginal and Torres Strait Islander worker, they require access to both Lived Experience (peer) practice supervision and access to Aboriginal and Torres Strait Islander reflective yarning.

3.4 Frequency of Supervision of Supervision

It is essential that supervisors have protected time to reflective on and review their supervision practice to ensure professional wellbeing and quality practice.[36,37] Supervision of supervision assists supervisors to build confidence and competence in supervisory skills and provides a space to build sensitivity and awareness to the wider context of the supervisory relationship.[36] Factors that impact supervisory and clinical relationships such as parallel process, transference, and countertransference, can be attended to in supervision of supervision for the purpose of improving clinical outcomes.[36,37,38] Supervision of supervision should be provided only by an individual who has attended appropriate training and has a high level of demonstrated competence in the provision of practice supervision.[36]

Methods for engaging in supervision of supervision include:

- individual supervision of supervision with an internal or external supervisor
- structured facilitated supervision of supervision groups (supervisors share supervision experiences and seek feedback and support facilitated by a trained supervisor of supervision)[38]
- peer supervision of supervision groups (supervisors meet to review and share their practice).[37,38]

Table 3 provides recommended guidelines for determining the frequency of supervision of supervision for supervisors.

Level of Supervision	Weighting Factors	Minimum Expected Frequency
Level 1		
High frequency supervision of supervision	Novice supervisor with less than five years of supervisory experience	One (1) hour of individual or group supervision fortnightly
Level 2		
Low frequency supervision of supervision	Experienced supervisors	One (1) hour of individual or group supervision monthly

Table 3: Weighting factors for frequency of supervision of supervision

Appendices

Appendix 1

Supervision processes for establishing and guiding new supervision discussions.

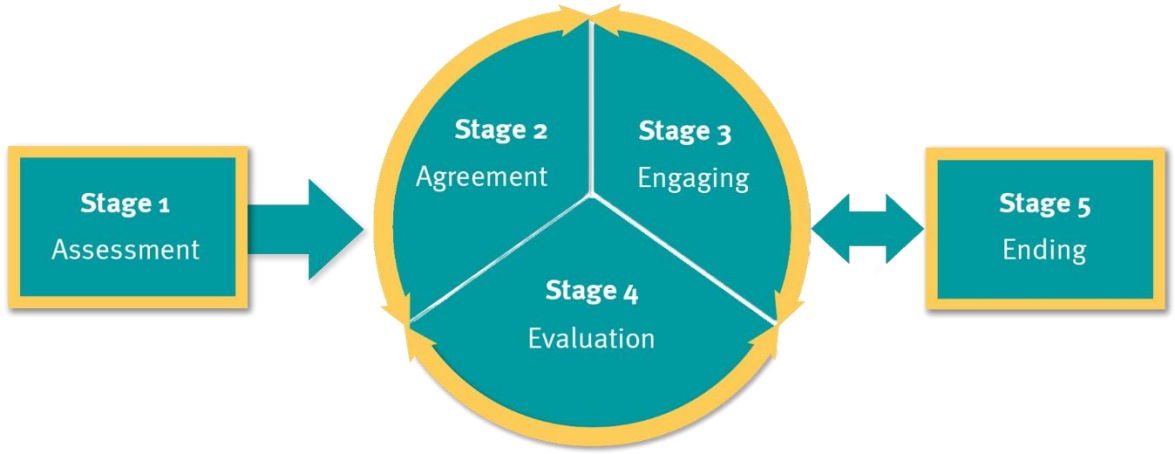

Image: The Learning Centre, Queensland Health - Adapted from Michael Carroll, 2014[40]

Attention given to establishing and maintaining the supervisory working alliance is critical to its effectiveness.27,43 The pressures of everyday practice and struggles accessing supervision often result in new supervisory relationships beginning in the 'doing' without adequate attention given to defining the purpose of the working relationship. Exploring what each party brings to the relationship and setting the scene for how learning will take place enhances the working relationship.[40] Positive outcomes can include:

- Reduced conflict and misunderstandings
- Cultural diversity is recognised
- Enhanced workforce psychosocial wellbeing
- Expectations are clarified reducing the unambiguous
- Promotes a working relationship embedded in transparency and collaboration
- Feedback processes are enhanced in turn enhancing supervisee self-efficacy
- Reflective practices are expanded.

Question examples for establishment of new supervision relationships

Establishing

- What is the context of the supervision being explored?
- How does the supervisee envision the supervision enhancing their practice?
- What is supervisees experience and understanding of supervision and their preferred learning style?
- What are the supervisors preferred framework/model for supervision?
- How long will this arrangement be for? What are the availability needs of the supervisee?
- What are the roles and responsibilities of both parties? What are the expectations for example of preparing for supervision sessions?
- Are there any dual relationships or additional supervision relationships that need clarifying?
- What stage of professional development does the supervisee see themselves as being at? Where would they like to be?
- What model/s of giving and receiving feedback do you prefer? What is your shared understanding/experience of holding/attending to emotion in the supervisory space?
- Are there any registration requirements for this supervision relationship?

Consolidating & Engaging

- What does the organisation expect of this supervisory relationship?
- What practicalities regarding the management of the supervision relationship need to be confirmed for example is the supervisor contactable in an emergency?
- What are the differences or similarities regarding cultural diversity in this supervision relationship (e.g., race, ethnicity, culture, religion, age, gender, sexuality, privilege, power, class, ability). What will culturally responsive supervision look like in this supervision relationship when reflecting on practice?
- How will you set agenda's to best utilise your time working together?
- What objectives will you be working on together and what tasks would support meeting these objectives? Are there any outside influences on the setting of these as objectives (checking supervisee investment/ownership of objectives)?
- When have you worked on an ethical dilemma in supervision? What worked and what didn't work, how will you integrate regular discussion on ethical issues?
- How would you monitor the working alliance? How would you address any concerns regarding a possible rupture in the working relationship?

- How will you attend to and maintain ethical boundaries and confidentiality in this relationship:
  - What are the agreed boundaries of confidentiality?
  - What are your professional guidelines and department guidelines?
  - How will any discussions related to performance and development plans be conducted?
  - Are there any external influences that need clarification?
  - What situations would involve a requirement to report elsewhere on the work undertaken in supervision?
  - How will you address any professional performance concerns should they arise?

Evaluation

- Is formal evaluation a part of this supervision relationship? If so, what form will that take? And who will have access?
- How will you evaluate (e.g., supervisee, supervisor, supervisory relationship, objectives, tasks) in supervision?
- Are there any organisational evaluation requirements?
- How will you review the effectiveness of your supervision?
- How often will you review the supervision?

Ending / New beginnings

Endings are one of the least attended to aspects of supervision processes yet are critical for aiding critical reflecting on development and learning and modelling best practice for the ending of working relationships[78]

- What will be your indicators that the relationship needs to change?
- How will you plan for future objectives/directions?
- How will you recognise transitions into new phases of your professional development or role change?
- How will you ensure time is spent exploring unfinished work at the end of the supervisory relationship?
- Are there any past experiences of endings that may impact on or influence this working relationship?
- What are the agreed understandings of processes for ensuring the supervisee engages in a new supervisory agreement once this relationship ends?
- Who needs to know when this relationship ends?

Appendix 2

Sample Clinical Supervision Agreement

Clinical supervision agreement

Please note –*The Queensland Health Clinical Supervision Guidelines for Mental Health Alcohol and Other Drugs Services (2023)* references below may assist agreement development and need to be considered alongside your professional supervision guidelines.

Supervisor:	
Supervisee:	
Agreement start date:	
End date:	

1. Establishing the supervisory relationship

Developing a working alliance in supervision is the foremost goal. A written agreement protects both the supervisor and supervisee and provides a forum for exploring each person's expectations at the onset of supervision. It also sets the boundaries and parameters of future sessions. Both the supervisor and supervisee should mutually negotiate the agreement within the first two to three sessions. Examples to explore include,

- context of the supervision to be undertaken
- roles and responsibilities of both parties
- understanding of the principles and purpose of supervision
- management of privacy, confidentiality and conflict (see Part Two and Three of Supervision Guidelines)

2. Supervision Objectives (What are the overarching objectives of this supervision relationship? (see Part Two of the Guidelines)

Supervisee objectives:	
Supervisor objectives:	

Professional wellbeing objectives:	
Shared objectives:	

3. Content of Supervision

To be negotiated between supervisee and supervisor and should include a list of the knowledge and skills that the supervisee would like to develop in supervision sessions. Include the agreed tasks for the supervisor and supervisee to support the development of these skills. Should be regularly reviewed and renegotiated between the supervisor and supervisee as factors such as supervisee developmental stage change (see Part One of the Guidelines)	
Knowledge and Skills:	
Supervisee tasks:	
Supervisor tasks:	

4. **Shared Understanding - roles and responsibilities** (see Part Two and Three of Guidelines)

Supervisee expectations	
Supervisor expectations	
Dual relationships	Detail how any dual roles will be discussed, managed and reviewed regularly.
Additional Supervision Arrangements internal or external	Requires clarification of each role's contribution to overall supervision provision. Includes secondary internal supervisors and / or external supervision.

How will any different forms of supervision be integrated?	(boundaries of any multiple supervision arrangements, any overlap of goals and task)

5. Structure of supervision (see Part Two 'Structure of supervision' in Guidelines)

Frequency:	
Duration:	
Location:	
What resources do we require for effective supervision (e.g., guidelines, frameworks, time, space, technology, absence of interruptions)?	
What preparation will be required prior to each session?	
How will agendas for each session be set?	
What supervision model/s and principles will guide the supervision? (e.g., requirements for new graduates/students, professional frameworks, preferred reflective practice frameworks, specialist supervision)	
How will cultural diversity be addressed in this relationship as part of culturally responsive practice (e.g., race, ethnicity, culture, language, sexuality, gender, ability, power, religion privilege, age)?	
Availability between sessions: (e.g., phone calls, emails)	

6. Evaluating supervision (see Part Two 'Evaluation' in Guidelines)

What is the preferred process for evaluating the supervision working relationship, supervision agreement, and goals and tasks?
When will the supervision agreement be reviewed?
What professional registration evaluation requirements will guide the boundaries of this? (professional registration policies/guidelines, credentialing requirements, and QH ethical codes)

7. Limits to confidentiality (see Part Two 'Information Management' in the Guidelines)

What are the agreed boundaries of confidentiality and privacy for this supervision? What are the organisational, ethical and professional requirements on confidentiality? Which aspects may be discussed outside of the supervision relationship and with whom? (e.g., professional development reviews, supervision of supervision, external supervisor/s)
What do your professional code and organisational policies outline as ethical conduct in supervision practice?
How will difficulties in supervision be dealt with?
What processes will we follow if the supervision relationship completely breaks down?

8. **Supervision records** (see Part Two 'Documentation' in Guidelines)

What form will supervision records take (e.g., agendas and signed record of meeting)?
How will supervision records be used? (i.e., QH record of supervision, CPD, professional registration, credentialing).
Who will have access to records and in what circumstances? Note: Outline how any performance issue would be addressed if a concern was ongoing. What would be the communication responsibilities of both parties? And how would this be reviewed?
Where will records be stored? And for how long?
What records will be used/provided for performance purposes (e.g., that supervision has occurred?

9. **Notes**

Additional notes not covered above:	
Supervisee name:	
signature:	
Date:	

Supervisor name:	
Signature:	
Date:	

Line manager	
Line manager name:	
Signature:	
Date:	

Appendix 3

Sample Record of Supervision Meetings

Supervisee's Name: ……..

Supervisor's Name: ……..

1. Review of clinical notes/reports

2. Reflection about practice by supervisee

3. Problem solving about practice issues

4. Discussion of additional skills or strategies

5. Demonstration of skills or strategies by supervisor

6. Demonstration/rehearsal by supervisee

7. Discussion of secondary practice issues (e.g., team relationships, responses to work demands).

8. Personal or career development.

Date of meeting	**Time spent**	**Material covered** (please write numbers as per above list)	**Comments**	**Initials**	
				Sup'or	**Sup'ee**
2/7/09	*1 hour*	*1,3,4,6*	*Supervisor observed clinical practice*		

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