INTRODUCTION

Country Health SA (CHSA) employs approximately 500 allied health professionals across non metropolitan South Australia. This covers a geographically large area with a comparatively low population density. In 2009 CHSA funded a 6 month project to explore supervision and mentoring needs and to develop a supervision and mentoring structure of Allied Health Professionals (AHPs) within CHSA. The project consultant conducted a literature review and scoping exercise with managers and interstate colleagues. Five focus groups were then conducted throughout South Australia to gain an understanding of clinicians’, supervisors’ and managers’ perspectives and needs in relation to clinical support. A workshop was then held at the CHSA Country Allied Health Forum where the recommendations from the literature and focus groups were further explored and prioritised. On completion of the project, the consultant developed the Allied Health Clinical Support Framework, a policy and two training modules for implementation. Following the completion of the project, the Allied Health Principal Consultant has further implemented the project recommendations.

Definition: Allied Health

For the purpose of this project, AHP’s will refer to the definition endorsed by Services for Rural and Remote Allied Health (SARRAH). “SARRAH recognised that allied health professionals are - Tertiary qualified health professionals who apply their skills to restore optimal physical, sensory, psychological, cognitive and social function. They are aligned to each other and their clients. Professions may include, but are not limited to: Audiology; Nutrition & Dietetics; Occupational therapy; Optometry; Orthoptics; Orthotics; Pharmacy; Physiotherapy; Podiatry; Psychology; Radiography; Social Work; Speech Pathology” (Lowe 2007 in Ashworth 2007)

Definition: Clinical Supervision

Clinical supervision is defined in a range of different ways in both published and unpublished literature. Williams et al 2005 (in Victorian Healthcare Association 2008) defines clinical supervision as a dedicated interaction between 2 or more practitioners, with a focus on reflective practice, a means to generate learning and practice enhancement through self evaluation and development. Furthermore it is also described as:

“a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety in complex situations” (Doll 1993 in Winstanley and White 2003 in Victorian Healthcare Association 2008)

Definition: Mentoring

Mentoring is defined as:

“The process whereby two (clinicians), who have been deliberately matched, have regular dialogue on a range of issues with the agreed upon goal of having the lesser experienced/skilled (clinician) grow, develop, and address career development, where desired” (Marais-Strydom 1999 in OT AUSTRALIA 2000 p4)
“Mentoring is a relationship which gives people the opportunity to share their professional skills and experiences, and to grow and develop in the process. Typically mentoring takes place between a more experienced and less experienced employee”
(Office of the Director of Equal Opportunity in Public Employment 1997 in Cunningham Centre QLD Health 2008)

CLINICAL SUPERVISION

Clinical supervision means different things to different professions and individuals; social workers and psychologists have embraced clinical supervision for many years whereas other allied health professions have had less exposure to it. Some professions may only consider clinical supervision to be relevant for students or new graduates or to always be associated with teaching from an expert. This has led to many professions and organisations having their own definition of clinical supervision that suits their particular needs and purposes to ensure clinicians understand what is expected of them (Wagner 2008).

In his 2008 paper Wagner concluded that the following definition met the needs of most allied health clinicians after considering a range of literature sources:
“Clinical supervision is the formal provision by senior/qualified health practitioners of an intensive relationship based education and training that is case focused and which supports, directs and guides the work of colleagues (supervisees)” (Bernard and Goodyear, 2004, Department of Health NSW 1993, Proctor 1998, Watkins 1997 in Wagner 2008).

Profession specific clinical supervision is usually the most effective for clinicians with in depth training and education. Complex assessment and therapy requires supervisors have sufficient skills and knowledge about specific clinical techniques in order to monitor and assess the quality of the supervisee’s professional practice, provide feedback about their performance and give guidance for profession specific activities to improve client outcomes (Spence et al 2001 in in Livingstone, Donaghey & Beare 2007).

Some clinicians who work in specialty areas, remote locations or in interdisciplinary teams may choose to access clinical supervision from another profession. In this case it may be useful to link in with a mentor who is from the same allied health profession or maintain other profession specific support networks for intermittent support and discussion. Conversely, clinicians who work closely with other professions in their day to day work may benefit from a profession specific clinical supervisor but also access peer group supervision, an external mentor, journal club or case review group for their support and guidance from other professions.

Rural and Remote Practice

Clinicians working in rural and remote locations face unique and different challenges both professionally and personally compared to their metropolitan counterparts. There are many factors that impact on this including:

- Dispersed population
- Unique health issues
- Language and cultural barriers
- Seasonal travel problems
- Relative inexperience
- Small workforce (Campbell and Moore 2008)
- Professional isolation
- Lack of access to training and supervision
Financial constraints  
Complex workloads  
Long wait lists  
Geographical isolation  
Vacancies in allied health professions and difficulty recruiting  
Low retention of staff (Wagner 2008)

For these and many other reasons that local health units may identify, it is imperative that clinicians feel supported in their role. It is well understood that retention in rural areas is an issue for health organisations and the further a health unit is from metropolitan areas the worse retention, isolation and stress appear to be (Wagner 2008). Personal factors that influence retention are difficult to influence but professional issues may be more easily changed to improve retention (Stagnitti et al 2006).

Poor career structure, risk of deskilling, lack of financial rewards, low levels of autonomy, lack of involvement in decision making, minimal support and low job satisfaction can all negatively impact on retention (US dept of Health and Human Services 2004 in Stagnitti et al 2006).

Factors that can improve retention and job satisfaction include: rewarding and flexible work, a degree of autonomy, broad range of clinical and management experience, positive working environment, good support structures and preferably support from same profession on site (Stagnitti et al 2006).

Battye and McTaggart (2003) and Fitzgerald, Hornsby and Hudson (2000) (in Wagner 2008) describe clinical supervision and professional isolation as the major limiting factors in recruitment and retention of AH workers in rural and remote areas. Furthermore, Paskevicius 2002 (in Wagner 2008) reported lack of management and supervision support as the 2nd biggest reason for rural and remote AHP's for leaving their positions. Short term savings gained from providing less support results in long term limitations in quality of practice and health care. Supervision usually costs approximately 1% salary, this is offset by increased retention, recruitment, productivity, decreased professional drift and increased alignment to organisational goals. As well as improving retention, clinical supervision also increases quality and safety of care for clients and the organisation (Wagner 2008).

Most of the evidence for clinical supervision and support focuses on new graduates but there is less rigorous evidence that shows supervision is important for all AHP's regardless of their level of experience. Benefits include networking and access to resources, increased clinical skills (Kavanagh et al 2004 and Parking et al 2001 in Campbell and Moore 2008), reduced burnout (Edwards et al 2006) and retention (Kavanagh et al 2004, Kavanagh et al 2003 and Brumfitt and Hoben 2004 in Campbell and Moore 2008). Supervision is a significant predictor of organisational commitment (Akroyd et al 1995 in Campbell and Moore 2008).

PROJECT PROCESSES

The project included the following processes:

- Reference Group development
- Consultation with managers throughout CHSA in relation to their needs and preferences for clinical support
- Consultation with WA, QLD, NT and VIC re their clinical support structures and programs
- Literature Review and Scoping of other clinical support structures
- Discussion Paper and recommendations developed
- Focus Groups conducted with AHPs throughout CHSA to explore local needs and preferences
- Further consultation with reference group metro directors and interstate programs
- Workshop held to further refine recommendations and outcomes
- Clinical Support Framework and Policy developed
- Clinical supervision Training developed and refined with NT and WA
- Further recommendations made

**Literature review recommendations**

Several recommendations were made based on the literature review, these included:

- Consultation with managers, supervisors and clinicians in regards to possible clinical support models and tools to develop a useful and appropriate framework for CHSA Endorsement of a consistent allied health supervision and mentoring framework at all levels of CHSA
- Access to clinical supervision and/or mentoring for all AHP’s in CHSA regardless of classification and role
- Minimum standards for supervision and mentoring be set for AHP’s in line with recommendations in the literature and consistent with work level definitions
- The availability of a range of models, tools and modes for accessing supervision and mentoring to cater to the needs of various professional groups and locations
- Regular training in supervision and mentoring for supervisors/mentors and supervisees/mentees that is accessible and applicable for rural and remote clinicians
- Regular evaluation of supervision and mentoring programs running in CHSA to ensure clinicians’ needs are being met and to inform necessary changes to improve the quality of programs delivered
- The embedding of supervision and mentoring minimum standards and expectations in policy, job and person specifications, performance appraisals and professional development plans

**Focus Groups**

Focus groups were conducted at several locations around the state to explore AHPs clinical support needs and preferences. The focus groups identified the following:

- Supervision is multifaceted
- Good supervision requires training and support
- Allied health value autonomy
- Interdisciplinary team work is important
- Mentoring is valued but not common
- Pockets of great clinical support
- Generally clinical support is inconsistent
- Heavy and complex workloads
- Lack of support for senior and advanced roles
- Needs vary within classification levels and disciplines

The group participants recommended the following for CHSA AHPs:

- Consistent approach to clinical support across CHSA
- Minimum standards of clinical support time
- Framework/guidelines developed
- Training and support available
- Embed clinical support in PDR process
- Utilise the expertise we have in CHSA to support clinicians where possible
- Foster links with metropolitan health services for specialised support
- Increase resource and skill sharing across CHSA regions
PRIORITISED RECOMMENDATIONS

The recommendations were further explored with managers, interstate colleagues, the literature and the reference group. A workshop was held at the Country Allied Health Forum where the recommendations were further explored and then prioritised:

1. The development of minimum standards for supervision and mentoring. Include provisions all levels of allied health professionals (AHPs) e.g. P01, P02, P03 etc
2. Process or structure and templates for supervisors to use:
   - To support their ongoing and evolving supervision roles
   - To promote consistency of supervision across CHSA
   - To assist supervisors to use have a consistent level of expectation of clinicians across country
3. Facilitate regular training for supervisors, mentors, supervisee’s and mentees. Supervision and mentoring training offered regularly and in country areas and online. Local trainers could support ongoing needs
4. P03 level support for more specialised support and advocacy. P03 roles for clinical support across country for each discipline or specialty area
5. Protected time for supervision set aside in workload
6. Dedicated time from specialists in metropolitan and country areas to provide support to clinicians as part of their job description

The following 3 were also identified as important recommendations by the group:

6a. Development of a competency framework in order for clinicians to safely support others in various clinical areas
6b. Development of a mentoring structure that is flexible to the needs of clinicians
6c. Develop a process for off site support for small or remote centres as required

Clinical Support Framework

A clinical support framework was developed to meet the majority of the recommendations, this was based on the current literature available and programs and practices implemented in other states. In accordance with the recommendations the following was included in the framework:

Minimum Standards for Clinical Supervision

Victorian HealthCare Association Clinical Supervision in Community Health Practice Guidelines (2008) sets out quite flexible minimum recommendations and leading practice recommendations
Clinical supervision should be made available on a minimum monthly basis irrespective of level of experience
Part time, casual, overseas trained, sole practitioners, clinicians new to an area or program and those with additional support needs may need to be considered separately
For new graduates ideally supervision should be provided weekly for the first 6 months
Mental health clinicians should receive fortnightly clinical supervision
Minimum standards of clinical support for AHP’s are also discussed in various recent published and unpublished literature. The following table developed by the Northern Territory Government Department of Health and Families in 2007 as part of their Professional Practice Supervision and Support Program Guidelines is a good summary of recent literature for the minimum standards of clinical supervision that should be accessible for clinicians:

<table>
<thead>
<tr>
<th>Clinician</th>
<th>Amount of time required</th>
<th>Comments for manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Graduate Year (pharmacy/radiography)</td>
<td>4 hours/month</td>
<td>Participation in graduate year activities is likely to fulfil requirements for clinical support.</td>
</tr>
<tr>
<td>New Graduate</td>
<td>4 hours/month</td>
<td>If not participating in graduate year activities, supported implementation of clinical support is essential- the transition from student to professional is a critical time period</td>
</tr>
<tr>
<td>P01 position</td>
<td>4 hours/month</td>
<td>Need to consider previous relevant rural/remote experience (E.g. student placements, participation in graduate program, life experience, number of years already in the workforce)</td>
</tr>
<tr>
<td>Locum/Temporary employees</td>
<td>4 hours/month</td>
<td>Select suitable mentor during recruitment process to ensure clinical support can be implemented as quickly and easily as possible.</td>
</tr>
<tr>
<td>Experienced AHP</td>
<td>1 hour/month</td>
<td>Hours may be increased in circumstances requiring acquisition of new ‘skill’ area.</td>
</tr>
<tr>
<td>Moving into a new work area</td>
<td>4 hours/month</td>
<td>Depending on individual circumstances clinical support time should be subject to 6 monthly review</td>
</tr>
</tbody>
</table>

The Northern Territory Government Department Health and Families (2008) suggest locum and temporary employees should participate in clinical support. Recruitment processes for locums are often less stringent and clinicians may be recruited into isolated positions with a lack of support. Therefore clinical supervision is imperative to ensure professional competencies are developed and high level, effective and efficient services are delivered. Additionally AHP’s on contracts of less than three months represent a window of opportunity to recruit to more permanent positions and so should be supported with a view to investing in them for more permanent employment.

**Process or structure and templates for supervisors to use**

The framework included a range of templates to use in clinical support as well as proposed structures and processes. These are not prescriptive as it was recognised that the needs and preferences of AHPs are varied and so several options, processes and structures are described.

**Regular training for supervisors, mentors, supervisee’s and mentees**

Western Australia Country Health Service and Combined Universities for Rural Health were generous in allowing CHSA to utilise their Foundations to Clinical Support training package which was adapted to the needs of SA based AHPs and aimed to be an appropriate orientation to clinical support for all staff to undertake.

In conjunction with WA and NT allied health, an intermediate training package for supervisors was also developed and put onto DVD to allow any rural or remote clinician to access easily. Both of these packages are in their infancy of implementation and need to be evaluated for their effectiveness after implementation.
P03 level support for more specialised support and advocacy

Since completion of the project, a new enterprise bargaining agreement has been released and for the first time AHP’s have their own schedule within the agreement. The implications of this are currently being explored, costed and progressed, however it will mean level 3 clinicians will need to be in place to support all level 1 and 2 staff. These changes will support this recommendation and ensure all staff receive adequate support.

Protected time for supervision set aside in workload

The support framework was endorsed by CHSA executive and the policy is currently being endorsed and implemented. These documents outline the time required for supervision and the requirement to allow time in workloads to accommodate support. This time allocation is also a culture shift for many AHPs as they see clinical work more important than support for themselves. This will take time to change, however the new level 3 support will assist in enforcing more mandated clinical support.

Dedicated time from specialists in metropolitan and country areas to provide support to clinicians

This was a major issue for dietetics who often have highly complex clinical questions but had difficulty access support from their metropolitan counterparts when required. Since the completion of the project, a trial profession lead clinician was recruited for Dietetics to develop clinical leadership across CHSA and foster links with metropolitan clinicians. This has assisted local clinicians to access more specialised support. there are now plans to develop profession lead roles for all Allied Health disciplines after the success of the dietetics position.

Development of a supervision competency framework

A competency framework for supervision was adopted from Queensland Mental Health Services and added to the clinical support framework but has not been further explored. Further implementation and evaluation of this framework would be useful to ascertain the competency of supervisors across CHSA.

Development of a mentoring structure

Mentoring structures were described in detail throughout the support framework but a specific program has yet to be developed and implemented. Several professional associations offer their own mentoring programs however the need for a CHSA wide program is evident. Since the implementation of the framework, many clinicians have sought out their own mentors using the structures and tools described.

Develop a process for off site support for small or remote centres

The Clinical Support Framework is available for all CHSA AHPs and is being widely used. The training is electronic so is appropriate despite distance and remoteness. Actual access to clinical support for these clinicians has not been formally evaluated since the completion of the project and but would be very beneficial.

Conclusion

Clinical support for Allied Health Professionals (AHP's) is an important strategy to promote and facilitate safety and quality in the workplace. There are also strong links to retention, job satisfaction and recruitment. Rural and remote AHP’s face many different challenges to their metropolitan counterparts relating to remoteness, distance, access to specialised support and isolation. High quality and effective support structures have been shown to improve retention and job satisfaction which ultimately has a positive influence on the whole organisation and the community.
The clinical support policy and framework, policy and training developed during this project are assisting in improving the consistency and access to clinical support across CHSA. It is envisaged that ongoing support will be required to develop and maintain clinical supervision, mentoring and other support mechanisms across CHSA, however the outcomes of this project were useful first steps in the development of consistent, high quality support across Country SA.

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