

9.10 Addressing Challenges to Effective Implementation

Organisational administrators and managers assessing their readiness for adopting a new clinical supervision framework, or improving an existing one, should collaborate with frontline staff regarding barriers they face in their particular service context, and ideas for overcoming them.

Roche et al. (2007, p. 246) outline common barriers to implementation experienced by services (also see sections 9.1.2 and 9.1.3):

1. Managers who do not understand the benefits or value of supervision, or are unwilling to devote time and energy to developing a program (NCETA 2005, cited in Roche et al. 2007)
2. Workers who do not understand the benefits or value of supervision, or are unwilling to devote time and energy to developing a program (NCETA 2005, cited in Roche et al. 2007)
3. Supervisors who are not adequately trained in the delivery of supervision (Peake et al., cited in Roche et al. 2007)
4. An insufficient pool of qualified and available supervisors (NCETA 2005, cited in Roche et al. 2007)
5. Conflict between frontline and managerial staff, whose roles are often blurred (Webb, cited in Roche et al. 2007)
6. A lack of common language and conceptual framework amongst supervisors, supervisees and managers (NCETA 2005, cited in Roche et al. 2007)
7. Funding shortfalls and limitations (NCETA 2005, cited in Roche et al. 2007)
8. Geographical distance between supervisors and supervisees (Campbell et al., cited in Roche et al. 2007)
9. A cultural belief that practical benefits of clinical supervision are limited (Cleary et al., cited in Roche et al. 2007)
10. A perception that expressing a need for supervision may be indicative of an inability to manage the job (Olofsson, cited in Roche et al. 2007)

Issues related to staff misconceptions and organisational culture

Many of these problems (numbers 1, 2, 5, 6, 9 and 10) can be addressed through an ongoing process of collaboration between administrators, managers, workers, and supervisors. Without management driving and supporting implementation policies and processes, they are sure to fail. It is the role of organisational leaders to ensure that priority is given to engaging staff, and working out a viable plan for clinical supervision, and that it is understood to be an integral component of ethical and competent clinical governance. As

part of this dialogue, clear roles should be defined, and a conceptual framework decided upon.

However, in some organisations where little or no solid clinical supervision practice has been followed and staff habits are deeply ingrained, it may require months or years for the changes to be fully accepted and integrated. Managers should not expect to wait for every staff member to come on-board before rolling out a clinical supervision framework, but they should do their best to engage as many people as possible, to ease tensions, and to aid the uptake and follow through on supervision plans.

It's hard to know what the prevailing attitude towards clinical supervision is because it's the policy of our organisation. Participation is a reflection of policy, as well as individual supervisor and supervisee attitudes. I think for some people it's, "This is what I have gotta do or else I will get in trouble." Whereas for the more inexperienced it's like: "Phew, thank God. I need the extra support." (Manager, CMMH Service)

Geographical distance (number 8)

Where there may be few clinical supervisors available, accessing supervision via an external consultant, who either comes to the site or supervises via teleconferencing or videoconferencing, may be a viable and effective option. In the event that tele- or video-conference is used, the supervisor should also have direct face-to-face meetings, both initially and every few months, with supervisees. Other options that are gaining traction are the use of on-line chat rooms and e-mail correspondence, though these have their limitations, and guaranteeing privacy and confidentiality is very difficult, if not impossible.

Funding and resource constraints (number 7)

The following advice is offered by NCETA:

It may be appropriate for organisations to foster partnerships and share resources...It is important that organisations involved in such partnerships develop a memorandum of understanding that clarifies each organisation's responsibilities (e.g., administration, residence, managerial). Submitting tenders for additional funding is an additional option to consider (NCETA 2005, p. 14).

An insufficient pool of supervisors who are adequately qualified and trained in clinical supervision (numbers 3 and 4)

Organisations developing a clinical supervision framework must either source training for their existing staff, or outsource their clinical supervision to trained, experienced supervisors. Refer to *Geographical distance*, above, for suggestions on engaging external supervisors from other areas, if rural isolation is one cause of the understaffing. Also, refer to *Funding and Resource Constraints*, above, regarding ideas for engaging in partnerships with other services.

References for this section: NCETA (2005); Roche et al. (2007).