The Supporting Practice Leaders Project

SUPPORTING PRACTICE LEADERS
ALCOHOL AND OTHER DRUGS-ICE-MENTAL HEALTH

Oct 2015 – June 2019

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Executive Summary

Clinical supervision and practice support[1] were identified in the Victorian government's Ice Action Plan as critical enablers in strengthening the capacity of Mental Health (MH) and Alcohol and Other Drug (AOD) workforces to provide best practice responses to people with ice-related issues. The Bouverie Centre in partnership with Turning Point, Youth Support and Advocacy Service (YSAS) and the three mental health training coordination centres; NEVIL, LAMP and Western Cluster were commissioned by the Department of Health and Human Services (DHHS) to deliver a suite of training and support options that would:

1. Support clinical practice leaders to assist frontline workers deliver ice intervention strategies

2. Help clinical practice leaders gain training in a comprehensive and systemic model of clinical supervision

The catchment structure was utilised to engage organisations and clinical practice leaders to facilitate cross-sector collaboration and networking.

Notable Achievements and Successes

Over a 3-year period, The Bouverie Centre worked with clinical mental health, mental health community support and alcohol and other drug (AOD) services, located within rural and metropolitan catchments, to implement the Project.

- In total the Project was undertaken by 46 services at 13 sites. A site was comprised of mental health and AOD services that had cause to work with one another within a geographical area. Of these, 7 were regional and 6 were in Metropolitan Melbourne.

- Four hundred and thirty-six individual participants from clinical mental health, mental health community support and AOD services were involved in 37 training programs over 76 training days, including clinical supervision, group supervision, action learning sets, building team resilience training and booster sessions.

- The strongest representation from any discipline in the Project was 39% from nursing. The next most significant, 'Other', represented people with qualifications in welfare, the social sciences, counselling, family therapy, lived experience and AOD. Social work was the third highest area, followed by psychology and occupational therapy.

- Project participation by sector was proportional to sector size and included 34% AOD and Dual Diagnosis practitioners, 46% Clinical Mental Health (comprised

[1] Practice leadership is the preferred term within the literature that relates to practice support. A representative definition is 'the development and maintenance of good staff support for the people served through a variety of tasks (such as) focusing on the issue, allocating and organising staff, coaching staff, reviewing quality of work, reviewing team functioning' (Mansell, Beadle-Brown, Ashman & Ockendon, 2004 cited in Beadle-Brown, Mansell, Ashman, Ockenden, Iles & Whelton, 2014, p 839).

of 26% community, 22% bed-based services) and 18% Mental Health Community Support.

- Clinical Supervision Training was the most sought-after training. Of the 13 programs conducted, 303 people registered for the program with a 93% attendance rate. The low attrition rate could be attributed to satisfaction with the program and coordination efforts to increase participant preparedness.

- Clinical Supervision training evaluation showed that overall 97% of participants rated the training either as either 'Excellent' or `Good' on a five-point scale. Similarly, Group Supervision and Building Team Resilience had overall ratings of `Excellent' or ` Good' of 96% and 97% respectively. Ninety-two percent of people who responded to the evaluation question, '*Has your capacity to support your staff in responding to complex and/or challenging presentations improved post training?*' said that it had improved.

- Implementation activities included 73 consultation days with executive leaders, managers, team leaders and key staff. Other activities supporting implementation were Practice Enquiry Groups, focus groups and Booster sessions.

- The Project methodology included: Stakeholder Consultations, Project Partner Meetings, Stakeholder Reference Groups, Sector Engagement, Test and Pilot sites, Steering Groups and Training Selection and Development.

- Project evaluation was comprised of three phases focussing on the proposed outcomes of the Project. The evaluation used both qualitative (telephone interviews and focus groups) and quantitative (online survey and end of session rating form) data collection to strengthen the quality of the findings through utilising a range of methods.

- All three phases of the evaluation showed that a high proportion of people participating had increased knowledge about clinical supervision and practice support strategies as a result of the SPLice Project and were able to transfer that knowledge into their work contexts.

- A high number of participants considered that the Project had enabled clinical supervision to be prioritised within services, this supported their wish for line management and clinical supervision to not to be delivered by the same supervisor to individual staff.

- Many participants believed that in order to embed clinical supervision and practice support strategies as part of their everyday practice, organisations needed to advance and further develop relevant policies, procedures and guidelines.

Challenges

Evaluation findings suggest that a thorough implementation plan at each participating service is needed to ensure practice change. At the start of this Project it was known that clinical supervision and practice support was not likely to be afforded the priority status of direct service delivery. However, despite the frequent enthusiasm, good will and genuine desire of services to improve practice for clients and staff, the lack of a reporting imperative and adequate resources translated into a brief window in which organisations were able to attend to clinical supervision and practice support initiatives within their service.

Ethics approval was required to conduct Project evaluation in area mental health services. This was gained through St. Vincent's Hospital Human Research Ethics Committee (HREC/15/SVHM/150). Governance approval then needed to be sought at each participating service. As a result of the various demands and structures within each of the area mental health services, progress towards approval was often slow. One service was unable to participate in the Project because of protracted internal processes.

Other challenges included the quickly changing landscapes of organisations where restructures, investigations, quality audits and staffing shortages meant at times services were unable to follow through on their initial commitment to the Project.

Summary

The SPLice Project improved the capacity of leaders to support frontline staff around complex presentations associated with crystal methamphetamine (CM) use. This was evidenced in the strong take-up of Project offerings which included 436 participants in 37 training programs over 76 days. Feedback around the quality of the programs undertaken was outstanding with 97% of participants rating the trainings as either as either 'Excellent' or `Good' on a five-point scale. The Project was unable to achieve the systematic implementation of strategies to embed accessible, regular, structured practice support and clinical supervision across mental health and AOD services. For this to occur the following recommendations are made.

Recommendations

1. DHHS facilitate the development of a 'trans-discipline and trans-sector' high level definition of clinical supervision and practice support activities to enable more effective measurement of current levels of clinical supervision and practice support provided in services.

2. Services are supported to track and monitor the uptake of clinical supervision and practice support strategies through development of brief, easy-to-use monitoring tools. This will help determine current levels of clinical supervision and practice support to establish baselines and allow monitoring over time. For example, measurement could cover domains such as; access to individual clinical supervision and group supervision; numbers and frequency of provision of clinical supervision sessions and practice support; listing of clinical supervisors; choice of clinical supervisor, clinical supervision documentation including working agreements and session record sheets.

3. The Centre for Mental Health Learning (CMHL) or other relevant group, coordinate workforce development activities to ensure optimal uptake and impact.

4. CMHL or other relevant group, work with mental health and AOD services to further promote the importance of services focussing on practice change as an alternative to viewing training as an end in its own right.

5. DHHS mandate reporting of clinical supervision and practice support activities as part of service reporting.

6. Education sessions, explaining and endorsing the role of clinical supervision and other practice support activities, provided to team leaders and program managers. These sessions could emphasise the importance of clinical supervision for both quality improvement and staff wellbeing purposes.

7. The provision of clinical supervision and practice support be a priority area for CMHL and for the mental health training clusters.

8. Services are required to provide clinical supervision and practice support activities for all direct service staff. In smaller services or services in rural and remote areas, organisations can consider cross-sector collaboration and reciprocal arrangements to ensure access to clinical supervision, including the use of accessible technologies.

9. Services establish group processes, such as communities of practice, to develop and support new supervisors in their role. This could be achieved either internally or in collaboration with sector partners.

10. Services are encouraged to provide practitioners with specialised supervision (group or individual) from experts when a new practice or intervention model is being implemented. This needs to be in addition to receiving ongoing clinical supervision.

11. DHHS funds research exploring the relationship between clinical supervision, practice support, client outcomes and staff wellbeing.

1. Introduction

In 2015, The Bouverie Centre was commissioned by DHHS to undertake the Supporting Practice Leaders with Ice (SPLice) Project to increase the quality and consistency of

clinical supervision and practice support across Victorian specialist mental health (MH) and Alcohol and Other Drug (AOD) services, specifically in relation to supporting and embedding best practice responses to ice affected individuals.

The SPLice project was devised at a time of significant state government reforms to the AOD, mental health community support (MHCS) and clinical mental health sectors in Victoria. This included New Directions for Alcohol and Drug Treatment Services, 2013; Reforming Community Support Services for People with Mental Illness, 2013; The Mental Health Act, 2014.

Prior to the commencement of the SPLice project, a literature review and situational analysis of clinical supervision and practice support or practice leadership[2] was undertaken as part of *`Clinical Supervision Project Phase 1: 2015'*. This was undertaken to provide information and recommendations to the Department of Health and Human Services (DHHS) for phase two of the practice enhancement project for the Victorian Government's Ice Action Plan.

Clinical supervision and practice support were identified in both the literature review and situational analysis as critical enablers in strengthening the MH and AOD workforces to provide best practice responses to people with ice-related issues. Leaders were seen to be able to implement a range of methods to support knowledge transfer including: training, on-the-job coaching, 'incidental' / as needed support, mentoring, and online support, networks and communities of practice, peer support, reflective practice and interest groups. No singular strategy was identified in the situational analysis or literature review as the most effective in enabling knowledge transfer in all contexts.

The literature review and the situational analysis were consistent in finding that quality clinical supervision could contribute to a positive organisational culture affecting worker wellbeing through increased job satisfaction, decreased burnout, improved worker retention and positive work attitudes. Practitioners identified that they wanted improved access to quality supervision that utilised a strength-based approach, included a reflective component and attended to the relational aspects of supervision.

As not all aspects of practice support were in scope for this Project, emphasis was placed on ensuring practice leaders could provide frontline staff with occasions to reflect as well as deliver support and development opportunities. These were areas most frequently identified by practitioners as needing greater attention rather than the administrative and accountability functions of practice leadership.

At the commencement of this project it was known that there were many gaps in the provision of clinical supervision and practice leadership across the MH and AOD service sectors. It was clear that organisational readiness and openness to innovation

[2] Practice leadership was the preferred term within the literature that related to practice support. For further discussion around the around the variety and effectiveness of various practice leadership strategies please refer to the companion documents to this report, the *Literature Review, Clinical Supervision and Practice Leadership in Victorian Mental Health and Alcohol and Other Drugs Services* or *Situational Analysis Clinical Supervision and Practice Support Implementation Project.*

would be necessary for effective implementation of any initiatives in clinical supervision and practice support.

2. The Bouverie Centre Project Team

The core project team comprised:

- Dr Brendan O'Hanlon, Manager, Mental Health Program
- Dr Jacqui Sundbery, Manager Indigenous Program & Team Leader Community Services
- Angie Nyland, project officer
- Henry von Doussa, research and evaluation
- Dr John Bamberg, research and evaluation
- Michelle Wills, project officer
- Pam Rycroft, project officer

The team met regularly during the Project, firstly to develop an understanding of the key stakeholders and the service delivery context and then to review and refine strategies for facilitating Project implementation.

Additional staff assisted in the delivery of training, consultation, practice enquiry groups and booster sessions.

3. Project Methodology

The project methodology was congruent with implementation science as practiced within previous Bouverie Centre workforce development projects. This included the development of an authorising environment with service executives, an implementation focus within the training where participants reflected on how to transfer learning into their service context and continued training and support options to encourage the uptake of new skills and embed new practices. The methodology built upon learning from *`Clinical Supervision Project Phase 1: 2015'* which was foundational to the Supporting Practice Leaders project.

Project methodology included:

- Stakeholder Consultations
- Project Partner Meetings
- Stakeholder Reference Groups
- Sector Engagement
- Test and Pilot sites
- Steering Groups
- Training Selection and Development

3.1 Stakeholder Consultations

Project planning began in October 2015 and involved extensive stakeholder consultation to ensure that the Project was responsive to the needs of mental health and AOD services. There was considerable interest in the Ice Strategy at this time which meant that a range of input was easily gained.

This phase included a presentation to the Specialist Workforce Advisory Group and meetings with representatives from the Health and Community Services Union (HACSU), Australian Nursing and Midwifery Federation (ANMF), Centre for Psychiatric Nursing (CPN), and Office of the Chief Mental Health Nurse. In addition, there were consultations with managers from MH, AOD and Dual Diagnosis services to inform them of the Project and gauge readiness for their inclusion.

3.2 Project Partner Meetings

Early meetings with the Project Partners informed our engagement strategy, with the first being conducted in October 2015. The Project Partners included Turning Point, Youth Support and Advocacy Service (YSAS), and the Nevil, Lamps and Western MH Clusters. DHHS was also represented at Project Partner meetings.

In total there were 8 Project Partner meetings held over the reporting period, including 3 prior to SPLice Project training and practice support commencing and a further 5 occurring throughout the Project.

Project Partners recommended potential sites for the Project, provided contacts and strategies for engagement, indicated organisational readiness and possibilities for cross-sector collaboration, consulted around the adaptation of resources to a range of sectors and services including the online training.

Project Partners continued to provide project governance until the conclusion of the Project in mid-2019.

3.3 Stakeholder Reference Groups

Another important aspect of project governance was the convening of a Stakeholder Reference Group in the Project's establishment phase. The purpose of the Stakeholder Reference Group was to work closely on the design and implementation of the Project to ensure outcomes were met.

Group members provided input into discussions and feedback on key issues arising during the design and implementation phases of the Project. This included direction around knowledge transfer and clinical supervision. Members of the group helped to resolve policy and program issues connected to the program areas and sectors they represented.

Two meetings occurred in 2016 and were on an as needs basis after this time. A total of 6 meetings of 1.5-2 hour duration occurred throughout the Project.

Many members of the Stakeholder Reference Group continued to provide project governance until the conclusion of the project in mid-2019. Other representatives attended at key junctures or when available. See Appendix A for a list of members.

3.4 Test and Pilot Sites

As part of the project plan, test and pilot sites[3] were engaged. The purpose of these sites was to act as a `soft start' to the Project where offerings could be reviewed and adapted to ensure the suitability and quality of the activities.

Initially, it was thought that an expression of interest would be the method of engagement for test and pilot sites however, as the AOD and MH Community Support sectors were navigating significant changes at this time a more active recruitment of sites was indicated. Networks and contacts provided by Stakeholder Reference Groups members was an important part of the recruitment strategy.

Strategies used to promote the Project included:

- Feb 2016: contact with the Victorian Alcohol and Drug Association (VAADA) to set up ongoing communication. VAADA distributed a letter from The Bouverie Centre to managers and senior staff in AOD funded services detailing information about the Project and process for expressions of interest
- Feb 2016: communication with Psychiatric Disability Services of Victoria (VICSERV) including a request to distribute information amongst staff and members, as above
- Feb 2016: promotion through ongoing meetings with Project Partners - MH Clusters, YSAS, Turning Point, DHHS
- Feb 2016: use of networks to further distribute information and determine level of interest: Stakeholder Reference Group, networks within MH and AOD sectors (e.g. Change Agent Network and the statewide clinical adult mental health leaders group) and Bouverie Centre contacts
- Project information placed on The Bouverie Centre website and newsletter
- April 2016: Stall at Victorian AOD Service Providers Conference
- Feb 2017: Presentation at VAADA conference
- 'Cold calling' services in catchments where interest was building to ascertain capacity for involvement and including smaller services or locations that were part of larger consortiums.

After initial consultations The Bouverie Centre engaged the first test and pilot sites based on the following criteria:

- Area of high prevalence for CM use
- Organisational support including a preparedness to: actively support supervision and practice leadership; commit a significant number of practice leaders; time allocation for implementation of practice support initiatives
- Area MH involvement to ensure proportional representation between MH and AOD sectors

[3] A site, in the context of this Project, refers to an area, catchment or locality where services may work together to provide continuity of care for clients experiencing problematic CM use.

- Willingness to collaborate with other organisations and sectors
- Ability to act as a `critical friend' in evaluating the initiative
- Capacity to be involved for a minimum four-month period

The first test and pilot sites included metropolitan and regional areas, and involved a minimum of four services within each:

- Mid-West: first test started in Feb/March 2016 and included the following services:
    - Mid-West MH: Adult Inpatient Unit, Community Care Unit, Outer and Central Community Teams, Rehabilitation Unit, Emergency
    - Substance Use and Mental Illness Treatment Team (SUMITT)
    - Breakthru
    - Neami
    - Western Health – Drug Health Services
    - Odyssey House
    - Cohealth

- Albury-Wodonga: pilot site commenced in April 2016 and included the following services:
    - Albury Wodonga Health: Albury Community MH, Wangaratta Community MH, Wodonga Community Health, Nurse Education Unit, Nolan Acute Inpatient, Kerferd Acute Inpatient, Albury Older Persons
    - Mind: Service Managers (regional, community, youth)
    - Gateway Health: Team Leader/Coordinators, Pharmacotherapy & Withdrawal, Partners in Recovery, headspace
    - Australian Community Support Organisation (ACSO)

Review and development of the Project that occurred as part of Test and Piloting of the initiative is included in Training and Development section 7.2.

3.5 Steering Groups

Once test and pilot sites were selected, Steering Groups were assembled comprised of those able to support, guide and drive the Project in their service. Executive leaders, managers and team leaders from each of the participating agencies were identified as suitable Steering Group (SG) members. The Project Officer then convened meetings with interested services to progress planning and implementation. The first SG was most frequently conducted in the area where the Project was to be delivered with subsequent meetings utilising Skype, Zoom and/or teleconferencing. Each site averaged three SGs with one before Project commencement, one half way through the clinical supervision training and finally a meeting post completion of all trainings.

The purpose of SG meetings was to: increase understanding of the SPLice Project, discuss the implementation of skills and structures surrounding practice support within and across services and share experiences and strategies surrounding the barriers and enablers to practice change. Steering Group members also determined the best location for training, the process for training participant selection and key contact

people. Feedback from training participants was also given to the SG to ensure that the experience of implementing clinical supervision and practice support initiatives at a program level was considered.

In total, 28 SG meetings of 1.5-2 hour duration were conducted. Participating members included: Area Managers, Executive Managers, Directors and Associate Directors of Nursing, Regional Partnerships Coordinator, MH and AOD Program Managers, Clinical Nurse Educators, Psychiatric Nurse Consultant, Clinical Leads, Discipline Seniors and Team Leaders.

A difficulty encountered for SG members was keeping momentum for the Project amongst the many competing priorities and demands within services. At the first SG, there was frequently considerable enthusiasm and commitment to what could be achieved and then a distinct waning of interest and attendance at subsequent SGs. Further understanding and explanation of this is included in the Discussion section.

4. Training Selection and Development

The choice of activities for the Project was determined partially through the tender process and then in consultation with the Project Partners, DHHS and key stakeholders. SPLice Project initiatives were designed to complement the Ice Strategy training for frontline workers and then the VACCHO practice support training and Monash Centre for Scholarship in Health Education (MCSHE) supervision training. Initially, it was hoped that frontline workers (and managers) would firstly access the online *Ice: Training for Frontline Workers* before leaders attended SPLice initiatives, to support the workforce around the impact of working with clients who had complex needs associated with CM use. However, the coordination of trainings proved problematic.

The SPLice Project went live prior to the release of the online *Ice: Training for Frontline Workers*, then once the online training was available it did not receive the uptake that had been anticipated. The face-to-face trainings became available after SPLice Project commencement with the Monash Centre's shorter clinical supervision courses starting approximately 18 months into the SPLice Project. Endeavours were made to establish sequencing between the available trainings, however services were not able to commit or allocate their resources in the prescribed way. In the Recommendations section possible directions surrounding workforce training coordination are outlined.

4.1 Clinical Supervision Training

Clinical Supervision Training (CST) was considered an important component of the Project. For over 11 years The Bouverie Centre had provided CST within AOD workforce development projects, as well as on its Professional Development training calendar, and had devised a 6-day program to meet the needs of a range of workforces. An important aspect of the consultation process was to engage MH services to ascertain what length and mode of delivery the training should take in order to be most useful to Clinical MH services. Sector representatives suggested a blended mode of delivery with 4-days face-to-face training combined with online modules. It was suggested that many bed-based services would struggle to release

staff for 6 full days of training. Another suggested adaptation was the inclusion of `Incidental Supervision'. The situational analysis and further consultations indicated that in many services this was the most frequently accessed form of supervision. Training for Incidental Supervision drew on a `Single Session' framework which provides a containing structure to ascertain quickly practitioner concerns, priorities, strategies to manage and follow-up procedures. Training participants frequently indicated that this aspect of the training was highly applicable to their work.

The role of clinical supervision (CS) in knowledge transfer was an ongoing area of interest and discussion within the Project Team, Project Partner and Stakeholder Reference Groups. At the outset of the Project it was known that workers require opportunities for reflection in their work to integrate new knowledge and experience. It was also known that reflection was key to preventing and responding to primary, secondary and vicarious traumatisation. Training surrounding the reflective function of supervision was increased for participants and was emphasised throughout the CST.

What was more contentious for the Project Team was the degree to which education should play a part in CS. Through consultation with stakeholders, the direction became clear as nursing representatives strongly felt that any skills training should occur through other mechanisms such as preceptorship and that education within CS needed to focus on the development of supervisees which needed to be largely supervisee led. AOD and MH representatives also strongly recommended that content about CM use not be a feature of the CS training except through case studies.

Leaders from a range of program areas in the MH and AOD sectors were consulted to develop case studies on which training participants could reflect. The case studies highlighted the impact on the workforce of the complex issues surrounding CM use and how supervisors could most usefully respond to mitigate negative impacts. Feedback on the case studies was also sought from people with AOD and MH lived experience.

4.2 Practice Support Training

During the development of the SPLice Project, consideration was given to what other practice support measures could be most useful to the workforce. It was known that in some services access to and participation in individual supervision was low. In response, several activities were initiated. These involved training aimed at group participation, including Action Learning Sets (ALS) and then Group Supervision[4]. Bed-based services had indicated that group programs occurring at shift changeovers were more likely to be utilised.

Activities changed in response to feedback from the test and pilot sites indicating that Action Learning Sets were most applicable to nurses in bed-based services though were not always preferred and were of less interest to those in the AOD sector. This provided the rationale to substitute Group Supervision for ALS training along with the knowledge that ALS training was already available on MH Cluster training calendars. It

[4] Descriptions of the trainings can be found in Appendix B.

was thought that a structured group supervision format could be taken up by a greater number of services and could provide reflection, feedback and support for those participating.

Building Team Resilience (BTR) was devised for emerging leaders as well as those already in defined leadership roles. The training was developed to facilitate strategies to build team cultures of learning where team members could grow and be supported through challenging times.

4.3 Other Practice Support Initiatives

Other activities to support the aims of the Project included Practice Enquiry Groups (PEGs)[5]. The PEGs were designed to look at service implementation issues surrounding the provision of clinical supervision and practice support.

Though services, in principal, supported staff to attend PEGs, meetings had low attendance rates with a maximum of 15 attendees at the first meeting and then attendance declining at subsequent meetings. Attendees did emphasise the importance of these meetings for implementation and for their growth as leaders however did not feel CS and practice support was sufficiently prioritised within the service to justify attendance.

In June 2018, after PEGs were trialled at four sites, it was decided, in consultation with the Project Partners and the Stakeholder Reference Group, to replace PEGs with Booster sessions. It was thought if Booster sessions were promoted as containing new training content, they may attract greater numbers.

See section 7.2.4 for details and discussion surrounding uptake and success of PEG and Booster sessions.

5. Sector Engagement

After the testing and piloting phase was complete, the SPLice Project was launched with a communication and marketing strategy utilising existing networks and peak bodies to engage MH and AOD sectors.

5.4 Selection of Areas

In total 13 sites were engaged in the Project including the test and pilot sites. All interested MH and AOD services were responded to and those eligible were included.

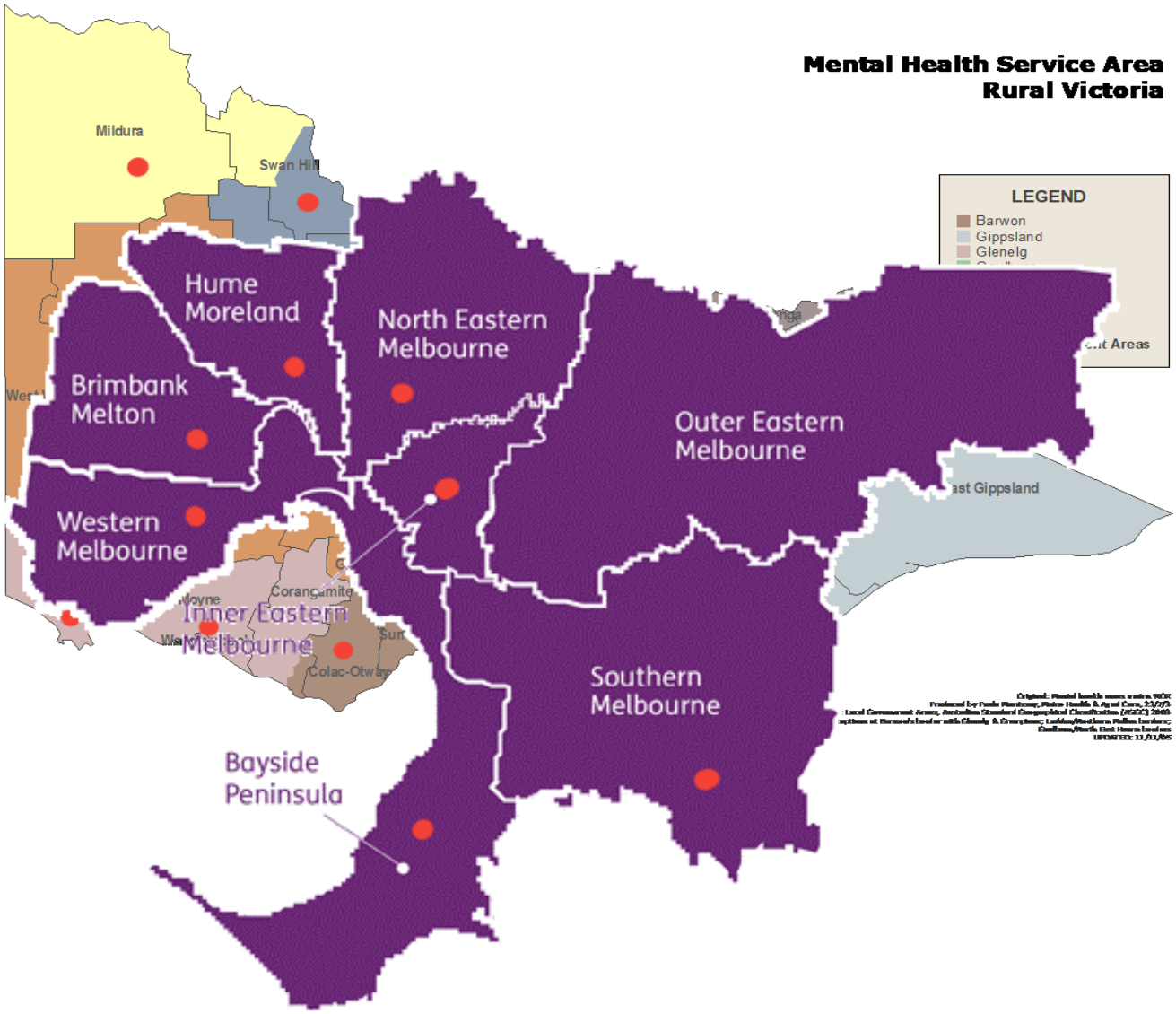
Of the 13 sites, 7 were regional including: Albury-Wodonga, Barwon, Goulburn Valley, Mildura, Ballarat, Gippsland and Warrnambool. The remaining 6 were comprised largely[6] of metropolitan services including those in the Mid West and South East, 2

[5] PEGs are an adaptation of communities of practice (Wenger, 2010), drawing together staff members leading change 'on the ground' to reflect on and improve their own work, as well as to share challenges and strategies for implementing new practices.

[6] If there were additional spaces available in training that the designated site could not fill, they were offered to participants from other locations.

rounds targeting youth services (Youth 2017 and Youth 2018 – both held at The Bouverie Centre), and 2 rounds responding to demand from services or participants unable to be accommodated previously ('Mixed' and '2019').

The 13 sites covered is beyond the initial aim of 12 out of the 15 catchment areas. The following maps represent the primary work location of participants, though many reported covering a far wider geographical area.



All Area Mental Health (AMH) services were invited to participate in the Project. Other significant AOD and MH service providers in the east, north and west of Melbourne were also approached. Some services were prevented from participating because of restructures, investigations, uncertainty surrounding funding and staffing shortages. In the case of Bendigo AMH service, they declined as they were already in the process of implementing a service wide program of clinical supervision training and support.

The Ballarat region was an example of when timing was crucial. After initial interest in the Project in 2016, an internal restructure at a key service along with sector reform meant the Project could not proceed. In mid-2017 there was sufficient stability and

preparedness in services for the Project to commence. In February 2018 a full cohort attended CST followed by training in BTR, GS and a Booster session. Ballarat Health Services were also able to implement strategies to improve access and participation in clinical supervision across a range of programs.

In the Goulburn Valley region, initial consultations indicated sufficient interest and commitment for the Project to proceed. Soon after, a key service changed its supervision policy so that all clinical supervision was to be provided externally and as a result no longer wished to participate. Another service, citing other training commitments, significantly reduced the numbers of participating staff, and structural changes at an AOD service meant that numbers of available staff was low. Despite the decreasing number of participants, Clinical Supervision training went ahead, however further Project training and activities did not.

6. Training and Project Participation

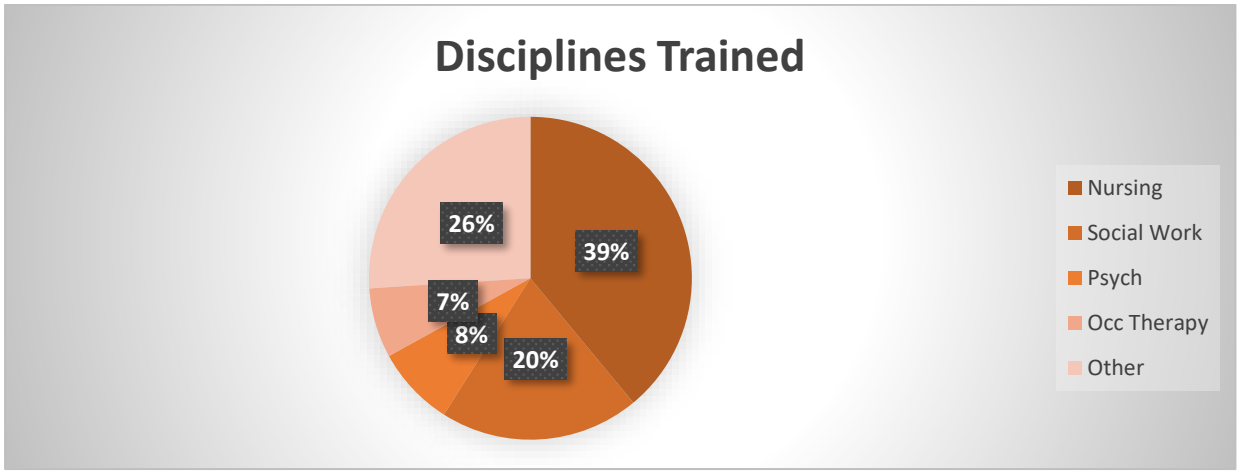
In total 436 MH and AOD practitioners from 46 different services attended training. A total of 37 training programs were delivered totalling 76 training days over the 13 sites. For details regarding participating services see Appendix C.

Twenty-four places were made available in each training program. There were 649 training places utilised including attendees at CST, ALS, GS, BTR and Booster sessions. The discrepancy between the individual number of participants in training and the training places that were utilised is a result of some participants attending more than one training.

6.1 Training Participants

6.1.1 Disciplines trained

The strongest representation from any discipline in the training was 39% from nursing. The next most significant, 'Other', represented people with qualifications in welfare, the social sciences, counselling, family therapy, lived experience and AOD. Social work was the third highest area, followed by psychology and occupational therapy.



Disciplines	Numbers
Nursing	171
Social Work	88
Psych	36
Occ Therapy	28
Other	113
Total	436

6.1.2 Sectors Trained

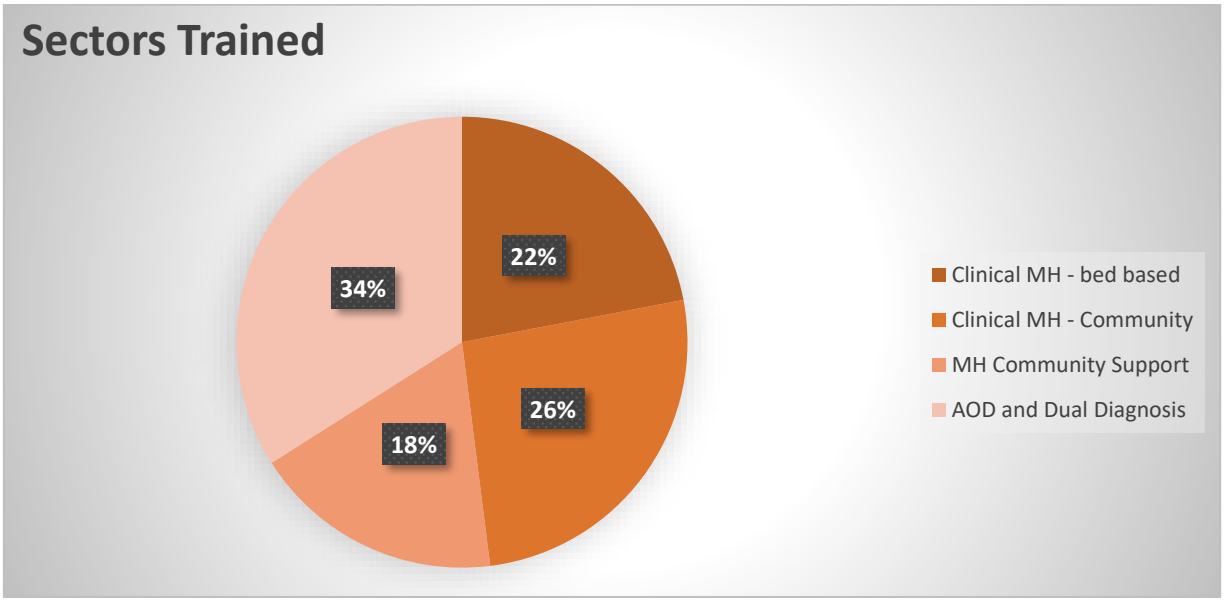
Training participants reported that an improved learning environment was created through the diverse range of participants from differing MH and AOD roles, settings and disciplines.

The Project was made available to staff from Aboriginal Community Controlled Organisations (ACCOs) though did not provide specific training for these practitioners. Participation included:

- 14 participants from 4 ACCOs
- Mallee District Aboriginal Services, Ballarat and District Aboriginal Co-operative, Winda-Mara Aboriginal Corporation and Victorian Aboriginal Health Service
- 3% of the total number of individuals

In addition to participants from ACCOs, a valuable contribution was made by Lived Experience Workers and Consumer Consultants, with at least 1-2 identified in most training groups.

Notably, 22% of those trained were from acute inpatient and other bed-based services. Services with staff participating in training often had to cover shifts in order for those staff to attend. This sometimes meant that participants missed training days due to unexpected staff shortages.



Sectors	Number
Clinical MH - bed based	135
Clinical MH - Community	157
MH Community Support	108
AOD and Dual Diagnosis	212
Total	612

7. Project Evaluation

7.1 Evaluation Methodology

The evaluation was comprised of three phases and focused on the proposed outcomes for the SPLice Project. The evaluation used both qualitative (telephone interviews and focus groups) and quantitative (online survey, end of session rating form) data collection to evaluate the training. Ethics approval for the evaluation was obtained from St. Vincent's Hospital Human Research Ethics Committee (HREC/15/SVHM/150).

Initially, the evaluation design included an evaluation tool, administered by supervisors to evaluate the usefulness of supervision in supporting knowledge transfer. After the piloting phase of the Project the decision was made to conclude the use of an evaluation tool. The decision was based on the poor take-up of the tool which decreased its relevance as a measure along with a shift in the focus of knowledge transfer.

Phase One (session rating form)

At the end of all training sessions participants were asked to complete a session evaluation. The mixed method evaluation asked them to reflect on their experiences of the training using a mixture of quantitative rating measures and qualitative short answer questions. The evaluation form also asked participants to identify the discipline in which they worked and if they worked in an acute mental health setting. This allowed us to better understand the experiences of those from a diverse range of clinical and non-clinical settings.

The analysis of data was completed in SPSS allowing for a simple frequency analysis.

Phase Two (online survey)

The online survey was implemented via Qualtrics. The survey was designed to help evaluate the efficacy of activities offered through the SPLice Project in relation to the uptake of skills and strategies for organisational change. We asked participants what they had implemented in the workplace after the training, how they felt this had changed practice, the barriers to implementation and their solutions. In addition to this, we asked participants what else they felt was needed to support clinical supervision and practice support implementation in their workplace and what information they wanted fed back to their organisation.

Phase Three (telephone interviews)

In Phase Three, brief telephone interviews were conducted. Questions sought to explore how useful the training design and content where for a subgroup of participants, as well as their implementation experiences 6 – 12 months post the training. The interview data was analysed to identify emerging themes.

7.2 Phase One - Training and Implementation Evaluation (session rating forms)

7.2.1 Clinical Supervision Training Evaluation

The training in highest demand was Clinical Supervision Training (CST). Of 13 of the courses conducted, there were 303 people registered a week before the start of training and 283 who attended CST. This represents a 93% attendance rate. The high attendance and low attrition rate could be attributed to the reputation of the training and the effective communication strategies employed. This included tracking the acceptance of training invitations, reminder calls and emails to participants, key service contacts and managers. This approach was essential to maximising the numbers able to attend.

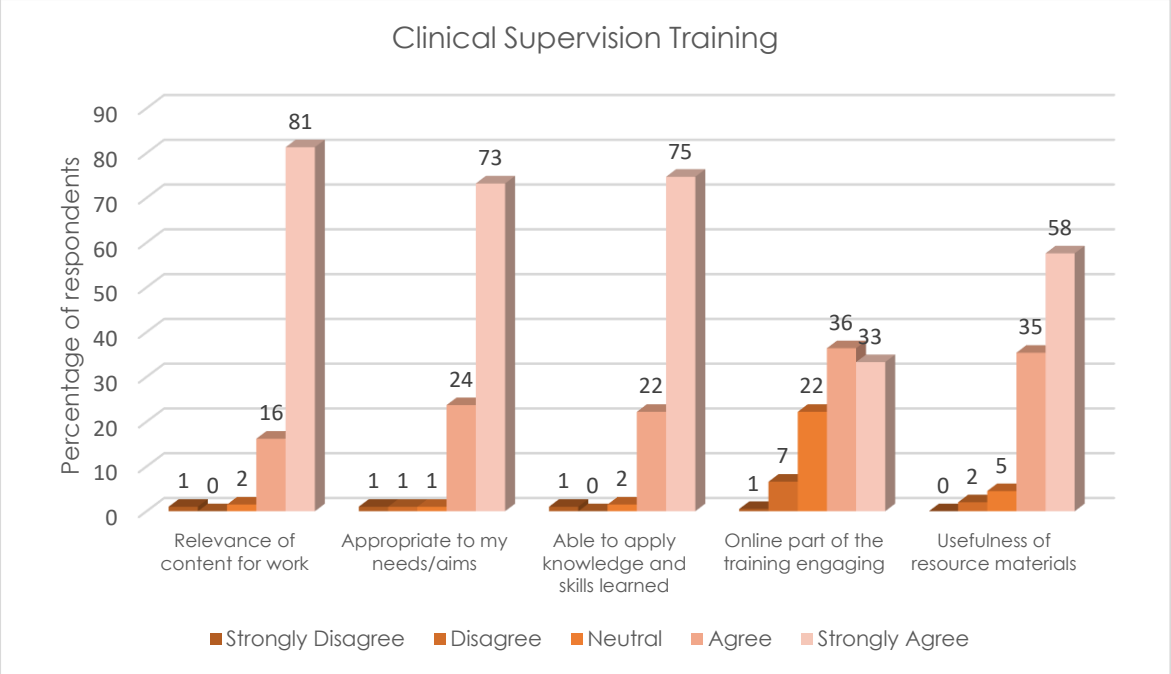
There were 198 out of 283 participants of the CST who completed a training evaluation. The evaluation shows that the training was both highly relevant to participants' work contexts (81% 'Strongly Agreed' and 16% 'Agreed') and was very appropriate to their needs (73% 'Strongly Agreed' and 24% 'Agreed').

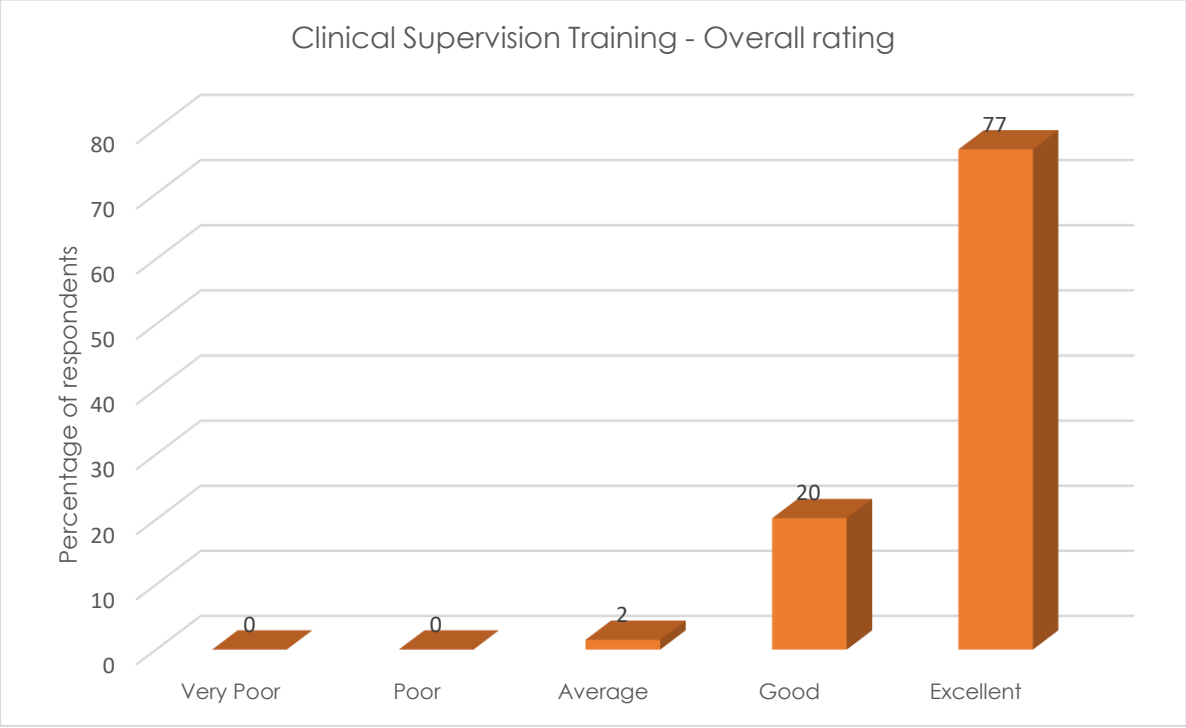
When asked if participants thought they would be able to apply the knowledge and skills learned, nearly all the participants (97%) 'Agreed' or 'Strongly Agreed' that they would be able to.

As the CST was made up of both online and face-to-face modules, we were interested to know what the online experience was like for participants and asked them to respond on a five-point scale to the statement, '*I found the online training engaging*'. Approximately one-third of participants 'Strongly agreed' and one-third (36%) 'Agreed' with the statement.

A high proportion of participants also agreed that the resource materials (USB and tools) were useful. Over 90% of the participants 'Strongly Agreed' or 'Agreed' that the resource materials given to them during the training were useful.

As part of the evaluation, participants were asked to give the training an overall rating. Overall, the ratings were very strong. On a five-point scale, 77% reported that the training was 'Excellent', and a further 20% of participants rated the training as 'Good'.





7.2.1.1 Clinical Supervision Training Evaluation – Nursing Discipline Only

Evaluation of the training by nurses is of particular interest as prior to the SPLice Project The Bouverie Centre had not engaged MH services in Clinical Supervision workforce development and it was unknown how relevant and suitable the training would be for this workforce.

Nurses who participated in the Clinical Supervision Training were drawn from a range of bed-based service settings including acute, community care, AOD withdrawal and residential units. Nurses from an acute setting represented 53% of all participating nurses.

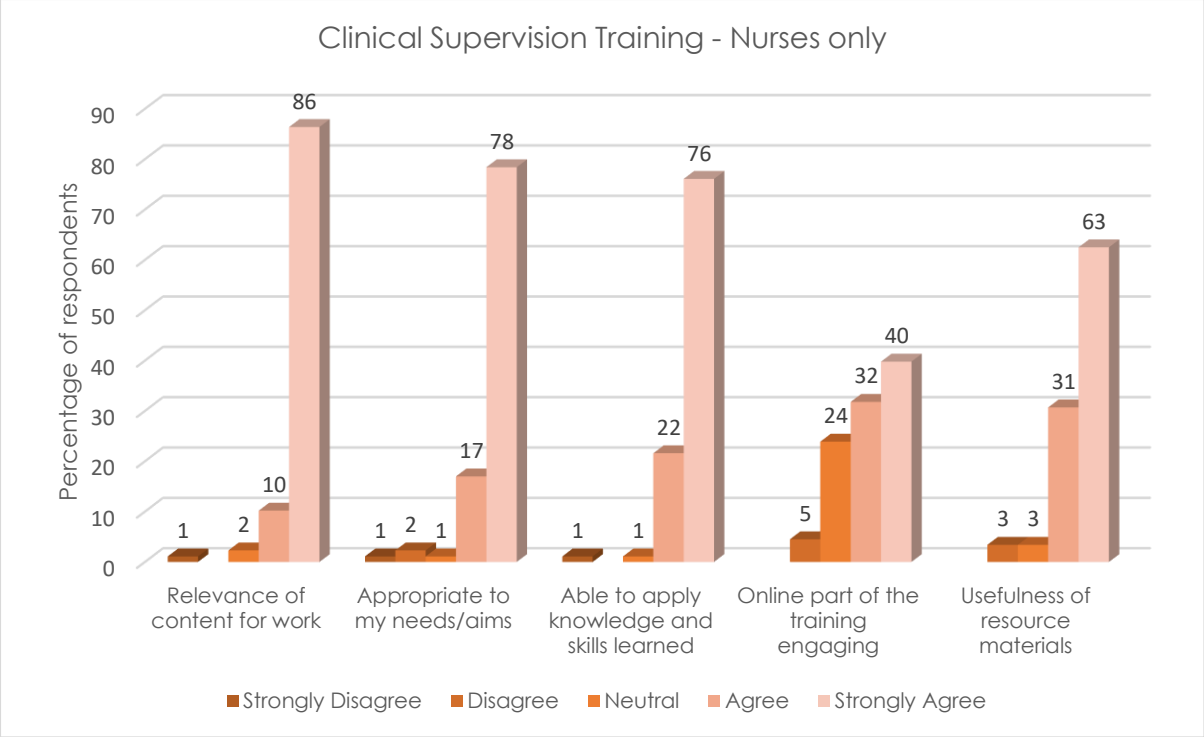
The evaluation shows that the training was both highly relevant to participants' work contexts (86% 'Strongly Agreed' and 10% 'Agreed') and was very appropriate to their needs (78% 'Strongly Agreed' and 17% 'Agreed').

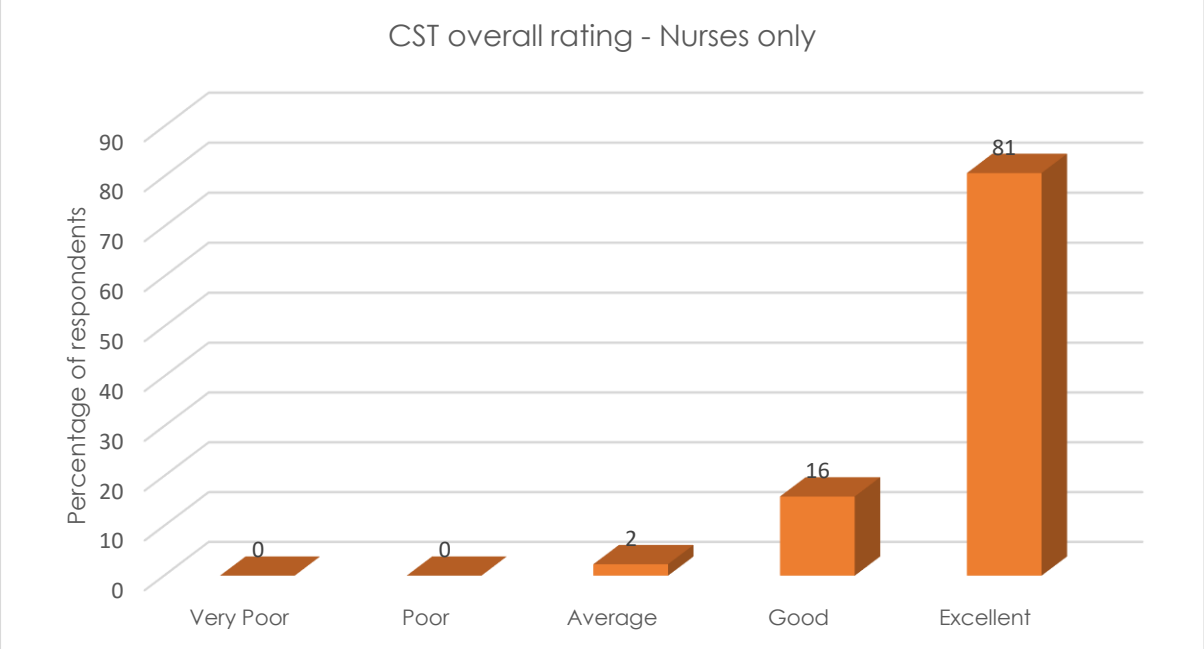
When asked if participants thought they would be able to apply the knowledge and skills learned, nearly all the nurse participants 'Agreed' or 'Strongly Agreed' (97% combined) that they would be able to apply the skills learned.

The Clinical Supervision Training was made up of both online and face-to-face modules. We were interested to know what the online experience was like for participants and asked them to respond, on a five-point scale, to the statement, *'I found the online training engaging'*. Approximately one-third of participants 'Strongly agreed' and one-third (36%) of 'Agreed' with the statement.

Over 90% of the participants 'Strongly Agreed' or 'Agreed' (93% combined) that the resource materials (including a USB with articles and tools) given to them during the training were useful.

As part of the evaluation, participants were asked to give the training an overall rating. Overall, the ratings were very strong. On a five-point scale, 80% reported that the training was 'Excellent' and a further 15% of participants rated the training as 'Good'.





7.2.1.2 Workplace Projects Submitted During the Clinical Supervision Training

It was hoped that implementation projects would be undertaken by services after the completion of the Clinical Supervision Training. During the test and pilot phase it was observed that attention quickly shifted post training. In order to harness the energy and attention garnered whilst the Clinical Supervision Training was in progress, a

Workplace Project was included in the online modules as a hurdle requirement in March 2017.

Several areas of interest emerged from the 190 Workplace Projects submitted: supervision documentation development including supervision policies, guidelines, contracts/working agreements and records (71%); conducting education sessions surrounding the aims and benefits of Clinical Supervision (34%); building networks across programs and organisations (24%); and the creation of accessible database of trained clinical supervisors (17%).

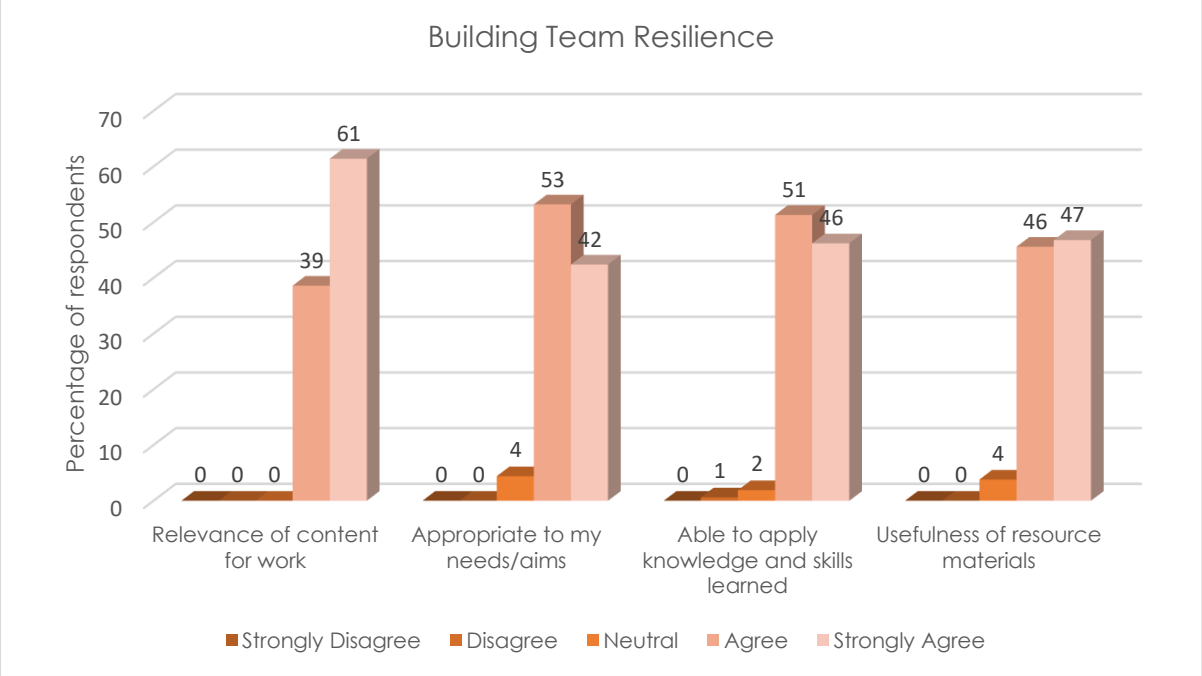
7.2.2 Building Team Resilience Training Evaluation

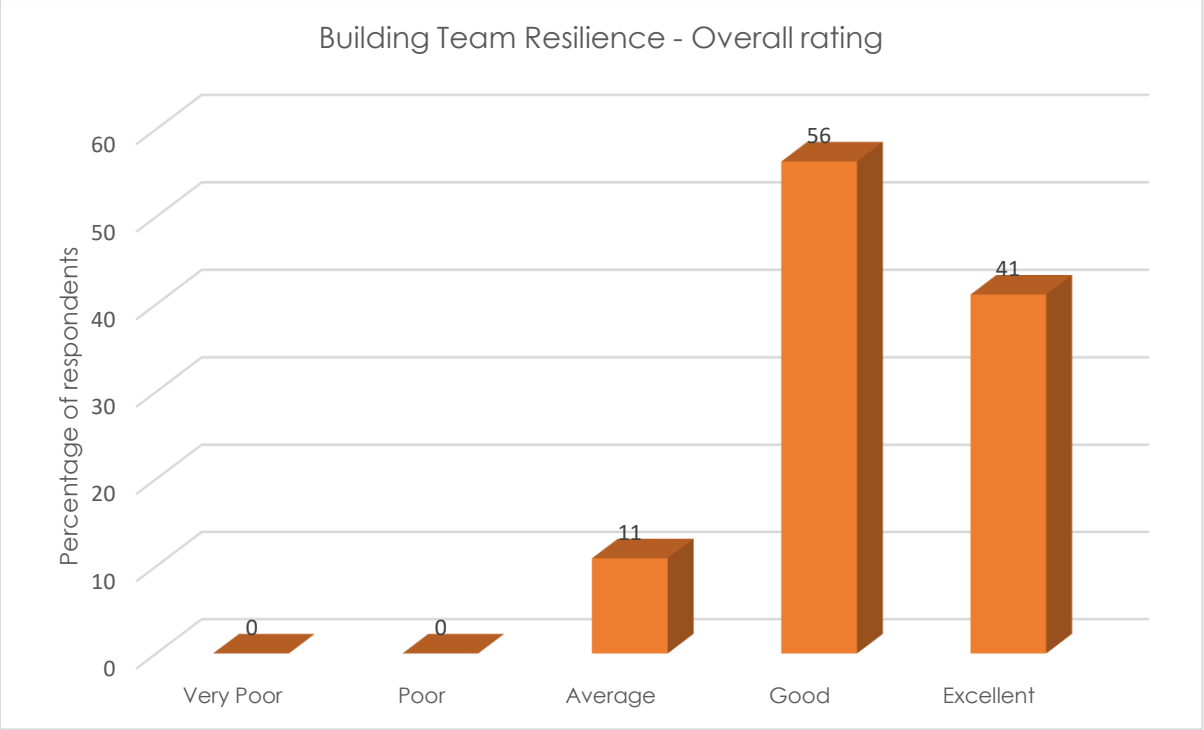
There were 158 out of 184 participants in the Building Team Resilience training who completed an evaluation. The evaluations show that the training was highly relevant to participants' work contexts and very appropriate to their needs.

When asked if participants thought they would be able to apply the knowledge and skills learned, nearly all the participants (97.5%) 'Agreed' or 'Strongly Agreed' that they would be able to apply the skills learned.

Over 90% of the participants 'Agreed' or 'Strongly Agreed' that the resource materials (including a USB with articles and tools) given to them during the training were useful.

As part of the evaluation, participants were asked to give the training an overall rating. On a five-point scale, 56% percent of participants rated the training 'Good' and a further 41% reported that overall, the training was 'Excellent'.





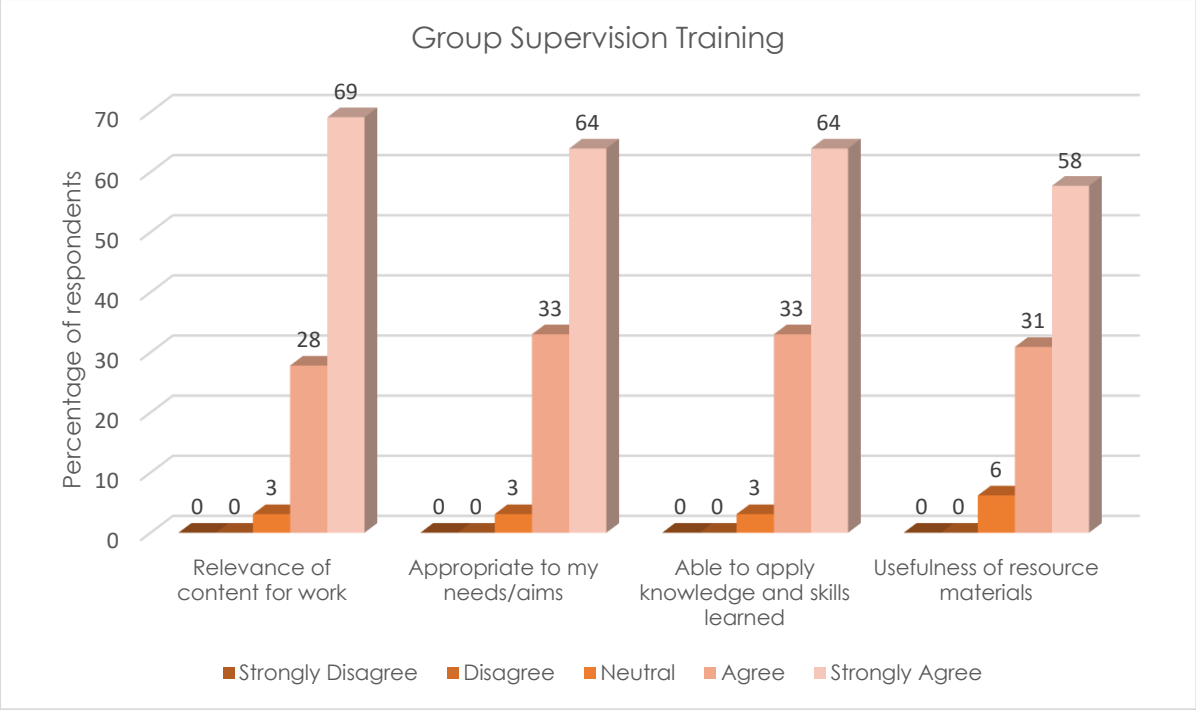
7.2.3 Group Supervision Training Evaluation

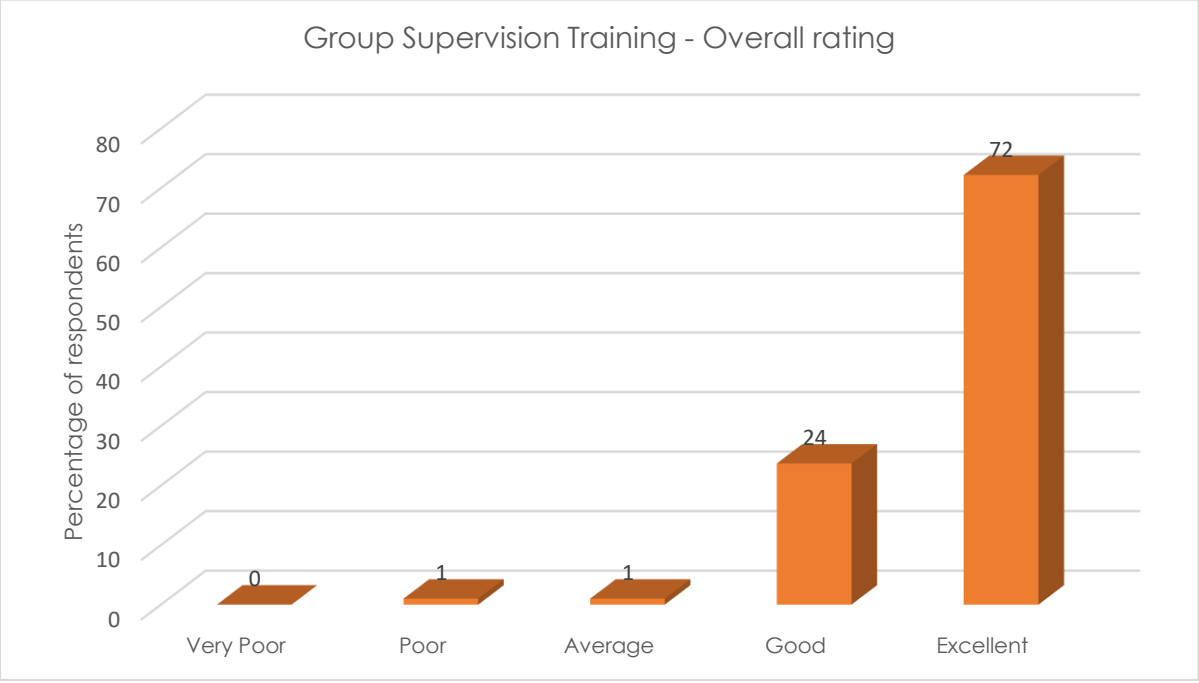
There were 97 out of 114 participants in the Group Supervision training who completed an evaluation. The evaluation shows that the training was both relevant to participants' work contexts (69% 'Strongly Agreed' and 27% 'Agreed') and was very appropriate to their needs (64% 'Strongly Agreed' 33% 'Agreed').

When asked if participants thought they would be able to apply the knowledge and skills learned, nearly all the participants (97%) 'Agreed' or 'Strongly Agreed' that they would be able to apply the skills learned.

Over 85% of the participants 'Agreed' or 'Strongly Agreed' that the resource materials(including a USB with articles and tools) given to them during the training were useful.

As part of the evaluation, participants were asked to give the training an overall rating. Overall, the training was rated very strongly. On a five-point scale, 72% reported that the training was 'Excellent' and 24% of participants rated the training 'Good'.





7.2.4 Practice Enquiry Groups (PEGs) and Booster Sessions

At each site of the Project, PEGs and Booster Sessions were offered. Preference for attendance at these sessions was firstly given to participants from the site where the session was held and then if places were available these were offered to others from previous cohorts.

Table 1: Practice Enquiry Groups

Date	Site	Venue	No. of groups
July – Sept 2016	Mid-West	Harvester Clinic, Sunshine	3
Nov 2016 – April 2017	Albury Wodonga	GK Hotel, Beechworth	3
Dec 2017 – April 2018	South East	Southern Dual Diagnosis Service, Dandenong	3
Dec 2017 – June 2018	Mildura	Mallee District Aboriginal Service & Mildura Base Hospital	3
Total	**4**		**12**

Table 2: Booster Session dates, venues and participant numbers

Date	Site	Venue	No. of attendees
August 2018	Ballarat	Ballarat Community Health Service, Lucas	12
Oct 2018	Albury Wodonga	Albury Wodonga Health, Wangaratta	12
Feb 2019	Mixed 2019	The Bouverie Centre	13
Total	**3**		**37**

Despite significant interest expressed in attending Booster sessions, there were several challenges in organising them, both in metropolitan and regional locations. Three Booster sessions were cancelled due to low participation rates (i.e. less than 10 acceptances) including: Gippsland – Oct 2018; Warrnambool – Oct 2018; Youth Melbourne – Nov 2018.

7.3 Phase Two – Online Follow-up Survey

Phase Two of the Project evaluation was an online survey implemented via Qualtrics, 6 to 12 months post training. The data collected from the quantitative surveys was analysed to identify descriptive statistics using SPSS software. Short answer qualitative responses were thematically grouped and analysed.

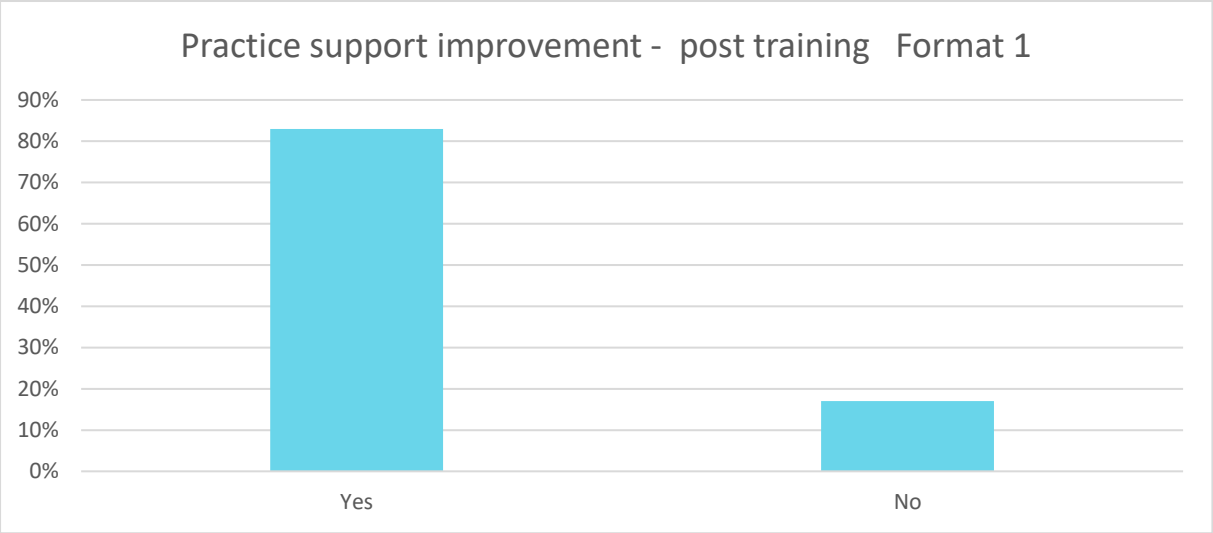
7.3.1 Online Survey Results

Eighty-six people who completed the clinical supervion training[7] participated in an online survey.

Initially, we asked people to respond to the question '*Has your capacity to deliver practice support in ice related cases improved post training?*' with a dichotomous Yes/No choice. Of over half the people who responded to this question (62%) did so in this format (Format 1). After some consideration and review, it was decided to ask the less CM specific question '*Has your capacity to support your staff in responding to complex and/or challenging presentations improved post training?*'. Rather than the dichotomous choice, we asked respondents to choose from a five-point Likert scale to better understand the extent to which participants felt improvement had occurred. Twenty-eight percent responded to the question in this format (Format 2). Ten percent of the people did not complete this question.

Format One

Has your capacity to deliver practice support in ice related cases improved post training?

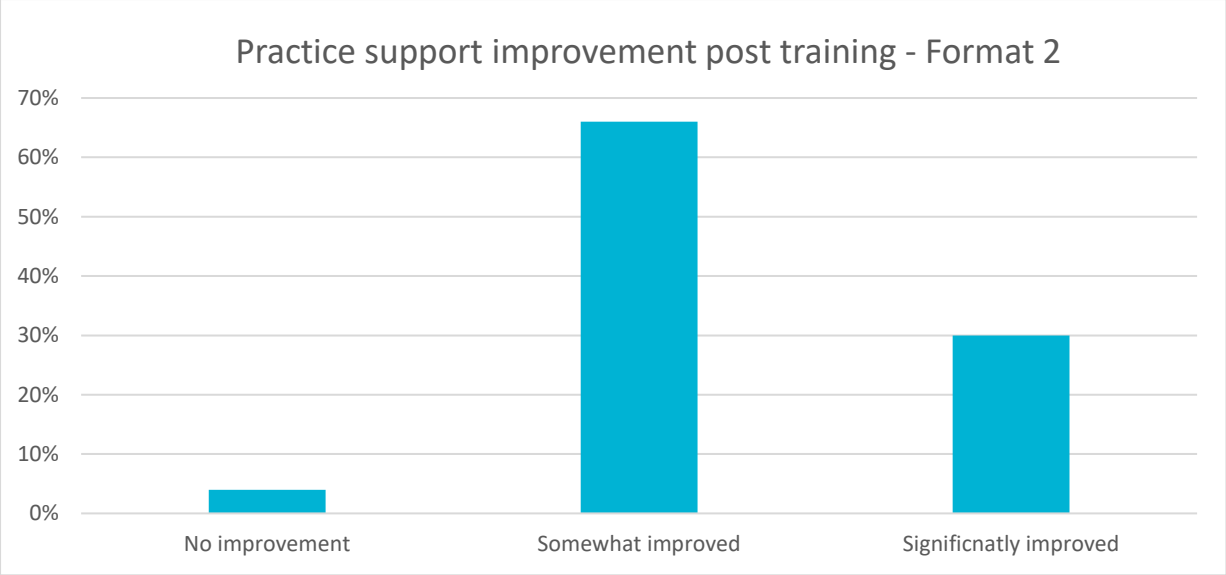


As can be seen from the graphs above, 84% of those who responded to format one said their capacity to deliver practice support in CM related cases had improved.

Format Two

Has your capacity to support your staff in responding to complex and/or challenging presentations improved post training?

[7] CST participants were chosen as the sample from which to draw as they had committed to a greater extent than those in the trainings of shorter duration. However, some had also participated in other SPLice practice support training.



Of those who responded to format two, 30% said that their capacity had 'Significantly Improved'; 66% said it had 'Somewhat Improved'; and 4% (n=1) said their capacity to support staff in responding to complex and/or challenging presentations had not improved post training.

When taken together then, we can see that 66 of the 72 (92%) people who responded to this question had experienced increased capacity in practice support relating to CM use because of the training.

Those who had not can perhaps be understood as responding to the focus of the trainings being on the impact of CM related presentations rather than specific CM education as contained within other Ice Strategy workforce development.

7.3.1.1 Qualitative Questions

Most of the survey consisted of short answer qualitative questions. We asked participants to tell us how they thought their practice had improved. Sixty-four people (80%) responded to this question. As can been seen from the top three responses reported below, the most reported way that practice had improved was the ability to be more reflective in their work. Responses under this theme included both the capacity to be more reflective about one's own style of doing supervision, and to be more reflective (and less reactive) about what supervisees brought to sessions. Increased reflective capacity correlated with an increased ability to be supervisee led rather than feeling they needed to find solutions for supervisees. Respondents talked about 'strengths-based practice' where it was recognised that supervisees often had many resources to draw on and the role of the supervisor was to help identify and build upon those resources. Participants also felt they had more skills to draw on. This included creative ways to do supervision and 11 people reported that there were more tools in their tool box.

How has your practice improved?
I'm more reflective and my confidence has increased to use my own style. I'm less reactive
Feeling less pressure to have an answer. More able to help supervisee arrive at their own solutions. Increased reflective practice
More strategies in my tool box, being more creative

We next asked people:

Which strategies for improving clinical supervision and practice support have you utilised, if any?
7-eyed model
Being more reflective (rather than goal setting)/active listening for individual and group supervision
Contracting

Throughout the online survey (and the following telephone interviews), respondents highlighted the usefulness of having models to refer to. Respondents talked often about doing supervision work informally but not having a framework to organise their supervision sessions. The 7-eyed model was a framework that training participants responded to well and, unsurprisingly, was the most utilised strategy post training.

Secondly, respondents utilised reflective skills and active listening, rather than being directive. This was understood to be one of the important differences between line-management and clinical supervision.

Utilising contracts or working agreements in supervision was an important strategy for improving quality and effectiveness.

We then asked respondents**:**

What difficulties have you experienced when trying to improve clinical supervision or practice support, if any?
None
Time and consistency of supervision
Lack of supervisee or staff buy in
Lack of supervision structure in workplace

The highest number of responses to this question was that there were no difficulties to improving supervision or support 6 to 12 months post the training. The second most frequent response was that it was difficult to preserve dedicated time for supervision which impacted the consistency of supervision in the organisation. This was reported particularly in the nursing sphere. Closely related to this was a lack of supervision structure in the workplace. People reported, '*supervision is supported in theory but not practice*', '*It is difficult for Managers with competing priorities*' and '(I) *didn't get a foot in the door with Child Protection (around implementing regular clinical*

supervision) and ended up withdrawing from the position as DHHS were not organisationally ready'.

As part of understanding implementation challenges related to clinical supervision, we asked participants**:**

What changes, if any, have you noticed in relation to clinical supervision and practice support in your organisation?
Review and development of supervision policy in the organisation - supervision becoming a priority
More staff engagement with supervision and increased supervision opportunities and projected, organised times
General increased awareness and knowledge about clinical supervision

Respondents reported positive improvements to the way organisations are responding to clinical supervision. People reported that they had noticed a review or development (or both) of supervision policy. Further to this, respondents had noticed supervision being given a greater priority that it had not had in the past. As a result, participants reported that there was more staff engagement with clinical supervision and scheduled sessions for clinical supervision increased.

The third most reported change people had noticed was an increase in awareness and knowledge of clinical supervision in their organisation.

Next, we asked respondents:

What else do you think needs to happen in your organisation to improve clinical supervision and practice support, if anything?
Organisations need to have policy and procedures that embed clinical supervision
More protected time and funding to sustain and make supervision a priority
More staff trained (which increases choice)

The most common response was that organisations need to develop or improve policy and procedures to embed clinical supervision as part of everyday practice. Training was included in this theme as it was frequently tied to, *`Creating a culture of learning across the service and develop mechanisms that support and nurture staff, with commitment from senior management and the executive'; 'it needs to be prioritised within the organisation and have more staff available to provide supervision'*; and '*we are working on implementing a new policy and model for supervision to ensure that clinical supervision is available to staff outside of line management.'*

Closely related to increased policy and procedures is the need to embed protected time for supervision to demonstrate that clinical supervision is a priority.

The third theme under this question was about the quality and choice of supervisor. Participants reported the need to have more available Clinical Supervision training opportunities so that there was a greater choice of supervisors available. Responses were: '*Freedom for staff to choose their own supervisor from across disciplines rather than a supervisor be allocated'; 'better matching and supervisor choice'*; and '*it*

needs to be prioritised within the organisation and have more staff available to provide supervision'.

The online survey was an opportunity for us to understand what those who completed the survey would like to know from the online evaluation process.

What findings from of the evaluation of the SPLice project would be of most interest to you? For example, difficulties other people or sectors experienced in improving clinical supervision.
How to implement what was learned in the training in the workplace
What other people have found most useful in clinical supervision - what models they are using
Common barriers and solutions when conducting clinical supervision sessions.

It was evident from the responses above that participants wanted to understand how others in similar situations had navigated the challenges of implementing learnings from the training in both organisational and one-on-one supervision settings. For example, participants were most keen to understand the barriers to clinical supervision others had faced, and the solutions they had deployed to overcome them. They said, '*Things tried in organisations, i.e. implementation of supervision successes or failures for other organisations to learn from*' and '*I would be interested in the difficulties and also examples of where people in other sectors have implemented positive changes*.'

7.4 Phase Three - Telephone Interviews

In Phase Three, 23 telephone interviews of up to 30 minutes were conducted utilising questions informed by the results from the online survey. Questions were designed to explore the usefulness of the Project's activities and what the implementation experiences of participants had been. The interview data was thematically analysed to explore emerging categories and themes.

The interviewees were drawn randomly from a range of project sites.

1. **Clarifying the difference between line management and clinical supervision**

   The difference between line management and clinical supervision was discussed frequently during interviews. For many participants most of their experience, both as a supervisor and a supervisee, had been with line management. For some participants, the distinction between and theories around the two different types of supervision was new. For others, the training supported practice change in their organisation, helping to articulate a clear distinction between clinical supervision and line management.

   "*Our organisation is now trying to deal with line management in the day-to-day time and use supervision time for a more clinical approach*"

   "*Clinical* (supervision) *is usually outsourced. I want to understand and implement more of a distinction between line management and clinical supervision.*"

"The idea of clinical supervision is a foreign concept to the general health setting. In the past, clinical supervision has just been going through case notes."

"A big investment is being made in our organisation so that every clinician has a supervisor who is not their line manager. The training has really supported this."

2. **Delaying the urge to problem solve**

When asked to consider how their supervision practice had changed as a result of the training, it was clear many participants had noticed a tendency for them to move quickly into problem solving with supervisees (often as a result of being more practiced in line-management). Building a reflective space and encouraging the supervisee to arrive at their own solutions was considered a key difference between line management and clinical supervision. Participants felt a sense of relief that they had been given permission through the Clinical Supervision training, to not have all the answers for supervisees.

"The training helped me to try and honour the space for them (supervisees) and make it more 'their' supervision."

"It's helped me not move directly into problem solving."

"Most helpful aspect is not giving answers and allowing the person to figure things out on their own, which is actually a relief for me, as a supervisor."

3. **The value of the models presented: The Single Session model and the 7-eyed model**

Participants valued the two key models that were presented: The Single Session and the 7-eyed model. For some, they had previously not had exposure to frameworks with which to organise and articulate clinical supervision sessions and as a result lacked confidence in their practice.

"Here we have been moving more towards a line management model than clinical supervision and I wanted to put the lens back on clinical supervision and client/self-care and the 7-eyed model does allow this scope."

"The two models were the most useful part, people want skills."

"I have felt like I've 'winged it' over the years. The two models and the theoretical information allowed focus."

"Oh look, it was brilliant. It put a framework around supervision that you don't get in your clinical training. I liked how it built up to a model that made sense."

4. **Appreciating practice and role plays**

Training participants can often feel ambivalent about participation in role plays. It was clear from participants in this training that opportunities to practice were highly valued as participants had the opportunity to bring real situations to the practice sessions. The demonstrations that were provided were useful, and it was particularly appreciated when there was commentary to help understand what was happening in demonstrations. It was also valued when

practice sessions were monitored so that unhelpful practice did not run unchecked.

"We had a couple of opportunities to actually practice supervision with each other and it wasn't staged, it was actually real and I was involved in both sides of receiving and giving, and that was quite valuable."

"A good mix of practical and theoretical and I enjoyed the practical elements and valued the triads highly."

"The most useful aspects were the practice where we got up and had a go. The combination of theory and practice was very helpful. Practice helps to cement it and build confidence. It puts it in the realm of something you can do. I did like the practice. It was practical and very good."

"Great facilitators, with many great skills but more unpacking of what went well – moved a bit quickly."

"Demonstrations with a running commentary were really useful. It's good to unpick what is happening in roleplays."

5. The value of transferability

As funding for this training was drawn from the Ice Strategy, there was discussion about whether the training should have aimed to include more information specific to problematic CM use or whether what constituted strong clinical supervision practice across client presentations, programs and sectors was considered of greater benefit. Overall, participants felt that the transferable approach to the training was preferable. Those from the AOD sector especially felt they already had sufficient knowledge about CM and what they needed was the content about supervision. This was echoed by other participants.

"I liked that it was about supervision, not about methamphetamine use. It didn't need ice content, ice is not the issue, the issue is about supervising staff. The transferability was the good thing about the content."

"The transferability of knowledge was great…"

6. How the training was useful

When we asked telephone interviewees to reflect on what was most useful about the training, there were many positive responses. For some the training provided new information that helped situate the supervision work they were already doing within recognised frameworks, and for others the information reinforced and validated what they were already doing well. Others appreciated the experience of facilitators in negotiating various practice issues. They gained great benefit from facilitator demonstrations and when they deconstructed and commented on practice sessions. Others, especially those in regional areas, valued the networking opportunities.

"Some training you walk away from and it changes your paradigm and you really take the training on. I had that experience, particularly with the group supervision training."

"Anything that has the stamp of Bouverie on it, you know you are going to get top notch stuff."

"Facilitator knowledge and experience, e.g. ethics and the law, was very useful."

"The training had great detail."

"For me, the training reinforced that I'm doing the right thing."

"Bringing the consumer back into the room in supervision. Putting the self in the consumer's shoes."

"A great networking opportunity."

7. Reflections on training methods

Participants reported a good balance between the online and the face-to-face part of the Clinical Supervision training. Overall, the adult learning model used by The Bouverie Centre trainers, which includes theory, then demonstration, practice and reflection was appreciated by interviewees. For some, the training moved a bit quickly and these participants would have appreciated greater consolidation time. Some found it hard to find time to complete the online modules, others felt frustrated when others had not completed them and trainers allocated time towards reviewing online content.

"Some of it moved too quickly and just brushed over stuff. Like the single session stuff…brilliant stuff. But I haven't retained it. It wasn't expanded on. For me coming from a background of very little knowledge, to recap and build on it a bit more would have helped. I found I was trying to process information and then we went on to another concept and none of it really embedded in."

"So the individual supervision was really good, but what's always unfortunate is the lack of time to reflect on the learning, if that makes sense."

"I found it annoying that readings were covered twice for those who did them."

"Overall the feedback was very good and we all got a lot out of it but I just would have probably allowed a bit more time for actual supervision(practice) to be occurring. That would have been my little tweak. But overall it was really good."

"The most useful and relevant to me was the combination of online and face-to-face, and the blend of the chance to reflect with peers while having the support of trainers."

8. Incidental supervision

A significant proportion of those interviewed were not currently in roles where they provided regular, scheduled clinical supervision but rather provided

frequent informal or incidental supervision. Validating and presenting a framework for incidental supervision was valued.

"What was also useful was having some kind of (framework) for incidental supervision, doing that more effectively because the bulk of my time goes towards that and yet often I walk away from a situation thinking I'm not sure I worked that through well enough…so being more thoughtful about how important and valuable incidental supervision is and then how to bring more to those short, brief, encounters."

"The one-off style is much better suited to my needs. I got a lot from that."

9. The value of Booster sessions

Participants who'd participated in a Booster session had found it useful, and those who had not, reported wanting to do so. Booster sessions and Practice Enquiry Groups were designed to support implementation of new skills and practices however many participants, though valuing post training support, found attendance difficult.

"I'm desperate for a Booster because since doing the training I've taken on a bit more supervision."

"The Booster has been incredibly useful."

"Booster sessions would have been useful. This would have supported implementation…"[8]

"Community of practice around supervision could be encouraged."

"The problem with training is, if you don't use it, you lose it and we really don't want to lose this valuable stuff."

10. Organisational impact of the Project

Interviewees were asked to reflect on any organisational impacts as a result of the Project. Many said that Project had enabled clinical supervision to be kept on the agenda and prioritised within services where there are many completing demands for time and resources. Others spoke of the usefulness of having several people from the same organisation attending training as this served to bolster the profile and practice of clinical supervision.

"It was useful in keeping clinical supervision on the organisational agenda."

"More skilled supervisors has had a positive organisational impact."

"It has been good to have a number of colleagues go through the training – we can now support each other."

[8] Practice Enquiry Groups were offered at the first 3 Project sites and 3 Communities of Practice were continued post Project. All subsequent sites were offered Booster sessions with 3 sessions being delivered with enough numbers.

"In this organisation, the clinical supervision space had been diluted down to try and capture other organisational requirements like PD. I'm putting a spotlight back on supervision."

"The training has encouraged and supported services to increase clinical supervision."

7.5 Facilitator Focus Group

At the close of the Project, the facilitators from the training participated in a focus group. The aim of the group was to identify learnings from the Project.

1. **Condensing the usual 6-day clinical supervision training to a 4-day blended format.**

Overall, the facilitators reported that the blended program, while newly developed, was successful. It was reported that:

- The standard of the training had been maintained in the blended format
- Participants got to know each other (and the facilitators) during the first online module which proceeded the first day of face-to-face training and facilitators appreciated the opportunity to understand some of the needs of participants before face-to-face training began
- Groups cohered well as in the 6-day format
- The additional short video demonstrations that were part of the online modules were effective

Less positive parts of this blended format were:

- Participants were often so time poor that many had not completed all the online components before the face-to-face parts of the training
- Nurses were often expected to complete the online components in their breaks, which was difficult
- Starting the face-to-face with uneven online participation was difficult. The online content was sometimes summarised for those who had not completed it and this was frustrating for those who had
- It took a lot of Project Team resources to moderate the online modules and to guide participants through
- Online modules can be challenging for people who are less confident with reading and writing

2. **Communication surrounding relationship of Project to CM information**

Facilitators of the training at the first test site found the lack of clarity, at that time surrounding the relationship between the training and CM related content difficult. After the test site, the Project Team were clear in communicating that it was not `ice supervision' or `ice practice support' that was being provided.

Focus group participants made the following observations:

- It was important for Bouverie Centre facilitators to train in their areas of expertise
- Facilitators value-added to the work of people working with problematic CM use by offering new information about supervision and trauma and not revision about ice content which they were already familiar with
- The rationale of the training is to prevent (and deal with) the impacts of vicarious trauma by using evidence-based approaches
- The use of ice related case examples was useful
- The training had high levels of transferability

3. Supporting implementation after training

Facilitators discussed the importance of implementation, though reported the structural and systemic issues made implementation difficult:

- There is not a lot in place to support clinical supervision and practice support. There needs to be policy and key performance indicators (KPIs) to support top down and bottom up implementation
- Supervision standards in MH are being developed and these could have a positive impact if they are well implemented
- Backfilling for nurses to attend clinical supervision and practice support activities needs to be addressed for effective implementation

4. Supporting diversity

Diversity in this context related most to creating a culturally safe environment for Aboriginal and Torres Strait Islander people to participate. This was important as some of our training locations were places with significant Aboriginal populations, e.g. Warrnambool. Facilitators reported that:

- It would have been more culturally safe if we had had larger numbers of Aboriginal people in each cohort, but this was not possible
- We made adaptations to training to further include a cultural lens
- It would be good to start with self-reflection, rather than have that towards the end of the training
- Experience and knowledge gained outside of formal education were important to acknowledge in order to provide an inclusive experience
- An example of working with people of different abilities in the Project was with a participant who was legally blind. Support strategies agreed on with the participant included an extension for online completion and alternate avenues for delivery of online content
- There were also 1- 2 people in consumer roles in each of the trainings. Efforts were made to consider how to keep client's central in Clinical Supervision practice and how to integrate Intentional Peer Support with Clinical Supervision

5. What we would do differently if the Project was extended

The Project Team reported:

- Ideally, the Project would be part of a much larger suite of workplace change initiatives where there was an endorsed implementation strategy that could scaffold and sustain training activity
- Where does lived experience/expertise fit and how could this be incorporated into the training more – perhaps co-trainers, one with lived experience/expertise?
- Clinical Supervision training could be incorporated with government KPIs around trauma and trauma-informed practice

6. Closing comments

Focus group participants were given the opportunity to make further remarks:

- Group rules and contracting are important. This was an issue in rural locations where sometimes people left early leaving which impacted the group
- When senior staff participated in the training there was better uptake and commitment from others in the organisation

8. Discussion

Having engaged the MH and AOD sectors over the past 3.5 years[9] The Bouverie Centre understands the diverse and complex environments in which clinical supervision and practice support takes place. For the MH And AOD workforce to be adequately supported around the impacts of the working with complex presentations associated with CM use, practice support strategies need to be embedded within services through a variety of methods.

The key themes arising from the Project are to follow. The themes relate to the stated aims of the Project:

1. Support clinical practice leaders to assist frontline workers deliver ice intervention strategies

2. Help clinical practice leaders gain training in a comprehensive and systemic model of clinical supervision

Following the key themes and limitations of the Project, recommendations will be presented for future directions in clinical supervision and practice support for the AOD and MH sectors.

[9] The Bouverie Centre has delivered workforce development in Clinical Supervision to the AOD sector since 2005.

8.1 Key Themes

8.1.1 Access to Training

All of the participating services in the Project reported a lack of trained and accessible clinical supervisors. Staff turnover, which was evident during the Project, threatens the extent to which services can establish the routine provision of clinical supervision to their staff. Services require easy access to supervision training for practitioners who move into supervisory roles.

8.1.2 Knowledge Transfer

Many stakeholders felt strongly that issues facing practitioners surrounding problematic methamphetamine use was not the result of a deficit in the workforce's skills but rather pertained to organisational structures and systems. These systems had the greatest impact on workforce occupational health and safety issues including, direct and indirect trauma, staff retention and staff wellbeing. The AOD workforce were clear that they didn't need support around interventions surrounding CM use as it was `their bread and butter'.

The role of knowledge transfer in the Project was through the provision of reflective and supportive strategies that made possible practitioner learning and the integration of new knowledge and skills. Improved role modelling and a focus on practitioner development were also emphasised to aid knowledge transfer.

8.1.3 Coordination of Ice Strategy Workforce Development

The release of some of the Ice Strategy activities were delayed and others became available in subsequent phases of the Strategy. The take-up of the online *Ice: Training for Frontline Workers* was also not as great as had been anticipated. This resulted in difficulties coordinating all trainings to the optimum effect.

Monash Centre for Scholarship in Health Education (MCSHE) supervision training had the potential to provide a useful introduction to supervision practice prior to SPLice activities. This could have improved the readiness of service and their workforces. Eighteen months into the SPLice Project, the Monash Project began and efforts were made to sequence the trainings in the aforementioned way, however this did not occur. It transpired that collaborative efforts with Monash resulted in the Project Team sharing key service contacts which helped improve the reach of the Monash Project. Later collaboration involved sharing of evaluation methods and findings which influenced Project direction.

8.1.4 Support for Practice Leaders

During the course of the Project many practitioners expressed the need for Communities of Practice and/or supervision of supervision groups. Management also recognised the increased support needs of new practice leaders in order to integrate new skills and build confidence. SPLice activities aimed to support the development of Communities of Practice and 3 such groups continued after the completion of the Project. However, opportunities to attend Booster sessions or Practice Enquiry Groups was frequently not taken up and for many services the support of new practice leaders was not sustained. This was a result of service delivery imperatives along with

Communities of Practice and like activities, not being part of Quality Assurance or KPIs.

8.1.5 Implementation

Throughout the Project many organisations showed considerable enthusiasm regarding the potential to enhance clinical supervision and practice support in their service however, they often lacked the necessary commitment of resources to realise these possibilities.

The Workplace Project Plans, that were developed by training participants indicated the areas in which leaders believed practice change could begin. Supervision documentation including supervision policies, guidelines, contracts/working agreements and records were the most common areas identified for improvement (71%) then; conducting education sessions surrounding the aims and benefits of Clinical Supervision (34%); building networks across programs and organisations (24%); and creation of an accessible database of trained clinical supervisors (17%).

Competing demands meant services tended to prioritise direct service delivery and areas with reporting requirements over the implementation of clinical supervision and practice support strategies.

8.1.6 Limitations

As well as the limitations already noted surrounding the implementation of clinical supervision and practice support strategies within services, there were also limitations associated with the evaluation. During site engagement it was difficult to establish the extent to which clinical supervision and practice support strategies were being provided, this meant a baseline could not be determined. Services often did not report on these activities so it was difficult for them to resource an audit process which would have helped to better gauge the Project's impact.

The Project evaluation also did not include a direct measure of frontline worker's experience of clinical supervision and practice support before and after Project completion. Nor did the Project scope cover evaluation of staff retention and wellbeing or measure changes in outcomes for client's with problematic CM use.

8.2 Recommendations

To ensure clinical supervision and practice support strategies are available to the MH and AOD workforce the following recommendations are indicated:

1. DHHS facilitate the development of a 'trans-discipline and trans-sector' high level definition of clinical supervision and practice support activities to enable more effective measurement of current levels of clinical supervision and practice support provided in services.

2. Services are supported to track and monitor the uptake of clinical supervision and practice support strategies through development of brief, easy-to-use monitoring tools. This will help determine current levels of clinical supervision and practice support to establish baselines and allow monitoring over time. For example, measurement

could cover domains such as; access to individual clinical supervision and group supervision; numbers and frequency of provision of clinical supervision sessions and practice support; listing of clinical supervisors; choice of clinical supervisor, clinical supervision documentation including working agreements and session record sheets.

3. The Centre for Mental Health Learning (CMHL) or other relevant group, coordinate workforce development activities to ensure optimal uptake and impact.

4. CMHL or other relevant group, work with mental health and AOD services to further promote the importance of services focussing on practice change as an alternative to viewing training as an end in its own right.

5. DHHS mandate reporting of clinical supervision and practice support activities as part of service reporting.

6. Education sessions, explaining and endorsing the role of clinical supervision and other practice support activities, provided to team leaders and program managers. These sessions could emphasise the importance of clinical supervision for both quality improvement and staff wellbeing purposes.

7. The provision of clinical supervision and practice support be a priority area for CMHL and for the mental health training clusters.

8. Services are required to provide clinical supervision and practice support activities for all direct service staff. In smaller services or services in rural and remote areas, organisations can consider cross-sector collaboration and reciprocal arrangements to ensure access to clinical supervision, including the use of accessible technologies.

9. Services establish group processes, such as communities of practice, to develop and support new supervisors in their role. This could be achieved either internally or in collaboration with sector partners.

10. Services are encouraged to provide practitioners with specialised supervision (group or individual) from experts when a new practice or intervention model is being implemented. This needs to be in addition to receiving ongoing clinical supervision.

11. DHHS funds research exploring the relationship between clinical supervision, practice support, client outcomes and staff wellbeing.

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Appendix A

DHHS Stakeholder Reference Group Members

Representatives	**Role/Service**
Paul Healy Bella Anderson Denise Guppy	Health and Community Services Union
Sam Biondo Molly O'Reilly	Victorian Alcohol and Drug Association
Jacqui Sundbery Brendan O'Hanlon Angie Nyland	The Bouverie Centre
Donna Hansen-Vella	Australian Nursing and Midwifery Federation
Glen Tobias	(ex) NEAMI
Greg Logan	Logan Consulting
Tanya Sewards* Angie Martin* Emma Cadogan	Department of Health and Human Services

Robyn Humphries Helen Kennedy Geraldine Loeliger Vanessa Simpson Trevor Hunt* Anna Love Kate Thwaites*	 Office of Chief MH Nurse, DHHS As above
Daryl Oehm*	Victorian Transcultural Mental Health
Craig Holloway	Victorian Aboriginal Community Controlled Health Organisation
John Egan* Erryn Nundle	Victorian Aboriginal Health Service
Rosemary Charleston*	Western MH Cluster (later) Centre for MH Learning
Stephen Elsom* Bridget Hamilton	Centre for Psychiatric Nursing

*Resigned or changed positions

Appendix B

SPLice Training Information

Clinical Supervision Training

Four-days of face-to face training. 1-day online training and preparatory reading. First online module (Module 1) to be completed prior to the first face to face module (Module 2) and another online module (Module 3) completed prior to the second block of face to face training (Module 4).

Workshop Details

Quality supervision is consistently identified as a practice that directly benefits workers, agencies and clients. Effective supervision increases job satisfaction and morale, ensures clients are receiving optimal treatment through better communication, provides transference of complex clinical skills to workers and builds a culture of best practice and innovation.

This 4-day training course focusses on how clinical supervision can support theory into practice especially around complex and challenging presentations including those associated with ice use. It comprises a mixture of theory and practice relating to supervision and covers a number of topics, including the history of supervision, supervision models, contracting, feedback, legal issues and ethics, diversity, and action methods.

In general, the first half of each day covers theory and research related to these topics, and the afternoon involves practice exercises in small groups. Homework tasks (reading and applied exercises) are built into the course.

Please note: This course is designed for clinicians already providing supervision, and who are able to apply theory to practice with their own supervisees. Assignments which include pre-reading as well as live supervision exercises are required to be carried out between each of the two face to face modules.

Learning Outcomes

On completion of this course, participants will be able to:

- Describe a range of supervision modes, methods, and models, and begin to identify their own supervision practice model
- Identify the roles and tasks within supervision, and factors which enhance the process, and ensure professionalism
- Apply a range of techniques for giving and eliciting feedback in supervision
- Identify and respond to issues such as culture, power, class, age and gender in supervision
- Consider the organisational context of supervision
- Understand how clinical supervision can support the uptake of skills by practitioners including those associated with dealing with complex and challenging presentations
- Apply a range of skills relating to 'use of self' within supervision
- Describe compassion satisfaction and fatigue, and develop a self-care plan

Who Should Attend

Practitioners from the Clinical Mental Health, Mental Health Community Support or Alcohol and Other Drug Services who are currently or soon to be providing clinical supervision to others, and who have the capacity to be practising supervision for the duration of the course.

Participants will also be offered a booster session to consider how clinical supervision can be enhanced within the service in which they work.

Reference is made to the difference between line-management and clinical supervision, but the emphasis is on clinical supervision.

Structured Group Reflective Practice - Action Learning Sets

1-day training

Workshop Details

This workshop provides an introduction to structured group reflective practice with a focus on Action Learning Sets – an approach to individual and organisational learning. Working in small groups known as "sets", participants approach important organisational or social challenges and learn from their attempts to improve things. Action Learning is a continuous process of learning and reflection supported by peers/colleagues.

Learning Outcomes

- To understand the Action Learning Set process
- To experience the Action Learning Set process for providing group reflective practice
- To consider the role and application of Action Learning Sets in and for various work roles and settings

Who Should Attend

Those who are currently or soon-to-be facilitating and participating in group support or supervision processes including interested staff, Team leaders, ANUMs, senior practitioners and supervisors working in Clinical Mental Health, Mental Health Community Support or Alcohol and Other Drug services.

Group Supervision

1-day training

Workshop Details

This workshop provides an introduction to group supervision, as well as the opportunity to practice skills and increase confidence in facilitating and managing supervision with groups.

Learning Outcomes

- To understand the different types of group supervision
- To learn how to establish, set agreements, and close a group supervision arrangement
- To experience a particular structure for providing group supervision `The Bells that Ring' process
- To consider group process and the stages of group development and adapt supervision accordingly
- To develop skills for providing both support and challenge to supervision groups

Who Should Attend

Those who have experience as supervisors and who are currently or soon-to-be facilitating group supervision including Team leaders, ANUMs, senior practitioners and supervisors working in Clinical Mental Health, Mental Health Community Support or Alcohol and Other Drug services.

Building Team Resilience – training for facilitators

Half-day workshop

Workshop Details

This workshop invites participants to consider the impact of work in the helping professions on health and well-being, and to review strategies for sustaining teams that include personal, professional and organisational responses. The workshop describes a range of approaches to assessing, preventing and managing the negative impacts of the work, and celebrating the positive impacts. Theory and research are interwoven with experiential exercises, aimed at resourcing participants with tools to identify, respond to, and prevent compassion fatigue and that can build team resilience.

Learning Outcomes

On completion of this workshop, participants will be able to:

- Recognise and respond to the signs of compassion fatigue and vicarious traumatisation within teams
- Identify a range of available options for management of compassion fatigue

- Implement a trauma-informed response to working with teams exposed to challenging and complex presentations
- Identify factors involved in sustaining teams over the longer term

Who Should Attend

Team leaders, ANUMs, program managers and supervisors working in Clinical Mental Health, Mental Health Community Support or Alcohol and Other Drug services.

Please note: while various tools for prevention and treatment of compassion fatigue are covered in this workshop, it is not in and of itself a therapeutic intervention for compassion fatigue.

Appendix C

Participating Services

A total of 46 services were involved in the Project

Site & Location of trainings	Services Involved
Mid-West: Sunshine	Mid-West Area MH Odyssey SUMMIT
Albury Wodonga: Beechworth, Wangaratta	Albury Wodonga Health Gateway Health
Barwon: Geelong	Barwon Community Youth & Family Barwon Health Direct Barwon Health Salvation Army Stepping Up
Youth 2017: The Bouverie Centre	Anglicare Homeless Youth Dual Diagnosis Initiative (HYDDI)/SUMMIT Orygen YSAS
Mildura	Mallee District Aboriginal Service

	Mallee Family Services Mildura Base Hospital: Ramsay Health Sunraysia Community Health
Goulburn Valley (GV): Tatura (near Shepparton)	Albury Wodonga Health GV Area MH GV AOD Services Nexus North East Border MH Victorian Aboriginal Health Service **Primary Care Connect: invited, did not participate beyond initial meeting*
South East: Dandenong	Monash Health Peninsula Health (MH) TaskForce
Ballarat	ACSO Ballarat Community Health Ballarat District Aboriginal Cooperative Ballarat Health Services Uniting Care
Warrnambool	ACSO Brophy Family Services Ballarat Health Services Barwon Health South West Healthcare Wellways Winda-Mara **Portland District Health: invited, did not participate beyond initial meeting*
Gippsland: Moe, Warragul	ACSO Bass Coast Health Latrobe Community Health Latrobe Regional Hospital Mind Monash Health Peninsula Health Wellways
Youth 2018: The Bouverie Centre	Alfred CYMHS headspace Monash Health Odyssey Peninsula Health YSAS
CST 2018: Footscray	Ballarat Health Service Forensicare headspace Monash Health Odyssey Self Help Addiction Resource Centre (SHARC) Uniting Regen Windana

Mixed 2019: The Bouverie Centre	Alfred CYMHS Ballarat Health Service (MH) Barwon Health Forensicare headspace Inner West Area MH Monash Health Odyssey SHARC St Vincent's Uniting Regen YSAS