Title: Peer-mentoring and clinical supervision as career development strategies for health professionals working with children

Abstract

Peer-mentoring and clinical supervision are two strategies that support health professionals' critical reflection and professional development towards defined career goals. This discussion paper presents our experiences of peer-mentoring and clinical supervision. We explore how these approaches can benefit professional and career development and summarise how to address potential key challenges. Two case studies are presented. Firstly, AUTHOR 1 and AUTHOR 2 reflect on their experience of a peer-mentoring partnership, noting the multidisciplinary nature of the partnership as a key strength of the experience. Secondly, AUTHOR 3 reflects on her near 20 years of experience with clinical supervision, highlighting the power of group supervision and development of solution-oriented communication that inform high quality practice. While our experiences have been positive, there are several considerations to mitigate challenges that can arise in peer-mentoring and clinical supervision, such as mentee or supervisor fit, differing expectations, and resource/logistical issues. Whether participating in peer-mentoring or clinical supervision, all health professionals can benefit from sharing insights and empathy with a trusted colleague.

Introduction

Career development and progression in nursing requires deliberate planning and strategic professional development to meet career goals. For Australian registered nurses, professional development is essential to ensure high-quality nursing care and maintain capability for practice (1). Nurses working in specialist settings, such as Children and Young People's Nurses (CYPNs), have additional standards (*Standards of Practice for Children and Young People's Nurses*), which require critical reflection on practice and a commitment to professional development (2). Although each health discipline has their own unique standards to guide practice, (for example, *National competency standards for dietitians in Australia* (3)) these generally also require professional development to promote optimal client outcomes. This paper outlines two strategies, peer-mentoring and clinical supervision, which support health professionals' critical reflection and professional development towards defined career goals.

Mentoring is a professional learning relationship that promotes shared learning and growth within an atmosphere of mutual respect (4). Mentoring is not the same as supervision or a mentor providing all the answers, instead it is an opportunity for guided self-reflection and action planning, where a mentor can be a sounding board, asking questions and in some instances offering advice (5). Mentoring can promote development of knowledge, skills and expertise, but mentoring also has psychosocial functions such as role modelling, acceptance, and counselling (5). The specific nature and goals of the mentoring relationship are defined by the mutual needs and expectations of the individuals involved.

A further strategy for personal and professional development is clinical supervision. Through clinical supervision health professionals are encouraged to reflect on experiences, knowledge, actions, feelings, and beliefs (6). The ability to think critically and analyse practice is important to maintain professional standards (1, 3). Clinical supervision carries a wide variety of understandings depending on context and professional background. For nurses working in child and youth mental health services there is sufficient guidance and a strong recommendation to engage in regular clinical supervision (7). Unlike allied health professions where clinical supervision is a professional requirement (3), nursing has no clear requirement for clinical supervision in practice. Professional organisations such as the Australian College of Mental Health (ACMH) Nurses, Australian College of Midwives (ACM) and Australian College of Nursing have joined to put forth a position statement that strongly supports clinical supervision for nurses and midwives (7). In areas where nurses and midwives are working in autonomous roles clinical supervision can be of great benefit. Supervision in these contexts allows professional development, professional accountability and facilitates collegial support particularly when working with challenging situations. An example is where protection of children is involved. A further example where clinical supervision would be beneficial is child and youth health where community nurses work in family homes, with non-government organisations, in education settings or when working and living in small communities.

In this discussion paper, we firstly draw upon the authors' experiences of peer-mentoring and clinical supervision case studies to explore how these approaches can benefit professional and career development for health professionals. Although the authors' experiences of peer-mentoring and clinical supervision have been predominantly positive,

we conclude this paper with a summary of important considerations and how to address the potential challenges linked with peer-mentoring and clinical supervision. In keeping with a case study approach, first person language is used throughout this paper.

Peer-mentoring

Most often, a mentoring relationship involves two individuals; a more experienced mentor and a comparatively less experienced mentee (4). Conversely, another model of mentoring is peer-mentoring, where both individuals are at similar career stages (8). Both traditional mentor-mentee relationships and peer-mentoring relationships have personal and professional benefits. In recent qualitative studies of mentoring, participants reported benefits that included increased confidence, a safe space to discuss failures and expansion of professional networks (9, 10). We believe that while mentors should have similar professional interests, we have found there is substantial benefit in working with a mentor from another health discipline to provide alternative insights and perspectives.

Clinical Supervision

In general, clinical supervision has three main functions—normative, formative and restorative (11). Normative functions include professional accountability, formative functions focus on knowledge development while restorative functions include peer support and to mediate stress (11). Health disciplines value life-long learning (1, 3) and herein lies the benefits of clinical supervision for both supervisors and supervisees. A fundamental component of effective supervision is that learning occurs within a supportive environment (12). Essentially supervision for health professionals is a process of reflective practice where there is an exchange between supervisee and a supervisor with the intention of enabling

professional development and support. Like peer-mentoring, participants should have some shared alignment of professional interests, but there is value in diversity whereby participants from different disciplines can offer fresh perspectives.

Peer-mentoring case study

What does peer-mentoring look like for you?

AUTHOR 1, a credentialled CYPN and lecturer, and AUTHOR 2, a research dietitian, working at the same university have been peer-mentors for over 12 months. Our peer-mentoring model is informal, and so we verbally discussed and agreed upon what we would like to achieve through peer-mentoring in our first meeting. This included deciding upon meeting frequency (every three months, revised to bimonthly), the type of support we were seeking and our respective capacity to provide support. This ensured that we had clear expectations on what we were hoping to achieve through peer-mentoring from the outset. For example, we were seeking support from a peer-mentor around career development, including accountability for meeting deadlines on self-identified goals. As such, we kept notes on each other's goals, gave feedback/support between meetings and discussed progress in meeting our goals. For example, when applying for career opportunities such as research grants or promotions, we have been able to provide constructive feedback from a different disciplinary perspective.

Tell us about your professional background in children and young people's health.

AUTHOR 1

I am a Credentialled CYPN, and my current role involves teaching and research at Flinders University. I contribute to curriculum development and teaching in both undergraduate

nursing and postgraduate nursing (child and family health). In my research, I aim to advance the health and wellbeing of children in Australia by exploring current and potential roles for nurses and midwives in preventing and responding to child abuse and neglect. My recent PhD (2020) explored nurses' experiences of keeping children safe from abuse, and found that nurses' address child abuse through a range of complex skills (13, 14). My ongoing work explores how we can build capacity of the nursing and midwifery workforce so they are equipped to respond to children experiencing adversity. I have been a registered nurse for more than ten years, and I am at the beginning of my research career. My career goals include expanding my expertise and networks so my research can ensure all children and young people live in safe and supportive communities.

AUTHOR 2

I am an Accredited Practising Dietitian, working in a research role at Flinders University. My PhD (2020) focussed on finding ways to support parents to reduce provision of nutrient-poor foods to their young children, by exploring parents' motivation (15) and decision-making when providing snacks to their children (16). While my discipline training and PhD were in dietetics, my current research extends to other areas such as early childhood obesity prevention, with my research having a common focus on health behaviour change for children and families. Much of my current research involves optimising early childhood obesity prevention interventions, firstly by understanding which components are most effective at changing behaviour, and for whom (17). My research vision is to make healthy behaviours the norm and to ensure supports are tailored and accessible to all families. Similar to AUTHOR 1, I had worked in practice for several years before beginning my research career.

Why did you decide to become involved in peer-mentoring?

AUTHOR 1

Completing a PhD took up most of my time and energy, and when I was done, I realised that I hadn't given enough 'big picture' thought to career development. I knew that I wanted to do research to improve the health and wellbeing of children and young people, but I did not have a clear plan to navigate the logistics. Developing a successful research program requires a strategic approach to seeking funding, building professional networks and navigating political barriers. As such I was looking to expand my networks and connect with other researchers to learn about the more intangible skills of research. A colleague suggested that I get in touch with AUTHOR 2, who had an interest in supporting other early career researchers. AUTHOR 2 and I found that we had many things in common, and importantly, were both experiencing uncertainty about the next stages of our careers and seeking to learn about how others were navigating this transition.

AUTHOR 2

Being in a research-only role, I spend my time planning, conducting and writing up studies, as well as supervising research assistants and students, building relationships with stakeholders, writing grant applications, and trying to keep on top of the latest research. I really enjoy the diversity in a research position; however, the downside is there are very few secure positions, with many roles being dependant on getting the next big grant. I am fortunate to be part of a thriving research team and have been given lots of opportunities to be involved in collaborative projects and grants. Yet, parts of my work are self-directed, such as developing a personal research program, building leadership skills and applying for

fellowships. This requires strategic planning, forecasting opportunities and self-imposed goals and deadlines. AUTHOR 1 approached me soon after I completed a research leadership course, where I first learnt about peer-mentoring. I like that AUTHOR 1 comes from a different discipline but similar career stage, as she brings an outside perspective with the understanding Of similar career challenges.

How has peer-mentoring helped you personally and professionally?

AUTHOR 1 Peer-mentoring has helped me identify realistic and relevant goals with someone at a similar career stage, but in a different discipline and slightly different role. One of the benefits of peer-mentoring is that we often consider similar career opportunities simultaneously. However, given our different roles, we rarely compete for the same opportunities. Sharing my perspectives about upcoming opportunities has provided a safe space to receive suggestions, encouragement and build confidence as an early career researcher. This has made me more proactive in seeking and responding to opportunities, which I might otherwise have been hesitant to put myself "out there". The other key benefit of peer-mentoring has been accountability to someone who is not a senior colleague or supervisor. Accountability in peer-mentoring means I can discuss my goals and reflect upon successes and failures without it becoming performance management.

AUTHOR 2

The greatest benefits I have found from our peer-mentoring is accountability for my career and personal research goals. It is easy to set yourself a goal or timeframe, but then it gets pushed back by other priorities with external accountability. Talking through my goals with AUTHOR 1 in our sessions provides an outside perspective to ensure they are not too

ambitious and will add extra stress. Then when we are reviewing goals, AUTHOR 1 helps to provide a perhaps more "friendly reflection", than we might do to ourselves, turning it into a more critical reflection and learning to take forward. Personally, I have found peer-mentoring a great experience to debrief honestly on how things are going and provide encouragement and support to pursue various opportunities.

What characteristics are important in a mentoring relationship?

AUTHOR 1

I think the most important characteristic of a mentor is the ability to listen and empathise with the mentee's perspectives. Peer-mentoring is not performance management which means we can have open conversations when one of has not achieved our goals. I find having conversations about what I *wasn't* able to achieve helps me to normalise and put the inevitable road bumps into perspective. This means instead of feeling guilty, it can be a positive space to openly discuss future plans, including alternative trajectories. Similarly, when I experience success, I know that AUTHOR 2 will provide congratulations and encouragement which promotes confidence and motivation for the future.

AUTHOR 2

For me the most important aspect in any mentoring relationship is that both people feel comfortable speaking openly, as a mentee in terms of raising ambitions or concerns and as a mentor sharing personal experiences and suggestions. As AUTHOR 1 has mentioned the fact that mentoring is not part of performance management does help with this, but perhaps it is also enhanced in peer-mentoring when coming from similar career stages and experience. I find it easier to relate and empathise with peer-mentors/mentees.

What advice would you give to health professionals who are considering working with a peer-mentor?

AUTHOR 1

I would suggest seeking someone at a similar career stage, but in a different role or discipline. For me, this has meant AUTHOR 2 can empathise due to our similar experiences, but AUTHOR 2 can also offer new insights from a different perspective. Our shared experiences as early career researchers and research in children's health from different disciplines provides common ground for mutual understanding. For other CYPNs seeking peer-mentoring, you could consider a peer-mentor who cares for children in a different context of practice. Alternatively, you could connect with a non-nursing professional working with children or young people – such as a midwife, early childhood educator or social worker. This could help you develop a 'big picture' viewpoint of your career and inform future development and career objectives.

I also recommend seeking a person with whom you are not already friends. It can be difficult to give constructive suggestions to someone you have close existing emotional ties with as you don't want to risk harming the friendship. Having said this, I believe a peer-mentor must be someone you can trust. It is important to feel comfortable talking openly when sharing successes and inevitable failures. Trust is crucial to supporting you to explore potential pathways for professional development and career progression.

AUTHOR 2

Informal peer-mentoring provides a lot of great opportunities that I would encourage any CYPNs thinking about peer-mentoring to explore it further. As it is informal there is no fixed amount of time or rules, which means you can't get stuck in a mentoring relationship that is not working for you. I would suggest meeting with potential peer-mentors to see if you have some common interests/career stage and if they are someone you feel comfortable talking with, before launching into an informal agreement. Be open to opportunities if peers approach you to be a peer-mentor. Although generally informal in nature, it is still important to discuss the purpose, scope and logistics of your peer-mentoring relationship so that everyone is on the same page and mutually get the most out of the experience.

Clinical supervision case study

What does clinical supervision look like for you?

AUTHOR 3 is a credentialled CYPN and midwife and has been involved in clinical supervision for nearly 20 years. For the most part I have been involved in group clinical supervision but have also facilitated individual supervision. I was introduced to group clinical supervision based on an action learning set model (18). The "set" is a small group of nurses and the learning occurs through reflection on real issues encountered in practice. I personally engage in two group sessions per month of one hour each. One group I am the supervisor, and in the other I am a "supervisee". In the group supervision model the supervisor is often referred to as a facilitator.

In our group clinical supervision model a nurse will identify an issue that has occurred in practice and the facilitator supports group discussion that assists the nurse to explore the issue in a way that often challenges thinking and supports a variety of viewpoints. It may

assist them to think differently about a situation, to gain new insights and build strengths. Through exploration of the issue the group supports the nurse to “locate” the key issue for *them*. The facilitator guides members to use enabling, facilitating, exploring and clarifying questions to do this. Combining this process with reflective listening allows the group to gently challenge assumptions. I found it can be challenging to find the right questions, but this develops with time. The emphasis is always on a solution oriented approach; advice giving is not the aim.

In our model, line managers do not lead clinical supervision for their own staff. We also do not record what is discussed, although this is often the case in mental health services. A vital part of any clinical supervision is that discussions remain confidential within the group which fosters trust. Another success factor is for participants to decide on shared values for the group sessions and how these values will be operationalised during clinical supervision. We revisit these at least once a year or when a new member joins. The agreed values provide a solid base to return to regularly, to ensure everyone is deriving value from participating and there is a shared understanding as to the purpose and conduct of the clinical supervision.

A further success factor for clinical supervision is to be solution oriented rather than a means to provide advice to colleagues. The group supports the nurse presenting the issue with sensitive inquiry that is aimed to facilitate reflection and learning for them, but often the other nurses also gain benefits and new insights. One common misconception is that clinical supervision involves debriefing but this is not the case. It is also not for personal or operational issues. Supervision is suitable via videoconference, which makes it ideal for

those who work in remote areas where there are few colleagues with whom to reflect on practice. We currently are engaging in our clinical supervision via Microsoft TEAMS due to the COVID-19 social distancing requirements and it works very well for the most part. Over the years, clinical supervision has changed but it remains grounded in the same principles.

Tell us about your professional background in children and young people's health.

Similar to AUTHOR 1, I (Author 3) am a credentialled CYPN and a midwife. I work in a community setting in a large metropolitan area as a clinical nurse consultant in child and family health. Child and family health nurses need support because we often work intensively with families including those with complex needs in the community. We are often required to support families to ensure they have the skills and knowledge to protect their children. This work is demanding and we can work with individual families for many years.

Why did you decide to become involved in clinical supervision?

I became involved in clinical supervision when it was introduced within our service as a mandatory requirement for all nurses. Our service director was visionary, recognising the need to support staff and maintain professional practice. Our staff work in isolated practice even though this is a large metropolitan area. Community practice is very independent and clinical supervision was one way we could build personal skills, develop reflective practice, support peers, enhance peer review and develop accountability for practice. Some years later I helped to set up a model of clinical supervision for nurses working in remote and rural areas. I knew the value of this as I had previously worked as a sole practitioner in the bush. I

did not even have a mobile phone to contact peers on my travels years ago. Having supportive peers is invaluable and videoconferencing now makes this so much easier.

How has clinical supervision helped you personally and professionally?

Clinical supervision has helped me develop personally as a reflective practitioner through solution-oriented communication. Learning the right questions to ask at the right time and carefully listening for meaning builds empathy and understanding and is an important component of clinical leadership. I have learnt to identify when others are doing well, and it can be rewarding to point out when colleagues are being too hard on themselves. It supports an awareness of your own strengths and needs and helps you to "tune in" on what is occurring around you. It is valuable just having that hour each month to stop the "busyness" and reflect on issues that we have encountered. Professionally, I believe clinical supervision has the potential to keep standards of practice high, foster accountability and build a more resilient, engaged and caring workforce. It allows us to see the challenges faced by others and provides an opportunity to reflect on our own practice.

What characteristics are important in a clinical supervisory relationship?

It is important that the supervisors receive adequate training and can role model the support process. In the group supervision model this includes the ability to listen well and encourage all supervisees to actively engage. The facilitator must encourage a balance of formal structural processes (rules, attendance) with informal and supportive personal interactions. Encouraging those who may be less vocal in the clinical supervision group supports collegiality and recognises that we all have different knowledge and skills to bring.

It is also important to maintain a sense of purpose within clinical supervision to derive the most from the time spent together.

What advice would you give to CYPNs who are considering clinical supervision?

I would encourage all nurses and midwives to consider clinical supervision and, if it is not in the current workplace, to approach service managers to give it a try. Understanding how moral stress for example can be mediated in clinical supervision is especially important in times of uncertainty such as we have encountered with the COVID-19 pandemic. For nurses and midwives working in remote areas, I would reach out to colleagues throughout the state to find a supervisor or a group they can join. I would encourage those considering becoming leaders of supervision to gain training and develop personal skills needed to guide the action learning process where it is used and understand how to apply solution-oriented concepts in clinical supervision.

Considerations for peer-mentoring and clinical supervision

Although the authors found peer-mentoring and clinical supervision to be positive experiences, there are potential limitations to both approaches. Some of the challenges include lack of mentor-mentee fit (e.g. personality clashes, lack of trust), differing expectations and resource requirements (e.g. time, coordination) (4, 5). Clinical supervision has additional challenges because there may be multiple group members which add further logistical (e.g. scheduling times) and interpersonal considerations (6). Some of the downsides such as mentor-mentee fit, differing expectations and interpersonal challenges can be mitigated through formalised agreements to set clear expectations and boundaries (4). These formalised agreements can include strategies to hospitably end the formal

mentoring/clinical supervision relationship if the relationship is no longer beneficial, or for when there is a natural end. In having formalised agreements, those participating in mentoring or clinical supervision can ensure effective use of their limited time and resources. In some mentoring/clinical supervision relationships, there may be a natural end point such as conclusion of the program or change of employment. However, outside of designated mentoring/clinical supervision programs, participants must navigate how and when the formal relationship should conclude or when the time may be right to seek a new mentor or supervisor as needs change.

Furthermore, being a mentor or supervisor requires specific knowledge, skills and expertise to underpin effective relationships (8). Individuals considering becoming a mentor or supervisor must seek out professional development opportunities to develop the necessary expertise. In general, mentors/supervisors refrain from simply offering advice but instead encourage colleagues to identify and develop their own solutions (7, 19). In doing so, mentors and supervisors facilitate colleagues' personal and professional growth rather than simply building reliance upon the mentor/supervisor (7, 19).

Within group-based relationships, such as the action learning set model, frequent changes to membership can affect group cohesion. Each time a group gains a new member ground rules are re-visited and this can affect the flow of the sessions. It requires great skill as a supervisor to keep groups energised and to draw together nurse colleagues from diverse practice backgrounds and experience. Raising individual issues to a professional level can assist with linkages to ensure all can gain.

A further important consideration is building trust in the mentoring relationship or clinical supervision groups. An important part of this is maintaining confidentiality of what is discussed. This includes when using videoconferencing for clinical supervision, to keep "on screen" in discussions and ensure conversations occur in a private space.

To help mitigate the aforementioned considerations, we have summarised our recommendations for successful peer-mentoring and clinical supervision (**Figure 1**).

Tips for successful peer-mentoring or clinical supervision relationships

- Spend time to find the right fit before entering a relationship
- Set a clear purpose, expectations and boundaries for the relationship
- Develop formal or informal agreements for the relationship, as appropriate
- Reflect on your own knowledge and skills in mentoring/clinical supervision and seek out training and professional development opportunities
- Give the energy and time to the relationship that you would like to receive
- Always maintain confidentiality to develop trust
- Be flexible and revise the relationship agreement as needed
- End the relationship when it is no longer working or comes to a natural end

Figure 1: Summary of key recommendations for peer-mentoring and clinical supervision in practice

Conclusion

Peer-mentoring and clinical supervision are two strategies widely used by health professionals to enhance professional skills and career development. Both peer-mentoring and clinical supervision can enhance professional growth and critical reflection on practice to identify goals for ongoing development. Goals may relate to specific and immediate learning needs to promote self-improvement and quality of service provision. However, goals can also inform broader career journeys by guiding participants towards new or different roles, or facilitating progression into more advanced positions. An understanding of key relational and behavioural influences on the relationship is core to promoting an atmosphere of trust and facilitating positive experiences. Whether participating in peer-mentoring or clinical supervision, all health professionals can benefit from sharing insights and empathy with a trusted colleague.

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